

Cartographic notes on the work in the Family Health Strategy: relationships between workers and the population

NOTAS CARTOGRÁFICAS DO TRABALHO NA ESTRATÉGIA SAÚDE DA FAMÍLIA: RELAÇÕES ENTRE TRABALHADORES E POPULAÇÃO

NOTAS CARTOGRÁFICAS DEL TRABAJO EN LA ESTRATEGIA SALUD DE LA FAMILIA: RELACIONES ENTRE TRABAJADORES Y POBLACIÓN

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ABSTRACT

The objective of this intervention study was to map instituted and instituting movements present in the work of the Family Health Strategy in the development of their care practices. The theoretical framework is based on institutional analysis, using the schizoanalytic approach. Group meetings were carried out with the staff to discuss how they provided collective care in continuing health education. The study subjects were professionals from the team and students who were engaged in academic activity in the service. The average attendance was twelve people per meeting, and there were a total of eight meetings from March to July 2010. Data were grouped into two immanent strata: the relationships of the team and the relationship with clients. The strata point to the intersection of education and legal institutions and the social and technical division of labor. Collective thinking in groups appeared to be effective in denaturalizing established processes and interrogating places, knowledge and practices.

DESCRIPTORS

Family health
Group processes
Primary Health Care
Health education
Patient care team

RESUMO

Essa pesquisa-intervenção teve como objetivo cartografar os movimentos instituídos e instituintes presentes no trabalho da Estratégia Saúde da Família, no que tange a composição de suas práticas cuidativas. O referencial teórico metodológico fundamentou-se na análise institucional, linha esquizoanalítica. Foram realizados encontros grupais com uma equipe para discutir o modo como realizavam os cuidados coletivos em ação de educação permanente em saúde. Os sujeitos da pesquisa foram trabalhadores da equipe e estudantes em atividade acadêmica no serviço. A média de participação foi de doze pessoas por encontro, sendo que se desenvolveram oito encontros no período de março a julho de 2010. Os dados foram agrupados em dois estratos imanentes: as relações da equipe e a relação com os usuários. Os estratos apontaram para o atravessamento das instituições de educação, justiça e da divisão técnica e social do trabalho. A reflexão coletiva em grupo mostrou-se potente, para desnaturalizar processos instituídos e interrogar lugares, saberes e práticas.

DESCRITORES

Saúde da família
Processos grupais
Atenção Primária à Saúde
Educação em saúde
Equipe de assistência ao paciente

RESUMEN

Investigación-intervención que objetivó cartografiar los movimientos presentes en el trabajo en la Estrategia Salud de la Familia sobre la composición de sus prácticas de atención. Referencial teórico-metodológico fundamentado en análisis institucional, línea esquizoanalítica. Fueron realizados encuentros grupales con un equipo para discutir cómo se realizaban los cuidados colectivos en acción de educación continua en salud. Los sujetos de investigación fueron trabajadores del equipo y estudiantes en actividad académica en el servicio. El promedio de participación fue de doce personas por encuentro, sobre ocho encuentros entre marzo y julio de 2010. Se agruparon los datos en dos estratos immanentes: las relaciones del equipo y la relación con los pacientes. Los estratos indicaron la obstaculización de las instituciones de educación, de la justicia y de la división técnica y social del trabajo. La reflexión colectiva en grupo se mostró potente para desnaturalizar procesos instituidos y plantear interrogantes sobre lugares, saberes y prácticas.

DESCRIPTORES

Salud de la familia
Procesos de grupo
Atención Primaria de Salud
Educación en salud
Grupo de atención al paciente

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INTRODUCTION

In the primary care context, family health teams represent a bet to redirect health practices and confirm the defense of the principles and guidelines of the Unified Health System (SUS), as the full right to high-quality health, comprehensive care, equity, among others⁽¹⁾.

Studies⁽²⁻⁴⁾ have been demonstrating that, in the Family Health Strategy (FHS), the reproduction of the hegemonic care model, centered on prescriptive and curative actions, embeds both a risk and an imminent possibility. The reproduction of this model, which privileges biomedical knowledge, often as the only possible one, maintains the traditional relation of knowledge-power over the monitoring of the attended families.

On the other hand, the family health teams display potential to develop care practices⁽⁵⁾ that articulate hard, light-hard and light⁽⁶⁾ technologies, commanded by the light type (relations, such as welcoming and bonding).

This potential to generate a new, singular way of care can be enounced through devices, which are practices, phenomena, discourses and other elements that incarnate, personify, concretely and at the same time dynamically represent the logics that rule in a given reality, taking the peculiar form of permitting the explanation and analysis of these logics⁽⁷⁻¹⁰⁾. In this paper, as an example, the group format served as a device to analyze the care practices of an FHS team.

A team's practices can be mapped, platted, through the movement of its lines⁽⁷⁾, which are forces that constitute the reality and the institutions, and their disclosure permits capturing modes and movements produced in a given practice.

This is not about naming the lines that constitute reality to predict destinies or obtain immobile findings, but about capturing the lines' forms of passage, no matter which: hard, linear, binary or circular, as well as the forms of escape, to intensify and vitalize creativity, desire and singularity⁽¹⁰⁾.

Groups, health, professions, the technical and social division of work, family, education, language are institutions, standards, rules and bylaws, whether spoken or not, written or not, whose entanglement grants body and life to society^(9,11).

Institutions constitute what is given, permitted and accepted. They are marked by incessant movements of change (instituting) and reproduction (instituted). It is in this interplay that its updates, continuity and changes are processed⁽⁹⁾.

For didactical purposes, it is interesting to use the metaphor of institutions as sand statutes⁽¹²⁾, with a fixed

appearance but, at its heart, intense movements of sand grains (instituting) that can go with the wind, form dunes, cover landscapes, undo the static form to compose other expressions, again with a fixed appearance.

This study fits in at the intersection between Permanent Health Education^(6,13-14) and Institutional Analysis⁽⁷⁾, especially the schizoanalytic current⁽¹²⁾ and the micro-policy of health work⁽⁶⁾.

The most explicit intersection of these fields is the group as a learning instance, which can be a space for self-analysis and self-management, evidencing the micro-policy of health work with its cross-sectional movements, as well as the incessant co-production of subjectivities, workers, knowledge, services and users.

In this research, group is understood as a structure that is permanently being eliminated⁽¹⁴⁾, focusing on an institution whose strength lines to reproduce and maintain society are manifested (what is given), as well as the production lines of what is new and different, in a dialectical process. It is a device in action⁽⁸⁾, which carries the trend to change and to meet with other things and people.

As devices, groups make their participants see and talk⁽⁸⁾, thus, the intent is to capture and express some compositions of the micro-political of health work, manifested during group meetings of a family health strategy team. These compositions involve an infinite range of movements. When questioned and problematized, reproductive movements have the strength to be a new care mode.

Little has been published so far on the theoretical-methodological framework of institutional analysis in collective health, despite its coherence with the perspectives of the Brazilian sanitary movement to make workers and users into protagonists through democratic processes⁽¹⁵⁾. In that sense, this study offers contributions.

It is the task of institutional analysis and Permanent Health Education to examine the subjects involved, movements and compositions. For schizoanalysis, the guideline is the radical defense of difference, estrangement from the established and apparently finished, believing in the potential of possible series of transformations to renew practices.

This research will focus on the encounters and mismatches, similarities and differences between the health practices revealed and discussed during group meetings.

The question that guided this production was: What instituted and instituting movements can be revealed and discussed during Permanent Health Education (PHE) groups with the family health team, with care practices as the central axis?

A team's practices can be mapped, platted, through the movement of its lines, which are forces that constitute the reality and the institutions, and their disclosure permits capturing modes and movements produced in a given practice.

OBJECTIVE

To map instituted and instituting movements in the composition of a family health strategy team's care practices.

METHOD

Research can be considered an institution⁽¹⁶⁾ and, as such, has established itself as the search for generalizable truths that can explain causes and effects of problems identified in a given reality.

Binary logic is hegemonically present in the scientific universe, in the distinction between subject and object, subjectivity and objectivity, reality and subject, samples and populations, quality and quantity, knowledge and transformation, among other aspects.

As an institution, the study comprises instituting processes that provoke and intend to break with the dominant logic, whose usual expression is scientific positivism. The present study is not affiliated with this form of research as, for institutional analysis, research is a process that is not separated from the intervention: any research is at the same time a process of knowing and transforming⁽⁷⁾.

Instead of a predetermined route called method, with premises, intervention research follows a *hodos metá*⁽⁷⁾ course, which involves a reversion of the methodological trajectory in comparison with traditional research strategies. In this process, the targets and phases are outlined along its execution, (...) *clues that guide the research trajectory, always considering the effects of the research process on the research object, the researchers and his results*⁽⁷⁾.

Thus, intervention research does not presuppose a researcher that goes to a field or a reality in search of the data that are there. In schizoanalytic research, the researcher is a cartographer that intends to map lines and territories, knowing that they are temporary and mutually inherent.

This means that data are admittedly produced instead of collected. They are produced during meetings between the cartographer and the forces of change and reproduction as: inherent plans and instituting and instituted strength lines. Institutions cross the researcher-cartographer and, therefore, analysis of his/her involvement is due with a view to announcing him/herself as a product and producer of one of the multiple possible written expressions about the reality that is studied/produced^(7,11).

The intervention research proposal was presented to five health teams affiliated with the University of São Paulo at Ribeirão Preto (SP), three of which were available, among which one was drafted.

This team comprised 14 people: one community health agent, one dentist, one nursing auxiliary, one nursing technician, one maintenance aid, one nurse, one phy-

sician, one nurse taking a master's program, one fourth-year nursing undergraduate, two resident physicians in family health, a graduate student in psychology and two undergraduate dentistry students.

The group of researchers included three members: one coordinator, one silent observer (both trained in group coordination according to Pichon-Rivière⁽¹⁴⁾ and taking a specialization course in institutional analysis and schizoanalysis at the Felix Guattari foundation); and an undergraduate nursing student, a research project grantee, who participated as a silent observer.

In this study, data were produced together with the selected family health team, and collected in the Western Health District of Ribeirão Preto, interior of São Paulo State, during eight permanent health education group meetings, when the team intended to analyze the collective care delivered to the population covered. These meetings took place between March and July 2010. On the average, 12 persons were present, who provided the analysis material produced in two phases.

In the first, after each group meeting, the researchers met with the team to identify the group's movements, institution present, crossings, what the team had left unsaid, and the elements that would structure the preparation of the following meeting and the elaboration of a report. These reports were presented and discussed with the health team during subsequent meetings.

The researchers tape-recorded each of the eight meetings. In the second phase, these recordings were transcribed and ordered.

Both the material produced after these two phases and the researchers' experience in this process (impressions, anguish, joy, doubts) were analyzed and will be presented further ahead in the results section, including the analysis of implication, the institutional analysis concept in which the interests, feelings and reactions towards the organization studied are expressed^(9,16).

The research project received approval from the Institutional Review Board under protocol No. 251/2007. All members of the selected team signed the informed consent term, in compliance with National Health Council Resolution.

The research received funding from the São Paulo State Research Foundation – FAPESP (process number 2008/00921-0).

RESULTS

In the intervention research and the institutional analysis framework, the implication analysis is considered the result (and resulting). It indicates the analyst and researcher's level of involvement with the establishment under analysis and his/her multiple institutions⁽¹⁶⁾.

Therefore, the presentation of the results starts with the implication analysis, followed by two excerpts or dimensions of the teamwork micro-policy: the relations among the workers and the relations with the population.

Implication analysis

One difficulty that emerges in this study is the analysis of different authors' implication in a collective production. Thus, those aspects of the implication all authors who assumed authorship held in common were chosen. In a way, the authors are affiliated with the university and, hence, the educational institution is present in each of them. The team chosen to accomplish the study is administratively linked with the same college where the researchers work or graduated. The extent to which the research could represent *more work* for the family health team under analysis was questioned, and this modulated the demand: *take care of use, we're already overloaded*.

It also modulated the supply: the collective analysis in which the research institution is also present. Let us explain: the scientific institution that *goes to the field*, that *analyzes*, that *explains* also crosses the authors. How can this be done by questioning these instituted elements in each, permitting the *place of not knowing*? This was the most precious challenge. An intervention research was offered to the workers, together with the service's task of receiving and supporting the academy in its research and teaching mission. During the first meeting, when the team had already agreed to participate in the intervention research, the number of meetings was agreed upon, the form of participation, the subjects, tasks and activities.

The team's demand took the form of a demand for a *relaxation space*:

Participant 1 – I think I didn't express myself very clearly. I meant, like, there's gonna be work, like I launch a ball here and then give an answer? Or is there going to be something different, another type of relaxation? (Meeting 1)

The team had announced a work overload, and also some discomfort, as analyzing the care the team produces could disclose difficulties, and this caused fear:

Participant 1 – Is there a way of working, (...), so as not to get stressed further ahead? It's to relax the team. It's very overloaded, it's a lot coming onto us. A lot of charges, a lot of things to do. You see? We, the team, who's delivering care? (...) Coordinator – And this issue of fear for what can happen, let's talk some more about that?

Participant 3 – I'm not very experienced, but I've participated in group (...) I think there's always some expectation as anything you'll do may entail some difficulties, some problems. But fear of something bad, fear, the feeling that something may happen.

(Meeting 1)

This care demand the workers presented also aroused fear in the researchers, including the fear of producing further suffering, inability to deal with the expressed problems and fear of *fleeing* from the analysis proposal of teamwork. This fear manifests the research institution in the researchers, as the instituted under analysis refers to the illusion that researchers control research processes, know what they do and are the main responsible for the research results.

The challenge of developing an intervention research clearly appears here when evidencing the group demand for a group contract that would welcome and guarantee a distinguished space from traditional stressing spaces. Being an implied researcher demands a position distant from a researcher's traditional neutrality and calls for involvement in the here and now and in the group construction process as, in this case, the workers' welcoming was present, who were also welcoming the researchers.

Next, the elements of the team relation are presented.

Team relations

The organization and division of work were expressed when the performed group work was discussed:

Participant 1 – And the nursing agenda, how is that made up?

Participant 4 – The nursing agenda?

Participant 1 – I and she (name), for example, we cannot participate in groups because reception takes 100% of our time and, when this is not the case, it's a home visit and then neither I nor she ever participate in a group, except when the unit is closed.

Coordinator – Would you like to participate?

Participant 1 – Everybody wants to participate.

(Meeting 2)

It was expressed that the difficulties processed among the workers made the team lose the focus on user care. During the sixth meeting, three collective histories were produced. At first, the three different participants received a sheet of paper with a trigger phrase that mentioned the theme of users' (non-) adherence to the activities the team proposed. After a while, they were asked to stop writing and pass on the sheet for another participant to add on to the phrase. The following histories were constructed:

Participant 5 (starts reading) – I'd love to say that I like this Unit and the people who live here a lot. Despite being far from my family and friends, I've learned to find new relatives and friends for my life. (...) this place is marvelous. Everyone claps hands.

Participant 6 - (reads the second story) And the user does not adhere to the group as work times do not permit its priority; fear of being absent from work and being fired; obesity does not bother that much as for other people; (s) he is unable to tell her problems to the professional (...)

Why are we unable to make things happen? (...).

Participant 3 (reads story 3) – Yesterday something happened, the tap burst in the kitchen. When I arrived at the unit, I heard some noise, I opened the door and the unit was flooded. There were desperate employees, looking for empty buckets stored in the back (...). Concerned that we wouldn't even have drinking water then, I had a brilliant idea. I put on the air-conditioning at the maximum, almost North Pole temperature and it turned into an icemaker. And there was a lot of ice, several icebergs (...) We had no bread and coffee. So, I lost weight (...). Laughs...

Participant 3 – They forgot the user...

Participant 5 – It's a fact that happened...

Participant 3- But you were supposed to talk about the user's non adherence.

(Meeting 6)

Through the development of this group discussion, the team members could also mention a fact that had happened that week and referred to the workers' access or not to the health unit's telephone password:

(...) Coordinator – Is there something you would like to talk about how the team is doing which may be necessary to discuss? (...)

Participant 3 – Isn't anyone gonna talk about password?

Participant 7 - Password?

Participant 3 - Ah, it will be later at the administrative meeting.

Coordinator – What's this password thing?

Participant 5 – It's that you need a password for the phone to call mobile phones.

Coordinator – And some people have the password but others don't. Is that it?

Participant 5 - Yes.(...)

Participant 8 - She (name) said that we cast the bomb, she had answered and nobody wanted to keep the password. I'm not gonna keep the password. I don't want to because they played like: If something happens it's your fault and you'll have to assume the responsibility...

Coordinator – Who said that, guys?

Participant 8 – The heads.

Coordinator – Who are the heads?

Participant 8 - He (name of the physician) and she (name of the nurse).

(Meeting 6)

Relations with the population

One of the instituted ways in which the health worker relates with the users is the prescription of healthy measures or conducts and medication. When the user does

not *adhere* to what was oriented, difficulties arise that are treated in different ways:

Participant 1 – There are really a lot of tigers^(a) around.

Participant 4 – We give information, but if she wants to follow her own way...

Participant 1 – We cannot oblige her to take care of herself (...)

Participant 9 – I think it's a matter of priorities. The person understood the information, but did she get the priority of the information? If she sets that as a priority, perhaps she'll leave some of the other things she has to do behind.

(Meeting 4)

The contextualization of the ways of living and giving meaning can raise questions on this instituted form of the health worker-user relation. In one of the meetings, as a trigger technique, one activity was requested in which one participant gave directions to make a drawing while the other, blindfolded, made the drawing. The final format of the drawing could not be said, but only the description of the lines that should be drawn.

Participant 9 – We see the problem one way and the patient in another way. What is our priority sometimes isn't the person's priority. And that hampers adherence. I think it's easy for us to do something we are seeing, but we know how complicated it is for the patient who does not have this view we've got.

(Meeting 7)

Another way of dealing with the *user who does not adhere* is discharge:

Participant 9 – I think there's another perspective too, that we're seeing the patient as the victim, of being unable to understand or having difficulties. But I also think there's another side. To give an example, I saw in speech, language and hearing therapy, my girlfriend is a therapist, and there, if the patient does not attend for that many times, he's disconnected from the service. But there are also situations in which the patient ends up not adhering because of a certain lack of care, lack of priority. And then the situation moves on and the patient gets accommodated. So, I think you have to talk about limits. To give an example, three opportunities... at the moment two or three opportunities are agreed upon and, if you continue missing appointments, you'll be disconnected (...)

Coordinator – What do you think, guys?

Participant 3 – I just think, like, this patient's problem is very different. When he needs forwarding again, he'll come here and not there. You see? Here it's more difficult for you... (...) In fact, it's like, it's the concept of primary health care as the entry door. So...

(Meeting 6)

(a) The term *tiger* is a popular denomination common at health services and is commonly given to users whom the health team has difficulties to deal with, as they consider these users "relaxed" towards orientations, prescriptions, etc.

When the users do not follow the nursing team's orientations, their disconnection, discharge from the service occurs according to the same rules as the medical team:

(...)Participant 1- What was the case of the dressing, (name), which you commented on? I'm going to do the dressing with that ointment, I want it like that.

Participant 3 – To do dressings, nurses and physicians are the same.

Participant 1 – Then, if the patient decides by himself to use other material, she (nurse) says that I'm not gonna do it with that product. More or less like that?

Coordinator – What do you mean?

Participant 4- We follow a protocol here and...

Participant 3 –That's why it's like the physician, because a protocol is followed.

Participant 4 – And we have autonomy to prescribe some products. So, there are some patients who say: No, I'm using barbatimao extract because my uncle brought it. Ah, you should use this (...).

Coordinator – Why did you think it was the same, what did you think it was similar to?

Participant 1 – Similar to discharging the patient. So, either you follow the standards that have to be according to the protocol or... Once this happened to a patient, or you follow protocol, or you do it yourself at your home and, when you think it didn't work, you come and ask and follow it the way it has to be followed.

(Meeting 6)

Another aspect of the relations between the workers and the population is the difficulty to include the relationship forms the team identifies as problematic into the therapeutic care project:

Coordinator – What's that, guys?

Participant 10 – She's active.

Participant 1 – That's it, she's active. But, sometimes, she wants to take control of the situation (...)

Participant 4 – She creates enemies.

Participant 1 – Yeah, you have to know how to treat her.

Participant 4 – In fact, she wants to solve everything and is unable to share decisions with the group and, then, she ends up creating enmity with other users (...)

Participant 1 – There needs to be control of the situation, if not, she thinks she can take charge. So, she thinks it's only her way. She doesn't respect whether others want it that way or not.

Coordinator – So, (...) she seems very active.

Participant 1 – She is.

Coordinator – So, we needed to talk... Our task, in collective care spaces, is exactly to develop this active attitude (...).

Participant 2 – But, with her... To give an example, when I was part of the walking group and was going to do something and we saw she was going much further, the walking group, I, she (name) and she (name) in that case, came and say: We coordinate this group and we have to decide. So, we kind of left her... put her in her place. (...) you participate, but who coordinates the group am I and she (name). Now she already knows her place, which is that of a user. Do you understand?

Coordinator – Wait a bit, what's the user's place like here?

Participant 1 – Yes. Participating, but not wanting to invade and take control of the situation, and thinking you can lead. I don't know.

Coordinator – But is there a problem if the user takes the lead?

Participant 3 – It's not a leadership problem. Perhaps the way the person deals with the group is not good.

(Meeting 7)

DISCUSSION

The discussion about the implication analysis is pertinent because it refers to the researcher's insertion in the research and intervention, in the production and dissemination of results. According to the theoretical perspective of institutional analysis and schizoanalysis, in which research is considered as a process and articulated with the intervention, the researcher plays an active role and is implied in and crossed by instituted and instituting aspects. The expression of these crossing represents the approach's methodological rigor. Hence, the implication analysis is considered a fundamental part here, providing rigor and validity to the research.

The position of the studied team at the moment of the *contract* reveals its exhaustion in health work, which also derives from the production process of contemporary subjectivities in capitalist society, of production, competition, consumerism. In this context, workers ask for *relaxation*, which had to be problematized and agreed upon in view of the production of research data and the team's equipment for collective group work. While their work with groups was discussed during team meetings, the contract demanded a careful position from the coordinators-researchers, so as to welcome the team's needs at that moment, which permitted the unveiling of the strength and visibility lines present in the composition of the group-device.

Also, an ambiguous movement was observed in the team, showing the desire to participate but also to flee, as group work could mean difficulties and more work.

The relations among team workers and with the population concretize and update the crossing among institu-

tions, the technical and social division of work, the education institution and justice in the practices of the health institution.

The crossing refers to a conservative intertwining or interpenetration⁽⁹⁾, a network of instituted movements for reproductive purposes.

As a standard, law of conduct, the institution, the technical and social division of work, hierarchizes the workers and actions that any team member can or should accomplish. The nursing team is divided between the functions of nursing auxiliaries and technicians, under the coordination of nurses. This is not just about a technical task division, but also a social division, as it updates the division of social classes at the heart of work⁽¹⁷⁾.

Nursing first receives users at the reception desk, deals with unscheduled cases, accepting or denying the population's access to the medical consultation.

The difficulty to define and agree on what cases should be *fit into* medical care remains untouched. It seems that a natural analyzer⁽⁹⁾ of the way primary care teams function is the way of dealing with spontaneous demand, the health unit's black box⁽⁶⁾.

In the family health strategy, as nursing auxiliaries and technicians perform more technical actions, they can hardly participate in other activities like group meetings. The expressed desire to participate in other forms of care arouses questions about the team's functioning and dislocation, so as to make other workers consider the possibility of participating in reception. An escape line the instituted soon captures.

Another expression of the technical and social institution of work is the way nurses get into user care. Their consultations involve protocols and nursing care systemization. This entry can follow the same established work logic as the physicians', which will reproduce an asymmetric power relation, with the consequent *disconnection* of users who do not follow indicated conducts. This aspect cooperates for nurses' work in the family health strategy to help and maintain ways of working in health⁽⁴⁾.

The education institution⁽¹⁸⁾ hierarchizes those who know and those who do not. In this case, the population is considered as dispossessed of scientific knowledge about health. Only this know-how is capable of re-establishing the normal position, of ideal weight, glucose levels, blood pressure levels, the body mass index, cholesterol levels etc. Therefore, users need to adhere to what they are taught and prescribed. Thus, when they exert their autonomy or when the workers are confronted with difficulties to maintain monitoring and discover the true living and work conditions, in which the measures do not fit, a crack appears in the instituted. This crack permits a connection in this relation, even if guided by a hierarchy of knowledge, like in the team under analysis as, despite empathy with the condition of non-adherent users, the possibility of considering a different choice did not exist.

This escape line, which verifies the adequacy and feasibility of orientations and leads the team to an opening, to the possibility of problematizing what is being offered, is characterized as a first route towards future negotiations with users and their care. An escape line captured by the normative nature of discharge and refusing care when users are rebellious, *tigers*.

The justice institution establishes those who judge as competent and those considered as breaking the rules. Those who judge establish a penalty. In health practices, the punishment is disconnection, non-care. The workers' justification is to educate the population. One difference appears: how can a user living in the territory the family health team is responsible for be discharged?

The team proposes *time* for users to think about their health condition and the treatment proposal offered. Expressing these processes that occur naturally in the team can also make members rethink their care proposals.

The inclusion of relationship difficulties as a part of care project appointed difficulties to deal with some users, arousing questions on their place: subordinate or active? Patient? A place that withdraws the team from the coordination of walks and groups and which it tries to recover by silencing and standardizing. This creates a gap to question places, activities and knowledge: how can one coordinate without being bossy, hearing and considering opinions?

The three histories the team elaborated are linked, explain the ties and bonds among the workers. Perhaps the start showed a reparation of misunderstandings, user adherence difficulties and the *leaks* that happened in the relations that involved hierarchy and confidence among the workers. This made the user disappear from the scene and story. As a result of these aspects of the relations present in the micro-policy of health work, the caregiving dimension is lost⁽⁷⁾ and, thus, the care practices demand inquiries on the ways of knowing/doing, with a view to their feasibility in the teams' daily work.

CONCLUSION

This study platted some strength lines that reveal the presence of instituted and instituting work forms in a family health team's performance of its care task. The workers' mutual relations and with the population follow the traditional health care models, which reveal the crossing of institutions, the technical and social division of work, justice and education. Other institutions definitely cross the team's daily reality and functioning modes.

The experience, followed by reflections on how the workers' relations approximate or distance us from the care task, as well as the expression of difficulties to invent new forms of relating, tension the team.

This tension and the collective reflection that is possible in work analysis groups are able to denaturalize what

is instituted, what appears as “normal”, to make room for the invention of other forms of practicing health.

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