

# Work process and psychological suffering of primary care physicians during the COVID-19 pandemic

Processo de trabalho e sofrimento psíquico de médicos da atenção primária na pandemia do covid-19

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## Abstract

Work organization and process are privileged spaces to recognize the forces that lead to psychological suffering. This study aims to analyze the perceptions of physicians of primary health care, who work in the More Doctors Program, on the relation between psychological suffering and work process during the COVID-19 pandemic. This research was conducted with a case study using qualitative data collection, description, and analysis. An intentional sample was selected in accordance with the theoretical saturation technique. Information was collected by semi-structured interviews, following a script built to meet the objectives of this research. The analysis of interviewees' discourse articulated categories of analysis drawn from five thematic axes with points of articulation between them, consensuses and contradictions that give meaning to the visions and positions of the actors in health. Results evinced the pandemic as a health and traumatic catastrophe, resizing the work process and contributing to overload, conflicts, fear, feelings of helplessness, and psychological suffering. Numerous shortcomings, infrastructure problems, bureaucracy, political interference, mismatch between training and practice also contributed to this suffering.

**Keywords:** Work; Mental Suffering; Pandemic; Primary Health Care; Physicians.

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## Resumo

A organização e o processo de trabalho são espaços privilegiados para reconhecer as forças que levam ao sofrimento psíquico. Este artigo pretende analisar as percepções de médicos(as) da atenção primária à saúde, que atuam no Programa Mais Médicos, sobre as relações entre sofrimento psíquico e processo de trabalho, no contexto da pandemia do coronavírus. Esta pesquisa foi realizada por meio de um estudo de caso, utilizando métodos e técnicas qualitativas para a coleta, descrição e análise dos dados. Foi selecionada uma amostra intencional em conformidade com a técnica de saturação teórica. A coleta de informações foi realizada com ajuda de entrevistas semiestruturadas, seguindo um roteiro construído para atender aos objetivos desta pesquisa. A análise do discurso dos entrevistados articulou categorias de análise extraídas de cinco eixos temáticos que têm pontos de articulação entre si, com consensos e contradições que dão sentido às visões e posições dos atores no campo da saúde. Os resultados evidenciaram a pandemia como catástrofe sanitária e traumática, redimensionando o processo de trabalho e contribuindo para a sobrecarga, conflitos, medo, sentimento de desamparo e sofrimento psíquico. Inúmeras carências, problemas de infraestrutura, burocracia, interferências políticas, descompasso entre a formação e a prática também contribuíram para esse sofrimento.

**Palavras-chave:** Trabalho; Sofrimento Psíquico; Pandemia; Atenção Primária à Saúde; Médicos.

## Introduction

Contemporary fluidity, instability, and uncertainty experiences led Bauman (2001) to situate them in a context he called liquid modernity. Thus, substantive economic, political, and cultural changes have reconstituted social relations, symbolic reference values, and modes of subjectivation (Birman, 2022). Technological advances, changes in labor relations, and disenchantment with collective projects have contributed to the emergence of a technicism centered on individuality, meritocracy, ephemeral social bonds, and consumerism, emptying human lives of meaning and the relationships between people and their jobs.

The oil crisis in the 1970s hit welfare states and demanded from capitalism a productive restructuring, a process of radical changes within the neoliberal framework. Thus, new technologies to manage work have been developed together with its flexibilization, intensification, and precariousness (Antunes, 2009; Antunes; Praun, 2015; Martin; Ferraz; Areosa, 2018). However, neoliberalism has established itself as a socioeconomic model and a disciplinary mechanism to manage psychological suffering (PS), using moral and psychological categories that induce maximum productivity as implicit foundations of economic action. Notably, in this model, a notion of “freedom as self-ownership” reinforces the fragmentation and alienation of activities and the precariousness of labor relations, producing individuals with the horizon of becoming their own entrepreneurs. Thus, neoliberalism also constitutes a political-social operator and a producer of workers’ subjectivity and PS (Antunes; Praun, 2015; Safatle; Silva; Dunker, 2021).

The work of healthcare providers is permeated by tensions, conflicts, uncertainties, and difficulties making clinical and ethical decisions in the face of the suffering of others and includes a growing trend of precarious working conditions affecting the health sector. Life, suffering, and death are omnipresent in these professionals’ daily lives, belonging to the object of their work and conditioning the emergence of the PS immanent of their otherness, especially due to their empathy with health service users.

The following stand out as potential determinants of this suffering: number of users aided daily; communication difficulties; communicating deaths; ethical dilemmas; fear of error; overwork due to pressure; and precarious employment relationships. These medical work characteristics configure the sociocultural and institutional constraints of medical practice and contribute to a higher prevalence of PS than in the general population (Farina, 2004; Turíbio et al., 2020).

Primary health care (PHC) physicians are supposed to establish a territorial commitment and bonds with users, provide care beyond clinical attention, and face a dual perspective: a strategic space to directly observe health problems in patients' living spaces and a greater vulnerability to PS in the face of feelings of impotence to solve complex problems (Esperidião; Saidel; Rodrigues, 2010; Fontana et al., 2016). Some structural contradictions in health policies also contribute to this PS, such as announcing resource priority while maintaining its scarcity within PHC; focusing on the comprehensive model of care networks while also reinforcing medical practices based on the biomedical/curative model; and highlighting teamwork while developing a fragmented work process (Maissiat et al., 2015).

In view of the historical insufficiency of PHC team professionals in Brazil and their inadequate distribution, the *Programa Mais Médicos* (PMM - More Doctors Program) was created in 2013, seeking to provide answers to these problems without being limited to a policy of providing doctors (Kemper; Marie; Sousa, 2016; Pinto; Oliveira; Soares, 2022). The program would serve PHC units in territorial voids, providing physicians to meet the basic health needs of local populations, together with infrastructure and training components by partnerships with public universities to promote their training.

Thus, research indicates that physicians' profile has changed since the beginning of the program, pointing to a relative balance between genders and the progressive growth of young Brazilian physicians who have recently graduated or have a few years of professional experience (Damico et al., 2019; Kemper; Marie; Sousa, 2016; M; M; Castro, 2021;

Pinto; Oliveira; Soares, 2022). As of 2015, with the integration between the *Programa de Valorização do Profissional da Atenção Básica* (PROVAB - Primary Care Professional Valorization Program) and the PMM; the population, managers, and participating physicians' positive evaluation; and the definition of an additional score of 10% in the selection tests for medical residency exponentially increased young Brazilian physicians' adherence (Damico et al., 2019; Pinto; Oliveira; Soares, 2022). During the interviews for the research that gave rise to this study, few interviewees declared having a *lato sensu* graduate degree in family and community medicine or general medicine before joining the program.

A comparative study of the status of the PMM in 2013 and 2015 found expanded and improved access (Damico et al., 2019). Other studies have shown improved health indicators after the PMM implementation, leading to its high legitimacy in the eyes of the population and the managers of the benefited municipalities (Pinto; Oliveira; Soares, 2022). This contributed to Brazilian physicians adhering to the PMM, especially from 2015 onward as previously mentioned. However, the 2019 conjunctural change of, with successive cuts in physicians and supervisors and even the Ministry of Health creating a competing program called "*Médicos pelo Brasil*" (Doctors for Brazil) generated uncertainties about the continuity of the PMM (Macedo; Castro, 2021).

The COVID-19 pandemic in 2019 exacerbated problems in contemporary societies, introducing new patterns of behavior in individuals and social groups. The care and protective measures to face these issues on a global scale have produced diverse reactions and significantly changed sociability, giving new meaning to the daily lives of individuals (Harari, 2020). These changes have contributed to the emergence of new modes of subjectivation. The concept of trauma takes us back to its genealogy in a world that has been turned upside down; a traumatic experience modulated by pain and suffering that affects individuals in a singular way (Birman, 2020) and was intensified by an entirely unknown health problem, constituting a source of uncertainties, tensions, fears, and traumas and

increasing PS and work relationship and process problems (Costa; Carvalho; Coelho, 2020; Galon; Navarro; Gonçalves, 2022).

During the pandemic, care in Brazil was focused in hospitals, but PHC played a relevant role in mass vaccination, identification and treatment of non-serious cases, and referral to other levels of care if necessary, thus developing new service protocols and technologies, changing work routines, and reorganizing responsibilities in teams (Fontana et al., 2016; Medina et al., 2020; Seda-Gombau et al., 2021). Thus, physicians had a higher mortality rate than the general population, and the changes to work processes contributed to tensions and PS in PHC providers (Miranda et al., 2021; Zille; Teles, 2021).

Work organization and process are privileged spaces to recognize the forces that lead to PS as they express subjects' dissatisfaction with the fulfillment of their expectations and motivations in these scenarios. Individuals seek to give meaning to their activities, adopting defensive strategies in the face of "pathogenic" or "creative" suffering due to work situations (Dejours, 2017, 2018). This study aims to analyze the perceptions of PMM PHC physicians in Rio Grande do Norte (PMM-RN) about the relations between psychological suffering and work processes in health practices during the COVID-19 pandemic. We hope our results aid health management to find the appropriate strategies to ensure effective responses to this problem.

## Methodology

The research that gave rise to this study was developed as a case study with qualitative data collection, description, and analysis. This type of study is chosen when research seeks to deal with complex problems based on deep analysis and the development of strategies to organize, describe, and analyze the attributes and development of complex phenomena in individuals, social groups, and institutions (Minayo, 2014). In these cases, attention focuses on the nature of the phenomena and the meaning the actors involved with the problem attribute to it (Gaudet; Robert, 2018; Minayo; Deslandes; Gomes, 2013).

The study population was composed of 271 physicians who worked in PHC linked to the *Programa Mais Médicos* in the state of Rio Grande do Norte (PMM-RN) from 2021 and 2022. The choice of this population for this study stemmed from these physicians' characteristics, which currently resemble those of others who work in PHC in the state of Rio Grande do Norte and in most states in which the program was implemented (Costa; Carvalho; Coelho, 2020; Damico; Silva, 2019; Pinto; Oliveira; Soares, 2022) and whose work processes and the state context during the pandemic equally resemble other such workers and whose partnership with universities operationally facilitated access for researchers.

The intentional sample chosen from this population totaled 15 physicians (research subjects). Sampling was interrupted due to the theoretical saturation of the collected information (Fontanella; Ricas; Turato, 2008; Nascimento *et al.*, 2018). Its use is often employed in qualitative research as a criterion to define the cut-off point that stops the sampling process. Theoretical saturation is considered to be achieved when the information/data fail to offer any relevant contribution to the theoretical analysis of the collected material; responses become redundant and fail to significantly contribute to the understanding of the problem under study or research goals. Research subjects were categorized by health region with the help of the identification of their characteristics as previously discussed with some PMM supervisors. The following criteria were adopted for inclusion in this research: involvement with PHC for at least two years and vocalization capacity to represent the various existing thought perspectives and attitudes of this population as a whole. In this research, interviewees' profile was characterized by searching the PMM-RN database.

Data and information were collected from October 2021 to April 2022 by semi-structured interviews with a script to meet the objectives of this research. The interviews were conducted on Google Meet, respecting the need for social isolation and all recommended health precautions. Moreover, they were audio-recorded and transcribed into Word.

After each interview was transcribed, *pre-analysis* (superficial reading of the texts) was carried out, followed by the ordering of the interview corpus (systematic organization of the transcribed text for analysis, with preliminary identification of empirical categories). Once the possible theoretical saturation was observed, decisions were made on the resumption of interviews.

Analysis and interpretation were based on a hermeneutic perspective seeking to understand and apprehend the meaning in research subjects' responses (Minayo, 2014; Minayo; Deslandes, 2013). Thus, we sought to establish dialogical relations between physicians' perceptions about the research problem and produce a narrative coherent with the empirical results of actors' discourse, finding similarities, differences, and contradictions within the context of its elaboration in search of meaning and legitimacy (Mendonça; Sousa, 2021). Thus, text and context come to life, establishing relations between the content of the discourses and their contextual aspects. Operationally, "content analysis" and "thematic analysis" were used, treating "mental" complaints by a broad category, "psychological suffering," which differs from the concept of pathological "mental disorders" (Macedo; Macedo, 2012; 2018). The content analysis technique is structured around three phases: (1) pre-analysis; (2) material categorization, coding, or exploration; (3) result treatment, inference, and interpretation (Bardin, 2011; Minayo; Deslandes, 2013). Thematic analysis was understood as a component of the third phase of content analysis, which aims to find thematic axes or themes in actors' discourse, structuring the plot of the senses and meanings of their perceptions and actions (Minayo, 2014), although some authors perceive thematic analysis as an analytical method (Braun; Clarke, 2006).

The study was conducted in compliance with the ethical principles and standards for research with human beings in Resolution No. 466, of December 12, 2012, of the Brazilian National Health Council. The project was submitted to the Research Ethics Committee at Hospital Universitário Onofre Lopes (HUOL) and was approved by it. To preserve these ethical principles, informed and voice recording consent forms were signed by participants.

## Results and discussion

Our analytical work found five thematic axes that articulate categories of analysis in interviewees' discourse. These axes have points of articulation between themselves, consensuses, and contradictions that give meaning to the views and positions of the actors in this field.

### Perception of Psychological Suffering

The concept of PS lies at the crossroads of the scientific thought perspectives that thematize the problem and the discourses from the knowledge of different cultures. Current complex societies, which constitute a mosaic of heterogeneous voices, contain distinct perceptions and cognitive experiences that can define PS as something close to the concepts of "anxiety" and "common stress." Others, in keeping with medical culture, use categories from psychopathology, such as "mental disorder," "deep sadness," or "depression." Thus, as physicians, some interviewees perceived PS as a pathological problem that dramatically interferes in people's lives, taking away their ability to perform basic activities of daily living or producing a loss of control of their emotional life.

*PS can encompass depression, stress, post-trauma situations, and, from a personal point of view, it is a feeling of deep sadness.* (Tupã)

*[...] A psychological obstacle with a depressive or even psychotic nature that decreases performance in day-to-day activities such as eating and sleeping.* (Oxum)

However, several interviewees defined PS more broadly: a human condition related to some emotional (punctual, intermittent, or constant) imbalance that can eventually become pathological. Thus—and consistent with the literature (Cardoso; Campos, 2020; Farina, 2004; M; Macedo, 2012; M; M; Castro, 2021; Turibio et al, 2020)—PS is seen as a normal, universal phenomenon that is often referred to as an intangible pain that is difficult

to describe and is associated with daily stress, personal, family, or work problems, simple worries, concentration difficulties, sleep or eating problems, and the “somatization” of psychological conflicts, which can even manifest itself as an organic disease and, even if it fails to prevent daily activities, can hinder them and interfere in people’s lives, promoting limitations and displeasure.

*[...] It is a pain that is not palpable, it is not visible. Sometimes it cannot be described or expressed, but it is real, it hurts, it takes away the conditions of people to do what they like and plan and limits life a lot. (Janaina)*

*PS is a psychological issue. We start to somatize and have something external, but at first it’s psychological. It’s what you keep going over and over not knowing what to do and suffering inside. (Osíris)*

Thus, an immanent malaise of the experience of modernity has been updated in contemporary societies. According to Birman (2020), these changes become new modes of subjectivation that are modulated by traumatic experiences, pain, and the suffering of each individual in their uniqueness.

## Perception of PS and how the served population is affected

Most interviewed physicians stated experiencing some type of PS associated with crises, intense stress, and many demands and competition, reporting anxiety, somatic complaints, and, in some cases, depression. Several participants reported experiences that began in medical school and continued in their professional lives, reinforcing literature findings (Farina, 2004; Turibio et al, 2020). Few denied having some kind of PS. In this case, these interviewees related PS to the condition of depression or mental disorders, seeing the disorder as an established, structured phenomenon without the possibility of resolution.

*Yes! I have anxiety [...] but I never used medication, I always did psychotherapy. We know that anxiety*

*has no definitive cure. What we have is more of a control of it but I consider myself under control with psychotherapy. (Ísis)*

The concept of mental disorder as something irreversible, even if mild, associates chronic diseases such as diabetes and hypertension, which have no cure but can be controlled, a medical rationality that has cure as its central objective but ultimately accepts control as a possible therapeutic alternative.

On the other hand, the PHC scenario is ideal to observe daily PS. All participants reported that PS is a problem challenging professionals’ possibilities for action. Unit infrastructure, medicine shortage, the inability of some trained professionals to deal with PS, and lack of training generate frustration in physicians.

*It is a daily experience for us at PHC. [...] There is a lack of medication or opportunity to offer better treatment to patients. This generates frustration and the patient ends up getting worse [...] In most cases, therapy could solve it, but since we don’t have a psychologist on the team, we end up repeating cycles of medication. (Ceuci)*

Thus, amidst a restrictive and frustrating context, physicians highlighted their commitment and empathy toward users and their problems, identifying PS in the population and reporting concern and impotence when dealing with these situations. In these cases, PS is associated with structural economic deprivation or social vulnerability, which is closer to what some authors call “social suffering” (Cardoso; Campos, 2020).

*When I care for a child without the same opportunities as my daughter or at the same age or when I receive a vulnerable older adult experiencing abandonment and great suffering, it affects me deeply. [...] At night when I go to sleep I relive these facts of the day, which leads me to moments of great sadness and loneliness. (Zeus)*

*My suffering is when [...] they ask for help and I don’t know what to say because my ability to*

*help is beyond my sphere of action. I listen and I give words of comfort. That's all I can do.* (Krishna)

Changes to the contemporary malaise express the fragmentation and “fluidification” of the current experiences of life in society, the acceleration and restrictions of the lived time, and the difficulties to activate the mechanisms of symbolic protection of the psyche established by culture (Birman, 2020). The body becomes a privileged space for manifestations of somatized “psychological pain.” These changes also include a higher prevalence of anxiety disorders (including panic disorder), depression, chronic fatigue (burnout), and compulsions (including drug abuse). The territories where the interviewed physicians worked at presented a predominance of alcohol abuse among psychoactive substances, although they always mention dependence to psychotropic drugs as relevant in PHC. The use of these substances is associated with attempts to relieve a life of suffering that varies between urban-rural areas. Participants also highlighted “relapses,” which always frustrate those in therapeutic projects.

*In the municipality where I work, I see alcohol abuse, but in the other neighborhood where I worked before in the same municipality, I saw alcohol and cocaine abuse on a common basis.* (Amon)

*[...] I have several patients who use benzodiazepines and are dependent [on them].* (Ísis)

## Psychological suffering and the work process

Interviewees show the dominance of the perspective of comprehensive health and its system, reinforcing the importance of multidisciplinary teams and the implementation of health networks at SUS, in which PHC configures the main gateway to the system. However, most PHC units show a persistent tension between this broader view and the emphasis given to individual medical care. Physicians attribute this pressure toward individual medical attention to management and some users’

interests, limiting physicians’ role to diagnostic agents and medication prescribers. This shows managers and the population’s medicalization, reinforcing the biomedical model of care and inducing this medicalized culture. This paradigm gives centrality to curative care and to the physician, thus prioritizing medical consultations at units, compromising the establishment of bonds with the territory and users, teamwork, the development of other activities (health promotion, disease prevention, and rehabilitation) and local planning. Finally, it causes work overload, conflicts, dissatisfaction, and suffering, worsened under the COVID-19 pandemic.

*The doctor's work within the team and the health unit is very limited to individual care in the office and a huge demand.* (Shiva)

*We don't get to rest. There is a lot of pressure not only from management but from patients themselves. It would be very interesting if we were available to carry out other activities and develop comprehensive health as the PHC proposes, dedicating better attention to people with psychological distress.* (Ceuci)

Medicine is a social practice determined by its historical context and economic, social, political, cultural, and institutional components that, mediated by medical knowledge and techniques, enable the development of actions and care in the different spaces of its practice with greater or lesser autonomy. Contemporary times have changed work, deregulating and flexibilizing it by neoliberal production and management mechanisms that fragment, worsen, and intensify activities in practice scenarios, the expressing local contradictions between a desire for freedom/autonomy, which can give meaning to the process of alienation from work, and the objective dimension of the structural contradictions of the context and health policies in their various manifestations in the work scenario.

Thus, most physicians stated being satisfied with their work, despite having various criticisms and complaints, especially about excessive demands,

productivity requirements, problems in unit infrastructure, a lack of mediation/personal protective equipment, and insufficient professionals in teams. A flagrant contradiction between a discourse of satisfaction, which relates more to established affective bonds, the idealization of professional practice and individual life projects, and complaints about working conditions and processes, with reports of suffering and even exhaustion.

*I get a lot of satisfaction from what I do, I like the place I work, and I've been there for a long time, so I've created bonds with the community. (Amon)*

*The structure of the health unit also bothers me, very precarious, scarce materials and medications. We work at the limit of what is essential for care. (Zeus)*

*In my primary healthcare unit, masks, caps, gowns were often lacking, aprons were often not served, and sometimes they were only offered to doctors, and the entire team was exposed. (Oxóssi)*

Problems arise within management mechanisms, which ensure comprehensive care and define the attributions of different levels, use of clinical protocols, local programming, among others. Physicians consider the strenuous, limited, and bureaucratized work as a management problem, recurrently refer to the pressure of managers on teams, especially themselves. The evident use of “defensive strategies” (Dejours, 2018) is associated with the objective limitations of professionals in the face of the type of activity they perform and the contexts of action. Creative suffering occurs in the presence of the concrete possibility for professionals to defend themselves from suffering, even if unconsciously, given the objective working conditions in each municipality.

*This year, I was able to move to another environment and put into practice what I learned in my Family Medicine residency, doing practices with groups... And I'm feeling more satisfied. (Oxóssi)*

*Some things get me stuck in the work process, they bother me a lot. Sometimes, if a death occurs, the patient's family comes after us. There are even death threats, especially in peripheral areas. But most patients like the work I do. I try to make connections and I like my job. (Tupã)*

On the other hand, faced with the impossibility of a creative strategy, physicians defend themselves by resorting to pathological expression mechanisms of their psychological suffering (Dejours, 2018). When subjects lose the conditions to defend themselves from the exhaustion of working conditions, they seek alternative solutions within the limits of balance, expressing suffering more dramatically.

*I had problems! Work overload, overdemands, and misunderstandings. I developed an anxiety disorder and managed to get out of it with psychotherapy and personal help, without needing medication. (Janaina)*

*I had depressive episodes, bouts of insomnia, as well as the abuse of coffee, alcohol, and food to compensate for this consuming career. (Brahma)*

*[...] There was a huge demand there. There was even personal persecution and I had to undergo a psychiatric follow-up. (Afrodite)*

The socioeconomic context, bureaucracy, and political interference in services contribute to local and clinical management problems as they can reduce the ability of PHC to solve health problems and, thus, its credibility. The PMM-RN differs from other PHC services: supervision and pedagogical and supervisory roles contribute to improving physicians' work. The supervisors of this program also act as institutional articulators, “bridging” PHC teams and managers.

*Bureaucracy prevents us from being able to order an electrocardiogram or even an echocardiogram for a cardiac patient in PHC, the municipality does not allow it. Only the cardiologist can ask for it and we are left with no problem-solving capacity in Primary Care. (Tupã)*

*There is also the need to improve management because there is a lot of political interference in the municipalities. (Shiva)*

## Trauma and psychological suffering in the Pandemic

The outbreak of the COVID-19 pandemic was a traumatic and greatly dramatic moment. Images of the plague resurfaced from the popular imagination to haunt the population, especially those who were directly involved in strategies to cope with this problem. Medical practice in PHC services has undergone readjustments in conditions of great health risk, adopting control and prevention measures to avoid transmitting the virus. Many physicians withdrew from family life and experienced fear of contagion, anxiety, and even more serious psychological problems, such as “panic disorders” and “depression”.

*With COVID, there was a lot of tension in relation to contagion. I was very isolated, alone, without my family and, at that moment, I felt a lot of suffering and I looked for ways to protect myself. (Oxum)*

*[...] We were all insecure, I was afraid of dying or contaminating my parents and my husband, who has comorbidities. [...] My suffering was very great but I couldn't help tending to them, I couldn't help but be with them. (Shiva)*

Daily PS reports increased with the emergence of the pandemic; including users who previously manifested no such complaints reporting anxiety and depression disorders. Work under pressure grew and interviewees associate it with their own PS. Participants reported omnipresent fear and the pressure from local management for greater production of care, referred to as an important element for professionals' PS.

*The diagnosis of “anxiety disorder” has greatly increased and some cases have evolved into a depressive condition [...] Even those who never had*

*a psychological problem started to have it. (Atena)*

*I had to deal with my own fear, that of staff and that of patients. [...] It was a huge pressure, a very big emotional load, and I developed a panic disorder. (Afrodite)*

Pandemic, trauma, catastrophe, and psychological helplessness. The universe of care articulates issues that refer to a context of isolation and loneliness. Strenuous work often gave way to burnout (Seda-Gombau et al., 2021). The search for pleasurable activities and even a heroic perspective were imposed as defensive strategies by resistance or sacrifice. The normality limit of mild psychological distress has been exceeded several times and some physicians have developed mental disorders. Both individual and public suffering interpenetrated, increasing the search for therapy. The usual health problems continue but the pandemic is high on the agenda of all. Singular dramas touch the sensibilities of some physicians and become a repertoire of sad stories to be remembered in the social imaginary and in health institutions.

*The stress increased even more during the pandemic, everyone was much stressed, and the workload was very confusing. Everyone was afraid of dying... Some colleagues didn't go to work and we have to make up for their absence. It increased stress, anguish, worry. By itself, the pandemic was a cause for concern. (Brahma)*

*I was seeing a patient during the pandemic after seeing nine deaths in one day and having to give news to her family, I started to feel short of breath. Only later did I realize it was a panic attack. (Afrodite)*

## The need for training

Although PMM has a training component with the support of universities, most interviewees claim the desire for further training to meet the problems of PHC units. Due to the wide and complex spectrum of activities and situations they face in the various

community contexts in which they work, physicians still feel insecure in some specific areas of knowledge and situations they must face; especially in mental health, communication skills, group dynamics, and conflict management. When talking about mental health, even with a dominance of the comprehensive, interdisciplinary, and multiprofessional health perspective, PHC physicians have as their central concern the administration of psychotropic medications.

Some realize that the presence of many cases of addiction to these drugs requires address. Others persist with a traditional and medicalizing psychiatric view centered on the uncritical prescription of these psychotropic drugs. They generally show an awareness of the need to rely on simple technologies, even if they are very complex in their implementation, such as psychotherapies and group dynamics techniques. For this, they suggest hiring psychologists for PHC and training in these areas.

*Learning how to deal with the collective would be very important. Knowing how to talk, asking questions, expressing one's suffering, knowing how to dialogue, learning how to hold a team meeting, reaching consensus, without aggression, reducing sources of suffering, would be good if we had the skills to do so. (Zeus)*

*I need to update psychiatric medications because there are patients who use antidepressants for a long time and who could wean them off and start holistic therapy. (Jaci)*

*We need something simple, sometimes a light technology, and we don't have it. Sometimes you need a psychologist in primary care [...] to intervene at that moment in an appropriate way with psychotherapy... (Janaina)*

## Final considerations

This research was conducted amidst the difficulties of the pandemic context, leading us to adopt investigation techniques mediated by digital platforms, which certainly brought advantages

(but also problems that researchers are yet to analyze sufficiently). The political polarization in Brazil also required researchers to be very sensitive in their approach to interviewees. Physicians neither having employment relationships nor being hired by public tenders or other forms of contracts with greater stability may have prevented more forceful criticism of the management or dimensions of the work process, contributing to some contradictions in responses.

PS is a human condition, a normal phenomenon associated with stressful situations of daily life, which can worsen and eventually become pathological suffering. Most interviewees perceive it as thus, but some adhere to the medicalizing view of traditional psychiatry, which insists on pathologizing and seeing medication as the only strategy to deal with psychological suffering. Although they recognize the physical and mental exhaustion of the exercise of a stressful and exhausting profession, they fail to always perceive the defensive strategies of different natures produced in subjectivity and developed in their practices in the territories.

The process of dismantling PHC, in a restrictive political context worsened by the pandemic, intensified the fragmentation and deterioration of work processes. The contact with a population with numerous needs, the structural problems of the health units, bureaucracy, the political interference in work, the mismatch between the training and the knowledge necessary to respond safely to the problems that arise in the daily life of the health services, contributed to physicians' uncertainties, frustrations, and suffering.

The emergence of the pandemic with its characteristic of a health and traumatic catastrophe has redimensioned the PHC work process and haunted the different actors, turning expectations upside down. Work overload, conflicts, dissatisfaction, and suffering are amplified. Fear and a feeling of helplessness set in. Creative work is suffocated by the shadows of an inhospitable health context and a national political context of dismantling public policies and scientific negativism. Fertile ground for pathological defensive strategies that also manifest themselves as various disorders, including burnout,

anxiety disorders, and depression. In this context, mental health is referred to as a strategic area for training and to competently exercise PHC practices.

Within the scope of the PMM-RN, problems related to the precariousness of labor relations arose due to an indefinitely extended scholarship without the formalization of a contract and the establishment of universal labor rights. In a conjuncture that began in 2019, marked by a government that expressed its opposition to this program and successively cut its contingent of physicians, reducing their care coverage, this prolonged scholarship condition contributed to a feeling of uncertainty in the face of the professional career under construction. On the other hand, even with the differentiated support of the supervision and tutoring of the universities, this study found the desire for knowledge in the face of the weaknesses of a complex universe that transcends university education and requires greater qualification.

*PMM was a fantastic opportunity for me. I only think one thing could be improved, and that is the labor relationship. To this day we receive a scholarship, I have been in this situation for five years, which is a way for the state not to generate ties and to have available labor. (Zeus)*

Under different influences, a mosaic of situations stems from the different territories that can foster or hinder creative or pathological strategies to respond to the work process. It is possible to show that, despite the specificities in case studies, most results reinforce the scientific literature on the subject. This study tried to describe and reflect on some of these experiences but further studies should be conducted to further develop some of the raised issues, expand knowledge, and support mental health policies and practices in PHC, involving work processes so these practice scenarios become spaces of affection and fulfillment.

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