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Specialization training courses on Family Health: what can training change in the work?*

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The persistence of bio-medically oriented practices and the mismatch between training and work are identified as the challenges for the rolling out of Primary Health Care (PHC) in Brazil. This paper analyzes work changes in PHC after following specialization level training courses on community and family health, from the point of view of the trained professionals. It is a qualitative study carried on from 2011 to 2013 in the Federal District (DF) involving doctors, nurses and dentists. Data was collected with the use of digital questionnaires, semistructured interviews and focal groups. From the thematic content analysis, two categories emerged: "a universe of knowledge has opened up" and a "new way of doing things in an adverse working environment". The context of the PHC in DF is a constraint but the training had the potential to generate professional competences.
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Introduction

The process of deploying the Health of the Family Strategy (HFS) in Brazil from 1994 on,is aimed to expand the access to health, through the consolidation of a model

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of care guided by the principles and guidelines of the Brazilian National Health System (SUS). In November 2014, the coverage of the HFS had reached 61,95%[1] of the population, showing the success of the policy in the country.

Primary Health Care (PHC), usually called "Basic Care" in Brazil, is the preferred gateway to the health system, based in a specific geographic catchment area with the mission of guaranteeing comprehensive care in all aspects. Furthermore, PHC should coordinate the care process, putting together in a synergic way health promotion, prevention, treatment and rehabilitation in interdisciplinary teamwork. The National Policy for Primary Health Care (NPPHC) is the guiding document to build liaisons and shared responsibility among teams and population, fostering popular participation and social control[2]. In spite of these guidelines, research about the teamwork process showed several elements that hamper its full implementation: the persistence of practices typical of the biomedical approach, the existence of asymmetry of relations between providers and users, hierarchies and inequities among professions and tensions between the clinical and the public health points of view[3,4].

Several main challenges are to be faced in the way of consolidating the proposed model, in terms of infrastructure, working conditions and the lack of institutional support in the implementation phase of changes to *status quo*.

The importance given to guidelines and directives, focused in tasks instead of potential skills of the workers and the existence of individual (thus fragmented) planning, shows the need of a new approach to professional training[5-8].

Not withstanding the successful experiences present in the literature of the process of deploying the HFS[9], showing remarkable impacts in health indicators [10], the main question of how the work process and professional training can be reorganized, remains without answer. The lack of providers (and specifically physicians) with the right profile to act in this context, are persistent problems that may be rightfully attributed to training gaps[4,11,12].

Teamwork has been neglected in professional training[12-14] in spite of the ample consensus of its fundamental role in implementing comprehensive actions.

The contradictions between professional practices and training call for revisiting the educational strategies[15] to incorporate the dialectic relations between labor and education. Complexity of health issues and of the actions that such issues demand, show the urgent need to develop pedagogic processes encompassing political, organizational and operational competences at all levels of the health system, thus breaking apart with the point of view that looks down on PHC while overrating technologically dense techniques developed in the secondary and tertiary levels of health care.

It is therefore a main task to put together teams able to act in synergy with different social policies and existing resources, taking into account the multiple factors that affect the quality of life of populations, and at the same time the imperatives of universal and democratic access to health, the interactions with other levels of care, the working conditions and the diversity of stakeholders that are needed to make SUS a reality. To effectively implant a model that goes beyond the biomedical approach, there is a need to make changes in the day-by-day context of work and in the professionals' mindset about the mode of production in health.

In this context, an array of graduate courses have being supported through grants of the Ministries of Health and Education since the 90's as a strategy to train professionals able to perform competently in HFS, following the NPPHC.

Working in PHC, using knowledge and practices to face problems that are frequently rooted outside the health area, demands specific competence. This competence may be characterized as a dialectic combination of different ingredients that integrate how to act, i.e. "the mastery of the precedent norms"[16], to be willing to act, " to be motivated to adhere to a collective project" and to be able to act, " to be capable of facing the environment's restrictions"[17].

Taking into account the fact that there is no competence outside the working context, and that training only makes sense when it gets closer to the world of labor [18], the present paper analyzes the shifts in the work process in PHC, using as sources the perceptions of professionals that graduated from two courses for Specialists in Family and Community Health in the Federal District (DF) of Brazil.

Methodological itinerary

The present research used as conceptual framework the Schwartz's ergology approach on work competences[16,19,20] as well as the guidelines in the NPPHC. The ergology framework as developed by Schwartz, is constituted by postulates that are useful in the comprehension of the work situation and of the educational process. Following this author, inside the labor activity the dialectic interaction between the degree of ownership of conceptualizing knowledge, the comprehension of the historicity of the situation, and the values discussion that every individual must do to make his/her choices in the political context, activates heterogeneous components of the competency, that are thus positioned in the "crossroads of technicity and social and economic alternatives"[16] (p. 106).

Mastering the contents of the NPPHC, as well as the full extent of its guidelines and norms is the first component of the competency, related to the conceptual domain of what is anticipated by the job. The second component is related to the past experience that the individual gathered when facing the environment. The third results of the combination of the first and the second, creating the choice of how and when to act in order to be effective. The fourth component is a product of a reflection on how to do, and what to do first, following norms and values, guiding the choice to adhere (or not) to a certain project. The fifth is related to actions that allow showing the potential capabilities thus mobilizing oneself for a plus in the work situation. Synergy is the characteristic of the sixth ingredient, seeking complementarity with others and strengthening of group cohesion in work.

All the components of competency are interrelated and interdependent. As the environment has a constitutional variance, the workers are bound to use the uniqueness of their experiences to find the resources to face the unprecedented that is present in each situation.

Training is basic for professional competency development, even though it has certain limitations as it is located in the field of previous norms, those that anticipate the work itself. Training deals with the experience still to happen, delivering

knowledge, and preparing for the encounter with the future work situations. This encounter will eventually take place, and it will constitute a process where the subject will be competent or not, depending on the synthesis done with acquired knowledge, previous experience and the values and choices done in relation with the ever unfaithful environment[20].

The research is a qualitative[21], retrospective study, performed in the Federal District of Brazil from March 2011 to July 2013, with graduates of two courses for Specialists in Family and Community Health. The graduates were included in the research because they had undergone a training process towards PHC practices in compliance with the principles of the Brazilian National Health System.

The first generation, that began in 2005 had physicians and nurses, both public servants and hired through contract, working in PHC when the HFS and the Program for Community Health Workers (PCHW) was rolled out. The second began in 2008 and included dentists. Both courses used active learning methodologies as their pedagogic proposal, with the difference that the second one included instances of distributed practicum activities, supervised by instructors. Both courses were framed in terms of contents within the guidelines of the NPPHC and the role description of the HFS teams.

The universe of the research was made of 130 nurses, doctors and dentists from both generations that graduated in 2006 and 2010 respectively.

They were found through a research in the records of the Health Department of the Federal District (SES/DF) and through electronic and telephone calls, excluding those that were not longer working in the SES/DF and those not found after three tries.

A total of 79 practitioners were included in this phase sending an electronic questionnaire to gather general information of the group under study and a Free Informed Consent Form that was completed by 45 participants, being 29 nurses, 9 physicians and 7 dentists. These differences in the size of the professional groups can be explained because more than 50% of the graduates were nurses and also because dentists were included only in the second group. The practitioners had ten or more years of experience in PHC with diverse training experience in this area and also had

worked in Health Units of the so called “traditional model” meaning that HFS was not in place in those facilities.

A total of 17 subjects (6 physicians, 3 dentists and 9 nurses) participated in semi-structured interviews, selected initially through a lottery following proportionality by profession and region, and later closed by saturation. The interview guide sought to identify the changes in the work process after the completion of the training courses. To ensure anonimity, a letter-number code was used for each interviewee, being D for dentist, E for nurses and M for physicians, followed in each case with an ordinal number corresponding to the order of the interviews.

Content analysis[22] was performed on the discourses recorded, and the Analysis Units were divided into Record Units and Context Units. The Record Unit was defined as the theme, which may be a simple sentence (subject and predicate), a group of sentences or a theme paragraph, being each theme a significance unit.

The theme is considered as the most useful record unit in Content Analysis to be able to access to opinions, expectations, values, concepts, attitudes and beliefs, making thematic analysis the preferred choice. To use a theme as record unit for the interpretation of the answers of a certain group of individuals has the consequence of getting a large number of responses that are permeated by different meanings.

Thus, it was needed to analyze and interpret the contents of each response in its own, unique meaning, beyond the Context Units, that constitute a general background giving significance to the Record Units.

The definition of the analysis categories is an operation for classifying the constituting elements of a group of texts, followed for a phase of regrouping based on analogies that emerge from pre-determined criteria. In this case a semantic criterion was used for the categorization. The option for a thematic unit is a result of the interdependence between the objectives of the study and the theoretical framework adopted by the researchers. Categories were not defined *a priori*; instead they emerged from the content of the discourses of the practitioners.

After the coding of each interview, the results were regrouped and analyzed through horizontal reading, to identify concordance and discordance among discourses. Categories may be defined as broad statements encompassing a variable number of themes, grouped by degree of proximity, expressing meanings and constructs of relevance, that address the objectives of the research and allow to build new knowledge, giving a singular vision on the topic.

The analysis was based on the conceptual framework of the Schwartz's ergological approach and of the NPPHC, and in the results an option was made to present each one of the two categories as broad statements.

The findings were submitted for discussion and validation by a focus group, to which all interviewees were invited, but just three physicians and three nurses effectively participated. The contents elicited from this group were part of the content analysis and are identified in the text as GF.

Following this process, the changes in the work induced by the training courses were grouped together in two broad thematic categories: 1) an universe of knowledge has opened up; 2) A new way of doing things in an adverse working environment. These two categories must be considered as intertwined, as components of competencies that act as change launchers in professional practices, may be present across both in several different ways and degrees. The fact of identifying one component in a theme does not necessarily mean the absence of the rest.

The Ethics and Research Committee of the SES/DF through resolution 0208/2011 approved the project and all ethical providences were contemplated.

Results and discussion

An universe of knowledge has opened up

The knowledge that is stored in the individuals, being it acquired in school, in college or by any other means, is the first ingredient of the competency[16]. It refers to

the conceptual dimension, of the contributors to allow the situation to be processed according with experimental guidelines. In the PHC situation, to be competent may be related to the degree of ownership of the whole array of concepts, directives and prescriptions of the field and the core of the professional activity. According to Schwartz[20], this ingredient is a permanent objective of learning and is in a dialectic and continuous interaction with the rest.

The courses were instrumental in rooting concepts, "*understanding the importance"* and *"widening the vision*", mainly in relation to the conceptual aspects of health, of primary care and of the corresponding model of services.

> The purpose of the course was to modify the training and the concepts, in all levels [to understand what health is] involving family, environment, food, school and work (M1).
> You work hard in education, prevention, early intervention. This is what is for me PHC. And the course helped me to give foundations to these concepts (E1)

To understand what is PHC and how it is integrated into the health system organization is crucial for turning into reality the principles and guidelines of SUS. To master the pre-existent norms, of all that anticipates the work itself, is a condition for the improvement of care and the efficacy of actions:

> You may begin to see with open eyes the importance of PHC and to concentrate in it; not only in Hospital-centered medicine, and also to perceive that a large proportion of problems may be solved in PHC (M2)

Meanwhile, conceptual appropriation and the various ways to use it in work, happen when there is interaction with reality, in the daily practice, that may not always be easily understandable:

> We get tired of working in PHC, is not easy, we would like to give up, but then these courses bring you back to the feeling that no, that this is the right thing to do. (M5)

The course gave the participants the chance to relate theory and their own experience in the workplace, anticipating somehow what may be come to be a new way of performing;

> I lacked theoretical foundations [...] now I know how to work, and this is the most important, now I understand how this PHC works (GF)

The experience allows the mobilization of previous knowledge that the practitioners have (in different depths and contents), and every new situation widens their experience. According to their knowledge structure, the practitioners may relate their present situation with previous circumstances, to be able to elicit more general rules, or on the other hand, the new elements will just be juxtaposed to the previous without establishing new links between them[23], thus creating a specific " unique way of being in the world"[24] (p. 87).

The research allowed perceiving the commitment of the practitioner with her/his work, even in adverse circumstances, and the learning process needed to confront the management gaps and deficits, remarkably, the ingredients 4 and 5 of the competency –reflection and action:

> I did not learn that anywhere, I came from the hospital, I worked 10 years there, I accidentally stepped into public health finding a team that I had to coordinate without any knowledge, I was not even able to do a Pap smear, everything was learned there with the doctor that began jointly with me. So it was all a learning experience, to learn by doing and the course helped to reflect on these issues (E1)

The fourth component "brings a kind of break down in the inventory"[16], (p.125) and opens up the chance for debating the dynamics and boundaries that are specific to the working milieu, where a "political-managerial"[16] (p. 126) will is developed and the chance of building a "true pedagogy of rediscovering their own resources"[16] (p. 126), that may be enhanced or alternatively, halted[16].

The participants realized that the course brought them a more humane perception of care, valuing family and creating liaisons with users, giving more power to the social relations technologies, that have evolved into powerful tools for building cozy and responsive relations with users and families[24].

> […] the course helped to perceive this link, of being responsible for territories […] we need to greet, to receive those who arrive, to talk about how to do things and accept the new ideas that that person in bringing in (M3).

> To see a citizen in the other, to perceive that he/she is a whole person, needing my intervention and that we may work together in a less bureaucratic fashion (E2)

Knowledge and skill-development to listen to the community and opening opportunities for its participation, were also mentioned as changes resulting from the training courses:

> […] to listen to the community, the issue of participative planning, to have the community helping to plan (E3)

The course gave the participants, technical and scientific knowledge and the willingness of innovating in the work process:

> The technical part of the Pap smear, […] that I didn't know and that I learned there. (E6)

> […] to gather more bibliography, to study more, I brought novelties with me, new methodologies that may be used in the program (D2)

It also brought the clear comprehension of how teamwork can improve PHC capability for case solving, as well as the interchange of experiences with other practitioners:

> To understand the importance of teamwork, joint learning, to stop seeing issues as physician-centered, but as a dialogue of the team with the patient and the other way around (M2)

To be able to speak about one self and to get to know what the other does develops trust and empowers cooperation, key elements for synergy in collective work. Each practitioner has a richness of experiences from work and life, characterizing the component two of competency. The experience is itself a trainer as long as we may reflect upon it and its contribution to professional life[25].

The training process may foster the development the third component, i.e. the capability of integrating previously stored knowledge and previous experiences to face each unique situation. When the practitioners learn the antecedent norm, the first anticipation, they are immersed in their working milieu, where the debate of normative and value issues takes place, and this richness will guide them in this second anticipation, in the moment of action, when they need to retool the norms and create a new way of doing[20].

A new way of doing things in an adverse working context.

The knowledge mobilization brought by the course, added to those previously existent, and in interaction with the real life experience, introduced changes in the day-by-day ways of doing thing during work, and put in evidence the potential of training as an activator of the whole lot of competency components. Applicability of

knowledge appropriated in *sensu lato* courses about Family Health, were already reported in a research by Maciel et al.[26].

Changes as such as those that will be reported in the following statements, are mainly associated to the attitude that is expressed in actions within the management realm, organizing and adapting the job to the needs of the community: in sharing problems and solutions with both the team and the users, in the way how meetings are organized and guided, in the task division, in how flowcharts are redefined, in the way how community groups are organized and conduced, and how is the rapport with the community. Attitude is a basic component for the professional activity and presupposes "not to be limited by the anticipations, to let oneself to re-create norms on behalf of those that are the subjects of care and to interpret and question the imposed normative"[17] (p.3209).

The research showed how the practitioners are protagonists even in an adverse PHC context. Many difficulties were linked to the vertical management model, to the continuous turnover in positions, to the inexistence of a truly organized care network, that adds up to the lack of preparedness of the practitioners to work in HFS, to the inadequacy of the structural aspects in the Units and to the growth in responsibility of the HFS teams that are summoned to cover previously underserved areas.

> We are thrown into PHC as if it were a simple thing (E5).
> […] Management changes, team changes and we are always beginning from scratch. At that point we find ourselves lost, we need to go back and regroup (M3).

Several studies[7,8,27] pointed out how inadequate working conditions hamper the achievements of proposed policy goals. In spite of efforts by SES/DF to implant the HFS as a model, those efforts were not in sync with the changes needed in the rest of levels of care, thus not ensuring an appropriate network that may encompass the reorganization of PHC[28]. Furthermore, HFS was organized in a fragmented fashion, hindering the comprehensiveness of care, resulting in an underdeveloped structure that delivers a low coverage[29], at around 15,33% of the population in 2012[1].

Changing the way things get done is not an easy task. Practitioners are faced with the conflict between the norms that come from the NPPHC and from the training course, frequently in contradiction with the directives of the local managers that have practices far from "communicative and co-management"[30].

> Whenever you ask the manager, he will tell you that you should not do that, that you only need to do the basic problem-solving, that you need to pay attention to the number of actions only (M5).

Productivity rationale as imposed by managers contradicts with the comprehensiveness and quality access to services that are mandated by the NPPHC, and the practitioners need to negotiate and exercise diverse degrees of autonomy:

> I began to interrogate my supervisor about this, I lowered my output of pre-natal [...] and as I improved [...] indicators, I improved making office visits in a more organized way, in more time. I think that it was also a big improvement for myself (GF).
>
> I tried to do [...] several changes and unfortunately we are limited by the predominant PHC model, resistance comes from the practitioners, from the Nurse Manager, [...] several of my colleagues are unable to implement it, [...] I myself tried in vain [...] (E7)

To perform according to the population health needs is directly related to the possibility of the person to build her/his own identity at work, which in turn depends on how much room is left for developing experience and on how hierarchies evaluate the ways these experiences are developed.

> I realized that regarding the patients' flow, it changed, serving a more spontaneous demand, less scheduled office visits like we used to have, opening exceptions, something we didn't use to do (GF)
>
> Groups changed a lot, not being only lectures but more conversation in circles, to listen more to the patients, to be closer to them (GF)

To put these changes in place means also to confront with the environment's limitations.

> We don't do them as much as we should [groups] because of the lack of space, it is one unit with two teams, so I need to share the room with the doctor, when I am there, she is in the street, anyways we try to cope with this, as always (E1)

> We manage to work independently, I don't even know if my manager or chief knows all that I am doing (M4).

The lack of inter-sectorial work has been identified as a key issue to be overcome in labor management in HFS[4,14]. The practitioners have pointed out that new ways of approaching community and inter-sectorial work were developed after the course, even though they remark the boundaries of the mainstream culture, the importance given by people to office visits instead of preventative actions or health promotion.

> We began to seek more contact with the local Council, the regional administration, the businesspeople (D2)

> Community mobilization is still a challenge [...] The participative planning topic that I learnt in the course is something that I am still trying to put in practice (E5)

Listening and including users in healthcare decision-making induces the practitioners to have a different look of the other and also of themselves, and to seek to be acknowledged for the job.

> At the time I selected a patient, I discussed with the team: let's see the best strategy for this patient, but I forgot to question, to discuss those actions with the patient herself, and that was changed by the course (GF)

> During the development of a certain job [...] that I found as excellent [...] not only for our fulfillment as doctors, the collegiality and the friendship among College students, among the team and the patients. You should be able to approach; to explain in the way that she may accept your intervention. To make the change. And then to receive the hug. I received plenty of hugs. From the lady that I saved from leg amputation [...] (M6)

Dejours[31] considers that work recognition is due to two types of judgments: utility judgment and aesthetic judgment. The first deals with the social, economic, and technical utility of the collective and individual contributions that lead the persons to feel that they belong to a collective. The second has to do with the attribution of qualities to the subject by her peers making her distinctive and singular, the execution of "beautiful deeds". Professional recognition will contribute to build an image of herself, to reinforce self esteem in the practitioner, thus strengthening collaboration.

Teamwork and service integration are part of the array of changes launched by the courses, with the purpose of a more comprehensive and improved quality of care:

> To listen more, to pay more attention when listening, to read between the lines and try to research more. All these areas were improved in my service, to summon everyone, to share the tasks (GF)

> The practice changes regarding menopause care. Those routines helped to establish a good relation with Gynecology in my region, I could discuss directly with him, I was free to call, to search for the patients of my referral (M6)

Teamwork and strengthening the leadership of the practitioners are strategic elements in the implementation of the HFS[13,30]. Still, teamwork is not at all an easy task:

> We need to know how to listen, to respect the boundaries and, when you stay working 40 hours a week with the same co-workers, it's like family, has its advantages and its disadvantages, each one has a day to be bitter, every one has that day to be overexcited. During the course we worked on the issue of respecting the other in the team and how to deal with those differences (E5).

Practitioners report the hardships of eliciting collaboration from the co-workers and the strategies to make changes in the work:

> Something that I also learned, in the course and during work is that novelties are rejected by everyone, they are frightened. Do you want to

> change? Great! But I cannot just enter and say: "We are going to change!" in that case no one will agree. So you need to put the idea in the table and after they get used to it, "now we are going to change". Got it? (E4)

Resistance to change by health professionals may be attributed many times to a refusal to accept certain conditions and modalities of such change. There should be ownership by the workers, using as a starting point their own richness of knowledge, of practical lore and values. Some changes may appear as being resisted, when in fact they are part of a way for the worker to exercise self-preservation and stay healthy at work: I can see that I became more respectful of my own body. I was enduring a process of continuous work and then I began to pay attention to myself as a human resource (D2).

To work in HFS demands the workers' diagnostic and problem-solving capabilities, to be able to make decisions, to intervene in the work process, to be able to work in teams and to cope with ever-changing situations, being always ready to respond to the population health needs, meaning that the worker has to be competent. Competency is always a personal attribute, a result of a set of ingredients dialectically articulated in interaction with the environment, demanding for responses here and now. It has the postulate of identifying the need to "reconfigure a situation, in a certain circumstance, and request for the existence of creativity to combine in each choice the local and general characteristics"[16].

Competency, as an effective action cannot be transmitted. It springs to existence within the individuals and the group, when the situation happens to favor it. When the persons have their degrees and qualifications, but competency fails to show, it is important to observe the working conditions, and refrain to act only upon the individuals, creating instead the conditions prone to the expression of that competency.

Change process in practitioners' practice is not only dependent upon de individuals in the job or the training process. Furthermore, we cannot deal with

knowledge as a good that may be transferred, but as the fruit of the reflective practice in a collective constructive environment.

To do a course has its limitations and cannot be considered as “the solution”, instead it may allow to identify an avenue to be followed to face the obstacles of implementing new practices according the principles and guidelines of PHC.

> The course showed that there is always a path that I can follow to look for a solution, in spite of the fact that sometimes I will not find it (D2).

Final considerations

From the perceptions of graduates, the courses were instrumental to enhance the competencies of practitioners, promoting the acquisition of knowledge and launching new operational modalities, even in an adverse environment.

In a conceptual level those changes were manifested as: 1) a more humane perception of health care, valuing family and the need of a rapport with users; 2) knowledge and developing skills to listen to the communities and open opportunities for their participation; 3) recognition of the importance of teamwork; 4) searching for new community and inter-sectorial approaches.

The training activities gave foundations and widened the knowledge of the activity field, giving the practitioners a better grasp of the antecedent norms and the chance of reflecting upon their own experience in the job. In our research, that reflexivity widened the capability to act, eliciting new ways to operate.

This new way of doing business is connected to the search of fulfillment and recognition on the work, and it is expressed above all in a change in attitudes that translates into action in managerial, organizational and adaptational transformations of the work process according to community needs. The changes in the relationship among professionals and with the community are also worth of remark.

The PHC environment in DF is a constraint, practitioners have different degrees of autonomy and different ways to deal with them, but the courses had the power to mobilize a set of components that were needed to create competencies, thus

suggesting that a policy of in-service permanent education may help the rolling out of the HFS in the context object of this study.

It is worth of note that the difficulties in including practitioners in the second stage of the study hindered its reach: to find the graduates, the availability to answer the questionnaire and the time elapsed since the first courses.

Collaborators

The authors worked together in all the stages of the production of the manuscript.

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