Dentists' perception about the work in the Family Health Program

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ABSTRACT

This qualitative study was conducted on dentists (CDs) that integrate the Oral Health Teams (ESB) of the Family Health Program (PSF) in a middle-size city in Southern Brazil, conducted from April to June 2017. The study aimed to identify the perception of these professionals about their work experiences in the Program. The CDs working in the PSF in each of the nine Basic Health Units (UBS) were invited to participate, adding up to seven interviewees. Data were collected by recorded, semi-structured interviews with script of questions, and assessed by analysis of thematic content, based on the assumptions of Laurence Bardin. The results indicated the involvement and actions of these professionals aiming at family care, yet the assistance approach is predominant in the oral health care. Among the interviewees, the high demand for curative dental procedures was perceived as a barrier to advances in integral care and teamwork, from a multiprofessional and interprofessional perspective. It was concluded that there are different understandings of interviewed professionals in relation to the work process in the PSF. There are challenges to be overcome concerning the integral care to the user, integration with the multiprofessional team and work from the perspective of permanent health education.

Descriptors: Oral health. Family health program. Qualitative research. SUS. Family health strategy.

1 INTRODUCTION

The inclusion of Dentistry in the Family Health Program (PSF) brought significant changes in the working practices and processes, due to the insertion in a multiprofessional team, thus with the challenge of team work[1].

The working process in the PSF includes actions for health protection, promotion, prevention, assistance and rehabilitation of individuals, families and communities in an integral and continuous manner[2]. In this program, the home visit promotes the construction of new relationships between users and the multiprofessional team, which favors a bond between the involved people. The home healthcare is not limited to leading the health team to individuals with ambulation problems or providing information about hygiene and feeding. It concerns advances in understanding the context in which the individuals are inserted, with involvement and co-responsibilization of users about their health[3].

It should be considered that the dental practice in SUS requires professionals with a broad view about the health-disease process, able to understand the individuals, considering different aspects of their realities, such as family, socioeconomic, cultural and expanded sanitary conditions of their environment. Therefore, it is not limited to a combination of signs and symptoms restricted to the oral cavity[4].

Therefore, the working process in the PSF requires the integration and interaction of professionals, by the exchange of experiences and knowledge, aiming to achieve an integral care. It requires abilities of communication, empathy and management of emotions[5]. Therefore, the work requires actions for promotion, prevention and assistance in a multiprofessional team, supported by evidences. Additionally, it demands intersectoral actions, aiming at the integral care[4].

Within this context, the working process of dentists (CD) in the PSF is challenging, because it breaks the models of uni-professional work and also those that prioritize the assistance. Therefore, this study aimed to discuss and understand the perceptions of these professionals concerning the reality they experience in the PSF.

2 METHODOLOGY

This was a qualitative study, with data collection in the period April to June 2017, conducted on CDs who composed the oral health teams (ESB) of the PSF in a middle-sized city in southern Brazil. This study was approved by the Institutional Review Board of the State University of Londrina (CAAE 65620317400005231).

In each UBS, the CD who worked on the PSF was invited to participate. Some professionals were invited personally and others by telephone. During this stage, one CD was in maternity leave and in other UBS there was no CD working on the PSF, adding up to seven interviewees chart 1 presents the characterization of interviewees.

The interviews were performed in the facilities of the UBS at onset or completion of the work of professionals, according to their preference and choice, to avoid interfering with their work routine. Before each interview there was an informal conversation in which the CD was informed about the study objectives and signed an informed consent form. The participation was entirely voluntary, and the CDs could refuse to participate at any moment, without any harm or damage to them. The information was handled with secrecy and confidentiality.

Data were collected by recorded interviews using a semi-structured script, then transcribed and deleted to keep absolute secrecy. Data were submitted to analysis of thematic content as described by Bardin (1995)[6]. The transcriptions of interviews were assigned alphanumeric codes. Thus, CD1 is the transcription of the first interview performed.

CD	Gender	Age	Specialty	Time of work in the PSF	Time of experience
CD1	Female	41 years	Family Health	Not informed	19 years
CD2	Female	30 years	None	6 years	6 years
CD3	Female	36 years	Family Health and Restorative Dentistry	12 years	12 years
CD4	Female	31 years	Endodontics	3 years	10 years
CD5	Female	40 years	Family Health	8 years	17 years
CD6	Male	45 years	Family Health and Bioethics	11 years	17 years
CD7	Female	41 years	Periodontology	7 years	21 years

Chart 1 – Characterization of interviewees

3 RESULTS AND DISCUSSION

Among the interviewees, there is an understanding regarding the context of work in the PSF.

> *"We are currently in a risky area, there is a social risk even and this is a cultural problem, there are large families in small houses, there are often five or six residents in a house with two bedrooms, there are very small houses, then they are cultural problems, even in relation to hygiene and personal care that reflect in everything, in general and oral health." (CD2)*
>
> *"I think it is extremely important because, today, if you do not create the bond with families and do not have that perception of how these families are, you cannot reach your goal more easily, then you need to know not just their oral health, but also the general health and the environment in which they are inserted ." CD3)*

This result reveals an understanding of the working process and the concepts of the PSF, in addition to questions strictly directed to the practice of curative dentistry.

According to Reyes et al. (2015),[7] the expanded understanding of CDs in the PSF is related to their greater involvement in a broader scenario, ranging from the accomplishment of technical dental procedures to understanding the family in their community, something broad and not restricted to curative care. There are relationships permeated by bonding and acceptance that require the development of new competencies[7].

The bond refers to the narrowing of relationships and the sense of belonging to a group. Reception is a strategy that enhances the access and enables the identification and prioritization of social and epidemiological risk groups. In each site, these care practices present particularities because they consider the ways of living, acting, the socioeconomic

conditions of each user, the degree of involvement, organization and resources available to the health teams[8].

The ability to respond to the users' needs translates effectively as professional practices are supported by careful searches of professionals to recognize the integral and particular needs of each person, in addition to the individual's explicit health demands[8]. Despite the advances and efforts in health practices developed by CDs, the study of Arantes et al.[9] demonstrated that there is little knowledge about the living conditions of users and families by ESF professionals.

On the other hand, despite the involvement of professionals with the family and the community, it was observed that some professionals still have a vision focused in the mouth, that is, their understanding and consequent practice are still limited to the treatment:

> *"I think it is extremely useful for the population, because I live with this population, I go to their homes and I see the treatment needs, some treatments are done in their homes but some not, then I schedule directly here with me." (CD1)*
>
> *"We visit and see the condition of that family, we try to treat as good as possible, but we are still unable to do this objectively." (CD3)*

The actions developed by health professionals during home or outpatient care should be far from the reductionist biomedical context of accomplishment of clinical procedures, moving to a working process that addresses the development of greater bond between professional and patient, by actions for health promotion, prevention and assistance to strengthen the autonomy, co-participation and active co-responsibilization of the health problems[8].

The health communication and education are means to understand and advance the integrality of care. Within this context, Paulo Freire (2011) presents the popular education (EP) as a freeing education that deserves much attention. Thus, the actions for promotion of health education are fundamental as a right of citizenship and to enhance the quality of life, which should not be left behind by health professionals during the working process. The population values initiates based on health promotion and resolution of problems. Therefore, these actions should focus on community actions and consider the loco-regional and particular needs of users[10].

In this sense, it is necessary to replace traditional models based only on unidirectional communication practices. The themes for collective educative actions related to Dentistry should be part of the daily routine of oral health professionals. They may address the main oral diseases, their manifestations and prevention; the importance of self-care, oral hygiene, toothbrushing with fluoride dentifrice and use of dental floss; the care to be taken to avoid fluorosis; general information about healthy diet; instructions for self-examination of the oral cavity; immediate care after dental trauma; prevention of unprotected sun exposure and prevention of alcohol and tobacco use. It is fundamental and mandatory to discuss, reflect and address all these aspects, considering the complexity of social determinants of behaviors and the health-disease process. The experience and understanding of the content by the involved people favor the reflection on their own health, encourage good self-care practices and responsibilization of users for their oral

health[10].

Other result observed concerns the high demand for dental procedures, which is perceived as a barrier for advances in integral care advocated by the PSF:

> *"I would like to assist the entire demand in shorter time. Maybe I do not have sufficient time to meet all that demand. I would like to have more time for visits, because on the other days I need to stay in the dental office." (CD1)*
>
> *"The time is short, I assist many patients in the office and we only have one afternoon in the week for the visits." (CD7)*

The working process of the CD is wide to meet the demands of the productive process. The professionals should understand that the protocols are not sufficient to meet the real demands, bringing the challenge to reinvent them to fill the existing gaps[7].

One of the concepts of the National Policy of Basic Care (PNAB) concerns the organization and orientation of health services on a user-centered basis. Within this context, the PSF proposes reorganization of the health working process, by changing the hegemonic model of a disease-centered care, which is predominantly biological, to an approach that meets the peculiar needs of users, presented in real spaces where the citizens build their history and represent their health-disease process[11].

The production of user-centered care may be able to potentiate the individual and collective healthcare, since it addresses social and cultural aspects in which the individuals are inserted. Therefore, the access to PSF services should be defined according to the needs of users, rather than a previously organized and hierarchic offer of services. Thus, the imbalance between the assistance offered by PSF teams and the real demands of related populations may be reduced[11].

In this result, the professionals seem to prioritize the curative assistance, also related to the high spontaneous demand:

> *"When the new nurse began I told her that we had to conduct the visits, and she said: no, why do you make visits? Then I told her: we follow and visit the individuals who are in bed, nursing women and babies. She said: No, I prefer you to keep assisting the patients." (CD4)*

This result elicits a reflection that the amplitude of curative demand may limit the further actions of CDs in the PSF. This may be related to the choices made by professionals in the daily routine of services. It may be influenced by the relationship between these professionals and the other members of the multiprofessional team of the UBS, and also by the understanding of other PSF members about the importance of Dentistry in the PSF. In this sense, the home visit conducted by the Oral Health Team is a valuable instrument to meet the objectives of the PSF, since it brings them closer and strengthens the bond between involved individuals. It favors the longitudinal care.

According to Bulgareli *et al.*[12], the oral health actions are highly focused on the attention the spontaneous demand, for curative and/or palliative dental treatments of dental complaints, limited to the individual needs in the context of biomedical care model, focused on healing diseases. According to the author, the extensive area assisted by each UBS impairs a closer follow-up of users, which interferes with the organization of the working process.

The interviewees reported collaborative

working actions with the other members of the multiprofessional team:

> *"We participated in an immunization campaign, Dentistry worked together to act in this field and make some risk stratification..." (CD7)*

> *"... if the patient presents high blood pressure, I refer to the nurses and they make the attendance, reception and the patient is assisted by the medical doctor or referred to the UPA..." (CD5)*

The interaction between members in the team allows exchange of knowledge, combined and shared learning, and identification of common points to guide the establishment of collective guidelines, both implicit and explicit, in the team dynamics, favoring its action. Soares *et al*.[5], in an investigation on PSF members, reported that the isolation of CDs in their dental office precludes the interaction of the ESB with the other members of the multiprofessional team[5].

However, in the present study, the individuals mentioned that dentistry is also isolated by the own team members:

> *"This aspect of team work depends a lot on the UBS where you work... At UBS XXX, they made an action, closed the street and organized a country party for the group of hypertensive and diabetic patients and the entire staff of the UBS was invited to participate, except for the Dentistry members." (CD7)*

The attitude of team members of not sharing the activities developed by the UBS with the dental team impairs the development of a relationship between professionals of the same team. This distance seems to impair the team work.

> *"I have worked in a UBS where we were upset with the exclusion of Dentistry and we had to insist to be involved, participate in the actions, to be recognized; this is revolting." (CD7)*

This result raises a reflection about the need that these excluding behaviors should be noticed by the UBS coordinators. It requires addressing this demand by permanent education processes.

According to Motta and Batista (2015)[13], the lack of collective work responsibility, which includes the low degree of interaction between professionals, hierarchy between professionals, fragmentation of the working process, and accomplishment of combined and isolated actions lead the professionals to be isolated in their "competence nuclei". They highlight that the daily work, construction and accomplishment of a common project pertinent to the needs of users are impaired by the lack of communicative practice, which requires a search for consensus among the team professionals. The communication between health team members, in several cases, is limited to the exchange or transmission of technical information; in few situations there is a critical discussion concerning the problems and needs of the team and population, in the search for collective consensus.

As reported by the interviewees, there is also isolation of dentists in their offices.

> *"It is a little complicated for us, we do not have time and habit to meet our and their schedule… and there are efforts to change this, we did not have meetings and now we are saving some spaces in our schedule to try to join them, but not yet very frequently,*

and I think there is still lack of case discussions, especially of clinical cases." (CD3)

The interaction of oral health professionals with the other health team members is necessary to advance the integral care of users. Thus, the team meetings are important opportunities to being the involved professionals closer for a collaborative work. This is challenging for the CDs in the PSF because introducing the "new" questions the values, places and powers consolidated by practices from previous models[14]. Additionally, the historic influence of the individual care model, the adverse work context, concepts of professionals about the PSF and their autonomy restrict their action as CD of the PSF[7]. The Ministry of Health (MS) advocates that the ESB should interact with professionals from other fields because this expands the knowledge, favors the team work and the integrality of care[14].

It should be highlighted that the professional action is influenced by the personal characteristics of each human being, yet always in a dialectic relationship with the environment. Without this understanding, there is the risk to reduce the obstacles to the implementation and integration of oral healthy in the PSF to blaming the individuals and groups, as if their capacity to act on the Basic Care guidelines was not part of greater (health system), middle (management) and smaller contexts (daily routine of services)[7].

Therefore, it should be remembered that the proposal to overcome the challenges and establish the health attention and integral care begins by the reorganization of working processes in the primary care and is combined to other healthcare actions[13]. Within this context, the reorganization might initiate by Permanent Health Education (EPS) actions aiming to construct a teaching-learning network within the SUS, directed by the needs of populations/users as citizens with rights[15].

This result indicates the need of advances in integral care with the other professionals working in the UBS:

"*I think I am part of a team and I am doing my part, which would be oral health; if I notice something that is not from my field I refer it to other fields, alike professionals from other fields also refer the oral problems for me." (CD6)*

"In some smaller units there is a greater interaction; here in UBS XXX I think there is still lack of integration. To achieve an integration with the team, with community agents; this has changed a little, because it was worse." (CD3)

Based on these talks, it is possible to understand that the integration with the team occurs casually, based on scarce communication and articulation, requiring advances within the multi- and interprofessional perspective.

This result might be related to the fact that, in Brazil, the training of health professionals is based on three models: uniprofessional, multiprofessional and interprofessional, with predominance of the first model[16].

The interprofessionalism is an advance of multidisciplinarity because it involves professionals with different health training backgrounds who act among specific training areas, articulating specific knowledge to others in the work organization. This also applies to a broader articulation between teams, promoting the integration of care networks by

collaborative practices or approaches. This is a characteristic of integrated teams, who present mutual respect and trust, recognition of the professional role played by the different specialties, interdependence and complementariness of knowledge and actions[16,17].

The interprofessional communication is a central aspect for the work in integrated teams. It allows the complementariness of actions, which is mandatory for the integral care to the user. The sharing of information and interaction depend on the communicative reciprocity, with active participation of involved individuals[17].

The health needs require increasingly more professionals prepared to work collaboratively in teams committed to the healthcare, since the increasingly complexity of health needs of users/populations, the changes in demographic and epidemiological profile related with aging and the increase in chronic diseases indicate the need of a new professional profile characterized by the interprofessional collaboration[17].

4 CONCLUDING REMARKS

It was concluded that there are different understandings and involvements of interviewed professionals concerning the working process in the PSF. The study evidenced challenges to be faced concerning the integral care to the user, focusing on all needs of users and not only on the disease, which include the needs of advances in the resolution of curative demands identified, establishment of actions for promotion and prevention.

Other challenge concerns the need of advances in the team working process from a multiprofessional and interprofessional perspective, aiming to improve the working process. There are challenges to be overcome in relation to work from the EPS perspective. Even though this study reports a specific reality in a given moment, these results may also be experienced in other places, since the work in the SUS is dynamic and processing. Therefore, there will always be challenges and advances within the SUS, because it is a process under construction, which also depends on the training and education of professionals from the perspective of integrality of care to the individuals.

RESUMO

Percepções de cirurgiões-dentistas sobre o trabalho no Programa Saúde da Família

Trata-se de uma pesquisa de natureza qualitativa realizada com cirurgiões-dentistas (CDs) que integram as Equipes de Saúde Bucal (ESB) do Programa Saúde da Família (PSF) em um município de médio porte do sul do Brasil, realizada no período de abril a junho de 2017. Objetivou identificar as percepções destes profissionais sobre o processo de trabalho que vivenciam no Programa. Em cada uma das nove Unidades Básicas de Saúde (UBS), foi convidado a participar o CD que estivesse atuando no PSF, totalizando sete entrevistados. Os dados foram coletados por meio de entrevistas gravadas, semiestruturadas por roteiro de questões e analisados por meio de análise de conteúdo temática, apoiada nos pressupostos de Laurence Bardin. Os resultados apontaram que há envolvimento e ações destes profissionais voltados para o cuidado da família, porém o enfoque assistencial é predominante na atenção à saúde bucal. Entre os entrevistados, a alta demanda por procedimentos odontológicos curativos foi percebida como barreira para avanços no cuidado integral, no trabalho em equipe na perspectiva multiprofissional e interprofissional. Concluiu-se que há diferentes entendimentos dos profissionais entrevistados em relação ao processo de

trabalho no PSF. Há desafios a serem superados em relação ao cuidado integral do usuário, à integração com a equipe multiprofissional e trabalho na perspectiva da EPS.
Descritores: Saúde Bucal. Programa Saúde da Família. Pesquisa Qualitativa. SUS. Estratégia Saúde da Família.

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