ORIGINAL RESEARCH

Meanings about the doctor-patient relationship in the family health strategy: Thoughts on health care from the perspective of the users.

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Abstract

Primary Health Care (PHC) appears as the main guideline for health actions in the Family Health Strategy (FHS). Its prerogatives include multidisciplinary teamwork focused on the users, families and communities where this strategy is inserted. However, the historical context of health practices in Brazil has shown that PHC did not settle without contradictions. Some of its principles, such as completeness, arise in clinical encounters between physicians and patients, that is still strongly marked by an asymmetry, as well as by the limitations of the biomedical discourse and practice. The aim of this study was to analyze and understand some of the meanings present in the doctor-patient relationship and this from the perspective of the users, as observed in meetings of a team from the FHS unit in the Areia Branca neighborhood of Santos-Sao Paulo. Also carried out were in-depth interviews, with a semi-structured script, with five users served by this FHS team. Therefore, in the interpretation of the meanings of the doctor-patient relationship, attributes related to familiarity, trust, and longitudinally as they are permeated by processes of symbolic resignification of the medical discourse by the users. This brought out components related to the autonomy of the interviewees as they dealt with their health-disease processes.

Keywords: Physician-patient relationship. Family Health Strategy. Meanings.

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Introduction

Understanding Primary Health Care (PHC) as a care model that shows us how to organize the actions of health care[1] We emphasize that the PHC implementation process in Brazil adopted as policy a healthcare model, called the Family Health Strategy (FHS), originally connected with a set of actions and services that go beyond medical care, that is, as a health policy in process.[2] The FHS also incorporates a central element in healthcare, namely the clinical relationship between doctor and patient.[3]

Therefore, the study of the doctor-patient relationship through the prism of beneficiaries of healthcare, is presented as a relevant topic to understand how the FHS has been implemented historically and at present, in Brazil.

The guidelines of the PHC and the FHS consolidation in Brazil

The Alma-Ata Conference, in 1978, established the doctrine of PHC as being oriented towards the main health problems of the community and to provide preventive, curative and rehabilitative health care and promotion.[2]

Organizational strategies and the reorganization of health systems were essential for the implementation of the PHC, which was conceived as the first level of care. This was coupled with the change in clinical care practice provided by health professionals, and was to be guided by essential PHC attributes. These attributes are: family and community orientation and cultural competence.[4] Regarding these attributes what stands out is:

A) Attention to the first contact.
B) Sustainability of care (regular source of care and use over time).[5 6]

C) Completeness, that is offering an integral approach of the individual and the family, including: promotion, prevention and protection and primacy of promotion and prevention.[7]

D) Coordination of care to ensure continuity of care through the recognition of the problems by the health teams.[8]

The prospect of an integral approach of the individual and the family, points to the need for redefinition of health practices, aiming to establish bonds, feelings of welcome and of autonomy, recognizing and valuing the intrinsic subjectivity to health work and allowing interventions to be user-centric.[4]

In Brazil, the principles and attributes of PHC were extremely relevant to the setting up of the Unified Health System/*Sistema Único de Saúde* (UHS/SUS). Considering the importance of FHS to the reorganization of primary care in Brazil, the Ministry of Health published Ordinance n° 648, of March 28, 2006, consolidating it as a strategic priority.[9] Currently, the FHS is established in 5,469 out of 5,570 municipalities, covering approximately 155 million people around the country.[10]

However, the establishment and expansion of the FHS took place in a manner that was not devoid of problems in its implementation

> ... a reduction in the role of the state and containment of public expenditure, an increase in alternative contracting arrangements, stigmatization of the workforce and shifts in the responsibility of the health system costs covered by the federal government and other levels of governments, all in light of the prevailing hegemonic project that was in the State.[5]

Because it was guided by a decentralization drive, the expansion of the FHS in Brazil, instead of helping to solve the problems related to the supply of basic adequate health attention in the different contexts in which it was inserted, ended up with the emergence of new problems and weaknesses, not addressing solutions to previous deadlocks and further impeding the expected political reorientation of the healthcare model.[11]

In this sense, although it is expected of professionals working in the FHS, especially doctors to develop a humanistic attitude that enhances the doctor-patient relationship and the ethical duties of the profession, this did not happen.[12] However, nothing guarantees that FHS strategies "(...) will break with the doctor-centered dynamics --the current hegemonic model."[13]

There are many questions in the literature[14,15,16] about doctors' political and professional practice attitude as problems to the consolidation of the FHS.

Sociocultural perspectives on the doctor-patient relationship

Reforms in the health system in Brazil, have been advocating the establishment of dialogue and greater horizontal relationship between professionals and users, especially doctors, as well the inclusion of new actors with knowledge and practices in favor of basic health actions.[17]

From a socio-historical perspective, the doctors do not lose the hegemony of knowledge in the consolidation of the capitalist model. With scientific progress and an exaggerated appreciation of science and rationalization of knowledge, the exercise of medicine has consolidated, giving the patient (and disease) a central part in its practice. Therefore, the patient (and disease) has lost its social and subjective dimension to become an object of scientifically recognized knowledge.[18]

Soares and Camargo Jr. emphasize the asymmetry of the doctor-patient relationship, pointing to an unequal distribution of authority, as a result of the presence of rational and technical values in this relationship; This gives passivity and dependency of the patient towards the doctor.[19]

This asymmetry in the doctor-patient relationship has been addressed by Luc Boltanski, a sociologist, who highlighted how actions and representations that constitute health practices are based on class structure, stressing various aspects present in this relationship such as the linguistic barrier that separates the patient's physician from the popular classes and the different meanings that medical services use can have on patients belonging to different social classes. The author points out a social gap in doctor-patient relationship,[20]showing that the way patients talk about their disease, their perceptions of the health

/disease process, as well as their notions of citizenship and rights in the face of the public health system can be related to their schooling level.[21]

LaPlantine[22] also highlights that medicine progresses through a cultural decontextualization of the disease saying that scientific thinking seeks to establish a rupture between the disease and the social context that surrounds it. However, this is an impossible task, because the disease cannot be isolated from the culture and from individuals. The experiences of the disease carry a symbolic reinterpretation by their respective cultures.

Meantime, the hegemony of the biomedical discourse has become a "global culture" that moralizes the health-disease process, establishing itself as a new normativity that rewards obedience, punishes transgression, measures ignorance and fights against unofficial medicines.[22]

Latour[23] contributes to these thoughts indicating the existence of inequalities in society, which cannot be ignored or treated as products of inertia, but as fruit of a process. He believes that the relations are not constituted only of social components. There are other actors in these relations responsible for the permanence of ties and maintenance of power relations.

One aspect that permeates the doctor-patient relationship, especially in the clinical encounter, is communication, which can be hampered by power relations, class and sociocultural issues. That said, socio-cultural perspectives can help us to build knowledge indicating that the reality can be better understood when looked at from the points of view of patients and other people involved in the therapeutic process.[24]

Therefore, the different explanations that patients and physicians talk about the disease, as well as the social and cultural meanings of their experiences of illness can end up in a "relational deadlock".[25]

Thus, the patient lay perspective can be permeated by the "magical thinking", consisting of a kind of knowledge based on perception and imagination, very close to the sensory intuition, having different forms of abstraction, not guided by concepts related to scientific rationality.[26]

We must emphasize that the response of the individual to a particular culture and society to a disease will always be permeated by the collective vision, family and / or community in which it operates. The symbolic efficacy of the therapeutic proposal to the patient[27] also has to do with the social recognition of the healing practices of the doctor and the belief of the doctor himself as a "healer."

Gomes et al., studying the doctor-patient relationship in the context of the PHC and the FHS drew up a didactic classification of this relationship, organized into three sections.[28]

The first refers to the meeting centered on the patient, in which the conversation is conducted to meet the needs brought by patients, valuing the resources of the individual itself and other therapeutic possibilities.[28]

The second profile refers to meeting without understanding and is permeated by incomprehensible technical and scientific expressions for most patients and a consultation focusing on treatment and diagnostic tests.[28]

Finally, there is the meeting in the short term, marked by a rapid consultation in which time is directed to a prescriptive resolution, limited to addressing symptoms.[28]

As pointed out in studies that address the doctor-patient relationship it is evident that dialogue and communication as main "substances" of this relationship are important, particularly in the clinical meeting.[29] Since the disease is an experience lived by an individual, the patient, which seeks to give it a sense, explains its importance from a patient's perspective.

Thus, in search of better communication with the patient, especially through dialogue and valuing their perspective, it is expected that the family doctor transcends the division body/mind, which has a reductionist and mechanistic character, emphasizing the construction of a bond with the patient based on complicity and affection.[3] Noteworthy is also the presence of intuition, regarded as synthetic ability of thought, arising out of sensitivity and not reason, that can assist in making specific decisions.[30]

In this sense, the fact that people develop singular explanations of the causes of disease gains value, generating different discourses and meanings about their conditions of health/disease, which cannot be tied to scientific medical rationality.[31]

Method

The qualitative approach proved to be the most suitable to study the sphere of health relationships as a social phenomenon.[32] It is also important to point out the importance of a hermeneutic perspective in the interpretative approach to the health / disease process, since the culture produces symbolic structures, metaphors and other figures linked to diseases that shape the individual's subjective impression of reality.[33 34 35] Soon, ethnographic approaches became important for allowing the study of a given context through discourse analysis, interpreting the meanings present in the event of speaking and behavior stream where these meanings occur.[35]

Pointing that symbolic and cultural dimension permeate the doctor-patient relationship, producing meanings, it seeks, with a specific form of "observe" and "listen",[36] to understand these meanings through a four-month immersion in field research (March to June 2017) with meetings of multidisciplinary teams, followed by home visits (HV), mediated by Community Health Agents (CHA), and selecting some users for in-depth interviews with a semi-structured script.

The following criteria were used to select the respondents:

- attend FHS unit for at least one year;
- be 18 years old or more;
- be monitored / under treatment by the unit in question.

Thus, we selected five users for interviews from three micro areas (corresponding to the areas covered by three CHA), accompanied by two staff of the FHS unit. These users had been previously consulted and participated in the survey upon their consent.

In the analysis of speech, we tried to understand and interpret the meanings attributed to the doctor-patient relationship, keeping in mind that the act of speaking is permeated by a context, which is a culture developer and also confers sense and meaning to lived phenomena, both in individuals and collective dimensions.[35]

The interpretative analysis of these meetings and interviews outlined the developing interactions between researcher and research subjects, through recovery and deployment of intersubjective processes, with the help of literature research in this work.

Results and discussion

Meanings of the doctor-patient relationship: insertion in the field; home visits and speeches of respondents:

By monitoring six meetings of the multidisciplinary team of the FHS unit studied, we tried to understand some features related to the context and dynamic where these meetings took place in order to establish contacts with the CHA so that they mediated contact between researchers and users.

Among many observed aspects, the users highlighted the presence of important attributes of PHC at the welcome, the establishment of bonds and familiarity permeating all these meetings discussions, revealing significant involvement on the part of professionals; some users related a preference for certain professionals for their health care, indicating consistency regarding the insertion of health professionals in families and communities by establishing bonds and familiarity relationships.[2]

On the HV, we believe that two factors were relevant. First, the distance between the health unit building where the field work was done (Bom Retiro neighborhood) and the reference health unit building of the Areia Branca neighborhood, which corroborated the increase in missed appointments and discontinuity in the monitoring of patients with chronic diseases. Second, the prioritization made by physicians only makes HV to patients unable to go to the health unit, to the detriment of those who, supposedly, could go to the health unit building in Bom Retiro neighborhood.

The principles such as longitudinally, familiarity and community orientation were complicated by the fact that the services were being offered in another health unit building of FHS, that was not the reference unit, that is, many people who were assisted at the Areia Branca neighborhood did not attend until the Bom Retiro neighborhood.

In terms of loss of consultations and increase in chronic diseases, in the followed meetings, doctors had complains about a "lack of commitment" of users across the suggested therapeutic, causing certain guilt to individuals vis-a-vis their health / disease process at the expense of other factors that could corroborate or not adherence to treatments; this reminds us

LaPlantine when he claims that contemporary medicine moralizes disease, punishing transgression and rewarding obedience of those who make use of it.

The CHA, in turn, reported in these same meetings, that the residents of the neighborhood Areia Branca are mostly elderly. This fact could bring difficulties to their displacement to the reference unit. Another prominent factor was the reference to a 'resistance' of certain users to the prescribed therapies.

Such reports indicated that the CHA is more familiar to users and community, ensuring their greater "cultural competence" compared with doctors, demonstrating empathy and recognition about missing consultation and resistance to provide prescriptions.

Professionals also said that some users had service preference for certain medical and / or professionals, both for queries and for the HV, which refers to the idea of bond and familiarity,[2] but also points to an exercise of autonomy of users against what was prescribed to them and options they considered relevant in their health / disease process, this autonomy can be marked out by the "magical thinking" and "symbolic efficiency"[26,27] present in the relationships established between professionals and users.

In a second moment, there was the approach to the respondents (4 women and 1 man), by establishing a relationship of empathy and trust between researcher and research subjects as fundamental aspects to favoring intersubjectivity, aiming for the appearance of significant structures in the discourse of these interlocutors.[36]

Already in these initial meetings had emerged aspects of the doctor-patient relationship, as emotional and psychological support of the doctors on life stories of respondents, but also the appreciation of the opportunity of being able to talk about the services offered

> *... It is for us to be comfortable to complain if we want?! (João Candido)*

In interviews, the fact that the FHS unit Areia Branca was providing their services outside their coverage area gained relevance, sometimes hindering the work of professionals, particularly the CHA in the HV corroborating certain dissatisfactions by them concerning the health care, as well as questioning some principles of PHC as longitudinally and attention to the first contact.[2]

> *... The only thing that we really need is to hope that they come here, right? Which is closer to us!* [referring to the building of the health unit that was located in the territory and was under renovation] *(Luana)*

Also in the interviews, we found facts about the high turnover of medical professionals, not allowing to encourage the strengthening of ties and familiarity relationships, indeed indispensable front of attributes longitudinally and completeness in PHC.[2]

> *So, we go and meet the doctor! Then a little time passes and ... the doctor's is already another! ... but, sometimes, we get used to that doctor, you know? ... that's already heard of your case. (Valencia)*

This seems to indicate that the lack of technological, managerial and scientific elements in clinical practice, e.g., various forms of hiring people, wages and incentives that do not promote professionals, are factors tensing and fragmentation of care, which also hinder the strengthening of PHC in Brazil, both in the FHS, and in UHS/SUS.[37]

However, some of the respondents did not judge this turnover to be a serious problem, because at least there was no lack doctors to serve them:

> *... I'm doing this ... I go to the doctor ... if there is no one, or it is another... [I do not care, at least] there are many doctors over there (Dona Margarida)*

In any case, we believe that high staff turnover and the distance between users and health unit corroborated in a "loosening" of the bonds between professionals and users, including doctors, as well as users with the unit, damages the attention to first contact and longitudinally and hinders the exercise of integral care.

On the HV, we seek to value the speech of users, their symbolic character, representing special care to the user, symbolizing a staff

commitment, strengthening the bond between professional staff and user and emerging as another space that promotes the user autonomy in attention to health.[38]

In the interviews, all stressed that they would like to receive the doctors, but said that other needy people should be visited by them:

> *I think.... we would like* [to receive the doctors], *right? ... it would be nice to us, but they never come to see us! Never! (João Candido).*

> *... they usually visit those who have a problem of movement or a more serious illness ... But how is not my case .... is not necessary! (Vivian)*

We note, therefore, that the priority of the doctors for some HV over others undermines the establishment of a bond and trust in the doctor-patient relationship, not allowing encouraging an attention to another health space and not assisting the development of self-care and self-perception in a diverse environment of the health unit. (38)

The reframing of the biomedical discourse: routine exams, conversations and user autonomy

Assuming that individuals, through the linguistic tools provided by their culture, symbolically resignify in their speech scholarly and medical language.[22] We found that respondents resignified the medical discourse developing autonomy proceedings with the provided prescriptions, sometimes following these prescriptions, sometimes not following them, as well as using this speech to give directions to their health / disease process, indicating resources of self-awareness and self-care.

> *I went to the doctor, and he said I had high cholesterol level ... ... then when I came back, he said that* [the cholesterol level] *it was normal! Now ... I'm going back there to do it again* [the diagnostic tests], *to know if did not come back* [the high cholesterol level], *right? You never know, right? (Valencia)*

> *No! That I do not do it*! [take medication correctly] *Because they gave to me the medicine for diabetes* [metformin] *... three pills to take a day ... . Then I get all day with dysentery ... so I take one pill and I'm feeling good! (João Candido)*

However, we could not help to notice the presence of tests, drugs and diagnostics, as 'meaning makers' marking the clinical encounter and enhancing the asymmetry in the doctor-patient relationship.[23]

Overall, the users themselves indicated going to consultations in order to speak exclusively on aspects of health, even when the clinical encounter transcended the technical dimension, providing psychological and emotional support to users.

> *... look! for me to talk like that, no! ... I do not have that intimacy as well, right? We talk that time there* [in the consultation room] *and it is over! (Valencia)*

However, we noticed the presence of short-term appointments that focus on disease (28), which are not promoting, perhaps, spaces for these users to speak. On the contrary, in some cases, users believed that a doctor's time is too important to be wasted on other matters than health.

> *... I do not feel good about wasting his time* [the doctor's time] *because it is a very busy time! So, because of this, I'll not be there, you know, chatting with him! (Vivian)*

Either way, we emphasize that the respondents develop parallel strategies on prescriptions, on making choices, not only guided by prescriptions, but mainly in their health / disease experiences and subjectivities, thus exercising their autonomy and extrapolating the dimensions of clinical encounters through symbolic resignification processes,[22] which does not prevent them, however, to value the importance of a relationship of trust with physicians.

> *... he is a person who make us feel comfortable… I do not get anxious, or something similar, you know? ..... he is a person, as well, very approachable too, you know? (Vivian)*

Another factor that corroborated the strengthening of ties and familiarity in doctor-patient relationship was the active participation of

community health agents (CHA), which, according to some reports, exerted greater influence on the users than the doctors themselves.

> *... so, I think that the difference in medical care involves the work of community* [health] *agents ... because they know what we have at home ... they know us better ... they have contact with us ... why the doctor has not!" (Valencia)*

This may have occurred because, unlike doctors, CHA's, who are health professionals who live in the same neighborhood where they accompany patients and their families, in their respective territories, already conduct their activities in the unit of FHS for years and live in the neighborhood, confirming perhaps the promotion of bond establishment and appearing as regular sources of care, thus contributing to the principles of comprehensiveness and longitudinality.[2]

Final considerations

The doctor-patient relationship and its meanings expressed by users proved to be extremely dynamic and complex.

We noted that bond formation and the establishment of a trust relationship proved to be important to a clinical encounter that goes beyond the technical dimension in health care.

Familiarity appeared as essential in the establishment of connection between users and the FHS unit, not only in relation to the doctor, but especially with the CHA, an important piece to "bridge" the gap between doctors and patients in clinical encounters.

It was evident to us that "things" and "objects" count as Latour[23] points out, that is, tests, diagnostics and drugs. In interviews, tests, medications and diagnoses appeared as elements used by the users to discern whether they were in good or bad health, giving them some autonomy in their perception.

Furthermore, using parameters and terms of the biomedical discourse, though without incorporating them passively, users began to reframe elements of

this discourse, giving particular meanings to their health/disease processes.[22]

To express their disturbance[39] facing the health and illness experiences, as well as their responses to suggested treatments, the patients add their own experiences, choosing to follow or not what was proposed to them, leading up, perhaps, to a kind of knowledge on the perception and imagination, very close to their sensitive intuition.[26]

We do not intend, however, to deny the existence of asymmetry in doctor-patient relationship[20] or the fact that the biomedical discourse is still hegemonic,[18 24] which are aspects well addressed in the analysis of political and power relations that underline the asymmetry of this relationship. We try to show, however, that the socio-cultural dimension proved to be relevant from the user's point of view concerning their health/disease process, and their relationship with the medical professionals.

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