

ORIGINAL ARTICLE

NURSES AND PHYSICIANS IN THE FAMILY HEALTH STRATEGY: WORKLOADS AND COPING

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ABSTRACT

Objective: To analyze factors that increase and reduce workloads of the FHS nurses and physicians and to identify coping strategies.

Method: A qualitative study conducted through semi-structured interviews in the five regions of Brazil. The participants were 27 nurses and 21 physicians, in the period from January 2017 to June 2019. Thematic content analysis was performed with the ATLAS.ti 8 software.


Results: The factors that increase the loads were excess demand, work overload, and failures in work conditions, organization, and management. Teamwork, planning, bonding with health care services users, and resoluteness of care help to reduce the loads. For coping with the loads, physical activity and disconnection from work stand out.


Conclusion: Elements that increase the loads prevailed; however, characteristics of the care model contribute to their reduction. The identification of loads is essential and contributes to the planning of coping actions.


DESCRIPTORS: Primary Health Care; Family Health Strategy; Worker's Health; Workload; Unified Health System; Nurse; Physicians; Primary Care.


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ENFERMEIROS E MÉDICOS NA ESTRATÉGIA SAÚDE DA FAMÍLIA: CARGAS DE TRABALHO E ENFRENTAMENTO

RESUMO

Objetivo: analisar fatores que aumentam e reduzem as cargas de trabalho de enfermeiros e médicos da ESF, e identificar as estratégias de enfrentamento.

Método: estudo qualitativo, realizado nas cinco regiões do país, através de entrevistas semiestruturadas. Participaram 27 enfermeiros e 21 médicos, no período de janeiro de 2017 a junho de 2019. Análise de conteúdo temática com software Atlas.ti 8.

Resultados: os fatores que aumentam as cargas foram o excesso de demanda, a sobrecarga de trabalho e falhas nas condições, organização e gestão do trabalho. O trabalho em equipe, o planejamento, o vínculo com o usuário e a resolutividade da assistência auxiliam na redução das cargas. Para o enfrentamento das cargas, destacam-se atividade física e desligar-se do trabalho.

Conclusão: predominaram elementos que aumentam as cargas, entretanto, características do modelo assistencial contribuem para a sua redução. A identificação das cargas é fundamental e contribui para o planejamento de ações de enfrentamento.

DESCRITORES: Atenção Primária à Saúde; Estratégia Saúde da Família; Saúde do Trabalhador; Carga de Trabalho; Sistema Único de Saúde.

ENFERMEROS Y MÉDICOS EN LA ESTRATEGIA DE SALUD DE LA FAMILIA: CARGAS DE TRABAJO Y AFRONTAMIENTO

RESUMEN:

Objetivo: analizar factores que aumentan y reducen las cargas de trabajo de enfermeros y médicos de la ESF, e identificar las estrategias de afrontamiento.

Método: estudio cualitativo realizado en las cinco regiones de Brasil por medio de entrevistas semiestructuradas. Participaron 27 enfermeros y 21 médicos, durante el período de enero de 2017 a junio de 2019. El análisis de contenido temático se realizó con el software ATLAS.ti 8.

Resultados: los factores que aumentan las cargas fueron el exceso de demanda, la sobrecarga de trabajo y diversas fallas en las condiciones, organización y gestión del trabajo. El trabajo en equipo, la planificación, el vínculo con el usuario y la capacidad resolutiva de la asistencia ayudan a reducir las cargas. Para afrontar las cargas, se destacan la actividad física y desligarse del trabajo.

Conclusión: predominaron elementos que aumentan las cargas; sin embargo, ciertas características del modelo asistencial contribuyen a su reducción. Identificar las cargas es fundamental y ayuda a planificar acciones de afrontamiento.

DESCRIPTORES: Atención Primaria de la Salud; Estrategia de Salud de la Familia; Salud del Trabajador; Carga de Trabajo; Sistema Único de Salud; Enfermeras y Enfermeros; Médicos de Atención Primaria.

INTRODUCTION

In the international debate on universal public health systems, Primary Health Care (PHC) stands out as a beneficial strategy contributing to order access to the health services and the development of practices guided by the principles of comprehensiveness and equity⁽¹⁾.

In Brazil, the attributes of PHC are included in the Family Health Strategy (FHS)⁽¹⁻²⁾, which provides that health care must be performed by multidisciplinary teams⁽¹⁻³⁾ composed at least of a physician, a nurse, a nursing assistant and/or technician, and community health agents.

In PHC, the debate about the workforce and its importance for the realization of the model has been highlighted. There are studies on the number and qualification of physicians and nurses⁽⁴⁾ and others that discuss the potential for expanding the scope of the practices developed by nurses⁽⁵⁾. Also relevant are those dealing with dissatisfaction and workloads⁽⁶⁻⁷⁾, with emphasis on the psychic burden⁽⁸⁾, which can be related to works that deal with human suffering⁽⁹⁾.

Workloads (WL) are elements present in the work process that can contribute to wear and/or illness, and can be classified as psychic, physiological, physical, biological, chemical, and mechanical⁽¹⁰⁾.

Studying the influence of the WL of nurses and physicians can contribute to the effectiveness of PHC and to the adoption of health protection measures. In this sense, this study aims to analyze the factors that increase and reduce the WL of nurses and physicians working in the FHS, as well as to identify the coping strategies used by them.

METHOD

A qualitative, descriptive and exploratory study conducted with 27 nurses and 21 physicians of the FHS in the five regions of Brazil, according to Chart 1. The sample was composed intentionally, considering data saturation as a sufficiency criterion.

Chart 1 – Number of study participants according to their professions and to the Brazilian regions. Florianópolis, SC, Brazil, 2020

REGION	CITIES	PROFESSIONAL CATEGORY		TOTAL
		Nurse	Physician	
NORTH	Manaus Nova Olinda do Norte	4	3	7
NORTHEAST	Natal	7	2	9
MIDWEST	Brasília	4	4	8
SOUTHEAST	Rio de Janeiro	6	7	13
SOUTH	Florianópolis Araranguá	6	5	11
TOTAL		27	21	48

Basic Health Units (BHU) and teams considered successful were chosen according to indications from the leaders of the municipalities, associating to this criterion the results obtained in the evaluation in the first cycle of the 2012 National Program for Improvement of Access and Quality (*Programa Nacional de Melhoria do Acesso e da Qualidade, PMAQ*) classified as “above the mean”⁽¹¹⁾.

Nurses and physicians who have been working in the FHS for at least one year were included, due to the fact that they knew the daily work, as well as those who were in full exercise of the function at the time of the interview. Professionals who were away and/or unavailable for data collection and incomplete teams were excluded. The professionals were contacted by telephone and, after explaining the research objectives and formalizing the invitation to participate, the place, date, and time for the interviews were scheduled.

Data collection took place between January 2017 and June 2019, by a team of properly trained researchers together with a research coordinator, in each region. The semi-structured interviews sought to characterize the information related to the work of nurses and physicians, organizational structure, composition of teams, and care practices aimed at users, organization and division of work in teams, and influence on the WL.

All the data were processed using the ATLAS.ti 8.4.15 (Qualitative Research and Solutions) software, guided by Bardin’s thematic content analysis⁽¹²⁾. Each interview was recorded, transcribed, and inserted into the software and coded based on the research objective.

The research respected the ethical precepts recommended in Resolutions 466/2012 and 510/2016 of the National Health Council, guaranteeing the right to information, to participate or not in the research, and to anonymity. The participants were identified with codes composed of the letters E for nurse (“*enfermeiro*” in Portuguese) and M for physician (“*médico*”), followed by the acronym of each of the regions of the country (N - North, NE - Northeast, CO - Midwest (“*Centro-Oeste*”), SE - Southeast, and S - South) and the order number of the data collection. The research project was approved by the Ethics Committee of the University of the State of Santa Catarina, under opinion No. 1,933,348.

RESULTS

The results are presented into four items including the profile of the participants and three analytical categories: factors related to the increase and to the reduction of the WL; and the coping strategies adopted.

Profile of the nurses and physicians surveyed

The majority are female (38-79.1%), aged between 20 and 40 years old (33-68.7%), with some specialization and/or internship (37-77.1%), and a professional experience of more than 5 years (36-75%). The professionals hired through a public tender, in a statutory regime (30-62.5%), with working hours of 40 hours per week (33-68.7%) were predominant, highlighting that most of the physicians have another job (18-85.7%).

Increase in the workloads

The factors identified by the FHS nurses and physicians that contribute to the increase in the WL are shown in Figure 1.

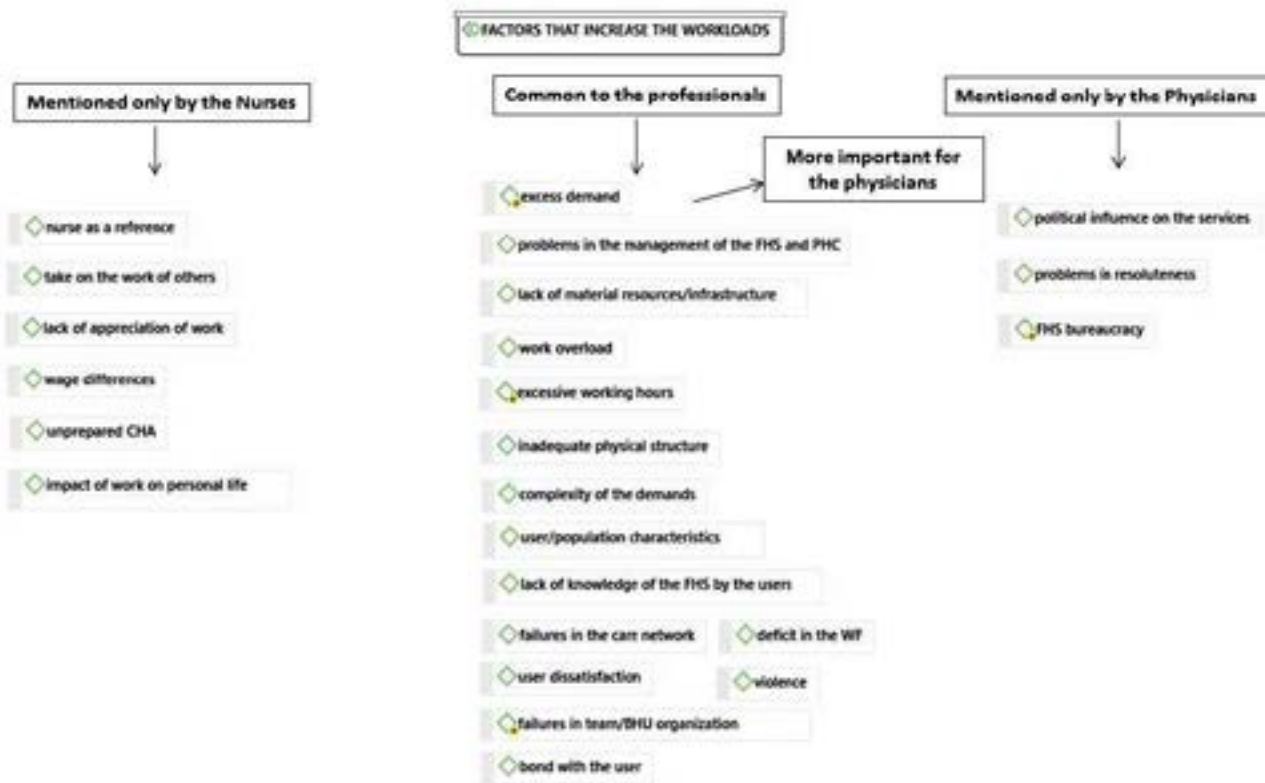


Figure 1 – Coding network generated in ATLAS.ti. Florianópolis, SC, Brazil, 2019

*WF- Work Force

*CHA – Community Health Agent. It means a person from the community who is officially hired to compose the FHS team.

*BHU – Basic Health Unit. It is the health unit where one or more FHS teams work.

Excess demand and work overload appear among the main factors of increase in the WL and are related to the number of visits and activities performed. Excess demand was the most significant among the physicians. On the other hand, the nurses highlighted the reference role they play and taking on the work of others.

We're overloaded with almost twice the recommended population. I would really need more than one team. (MS1)

[The nurse] is Jack of all Trades. So, all the administrative, bureaucratic services [...] are very different from our object of work, which is care. (ESE5)

Another group of factors that stood out is related to the conditions, organization and management of the care model, such as: deficits in work instruments, including physical structure; deficits in the workforce; excessive journey; dissatisfaction with salary; failures in the organization of the team/unit including the development of bureaucratic activities; and problems related to the management of the care model itself, with emphasis on the failures in the care network.

You have a much greater workload than you should have precisely because of a number of wrong things with the management or with other professionals. (MS6)

You have the patient scheduled, you have nowhere to offer the service, there's no room, there's no office. This situation makes you anxious. You get worried and you want to give quality [care]. (ESE1)

This is a rented house, adapted [...] we had a very serious problem. The house had a lot of

infiltration, a lot of mold, a lot of leaks [...] when it rained we couldn't stay in the unit [BHU]. (ENE6)

The lack of supplies is one of the things that makes work difficult. There was a day that I arrived and there were no prescriptions [...]. I'm tired of pooling money and making a photocopy of prescriptions. (MCO4)

A third group of factors which increase the WL is related to the users due to the characteristics and complexity of the problems and needs, to the ignorance of this model of care, to urban violence, to the bound established between professional and user/population, and to patient dissatisfaction.

I think that the issue of vulnerability in general increases the burden because it increases the demand for care. And there's still a lack of understanding of how it [PHC] works and how to access the health services. (ESE4)

I did a survey to find out if our problem here is drugs, crime [...] as soon as I got into the team that fear brought me suffering. Everyone said it was impossible to make visits since there was a risk to be mugged. (MCE3)

The problems related to resoluteness of care and to political influence, only mentioned by the physicians, as well as the lack of valuation and impact of work on personal life, only mentioned by the nurses, were still generating an increase in the WL.

The non-resoluteness of care [including problems related to] referrals and request for exams is discouraging. (MN1)

[...] it is that there is paternalism and they want everything in their time and according to the influence that one or another politician has here in the region, it is complicated. (MS1)

I think that perhaps the lack of recognition of the nursing professional within the team, both by other professionals and by the population. (ESE5)

Reduction in the workloads

Nurses and physicians agreed to report the factors that contribute to the reduction in the WL, as shown in Figure 2.

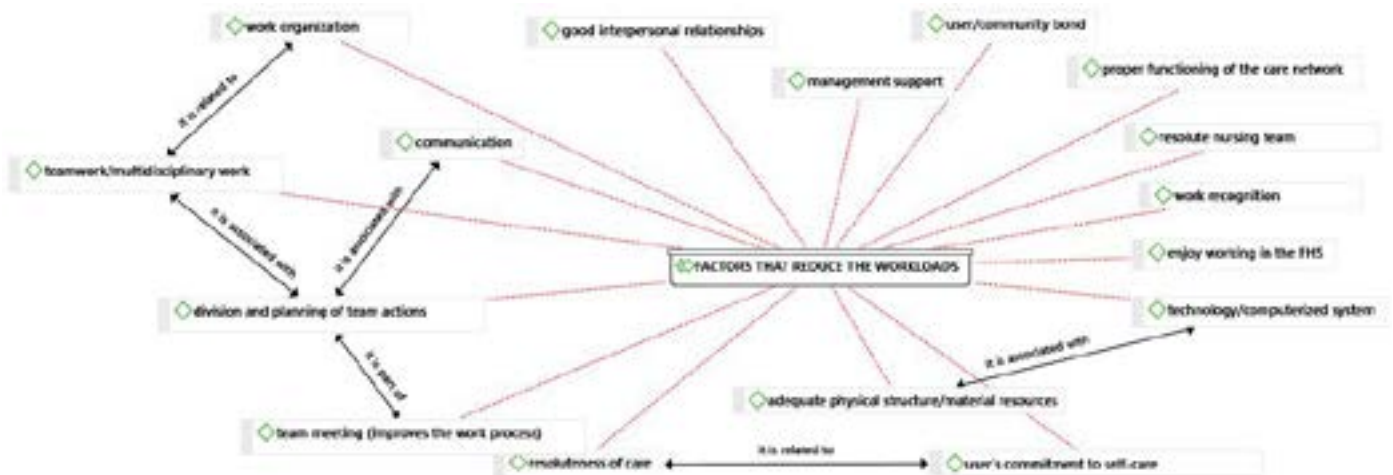


Figure 2 – Coding network generated in ATLAS.ti. Florianópolis, SC, Brazil, 2019

The division and planning of actions in a multidisciplinary team, adequate communication, work organization, and teamwork are factors with a strong influence in the reduction of the WL.

We try to work so that the work organization contributes in order to reduce our burden. (ES1)

Teamwork, working with nurses who, in addition to co-workers are close, companions, trained, competent people, who are able to share a very important job, I think both for me and for them. (MSE4)

The bond with the user/community was mentioned as a factor that facilitates work and tends to reduce the WL.

In the contact, in this bond with the population, I see that I can collaborate for his health and I can satisfy myself professionally. (ESE3)

I went visit the family, I got to know them, we get to know the reality of who is looking for the service and then it changes our concept of service and of who the patient is. (MN1)

Still, the resoluteness of care, linked to the individual's commitment and the proper functioning of the care network, are relevant factors in the reduction of the WL, as a component of satisfaction, of reward.

It's very satisfying to see that we can solve people's problems. (EN2)

In my team, the physician-nurse relationship is very good, we work as a team. Our focus is to resolve the complaint, the patient's demand. (MCO3)

Similar to this, the enjoyment of working in the FHS and the recognition for the work done have been shown to be positive in reducing the WL and, even in the face of adversity, making work more pleasurable.

I like what I do. It's a victory when you can be resolute in people's lives [...] that's what motivates me to work in the FHS, it's not salary or anything. It's to like what I do. (ES1)

Professional satisfaction is when you are recognized, you can have a greater appreciation of work. (MSE1)

As contributions to the reduction of WL, the adequate availability of work tools and having managerial support were also identified.

I think it's well-structured physically. There are other places that I think are not very good. An issue of physical structure, ease of work, when we have it, that helps a lot too. (ESD6)

What I think is that the manager should be someone who understands family health, not necessarily a physician, dentist or nurse, they need to understand family health.[...] the first thing that has to change is to put a manager who supports the team and for sure your working conditions will improve a lot. (MS3)

Coping strategies

The factors that increase the WL surpass those that reduce them and, for this, nurses and physicians have used coping strategies inside and outside the work environment to minimize the effect of the WL, as illustrated in Figure 3.

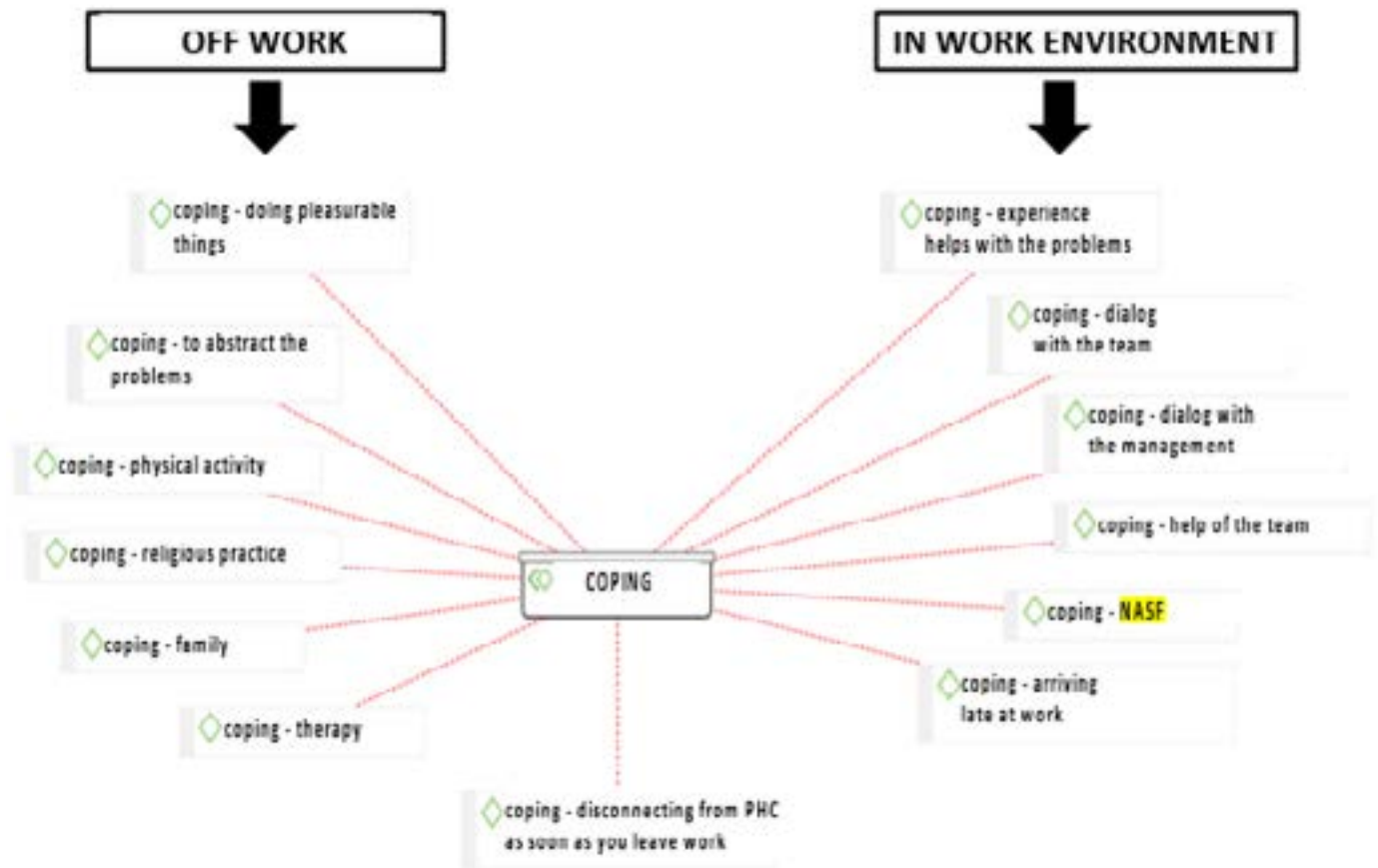


Figure 3 – Coding network generated in ATLAS.ti. Florianópolis, SC, Brazil, 2019

*NASF (Núcleos de Apoio à Saúde da Família): Family Health Support Centers.

Disconnect from work as soon as they leave the BHU is a resource used by most of the professionals. Abstracting problems and doing pleasurable things, associated with family support, physical activity, and religious practices are resources that contribute to dealing with the problems of daily routine.

I'm no longer a physician when I leave the BHU. That's what I've been doing for many years. (MS3)

When I'm here, I'm here. And when I leave here with some burden, I try to get home, relax, and forget. (ESE6)

In the scope of work, support and dialog with the team and the management, good relationships, and exchange of experiences with colleagues and with professionals who are part of the Family Health Support Centers (Núcleos de Apoio à Saúde da Família, NASF) were mentioned as the main strategies.

I seek horizontal dialog all the time, with my doctor, with my coordinator, with the teams, in order to avoid stress and overload. (ES1)

We try, at least once a month, to get everyone out of here. Go to a place that is not professional, for us to get to know each other better, make relationships that are not strictly professional. (MSD4)

Actions such as "arriving late at work" were also mentioned as a self-protection strategy to face the increase in the WL.

DISCUSSION

The profile of nurses and physicians in this study is mostly composed of young women with some post-graduate degree and more than five years of professional experience. Similar characteristics were found in another study, highlighting the trend towards feminization in health work, the increase in the level of education of the women and their presence in the paid work market, as well as the presence of young professionals in the FHS, justified by the current undergraduate curricula that stimulate contact with the public service and enable them to work with the Unified Health System⁽¹³⁾.

Although the majority of the respondents have a public contract, in a statutory regime, other regimes are registered with little financial incentive and lack of stability. The predominant working day represents 40 hours per week; however, there was a significant number of physicians with more than one job, which can be explained by the search for a complementary salary⁽¹³⁾.

Among the factors responsible for the increase in the WL, excess demand and overload make it difficult take care of patients and more complex cases, a reality found in other studies^(14,15). Work overload is due, especially, to the spontaneous demand and to the activities carried out beyond the planned, compromising the quality and favoring errors in the care provided⁽¹⁶⁾. In the case of nurses, it may be related to the understanding that they are reference in the FHS, generating excess activities, especially bureaucratic⁽¹⁷⁾.

Factors related to the work conditions and organization were significant, negatively influencing work and generating dissatisfaction, especially due to deficits in the work instruments. This reality, also registered in other studies, seems to be far from being modified^(18,19). The lack of minimum conditions for carrying out work generates suffering, wear and tear, increases accidents and occupational risks⁽²⁰⁾. As a model of care, the FHS faces several management problems, such as those related to the hiring and rotation of professionals, incomplete teams, and inadequate funding, impairing the care provided to the population⁽²¹⁾.

The health professions deal directly with various demands from the health services users, establishing direct and continuous interpersonal relationships, which ends up exposing the professional to psychosocial stressors, such as violence, incomprehension of the population about the PHC model, and dissatisfaction with the services provided⁽⁹⁾. The bond with patients, considering the prescribed on the FHS, involves follow-up of the people throughout the process of living, which can generate increased loads⁽¹⁴⁾.

The analysis of the data also shows factors that reduce the WL, such as teamwork and the bond itself. As an organizational structuring strategy, teamwork allows for the creation of a dynamic and interdependent relationship with common objectives⁽²²⁾, favoring the feeling of belonging. A number of studies reveal that establishing bonds contributes to the performance to care of and follow-up of registered families⁽²³⁾, enables the development of empathetic behavior and of concern for the suffering of others, contributing to the improvement of interpersonal relationships⁽²⁴⁾ and, furthermore, favors the commitment of the users, helping their participation and self-organization in the search for health services⁽²⁵⁾, which contributes to reducing the WL of the professionals.

One of the essential functions of PHC is resoluteness of care; in this context, the nursing consultation is one of the nurse's main actions for expanding access and resoluteness^(26,27). And, when shared between nurses and physicians, it promotes the exchange and use of knowledge and experiences in order to achieve an integrated vision of care.

Enjoying working in the FHS positively affects professional performance and work organization⁽¹⁸⁾. A study⁽¹⁴⁾ shows that, despite all the problems found in PHC, the physicians interviewed consider themselves satisfied with their work, especially due to the possibility of taking care of the population that needs it most, the feeling of doing the best, the bond,

and job stability⁽¹⁸⁾.

The coping strategies for excessive loads were similar for physicians and for nurses, and showed that who performs the work seeks external ways of gratification, in other areas of life, but also uses resources available in the work environment itself, as found by other authors in different scenarios^(28,29).

With regard to the strategies used in the work environment, the search for support in the team, in the leadership and in the structures of the care model stood out, as is the case with the NASF. They also recognized that the experience time helps in handling problems, helping to reduce loads and wear. This set of coping strategies shows that strengthening positive aspects of the model protects the worker^(28,29).

Both outside and inside the work environment, the use of strategies that signal certain exhaustion was also identified, which leads to the search for spiritual/religious or therapeutic support⁽²⁸⁾. Or, still, the use of resistance strategies^(28,29), as in the case of "arriving late".

Work takes up a large part of people's lives, but "disconnecting" from it, at the end of the daily routine, was the main coping strategy. This can be interpreted as the search for disconnecting from problems, from responsibilities, from the complexity intrinsic to the care model, and from the health-disease process. It is a form of resistance to face impotence in solving problems outside one's control^(28,29).

Although there are distinctions in the work scenarios in the regions of the country, there was a similarity in the factors that increase and decrease the WL, both for nurses and for physicians. This can be explained by the characteristics of the work in PHC and by the national parameters of the public policy in this field.

As a limitation of the study, it is highlighted that the results portray workloads in teams considered successful, not reflecting the general reality of the FHS in the country, whose results are certainly less positive.

FINAL CONSIDERATIONS

The study showed that, in the work process of FHS nurses and physicians, there was a predominance of factors that increase the WL, and these were strongly related to deficits in the working conditions, making it difficult to carry out what was prescribed in the care model. Typical aspects of the FHS, such as teamwork, with positive and appropriate relationships, and good relationships with the users and managers, are strongly protective, signaling that the identity with the model and its effectiveness contributes to reduce the WL and to protect against wear and illness.

Even in adverse conditions, physicians and nurses find, both inside and outside the work environment, ways to ease the workloads, when approaching activities and people that provide moments of pleasure and satisfaction.

A number of studies of this nature can contribute to support actions to improve the working conditions in the FHS, which is fundamental for the health care of the population.

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