Dentists' perception of teamwork in the Family Health Strategy: exploratory study*

Percepção dos dentistas sobre o trabalho em equipe na estratégia saúde da família: estudo exploratório

ORIGINAL ARTICLE

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ABSTRACT: The aim of this study was to investigate how dentists perceive their integration in family health teams and to elucidate the limits and possibilities of integration of this professional's work processes. This is a descriptive and exploratory study of qualitative nature that used the semi-structured interview as data collection procedure. The subjects of the research were six dentists who worked for at least six months in Family Health Units of a neighborhood in the city of Rio de Janeiro, Brazil. The analysis of the interviews was based on the principles of content analysis proposed by Bardin. The result of the interviews' analysis presented two thematic categories that were used to apprehend the aspects related to the insertion of dentists in the work process of the nuclear teams of the Family Health Strategy (FHS), which are: isolation of dentists by the ideation of their attachment to the dental chair and the organization of the dentist's work in the FHS. This study showed that the dentists surveyed think that their work process is related to a model in which the user is still seen in a fragmentary way although the policy guidelines and the proposed models point in the opposite direction.

KEYWORDS: Family health; Dentists; Health management; Family health strategy; Community health workers.

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RESUMO: Esta pesquisa buscou investigar como os dentistas percebem a sua inserção nas equipes de saúde da família e dar visibilidade para os limites e possibilidades da construção da integração dos processos de trabalho deste ator. Trata-se de um estudo de caráter descritivo exploratório, de natureza qualitativa que usou como procedimento de coleta de dados a entrevista semi-estruturada. Os sujeitos da pesquisa foram seis dentistas que trabalhavam há pelo menos seis meses em Unidades de Saúde da Família em um bairro da cidade do Rio de Janeiro. A análise das entrevistas se baseou nos princípios da análise de conteúdo proposta por Bardin. O resultado da análise das entrevistas elencou duas categorias temáticas que se constituíram como eixo para apreensão de aspectos referentes a inserção dos dentistas no processo de trabalho das equipes nucleares da Estratégia Saúde da Família (ESF) que são: Isolamento do dentista pela ideação do seu vínculo com a cadeira odontológica, A organização do trabalho do dentista na ESF. Este estudo demonstrou que na perspectiva dos dentistas entrevistados o seu processo de trabalho está atrelado a um modelo no qual o usuário ainda é visto de forma fragmentada a despeito das diretrizes políticas e dos modelos propostos apontarem na direção oposta.

DESCRITORES: Saúde da família; Odontólogos; Gestão em saúde; Estratégia saúde da família; Agentes comunitários de saúde.

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INTRODUCTION

The access of the population to Oral Health (OH) in Brazil is notable by the lack of services in the public system. This situation showed characteristics that favored the perspective of mutilation odontology, with operations centered in clinical cases and with few possibilities to expand the care in OH[1].

The process of overcoming this situation had two milestones. The first of them was the insertion of oral health teams as part of the Family Health Strategy (FHS), in 2001, and the second was the publication of the Brazilian Oral Health Policy (DNPSB) in 2004[1,2,3].

The publication of the DNPSB proposed new bases and criteria to organize the work on OH, which adopted the following assumptions as guidelines for the reorientation of the practice: interdisciplinarity, integrality of attention, intersectoral approach, expansion, and qualification of assistance[1].

On the other hand, the integration of OH teams in the FHS aimed to break the logic of the specialized work approaching this field of the proposals of the Brazilian Unified Health System (SUS), especially in Primary Health Care, contributing to the reorganization of the model in OH based on comprehensive care and territorial accountability[2].

These two milestones brought significant achievements for the field of OH in Brazil; however, some challenges are yet to be overcome for the effective increase of access and qualification of the service for the population in this area and, in particular, regarding the work process in the FHS.

Literature review, carried out by Soares et al.[3], about the work of OH teams in the FHS identified issues related to the work process including: excess demand; obstacles in relations among workers; invisibility of the Oral Health Team (OHT) by users; interface-related issues with other levels of care; the lack of focus on clinical care, which values the specialty; weakness in the construction of the intersectoral approach and epidemiological diagnosis; precarious contracts, low salaries, inadequate working conditions, and frustrations.

On the other hand, Moretti[4] stresses that the FHS model, despite the problems that need to be overcome, can enhance the work of the dentists, to that end, these professionals need to depart from the curative model, centered in the dental office, and get closer to the practices carried out by the nuclear team, empowering them and promoting multidisciplinary integration, generating benefits for the entire population, which will have their needs met in healthcare.

The author stresses that the dentist well integrated into the family health team can share the coordination of therapeutic projects breaking the paradigm of giving exclusive responsibility for the specialist[4].

Thus, by making contact with the situation presented above, the issue involving the integration of dentists in family health nuclear teams was the core of this study that aimed to investigate how dentists perceive their integration in these teams and to elucidate the limits and possibilities of integration in this professional's work processes.

This study may offer subsidies to understand the relationship of dentists with family health teams, knowing that the merger, on the agenda of these professionals, of interdisciplinary and intersectoral practices focused on health promotion and disease prevention in an expanded conception of oral health is something that needs to be discussed from the point of view of who performs the work.

METHOD

This article shows some of the results of the monograph entitled *Working with Family Health Strategy: the perception of professional dentists*[5], developed within the scope of the Multiprofessional Residency in Family Health and Community of the Learning Hospital São Francisco de Assis of the Federal University of Rio de Janeiro.

This is a descriptive exploratory study of qualitative nature that used semi-structured interviews as data collection procedure.

The survey of Family Health Units with OHT located in Rio de Janeiro was initially developed where the practical activities of the Residency Program were being conducted. Four Family Health Units were found and only one did not have OHT. Seven dentists were identified in three Family Health Units. Only one of these professionals did not meet the inclusion criterion of the research, which required having worked in the FHS in the six months before the data collection. Thus, six dentists were considered apt to participate in the study; all of them were interviewed.

The interviews were scheduled in advance and conducted in units where the professionals were allocated

in September 2013; they were recorded, transcribed, and then analyzed using the content analysis principles proposed by Bardin[6].

The content analysis of the statements was carried out in three phases. The first consisted in the organization of the material to be analyzed, by reading, choosing documents, formulating hypotheses and objectives, referencing contents, and elaborating indicators. The second phase constituted in decoding and categorizing the material. In the last phase we conducted the reflective and critical speech analysis[7].

The categories were based on the verification of the records made during the research, being, therefore, the open model of categories, which is recurrent in exploratory studies[8].

This study was approved by the Research Ethics Committee of the Municipal Department of Health and Civil Defense of Rio de Janeiro, under protocol no. 114/13. All data collection procedures respected the voluntary character of the subjects' participation and also the reading and signing of the informed consent form.

RESULTS

The result of the interviews' analysis showed two thematic categories used to apprehend the aspects related to the limits and possibilities of the insertion of dentists in the work process of the nuclear teams of FHS, which are: Isolation of dentists by the ideation of their attachment to the dental chair and organization of the dentist's work in the FHS.

Although the presentations of these categories are made separately, it is noteworthy that they are not impervious, thus the overlap and interdependence between these themes are intrinsic to apprehend the issue addressed by this article.

Isolation of dentists by the ideation of their attachment to the dental chair

This theme was recurrently approached by dentists, showing that individual appointments, in the dental chair, isolate the professional in his area of expertise, avoiding or hindering the sharing and exchange of information among the dentist and the other members of the family health team. Thus, terms such as: "annex", "detached", "separate sector", were used to define the work of the dentist as the following passage:

> *"We end up having many office shifts, which isolates the oral health professional inside the room" I6*

Among the causes of this isolation the respondents highlighted the excessive demand of users who need immediate assistance.

> *"The service here is very tiring; when I first started there were a lot of emergency cases. We used to attend an absurd amount of emergency cases. (...)" I2*

The dentists also reported the existence of ideation related to their work, which attaches them to the dental chair, creating resistance by the other members of the family health teams and by the users in their inclusion in typical activities of the FHS such as educational groups, home visits, and team meetings.

> *"And in order to make the team see you as part of it, you have to give a return (clinical) (...)" I1*
>
> *"(...) there in the community, they are required. They require the dentist, the assistance." I1*

The valuation of the clinical activity of the dentists to the detriment of collective practices is reflected on the organization of the work itself, which focuses on this professional's specific appointments saving little time for teamwork.

> *"We end up having many office shifts, which isolates the oral health professional inside the room. And as we don't participate in meetings every week we're not with them all the time. Then they see us, for sure, a little bit farther... It's hard." I6*

This theme will be detailed below for better apprehension of the organization of the work as a factor that interferes with the dentist's relationship with the family health teams.

The work organization of the dentist in FHS

Aspects of the organization of the work as a need to meet specific clinical care goals and the extent of the attendance capacity were mentioned by the respondents as aspects that influence negatively the development of activities with family health teams.

According to the respondents, the attendance goals must be achieved and reported monthly to the city

manager for the evaluation of the work. These goals are based on quantitative indicators and favor certain clinical procedures at the expense of interdisciplinary actions focused on health promotion and disease prevention as the following passages indicate

> *"It's difficult to prevent when their only requirement are procedures... dressings." I4*

> *"With the work process we currently have, it is really hard to achieve the goals. You reach the end of the month and stares at the variable in order to work. This should not happen. The variable should be a consequence of the work." I6*

This scenario unfolds another important issue that interferes in the relationship of dentists with the FHS nuclear teams: the gap that exists between the contents of the goals and the reality of the dentists' daily work.

> *"Instead of us working with the vulnerability, which is the correct, we are not allowed (...) so we attend a few of those who need it and attend more of those who doesn't, which is usually just a cleaning, a restoration, in order to achieve the goal." I2*

Another aspect related to the organization of the work that, according to the dentists, effects the integration of their activities with the family health teams is the extent of the demand. According to the speeches analyzed each dentist is responsible for two family health teams as showed in the following passage.

> *"But the demand is too high. There is one dentist for two teams, or three, because in some places there are three." I5*

The high demand is also identified as a difficulty for the development of integrated activities with family health teams as stressed in the excerpt that follows.

> *"(...) unfortunately this is much more difficult because we have more than one team. I mean, I don't participate in all the meetings, I don't participate in all the groups, I'm not with them in the territory every week, because I have to split myself. (...) For the dentist this is the worst thing. You have to split yourself into more than one team, deal with different realities, different times, do two things in the same shift, it's awful. But this is our reality." I6*

DISCUSSION

The results show that dentists face difficulties working with the teams because they are immersed in clinical practices. They declared that the service organization itself makes impossible to share the work with other FHS professionals.

The weakness in the integration of the dentists' work in practices of the family health teams impairs the acquisition of resolutive answers, in the perspective of the integrality of attention proposed by SUS, the common risk factors that the ascribed populations are exposed. Thus, it is important to encourage initiatives that seek to transform the organization of the work of the OHT in the FHS[9] because although the integrated and interdisciplinary practices are advocated, the logic of planning and evaluation of the work favors the specialized attention of the dentist, decreasing the possibility of sharing the activities of health promotion, disease prevention, and assistance.

When asked about how they work with the teams, regardless of the frequency of such activities, most respondents approached the grouped team modality proposed by Peduzzi[10], because even with the possibility of complementarity of work among the teams, the actions are performed in isolation, which results in the systematic reproduction of fragmented interventions focused on a particular aspect of health.

Therefore, the contribution of each worker is essential, both objectively, regarding his specific nucleus, and subjectively, concerning the zones of common knowledge, allowing the construction of a single intervention project that includes all the FHS users.

To this end, it is necessary for each agent to understand that their technical autonomy is not in independence or in isolation, but in the corporate spirit where there is no room for individual competitions[11].

The results also showed that even facing limitations for the realization of a shared work with FHS teams, the process of resignification exists; in which dentists no longer identify themselves as "curator dentists" but as "health professionals" in its broader concept. In accordance with Faccin et al.[11], the workers of this study seemed to be aware of the limited impact of their clinical practice when they stressed the need for a significant change in the organization of their work process, especially regarding the approach with other FHS health professionals.

FINAL CONSIDERATIONS

The aim of this study was to investigate the perceptions of dental practitioners regarding their integration in family health teams and to elucidate the limits and possibilities of the integration of work processes of this professional in the FHS, aiming to contribute for the understanding of this issue in the workers' perspective.

This study showed that the work process of the dentist is related to a model in which the user is seen in a fragmentary way although the policy guidelines and the proposed models point in opposite direction.

This situation is aggravated by the organization of the work of the OHT, which favors the intervention related to the dental chair for pathology cases. Two aspects deserve to be studied in more depth. The first one concerns the extent of demands of the oral health teams, which often take responsibility for twice the population attended by a family health team.

The second aspect is related to the fact that even under the scope of FHS, in which the practices should be predominantly directed toward health promotion and prevention of diseases, there is still a great demand for emergency care by the dentists, which overloads their agendas with clinical care so they cannot perform different practices.

Thus, although the dentists are concerned in approaching the oral health model proposed for FHS, the advances for integration of dentistry in the dynamics of family health teams depend on the inclusion of demands that emerge from the realities daily experienced in the FHS in the agenda of discussions from different levels of management, as well as the improvement of the organization of the OHT work on public health policies.

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