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Original Article

System of meanings about the purpose of family health work: a qualitative analysis*

SISTEMA DE SIGNIFICADOS SOBRE A FINALIDADE DO TRABALHO NA SAÚDE DA FAMÍLIA: UMA ABORDAGEM QUALITATIVA

SISTEMA DE SIGNIFICADOS SOBRE LA FINALIDAD DEL TRABAJO EN LA SALUD DE LA FAMILIA: UN ABORDAJE CUALITATIVO

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ABSTRACT

This exploratory study was performed to understand the system of meanings about the purpose of the nursing and medical work performed by Family Health teams, in the cities of Rio Grande and Pelotas (Brazil). Data collection was performed by semi-directed individual interviews. The interviews of 82 participants were recorded, and analyzed. The nuclear meaning of the purpose, as an end transmuted into the product of collective work, was in agreement with the possibility of the community implementing changes and acquiring healthy individual and collective behaviors. This gives evidence of the component of ethics in the process, by means of categories such as solidarity and compassion. This led to a marker, in the text production, of the human condition in the construction of the work purpose. Through the analysis and critical discussion of the theme, this study contributes to the macro-dimension of developing competencies and adjustment to the health needs of society.

RESUMO

Trata-se de um estudo exploratório e descritivo, com abordagem qualitativa, objetivando compreender o sistema de significados sobre a finalidade do trabalho de enfermeiros e médicos das equipes da Saúde da Família, nas cidades de Rio Grande e Pelotas. A entrevista semidirigida, individual e gravada, foi utilizada na coleta dos dados, seguindo-se uma análise temática dos depoimentos de 82 participantes. O significado nuclear da finalidade, como fim transmutado em produto do trabalho coletivo, mostrou-se alinhado com a possibilidade de mudanças e aquisição de comportamentos individuais e coletivos saudáveis por parte da comunidade, evidenciando-se o componente da eticidade no processo, por meio de categorias como a solidariedade e a compaixão. Disso decorreu, na produção textual, um marcador da condição humana na construção da finalidade do trabalho. Por meio da análise e discussão crítica da temática, este estudo contribui para a dimensão macro da formação de competências e adequação às necessidades sociais de saúde.

RESUMEN

Se trata de un estudio exploratorio y descriptivo, con un abordaje cualitativo, objetivando comprender el sistema de significados sobre la finalidad del trabajo de enfermeros y médicos de los equipos de la Salud de la Familia, en las ciudades de Rio Grande y Pelotas. La entrevista dirigida parcialmente, individual y grabada, fue utilizada en la recolección de los datos, siguiéndose un análisis temático de las declaraciones de 82 participantes. El significado nuclear de la finalidad, como fin transmutado en producto del trabajo colectivo, se mostró de acuerdo con la posibilidad de realizar cambios y adquirir comportamientos individuales y colectivos saludables por parte de la comunidad, evidenciándose el componente ético en el proceso, por medio de categorías como la solidaridad y la compasión. De esto se derivó, en la producción textual, un marcador de la condición humana en la construcción de la finalidad del trabajo. Por medio del análisis y discusión crítica de la temática, este estudio contribuye para la dimensión macro de la formación de competencias y adecuación a las necesidades sociales de salud.

KEY WORDS

Family Health Program.
Social conditions.
Primary health care.

DESCRITORES

Programa Saúde da Família.
Condições sociais.
Atenção primária à saúde.

DESCRIPTORES

Programa de Salud Familiar.
Condiciones sociales.
Atención primaria de salud.

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INTRODUCTION

The results presented herein refer to the study of the comprehension of the system of meanings of the work purpose related with the healthcare needs identified in the Family Healthcare Teams - Equipes da Saúde da Família (ESF) in the Third Regional Healthcare Branch of Rio Grande do Sul - Terceira Coordenadoria Regional de Saúde do Rio Grande do Sul (3ªCRS/RS), in the South of Brazil. The aforementioned teams comprise the set of structures of the Family Healthcare Program - Programa da Saúde da Família (PSF), which is the Unique Healthcare System's - Sistema Único de Saúde (SUS) current basic healthcare strategy to attain universality, with integrality and equity, in providing public healthcare to the Brazilian population. The strategy engendered by the Ministry of Health aims to overcome the logic based on the paradigms that shape and support the traditional healthcare model of providing care to the disease instead of the health situation. The plan is executed mostly within the municipal scope, with the implantation of multiprofessional teams in the Family Healthcare Units - Unidades Saúde da Família (USFs), aiming to prioritize the actions of health promotion, protection and recovery of individuals, families and communities[1-2].

This study is a part of a larger investigation, a research project named *Healthcare Work and the Technological Context of the Family Healthcare Policy*, developed and funded in accordance with regulation MS/CNPq/FAPERGS #008/2004/2007 of the SUS Research Program for shared healthcare management - file #0415374. That project aimed to analyze the technological construction of the Family Healthcare model according to the empiric base of the work processes of the ESFs, in order to contribute to the comprehension of the current stage of transformation of the public policy proposals, focused on a technological and humanized healthcare model in the organization of the SUS.

Overall, a society, in its different historical moments, is built on necessities that are pre-built by habits, i.e. following the conventions and habits of prior generations. They are needs that cover the social and constitute a complex system of necessities and potentials that are socially produced. They are necessities of particular individuals - who incorporate the plurality of the human beings - over natural necessities, regarding the maintenance of human life. They are essential because, when they are not met, the person cannot be preserved as a natural being[3-4].

Within such a complex system, social necessities are associated to mechanisms that focus on the health of individuals and communities. In a particular and formal way, the social structures for the production of material conditions with a view to the attainment of healthcare necessities are organized according to public policies, which aim to identify the necessities so that they can be met. Such necessities, within the scope of work, are surmised as work goals[5], which congregate the necessities and potentials of subjects/objects (individuals, families and communities) and the healthcare work subjects (physicians and nurses, among others), who execute the healthcare policies through their work so that the necessities can be met.

Healthcare workers, according to the proposed approach, are social agents of the production system of conditions that can meet human necessities[3-4], working under the guidance of a repertoire of guidelines and theoretical principles that establish the expected results of their work. The goal has the operational dimension of the organizational process of work, which attempts to meet the demands, as well as the dimension of ethics, which covers the execution of work in historic realities, the individuals, the families and the communities, considering the diversity of their needs. The facts that regulate the degree of meaning of the actions that have been socially agreed-upon to meet the needs and aggregate quality of life to individuals stem from the adequacy and interaction between the dimensions, which also influence the transformation of the social values that potentiate better living conditions[3-4].

Healthcare workers, according to the proposed approach, are social agents of the production system of conditions that can meet human necessities.

By acknowledging the healthcare workers as essential actors for the consolidation of the Family Healthcare strategy within the precepts of the SUS that point to a technological model of primary care that is more humanely adequate[6] in the basic healthcare network, the study presented herein had the goal of developing a qualitative description of the system of meanings of the work purpose in the PSF, apprehended in the analysis of narratives offered by nurses and physicians who are members of the program about the actions performed while working in Family Healthcare teams in the cities of Pelotas and Rio Grande, part of the 3rd CRS/RS, in the South of Brazil.

METHOD

This is an exploratory, descriptive and analogical study, constituting a hermeneutic and dialectic[7] construction of a social-historical phenomenon. According to the adopted approach, the relation of exteriority between subject and object, whose terms are separated and opposed to each other, only expresses a moment of its constitution. The hermeneutics allow for a more subjective approach of the senses of a phenomenon, while dialectics show the solution for the objective context that originated it, as well as the return to the subjective dimensions by means of expressed objectivity and objectified subjectivity. The subject does not pre-exist - instead, it is built, and its construction implies a process of development, as the study phenomenon is a complex reality. Therefore, its knowledge always presents a relation of incompleteness in the face of the wholeness announced by the phenomenon, and, at the

same time, *enough at that its instant and in its objective apprehension, meaning that the study of a given problem is never finished, neither as a whole nor as its elements*[8].

The 3rd CRS/RS covers 22 cities in the state of Rio Grande do Sul, reaching nearly 900 thousand inhabitants. Regarding the Family Healthcare strategy, there were 73 teams working in 12 cities of the regional division in 2006, according to the State Secretariat of Health, covering nearly 300 thousand people. The two cities analyzed account for 550 thousand inhabitants. Altogether, they had 52 active teams in 2006, being therefore responsible for 70% of healthcare availability in the regional division, providing coverage to over 180,000 people in accordance to the FH strategy.

The study, however, registered a lower amount of available teams for the investigation: 44. Therefore, the number of subjects was defined as 88 professionals to be considered in the study (44 physicians and 44 nurses). The difference between the official number of teams working for the PSF in the 3rd CRS and the actual number obtained in the study occurred because three teams refused to take part in the study, in addition to five others that considered the investigation unfeasible at that time.

Data were collected through pre-scheduled semi-structured interviews, recorded in audio, held in two stages: in February/March, 2006, and again in June/July, 2006. This occurred due to the availability of physicians and nurses to take part in the study at their own workplaces. The interview questions were tested in a pilot study and structured to provide a first stage focused on personal questions, such as gender, age, education and professional experience; and a second stage that allowed the workers to talk about their work at the PSF, with questions that would elicit answers to detect the intended concepts within the testimonies.

The participants were informed of the study goals and the interview procedures. According to the guidelines and norms that regulate research with human beings established by Resolution 196/96 of the National Healthcare Council, all interviewees signed two copies of the term of consent. They were granted the right to terminate their participation at any time without any damages incurred, and their anonymity would be preserved since they were not required to identify their own names, workplaces or hometowns. The study proposal was approved by the FURG Review Board - Comitê de Ética em Pesquisa na Área da Saúde (CEPAS), Pró-Reitoria de Pesquisa e Pós-Graduação da FURG, file #25000.092771/2004-88 and approval #02/ 2004. The 3rd CRS/RS was also requested to agree with the execution of the study.

The interviewers organized the acquired data in digital files in order to guarantee the express comprehension of the narratives. Each statement is identified by fictional numbers of the city (M), team (Eq) and professional (Ef = nurse, Md = physician). Altogether, 82 interviews were held, 38 of them with physicians and 44 with nurses. The lower number of interviews with the physicians occurred because two professionals refused to take part in the project, and also because four units had remained without these professionals after three successive attempts to schedule the interviews.

The testimonies were transcribed and selected according to interesting excerpts, following sequential stages within the reference framework of thematic qualitative analysis[9]. The use of excerpts to illustrate the texts and motivate the analysis expresses and exemplifies the group of subjects; therefore, the selection was justified in the broader content coverage presented by the group of 82 subjects and also in the space made available by this journal. The data set acquired in the field study makes up the primary source of the research, presented as a support for the analysis whose reference is the concept of goal as a group of structured senses/meanings of a system - the goal of work[5].

In the total analysis of the testimonies, the following themes arose: the instrumental sense of the relation between social healthcare necessities; the necessity to humanize the goals of work and the relation between the goal and the limit of work. It should be noted that, in order not to stray away from the available space for this presentation, the selected theme refers to the necessity of humanizing the goal. Also, due to the nature of the study object and the strict attention to its analysis, the choice showed to be possible and coherent.

RESULTS AND DISCUSSION

As mentioned before, 82 subjects, nurses and physicians, took part in the study, expressing the conceptions about the purpose of their work. Of them, 14 (17%) are males and 68 (83%) females. Among the males, 10 (71%) were physicians and 4 (29%) were nurses; among the females, 28 (41%) were physicians and 40 (59%) were nurses. The predominance of women is blatant, in both the nursing and the medical staffs. The phenomenon is described in literature as the *feminization* of different professional areas[10].

The age of the professionals ranges from 26 to 65 years, averaging at 40. Regarding education, 71 (87%) graduated from regional federal universities; 34 (41%) had already graduated by the early 1990s, and 75 (91%) had graduated by the end of the decade. The lato sensu education of the professionals is worth noting: 79 (96%) were specialists, with 52 (63%) of them holding a specialization degree in Family Healthcare. Only 6 (7%) hold a master's degree, and none holds a Ph.D. degree. The average time of involvement with the PSF is 2 years and 2 months (variation: 2 months - 5 years), a time that coincides with the structuring of the family healthcare teams within the studied region. The temporal characteristic is associated to the policies of the Ministry of Health, issued in 2003, of investing heavily in the PSF in order to guarantee the expansion of the Family Healthcare strategy within the SUS in cities with over 100,000 inhabitants.

The interviewed professionals conceive that the purpose of their work is to prevent diseases, reduce health problems, promote health and improve the conditions and quality of life. Both nurses and physicians used these terms to talk about the purpose of their work. The nuclear meaning of purpose was then interpreted as being aligned with the possibility of change and acquisition of new social behaviors, as a goal transmuted into the product of collective work[5]. In these terms, the testimonies of the professionals mingle with the normative discourse[11] that is present in the proposal of the Ministry of Health, in a reference to family healthcare[1-2].

The meaning of risk prevention of disease, in the sense of change towards healthier behaviors, with the improvement of quality of life, has the sense of limit due to the cultural components implied in the necessary changes, and remains within the limit of the cultural habits of people. Also, according to the interviews, it could be observed that most study subjects see the possibility of performing different social practices than those that are centered in curing diseases, i.e. practices built in the daily routine of the work that can reduce the negative possibilities of states of disease.

In the proposed scope, the senses were shown not to differ among themselves, i.e. the expressions prevention, reduction and improvement have their traditional meanings in health promotion - health education[12-13], as an instrumental component of the purpose of work.

The analysis presented herein attempted to go beyond the verification of the common repetition of the official discourse and the traditional sense of healthcare education, so as to broaden the comprehension of the system of meanings regarding the purpose of work that is developed in the daily routine of the actions of nurses and physicians working in Family Healthcare teams. Therefore, a theoretical marker - human condition[14] - was adopted, which is the connector in the relationship between instrumental change - change and acquisition of healthier behaviors - and the ethical component in the work process.

The concepts of work process and social needs, as mentioned before, were the theoretical base for the analytical route of the study. In this dimension, the concept of human condition joined the categories purpose of work and ethics, potentiating other (empirical) categories such as solidarity and compassion, awareness of life and the action of being. Figure 1 illustrates this analytical construction in the present study.

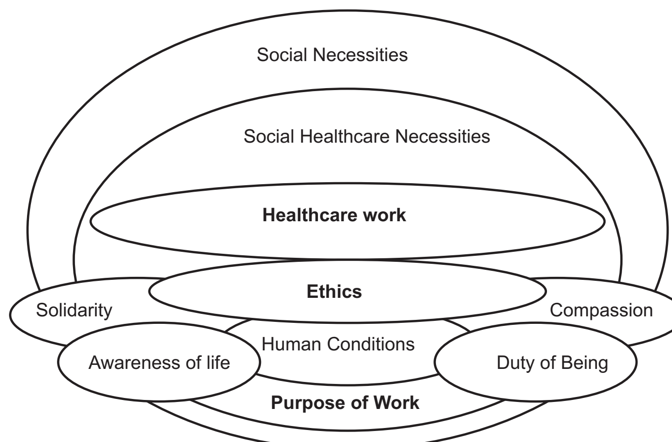

Figure 1 - Representation of the System of Meanings of the Purpose of Work. Relations between the Theoretical and Empirical Base Categories - Rio Grande - 2007

In the presented alignment and excerpts, the text will focus on the sense of the component of ethics in the purpose of work, one of the main themes for the study analyses, i.e. the social necessity of humanizing the purpose of work, not only regarding the feeling of need, but also the potential for changes in the historic reality that includes the individual and the different social groups. It is important to note that the complexity between individual and collective needs and potentials reflects the limit of the analysis of the study object (the system of meanings of the purpose of work), which was guided solely by the testimonies of one of its subjects, the workers.

The social necessity of humanizing purposes

The political and organizational design under which the Family Healthcare teams operate establishes the set of problems predicted for the work routine of each participating professional and defines the actions that are potentially capable of solving them. However, it is the social nature of the rationality of the professionals in the team, as humanized sensitivity, permeated by dignity and respect towards human condition[14], which ultimately distinguishes the system of meanings of the purpose of work.

When the professionals develop it, they establish bonds of commitment and co-responsibility with the population and broaden the purpose of their work, using the dimension of ethics as a reference in the sense of the willingness of one person towards another person. The social necessities experienced in the routine of work transcend the specifics of the healthcare sector and have determining effects on the conditions of life and health of the individuals, families and communities.

Work establishes this relation based on choice. Choice is determined by historical contingencies (culture, habits and the social and material conditions of life) of an individual or individuals in their relationship with another or others. The willingness of a person towards another person is developed, therefore, in the choice/decision placed in the action, which is self-determined in the context that produces it. The extracts of two narratives are shown below to illustrate the point:

The purpose of work is to improve the conditions of health and life of people. We can see that the result of the work performed by our team in the home visits is reflected in the community. People change their habits, their addictions, their diet, and this is health […] (M2-Eq27-Md8).

> […] I believe that it is necessary to improve the quality of life of our population […] at least that's what we try to do. If we go out for the home visits, if we're here […] we observe, mainly, that when people can improve their habits, their quality of life is also improved […] This part is very rewarding, when we see a great improvement in the quality of life of the population […] (M2-Eq41-Ef24).

The focus of the instrumental purpose of work on knowledge change and acquisition of healthier behaviors has the sense of a relation in the direction of the development of an awareness of life[4], i.e. making individuals and groups more sensitive to it in order to engender positive changes in the conditions of life. As such, the purpose of healthcare work is associated to the sense of promoting reflection, mainly in the individual dimension, so that it can concomitantly cause changes in quality of life, which covers the collective aspect of life by being social, as expressed in the following extract:

> […] It is always meant to improve the quality of life of people, for the community individuals to have a better view on how they live, in an attempt to change, to make changes in behavior and improve quality of life. We always seek to do it, developing actions and behavioral changes to make them happier and to help them. Many things are missing […] in the aspects of hygiene, housing, environment […] and to reduce the family risks. (M1-Eq7-Ef17).

The narrative above reports the existence of a positive differential sense in the purpose of work, associating the sense of promoting *happiness* to the focus of change and acquisition of knowledge and healthier behaviors to cause the habit of pleasure in the relationship with the clients and the communities. The sense of being able to make someone *happier* or the duty of making someone *happier*, which also comes up in the testimonies of nurses, is related to human feelings of compassion and solidarity, inherent to the bonds established in working with populations in poor conditions of subsistence.

Therefore, certain expressions were used to characterize the appalling conditions of existence in the communities where the interviewees work, making it possible to apprehend the sense of solidarity among people, i.e. compassion and emotions stirred by the suffering of others[14]. Evidence of such a statement is shown in the excerpts of the narratives of a nurse and a physician, shown below:

> […] It's possible to see, according to what the individuals have to offer, that the conditions are of real poverty, there are some families with better conditions, but most of them are really poor. Even the way they dress and smell, we also observe their lack of cleanliness, no socks, no shoes, their smell that lingers in the air […] they're really poor. […] (M1-Eq12-Md12).

> [...] the population here is under the poverty line, at first it even got me depressed [...] our home visits happen in the morning, we go to peoples' houses and nobody cooks lunch, there's no lunch, those are houses with children, with elderly people, people who are just lying or sitting around. The houses have dirty floors, and they don't sleep on made beds. (M2-Eq33-Ef42).

The contextualization of the sense of solidarity, or even the sense of compassion, can be observed by the expressions used in the narratives, such as improvement of quality and conditions of life. It justifies, or at least helps to understand the association between this feeling and the purpose of work, in the form of actions of social reciprocity. For it to occur, there is the need to establish bonds of commitment and co-responsibility among the individuals of community groups and the professionals who work there, promoting the duty of solidarity towards people and groups whose necessities are neither partially nor fully acknowledged[4]. The relations between the historical condition of human existence and the state of health and disease of the individuals and the communities are described in the different areas of knowledge, covering several senses according to the theoretical and empiric paradigms that support the approaches of those areas[15-17].

In the testimonies, both nurses and physicians refer to the living conditions of the people and the communities, incorporating the sense of identification of individuals with significant needs that affect the minimum biosocial conditions for survival and citizenship (diet, housing, jobs, education, security, affection, humor, autonomy, freedom…). The reported feelings, in addition to including the valuation that is inherent to the pragmatism of direct actions and the organizational dimension of work, also includes the sense of the possibility of valuation for the work itself within the dimension of ethics, as well as the valuation of the relationship among the same work and the acquired (or not

acquired) interests. These interests arise because the purpose of work is focused on human beings, especially in the narratives of the nurses, but also in those of some physicians: a particular interest towards human beings in poor living conditions[17], with whom they have to deal routinely at work. The excerpts of narratives shown below demonstrate such a meaning associated to the purpose of work:

> […] I consider that this is my home. I feel that my greatest motivation are the personal accomplishments, which are very rewarding. It's a job I've been involved in for a long time […] (M2-Eq31-Ef36).

> […] I work here to feel good, that's it. If my motivation were any other I wouldn't do this job. It's exhausting, it's time-consuming […] sometimes I have to abdicate from my own family. So, it's the retribution that the patients give us, and sometimes we don't quite see it like that, improvements in health, but we see that their spirits improve, they welcome us, they show us that they like us, and somehow that makes the difference. (M1-Eq1-Ef14).

The excerpts of the narratives suggest an acquired (or not acquired) interest in the form of an ideary, i.e. an inner, individual prowess to produce a positive state or condition at work. As such, it is possible that the acquired (or not acquired) interest may comprise the human sense of duty of being professional in the relationship with the community, especially for the nurses, but also for some physicians, which is potentially linked to a system of meanings of the purpose of work.

Regarding the term *interest*, according to its ideal-subjective characteristic (interest of a person towards another), although observed in its human sense of duty of being, it is observed to demand forms to become reality, and this can be done through work. Therefore, it is possible to see that, in the specific case of healthcare work, the work of the Family Healthcare teams can be directed to any person, therefore being a collective activity of public interest, since *everything that becomes public can be seen and heard by everyone [...] whatever is seen and heard by others and ourselves is reality*[14]. As such, the acquired (or not acquired) interest in healthcare work becomes real, and it is shown to have the human meaning of the duty of being professional in the relation with the community through the PSF activities, developed with actions of collective interest in the dimension of ethics of the purpose of work.

Another association of the human sense of the duty of being in the work of some of the interviewed physicians is expressed in the notes below. The association lies in the sense of the potentiality of the relationship between professionals and clients to make quality healthcare exchanges possible, either from the general community and the individuals in particular, or the healthcare workers themselves, as individuals who need to *feel welcome* in the community. It also has the sense of the human conduct in the purpose of work, as an association with the meaning of subjective willingness implied in the sense of the duty of being professional, focused on the medical act of having an appointment.

> [...] in the PSF reality, in our work, we have a very deep involvement with the community, this is the objective. One of the main goals of the PSF [...] is to know the community better, and, when we know the community better, they start to trust our work. They say: oh! The doctor knows my history, she knows where I live [...] So, that's why this work is important, because we work at the base, we can see where they live, the whole reality [...] (M2-Eq27-Md15).

> [...] the purpose of work actually lies in welcoming the individuals. In making the community really trust the professional and it depends on each professional, it's individual. It's really to welcome the patient, and, if I can say it, I have a good doctor-patient rapport. Then, as I see it, the PSF doctor has to be available to listen to the problems of the community. Often, the appointments can be surmised in listening to them. They don't really want an appointment, they want to be heard […] (M2-Eq38-Md69).

This last narrative exposes the need to provide mutual attention in the service. It also reveals the existence of a need for affection in the professional relations, the need for comprehension, assistance, help with difficulties, which becomes objective through the subjectivity of knowing how to listen to the client in the specific dimension of the professional relationship - physician and patient - where the sense of listening is not restricted to the *physiological auscultation*. The PSF proposal of healthcare has this logic, which extends to the multidisciplinary dimension of the work of the teams and comprehends the objective meaning of the action of listening, which can also have the meaning of welcoming and establishing bonds[6], starting with inherent necessities of people's•living conditions.

The operational development of work shows the conception that the human action has, or should have, the subjective meaning of vocation, something that goes well beyond inherent aptitude and is necessary for actions in the organizational process of work, because of its likelihood of social limits. On the other hand, since healthcare is a social practice, humanized actions do not necessarily correspond to a positive and natural sense, instead being a social construction. As such, they may either be adequate to the healthcare needs of a given group of people or the whole collectivity. Therefore, *[…] being willing to listen […]*(M2-Eq38-Md69), has the meaning of processes that represent the meaning built historically in the practices of basic healthcare, the human (in)capacity of developing the *attention* to the necessities of men and women themselves.

In this philosophical direction, the movement of concretization[18] of humanization is determined by the work, and the relationship between the willingness and the decision of humanizing is made explicit in the purpose. Work is a mediation of the individuals, which makes willingness concrete from decision, as

> willingness is only determined when it is decided. Through decision, willingness is seen as coming from an individual towards another […] Willingness that does not decide anything is not real willingness[18].

Work is a field of ethics, which *deals with the objective determinations or the social mediation of freedom*[18]. Therefore, in the dimension of work ethics, the worker is qualified according to the objective determinations, the results and consequences of his or her actions[19].

FINAL CONSIDERATIONS

The analysis of the testimonies of nurses and physicians in the study, according to the necessity of humanizing the purpose of the work developed in the PSF guided by the ESF, showed that the positive sense of health through work is viable, with the meaning of reaching the *best health state* possible for individuals and communities, considering the historic context in which the situation develops.

By developing work, according to the logic of insertion of the multiprofessional PSF team in the community, the professionals establish relations of mutual awareness with the population, therefore adding a humanized bond to the meaning of purpose of work, between the senses of *improving* the health conditions and quality of life and the instrumental/operational sense of the work, focused on changing the behavior of all those involved in the process, including people and the community.

The sense of *improving* is observed to be associated to the sensitivity of the professionals in the process of approximation with the community, which approximates potentials for changes established in individuals and communities. The focused sense was more frequent in the nurses' testimonies than in the physicians', even though the latter expressed the proximal sense of community insertion, and the meaning of the purpose of work was very close to the act of having a medical appointment.

Therefore, within the universe of the interview analyses, it is possible to say that talking about humanization in the purpose of work caused an introspection in the interviewed professionals, covering from the meaning of vocation to a perception of the sense that there are possibilities in the structure of the service, where historical-social forces emerge, representing necessities that are as real as the reality of health, to overcome a large share of those enlisted here, and consensually decide which should be prioritized to provide better conditions of life[4].

Talking about humanizing in the purpose of work means assuming an ontological redundancy. It means assuming the fact that there is universality in particular actions, and that it is expressed by the objective component of every action, including work, i.e. the willingness of an individual towards another. Also, talking about humanizing means elucidating the relationship between willingness and the limits set by the action itself. Therefore, it is worth noting that the subjective willingness assumes objectivity in the decision and the relationship - willingness and decision - is made possible because of work.

It is important to clarify that the position taken herein does not correspond to a valuation of the medical or nursing practice, or both thereof, over other healthcare practices. What is stated here has the intention of apprehending the meanings present in the particular space of the PSF work in the South of Brazil, one of the representatives within the historic context of Brazil regarding the implantation of a political proposal of changes in the model of care provided to the population, the particulars of the family healthcare network. The rationalities and feelings of the professionals are shown in the statements, which yielded the system of meanings of the purpose of work apprehended so far.

In view of the analyses and results presented herein, which derive from broader studies about the technological construction of the Family Healthcare model according to the empirical base of the work process of the ESF, such a study could be a part of the academic and technological discussion about the macro dimension of building competences and adequacy to the healthcare necessities of the Brazilian population. Also, it could contribute to the analysis of the process of the healthcare services, with a qualitative perspective of the microspace of work.

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