PREPARING THE CARE RELATIONSHIP: A WELCOMING TOOL IN HEALTH UNITS

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This study aimed to identify and analyze aspects regarding the preparation for the worker-user relationship in a primary health care unit in a city in the state of São Paulo–Brazil, from the perspective of welcoming. The health work process is the theoretical basis of the study; participant observation and semi-structured interviews were used as data collection techniques, and thematic analysis in the analysis stage. For the welcoming to be processed, there is a "moment" of preparation for the worker, the physical environment and the relationships present at work so that users are welcomed, in which the users' needs are sometimes disregarded. Despite the difficulties in terms of resource availability, especially in the public sector, when preparing the service/user and worker/user relationships, one should consider the aspects associated to a more human, welcoming relationship, since it is during live work, in this intersection, that care quality is established.

DESCRIPTORS: primary health care; interpersonal relations; health services

PREPARANDO LA RELACIÓN PARA ATENDER AL PACIENTE: UNA HERRAMIENTA PARA EL ACOGIMIENTO EN UNIDADES DE SALUD

Se tuvo por objetivo identificar y analizar aspectos pertinentes a la preparación para la relación trabajador/usuario en una unidad de salud de la red de atención básica de un municipio del Estado de San Pablo, Brasil, teniendo como perspectiva el acogimiento. El proceso de trabajo en salud sustenta teóricamente el estudio. Se utilizó la observación participante y la entrevista semiestructurada como técnicas de recolección de datos y el análisis temático en la etapa de análisis. Para que el acogimiento se procese deben existir un "momento" de preparación del trabajador; debe ser preparado su espacio físico y las relaciones presentes en el trabajo para que suceda la atención al usuario, donde no siempre son consideradas sus necesidades. A pesar de que existan dificultades en la disponibilidad de recursos, especialmente en el sector público, en la preparación de la relación servicio/usuario y trabajador/usuario, deben ser considerados los aspectos vinculados a una relación más humana, que debe ser acogedora, una vez que es en el trabajo vivo en acto, en esa intersección, donde se configura a calidad de la atención.

DESCRIPTORES: atención primaria de salud; relaciones interpersonales; servicios de salud

PREPARANDO A RELAÇÃO DE ATENDIMENTO: FERRAMENTA PARA O ACOLHIMENTO EM UNIDADES DE SAÚDE

Objetivou-se identificar e analisar aspectos pertinentes ao preparo para a relação trabalhador/usuário em unidade de saúde da rede de atenção básica de um município do Estado de São Paulo, Brasil, tendo como perspectiva o acolhimento. O processo de trabalho em saúde sustenta teoricamente o estudo. Utilizou-se a observação participante e entrevista semiestruturada como técnicas de coleta de dados e a análise temática na etapa de análise. Para o acolhimento se processar há um "momento" de preparo do trabalhador, do seu espaço físico e das relações presentes no trabalho para que se dê o atendimento ao usuário, onde nem sempre são consideradas suas necessidades. Embora haja dificuldades quanto à disponibilidade de recursos, especialmente no setor público, na preparação da relação serviço/usuário e trabalhador/usuário, devem ser considerados os aspectos ligados ao relacionamento mais humano, acolhedor, uma vez que é no trabalho vivo em ato, nessa intercessão, que se configura a qualidade do atendimento.

DESCRITORES: atenção primária à saúde; relações interpessoais; serviços de saúde

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INTRODUCTION

The development of health work is characterized by unique and singular encounters in which spaces of intercession[1] are established, spaces in which workers' and users' subjectivities and singularities are expressed and, hence, configured in the existence of unique moments, which demand relations and specific interventions for the needs the users expressed.

In this study, the relations explored were produced in the context of the Unique Health System (SUS), guided by the principles of integrality, universality, equity and accessibility, in which aspects stood out related to the preparation for these relations, which characterized welcoming at a health unit in a large city in São Paulo State, Brazil.

Welcoming is understood as a process here, a result of health practices, a product of the relation between health workers and users, thus constituting a set of actions performed in distinct ways at the moment of care delivery, involving postures and conceptions the workers adopt to identify user demands and needs. This means considering welcoming not only as receiving the user at a health services, but as an action of making the workers accountable for the users during their entire stay at the health service[2-4]. Hence, welcoming also pictures the dynamics and accessibility criteria users are submitted to at health services and, in this sense, workers can direct the work process to attend to users' needs, "thus becoming technology for service reorganization, which a view to guaranteeing universal access, problem solving ability and care humanization"[5].

Based on this perspective, it is considered that welcoming is marked by subjectivity, by listening to the subject's needs, by the acknowledgement process of accountability between services and users, thus permitting bonding[2,4].

Much before the worker/user encounter, the health unit as a whole prepares for this relation. This preparation is based on the conception of the health unit's goal, put in practice through the structuring of work, according to its care model, the destination given to a physical environment, the definition of what, who and in what circumstances the service will welcome, as well as the presence of certain work conditions. In this context, the workers practice care on behalf of the health unit. In this sense, one may say that welcoming presents some components, such as the mutual representation between worker and user, determining their forms of approximation, the objectivation of health/disease and health problem/ need for workers involved in health care, verbal and written communication used in the care process and, finally, accountability for work and for helping the other[2,4].

The understanding of welcoming in this sense is based on the theoretical perspective of the health work process[6]. "The understanding of the social in the health area provoked a rupture with the Cartesian research models that reduced cause-and-effect relations to the biological level and derived problem solving to the clinical model of diagnosis and treatment"[7]. In this sense, the introduction of the work category sustained the understanding of the health-disease-care process in our society, from the perspective of practices that are no longer exclusively directed at the biological bodies, but at social bodies for the analysis of this process "in their relations with the economic, political and ideological structure of society"[7].

Hence, from this perspective, health work is considered work like any other, producing men in relation to other men and nature in a given socio-historical process. The work process in health deals with human beings (agents and users), whose needs are also constituted historical and socially[2] and will constitute the goal that drives the work. In this sense, as man is the object of health work, they need to be apprehended and acknowledged "in their objectivation process of what health/disease is, that is, as a movement to objectify their health needs, when they exteriorize their subjectivity towards the health/ disease process"[2].

In the movement of attending to the needs this man expressed, and which are not any human needs, that is, "they appear as something that 'needs' to be complied with for this man to continue as a being"[6] in a given space/time, specific work instruments, knowledge and tasks are used that permit compliance with the expressed needs. The work instruments are tools for the development of the work process. They are not just any tools, but those determined by a given instrumental knowledge, translated into knowledge, equipment used to operate the transformation and/or comply with users' need. Workers are included there with their knowledge, with their work force, used in this dimension of the

transformation process, as a agents that can mobilize transformations[8-9].

Thus, for production to occur, these components need to be articulated around the accomplishment of a certain project that complies with socially established needs, a project that is mediated by a given know-how, an instrumental knowledge[7-9]. Hence, in health work, technological knowledge is used, which can involve hard (technological equipment like machinery, equipment, standards, organizational structures), light-hard (well-structured knowledge present in the health work process, such as clinical work, epidemiology, psychoanalysis, among others) and light technologies (relational technologies like bonding, listening)[9].

In this general picture, it can be affirmed that the health work process always has an intention, and is gradually constituted in a given social and historical context, expressed in its instrumental components: live work and dead work.

Live work in the act occurs at the moment it is executed by the workers, and work in the act, in process, is the work that is in action and, thus, loaded with possibilities of creation, inventiveness, humanely established attempts. Live work in the act differs from dead, already materialized work, as a result of previously produced work. Dead work is understood as all product-means, instruments used as tools or as raw material to put the productive act in practice, all now crystallized results of previously live work, materialized in the stethoscope, the sphygmomanometer and other materials needed for health work. But also a certain technological knowledge that allows workers to concretely practice what they have conceived as a project, besides the whole systemization and organization of the work process to put that project in practice. In this sense, live and dead work are dynamically present in the development of work, simultaneously practiced by the workers[7, 9].

Through the expression of live work, workers can take over the means/instruments to recreate the work, themselves and others, becoming both the product and producer of work.

Thus, this research aims to identify and analyze pertinent aspects of preparing for the relation established between worker/user at health units in the basic health care network of a large city in São Paulo State, Brazil, from the perspective of welcoming.

METHOD

This research took place at a health unit in the basic health care service network of a city in São Paulo State, Brazil. The city is an important regional center due to its extensive general service network and has a strong vocation for education and health, with 504,923 inhabitants according to the 2000 Demographic Census, and a projected number of 551,312 for 2005[10]. Its basic service network consists of 27 Basic Health Units (BHU) and 5 Basic and District Health Units (BDHS), functioning 24 hours per day and in different health care areas[10]. In 2008, 23 Family Health teams were functioning in the city, which had been implanted since the year 2000.

The unit selected for the research was a district health unit affiliated with the University of São Paulo, which performs specialized and programmed outpatient care activities, support and diagnosis services, treatment application, epidemiological surveillance, besides 24-hour urgency and emergency care.

Considering that welcoming occurs during the entire health care process, participant observation and semistructured interview were selected as instruments to approach the empirical. To organize participant observation, the *Analysis flowchart of a health service's care model*[11] was used. Nineteen care observations were performed, selecting the situations based on the users' agreement, so as to follow their movements through the health unit. In the selected situations, the user presented some health problem that could be attended at the emergency care sector or at the medical clinic, because the user's first contact with the health unit occurs in these areas and because these sectors display greater difficulties to welcome the users, either due to the complexity of their health problems/needs or due to the great demand the health services are confronted with. Sampling for the semistructured interview was intentional and involved 9 of the 41 workers participating in the observed care, with workers from different professional categories (1 guard, 1 pharmacy AID, 2 physicians and 5 nursing auxiliaries) and different care areas. Thematic analysis was used in the data analysis phase[12-13].

To develop the research, ethical guidelines were followed according to Decree 196/96 by the National Health Council. Data were collection after approval for the project was obtained from the

Research Ethics Committee at the Teaching Health Center of the University of São Paulo at Ribeirão Preto Medical School (Protocol 0022/02). Participants received and signed the free and informed consent term before the observation and interviews were held, with the commitment that their identities would be preserved and that they would not be subject to any damage.

RESULTS AND DISCUSSION: LOOKING AT AND TALKING WITH THE EMPIRICAL – PREPARATION FOR THE RELATIONSHIP

Doing health work demands the preparation of the physical environment as a space for relations[2]. The care moment represents the approximation between people, an explicit demand that expresses the user's needs. To try and solve some problem, minimal conditions of privacy and comfort become necessary[14].

In certain physical environments prepared for the relation, such as the glass desks with a small hole at the emergency care – EC* service, or counters in open environments at the medical clinic, users had to expose the reason for coming to the health service, without any privacy. In these circumstances, both users and workers had to raise their voice to manage to communicate and be mutually heard. In an open environment, environmental noise (conversations, children crying, ambulance sirens, communication through loudspeakers and others) interferes in the relation; in addition, momentary events occur, such as interruptions to request information, people who pass by and say hello, people who feel bad, which deviate the workers' attention beyond the intercession space they are trying to establish.

This environment interferes in welcoming, as users are constrained and limit themselves to a rapid expression of their problem or complaint. No private space is reserved for them, so that the other person's space is not respected[2-3], in similar circumstances, granting themselves the right to interrupt other relations. *I arrive at seven, I like to arrive earlier (...) then the patients arrive, - we get their card and the files (...) we weigh the patients and ask them to go over there to see the doctor. – in this time interval, patients come by to know where the ophthalmologist is, where the X-ray is, where the electro is, where the collection is (...) they forget the appointment card at home and we have to write another one – they did not schedule the exams correctly (...) they did not fill out the number, or did not fill out the name and come here for us to do this for them, that they, even if you explain, many come here for us to do it, all of that occurring in the interval while you are seeing and weighing the patient. Pressure..., we see pressure, - (...) always... (...) information, all the time there... Where is the pharmacy (...)* (Interview 6).

Even in closed environments, like in the case of the doctor's office, during observations, different interruptions were registered. These point towards the need to reflect on the extent to which the different relational spaces of the health work process are respected[2,14].

Post-consultations** for adults at the medical clinic take place in a room prepared to receive two users at the same time. Two nursing auxiliaries work at that room, who appoint unfavorable work conditions, due to a wide range of frequent interruptions, which interfere in compliance with their tasks. In addition, they do not demonstrate concern with interferences from the environment with a view to the establishment of closer, more humane care relations, which can help users to deal with their health problems, in which the construction of a relationship network that permits health care does not seem to be present[2-3]. Instead, they assume a position of conformity. *It's no use, there's no solution for that* (Interview 6), considering the situation practically 'normal'. *(...) You are talking, doing the post-consultation, the patient comes in there inside your room and cuts you off and you, because the door is open, and cuts off your post-consultation to ask or request some information... (...) You're always interrupted there ... I think it is really bad, I don't like it, I have already complained but there's no way of closing the door because I'm working together with a colleague ... The colleague is receiving one patient and I'm receiving another, there's always a companion ... and that room is small ... and there's no way for you to close the door there. If you close the door no patient comes in. The door has to remain open ... I think it's horrible, I don't like it... I have already complained but it's impossible ... there's no way ... there are no solutions for that ...* (Interview 6).

*Name of the sector in the Health Unit demanded by patients who need immediate care, characterized by care delivery to clinical, surgical urgencies and emergencies etc.

**Post-consultation is defined here as any care delivered by nursing staff aiming to, in most cases, strengthen user orientations after the medical appointments. Besides reinforcing orientations about indicated therapeutic actions, other activities can also be performed, such as: scheduling diagnostic support exams, returns etc. Post-consultations derive from the technical and social division of health work, as a way to rationalize medical work.

Another aspect of preparing the environment for care to take place refers to care with cleaning conditions. A clean, clear, organized environment reflects anticipated care for the users and the environment that needs to be developed. One user indicated the importance of cleaning the environment, comparing this health service to that in the city where he used to live. *In Rio, health stations are very bad, neglected, dirty, the doctors use dirty clothes, the cities are dirty, smell bad, people do not take care. Health care is much better over here* (OBS 6). There is a clear relation between cleaning and health, which is also part of what the users seeks at the health service.

Workers can also demonstrate their respect and attention for users by the care they take with and the adequacy of their clothing. This care causes a good impression to start the care relation[2]. One user explicitly expressed this, demonstrating confidence in the health service where she was.

Care with physical appearance and clothing is also observed in the users, demonstrating concern with presenting themselves in the best possible way to the other, preparing themselves for the relation they are going to construct. *(...) We see the patient here a lot (...) We see him clean, he comes to visit the health center, you know? He clean, the children, clean, pretty ... I'll never forget it, one day, I was doing visits now ... a month ago (...) It had rained ... the slum was a mud pool ... and everyone was wearing slippers, right? Taking care not to dirty their feet, with very nice clothes ... When he got to the corner of... he left that quarter of the slum, everyone put on shoes and socks, the children, 3 children, the mother ... you know? He took the bag and threw it in a corner, the bag, with the dirty slippers ... and came to the health center because I met her at the vaccination room, putting a bandage on a child, right?* (Interview 1).

Concern with the other, the user, can also be observed by the way signs are used and the location of rooms and care sectors is informed, that is, how hard technology is used: signs, posters, information panels and others. Right from the entry, signs are not very highlighted, hardly evident and, in many situations, there is nobody to give information at the sectors. This does not mean saying that all signs at the site should be changed, but that the service as a whole, through its workers, should consider signs as they are, guiding users according to their needs; thus paying attention to identify, among users, people with momentary difficulties to locate themselves inside the health unit, either due to educational limits or circumstantial difficulties, such as pain, anxiety, fear, in a constant exercise of equity and accessibility. *We reached the X-ray at 14h38min. There is a lady at the end of the corridor, she looks at one of the doors and the desk and asks us, getting closer: 'isn't anybody here? Are you on duty?' I answered that the service would be functioning after 16 hours and that we would be waiting. The patient thanked me and said: 'ah! Then I'm leaving', after which she got out.(...). At 15h8min a lady arrives carrying different papers and asks about service times. We inform about the start at 16 hours (...)* (OBS 6).

In the above situation, it seems that the importance of this care was not perceived, as the user did not receive any type of information or attention about the sector only being available for care delivery at another time. In this case, the environment was not sufficiently prepared to welcome users who arrive with doubts, generating a greater feeling of uncertainty.

Preparing the environment is not merely preparing a physical space, but also refers to the care the health unit and the workers take when performing this preparation, demonstrating their availability to establish the relation and to transform it into a space of welcoming, with the presence of workers who can give users more adequate answers and, at the same time, the use of available resources to solve the users' problems and needs, which implies workers' and the health service's interest in and accountability for situations that appear in daily health work[2-5,14].

Another act of care to prepare for the relation with the user can be considered the adoption of appointments at the medical clinic. *Over there at the Vila Tibério health station, there is a good doctor too, but I like Dr. X more ... My appointment is always at the same time... I come after lunch... You have to make appointments for everything now, right?* (OBS 17).

Agendas are not always followed, however. *A lady who is also waiting for her appointment says: 'when they're in a good mood everything works out. When they're in a bad mood the day is lost. (...) One day I had to cause a scandal. My appointment was set for 7 o'clock and I could go in at 11. I went there and scolded them so much. They let other people get in before me... They let other people in... Then I went there and told them! Then they let me in. (...) but they schedule a lot of people at the same time ...'* (OBS 19).

This report shows the other side to making appointments, that is, the adoption of this form o f work organization attends to the needs and priorities of the service itself, with a more adequate regulation of the demand flow for work performance, but without any concern with the users' need, setting the time

they need to arrive instead of the time they will be attended, which goes against the expectations that are created when stating that appointments can be made at the service.

This shock between the service structure and users' expectations produces a certain lack of availability to relate with the health workers in the latter, especially with nursing auxiliaries, who are held accountable when the patients are not attended according to the agenda, demonstrating a lack of credibility and confidence, which will definitely affect the worker/user bond and the welcoming of this user.

In some situations, the rule is taken in its strict sense, not facilitating welcoming, distant from the purpose it was established for, that is, to decrease waiting times, reduce the number of people circulating at the unit, to avoid commotion and loud noise. *(...) a lady hands over her appointment card to the auxiliary: 'I have an appointment today ..., Dr. PPP'. The auxiliary looks at the card: 'but it's at 14 hours. You can only come down here at 13h30min. 'The patient says: 'but I work ... the girls there, they're already there. They take my card and then I go to work'. Auxiliary: 'you can only get in half an hour before your appointment. You can wait'. At 13h30min you come down* (OBS 17).

This production of a certain bureaucratic practice pattern derives from the circumstances in which a therapeutic project is executed, organizing, dividing the work and allocating the worker to a given phase. In this process, the worker executes "acts without meaning, or whose sense depends on a continuation of what the worker not only does not control but even ignores"[15].

Both making appointments and regulating the users' entry flow at the unit pass the idea of disciplining users, more than the unit directing its focus at users. This discipline evidences the historical presence of power in worker/user relations, starting with their preparation. In daily reality, what seems predominant is that the user submits to these standards and powers of services and workers, in this discipline process, which fits the demand into the care offer, into the available menu.

This power relation is unequal, it is given by the role - of user and worker, a hierarchical relation that is social and historically determined by the relations themselves, by the mastery of knowledge, by the possession of information[16]. In a way, user and worker prepare themselves for the same, to the extent that they recognize one another, in some way, in that space of intercession. This recognition, called 'the work', refers to "recognition of the work result by the worker as well as the client and society"[15].

Users sometimes submit to workers so as to have their problems welcomed but, at other times, act as subjects, also being fully present in the relation within the same context and preparing themselves to get what they want. Workers, in turn, can use this power more freely, using a wide range of forms in the space of intercession with users, evidencing their power even more or using it in a more horizontal relation in which both users and workers are together in constructing answers to the users' problems. *There are two boys at the desk receiving orientations from the auxiliary. One of the boys says: 'return.' Auxiliary: 'you lost your appointment. It was at 13h30, it 's too late'. Patient: 'but work... I couldn't come earlier...' Auxiliary: 'I've just included the patients without an appointment'.* (OBS14).

Before relating with users, workers are confronted with their own work. Their representation of work is given by their conception of this work, by the conditions in which it is put in practice, by the return they can obtain, by their representation of users and their needs. In a way, this situation creates workers' availability to relate with users so that, besides interfering in the way workers will use (light, light-hard and hard) technologies in health work, will also influence the extent to which and for what workers will assume responsibility and what goal will guide their care[2-3].

One of the physicians (Interview 3) mentioned that, despite hearing the screams of conflict between auxiliaries and users, he does not leave the consultation room, that is, he does not help, and does not even know if the user received care or not. He acknowledges the problem but does not get involved. This report highlights the issue of workers' accountability for the work that needs to be developed as a whole, for its goal and, noticeably, for the issue of team work, in the sense of cooperation among team members[17], so as to try and solve the problems present in daily work. The form of acting the professional describes gives the idea that he is caught in a work division matrix, where the physician only performs the consultations, while nursing auxiliaries or any other worker active outside the doctor's office are responsible for user reception and appointment making, preparing the conditions for care delivery and listen to the users' expectations with regard to the health service.

Physicians' non-involvement with user welcoming indicate that they have been captured by

dead work, as confirmed in the interview, when the physician mentioned that the work structure and organization prevent him from attending to his patients in case of problems, which limits his work[2-3].

FINAL CONSIDERATIONS

The observation of the care, as well as the interviews with the workers, seem to reveal that it is the goal of care that structures the relation that needs to be constructed. This goal is not explicitly expressed, that is, it emerges in the relation with the elected response, which is the best and most viable in those circumstances, taken from a menu of possible interventions the workers thought of, departing from and inside that space of intercession.

Moreover, the structuring of care and the answers that will constitute the menu of interventions can take more or less broad dimensions, based on the conception of man and health/disease that support the goal of care[18]. In this process, the workers demonstrates for what and to what extent they assume responsibility, which also reveals their conceptions present in the care relation, that is, the decision taken expresses the workers' objectivation of the health/disease process and the goal they attribute to the work.

Hence, workers' availability to prepare the environment, themselves and the care relation itself involves the workers themselves (their affections, desires, projects) and the context they are inserted in, going well beyond the walls of the health unit. This assertion is based on the workers' perception as relational persons in the world, who suffer and produce reciprocal actions of maintenance and transformation. In their daily reality, however, workers normally do not perceive themselves as such, live full of anguish, rushing all the time, spending a lot of energy, without pausing to reflect on what they do.

Despite difficulties in the health sector in terms of resource availability, especially in the public sector, issues raised here about the preparation for the service/user and worker/user relations need to be heeded, attempting to incorporate them into the service structure, investing in increased problem-solving capacity, not only in terms of efficacy and efficiency, but through a more humane, more welcoming relationship, as it is in live work in the act, at this intersection, that care quality is configured.

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