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Production of care and intersubjective relationships with patients suffering of high blood pressure in the Family Health Strategy

Produção do cuidado e as relações intersubjetivas com usuários hipertensos na Estratégia Saúde da Família

Producción de cuidados y relaciones intersubjetivas con usuarios hipertensos en la Estrategia Salud de la Familia

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This is a descriptive study, with a qualitative approach, conducted in a city in the interior of the state of Ceará, Brazil, in 2016. It sought to analyze the production of care and the inter-subjective relationships with patients with high blood pressure in the Family Health Strategy. The data were collected through a checklist for systematic non-participant observation, treated by the Thematic Content Analysis. 14 patients and two medical professionals participated: a nurse and a doctor. Two categories emerged: "*Production of care in intersubjective relationships: welcoming, dialogue, listening, bonding*"; and, "*Elements emanating from interpersonal interaction: empathy, mutual respect, trust, accompaniment in reflections*". In the observations, these practices are still centered on the disease, with the need to strengthen the dialogue in the field of relational technologies to improve production of care from the perspective of intersubjectivity in care. There is a need to promote light technologies in the Family Health team that provide new skills for communication, subjectivity and the production of care.
Descriptors: Communication; Patient-centered Care; Professional Role; Hypertension; Family Health Strategy.

Trata-se de um estudo descritivo, com abordagem qualitativa, realizado em um Município do interior do Estado do Ceará, Brasil, em 2016, com o objetivo de analisar a produção do cuidado e as relações intersubjetivas com usuários hipertensos na Estratégia Saúde da Família. Os dados foram coletados por um *checklist* para observação sistemática não participante, tratados pela Análise de Conteúdo Temática. Participaram 14 usuários e dois profissionais: uma enfermeira e um médico. Duas categorias emergiram: *"Produção do cuidado nas relações intersubjetivas: acolhimento, diálogo, escuta, vínculo";* e, *"Elementos emanados na interação interpessoal: empatia, respeito mútuo, confiança, acompanhamento nas reflexões".* Nas observações, estas práticas ainda estão centradas na doença, necessitando fortalecer o diálogo no campo das tecnologias relacionais para aprimorar a produção do cuidado sob a perspectiva da intersubjetividade na atenção. Verifica-se a necessidade de impulsionar as tecnologias leves na equipe Saúde da Família que instrumentalizam novas habilidades direcionadas à comunicação, à subjetividade e à produção do cuidado.
Descritores: Comunicação; Assistência Centrada no Paciente; Papel Profissional; Hipertensão; Estratégia Saúde da Família.

Se trata de un estudio descriptivo, con enfoque cualitativo, realizado en un municipio del interior del Estado de Ceará, Brasil, en 2016, con el objetivo de analizar la producción de cuidado y las relaciones intersubjetivas con los usuarios hipertensos en la Estrategia Salud de la Familia. Los datos se reunieron mediante un checklist para la observación sistemática no participante y fueron tratados por el Análisis de Contenido Temático. Participaron 14 usuarios y dos profesionales: una enfermera y un médico. Surgieron dos categorías: "Producción de cuidados en las relaciones intersubjetivas: acogida, diálogo, escucha, vínculo"; y, "Elementos que emanan de la interacción interpersonal: empatía, respeto mutuo, confianza, acompañamiento en las reflexiones". En las observaciones, estas prácticas siguen centradas en la enfermedad, por lo que es necesario reforzar el diálogo en el ámbito de las tecnologías relacionales para mejorar la producción de cuidados desde la perspectiva de la intersubjetividad en la atención. Se observa la necesidad de promover tecnologías ligeras en el equipo Salud de la Familia, que instrumenten nuevas habilidades dirigidas a la comunicación, la subjetividad y la producción de cuidados.
Descriptores: Comunicación; Atención Dirigida al Paciente; Rol Professional; Hipertensión; Estrategia de Salud Familiar.

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INTRODUCTION

In the work of Family Health teams, the care process reveals a set of priority activities, such as individual and team care, health and in-service education, team coordination and procedures; and routine, home visits, team and management meetings, scheduling appointments and specialized exams, supervision, monitoring and evaluation of actions. Such activities can directly impact the provision of care to service users[1].

In addition to the technical aspects that guide daily practice of health, professionals working in Family Health Strategy (FHS) must be aware of the subjectivities present in relational networks for care to happen, as human relations[2] are considered as a fundamental principle for the understanding of self-care, since it goes through the process of mutual relationship between individuals, thus valuing interpersonal exchange that helps to protect subjectivity and, in turn, health.

In the context of health, the cartographies of the work process seek to make visible through relationships constituted in this territory, subjectivities that are crossed, manifestation of the diferent, desiring production of care flows, and also of "not care", the contradictory, the unexpected, deviations, strangeness, which translate the know-how before the world that produces care in its different scenarios[3].

The production of care must permeate different spaces built at different times of performance of the professionals who work in FHS, in the perspective of valuing singular and collective subjectivities, substantial to enhance health practices through more welcoming, humanized and horizontal relationships.

People should be cared for as individuals, in the singularity of their life, their future, their history, their desires, conflicts and delusions, without trying to frame them, organize them in a rigid, bureaucratic structure, centered only on symptoms[4], because the care work[5] transcends what is technical and prescribed, with workers' affection, intelligence and subjectivity involved.

Care, which is considered a foundation of our interpersonal relationships, is associated with the practice of communicating. Communication, in its various forms, plays an instrument of humanizing significance and, for this, the team needs to be willing and involved to establish this relationship and understand that it is essential to recognize the patient as the protagonist of care[6]. The intersubjective space established in this relationship allows communication and interpersonal interaction that makes it possible to transform health care practices.

Communication is an important tool in the health production process, and professionals working in FHS need to appropriately use light technologies so that inter-subjective relationships can be established effectively and efficiently, considering its potentializing character in offering quality care, positively impacting the health status of patients/family/community.

In this scenario, teams must seek to solve the user's health problem, or help them access the service that supposedly would solve their problem, therefore, they must also be resolute and a gateway to other system services[7]. These tools must take charge of the production of care, serving as a potentializing device for a work logic that values the subjectivities and the singularities of the subjects involved in the work process[8].

In this perspective, the approach of this theme is of interest here, due to the importance of revitalizing health practices, allowing a humanized, empathetic and respectful opening to the user, based on welcoming, bonding, listening, commitment, respect and ethics, as the act of caring[9] it has representativeness in the different dimensions of the human being, whether physical, psychological, emotional and spiritual, so it must be considered in its complexity, valuing the needs, singularities and particularities of the human being.

The establishment of relationships, the communication process, the reception and the construction of the bond are important elements that should be present in the Basic Health Units (BHU)[10]. In the magnitude that represents the production of care and intersubjective

relationships in FHS, health professionals must strengthen relational technologies in the work process, especially with hypertensive patients who require changes in lifestyle and daily care for the adequate control of disease, through a more affectionate connection with the other, under the logic of the bond, mutual respect, empathy, receptive listening and monitoring of those being cared for.

Communication between workers and patients is an element that can guarantee the success of care practices or lead to their failure, depending on the logic who guides it, that is, if it is aimed at understanding between the subjects involved, communicative action, or exclusively for technical, instrumental success[11].

Therefore, the question is: *How does the production of care and inter-subjective relationships with patients with high blood pressure in the FHS happen?* Thus considered, this study has established itself as an objective to analyze the production of care and the inter-subjective relationships with patients with high blood pressure in Family Health Strategy.

METHOD

This is a descriptive study with a qualitative approach, with the setting of a Family Health team, in a city in the interior of the state of Ceará, Brazil. Data were collected from April to May of 2016. Descriptive research[12] allows observation, recording, analysis, correlation of facts or social phenomena and establishing relationships between variables without manipulating them. And, the qualitative approach is concerned with analyzing and interpreting deeper aspects, describing the complexity of human behavior. Provides more detailed analysis of investigations, habits, attitudes, behavioral trends.

The municipality has seven Family Health (eFH) teams, with 100% coverage of the population; four Oral Health teams (eOH) and a Family Health Support Center (FHSC), to work in an integrated manner with the teams. The municipality has an estimated population of 16,070 inhabitants, and it is located 585 km away from the capital of Ceará, Fortaleza. It is inserted in the Macrorregião do Cariri and in the 20th Microregion of Crato, Ceará.

For this investigation, patients with high blood pressure and FHS professionals participated. For the patients, the following inclusion criteria were adopted: is registered at the Health Unit; lives in the FHS coverage area; has regular follow-up for at least six consecutive months; and exclusion: has cognitive disorders and is bedridden. The inclusion criterion for professionals was defined as: works in Family Health Strategy for at least one year; and exclusion, is away from work, due to vacation and/or paid leave.

Data collection was performed through non-participant systematic observation, with the aid of a checklist containing the groups of therapeutic communication strategies: expression, clarification and validation[13], subsidized by a field diary to record the information regarding observations and other notes perceived in intersubjective relationships, such as empathy, mutual respect, trust, receptive listening and monitoring the patient in their reflections. Each participant was observed, on average, for 15 minutes, with a total of 210 minutes of registration.

Communication techniques are classified into three groups: the expression[13] group, which organizes the techniques that help describe the experience and expression of thoughts and feelings about. The following techniques are used in this group: therapeutic use of silence; reflexive listening; verbalization of acceptance; verbalization of interest; use of incomplete sentences; repetition of the last words spoken by the patient; asking questions; development of questions asked; descriptive phrases; keep the patient on the same subject; allow the patient to choose subject; focus on the main idea; verbalize doubts; say no; stimulate expression of underlying feelings; and the therapeutic use of humor.

The clarification group[13] uses techniques that help to clarify what is expressed by the patient. Among these techniques, we can mention: stimulationg of comparisons; asking for

clarification on common terms; asking the patient to need the action agent; and describing the events in a logical sequence.

In turn, in the validation group[13], the techniques allow the existence of a common meaning of what is expressed, and are presented as: repeating the patient's message; asking the patient to repeat what was said; and summarizing the content of the interaction.

Observation helps the researcher to identify and obtain evidence regarding objectives about which individuals are unaware, but which guide their behavior[12]. In addition, it allows a more focused contact with reality.

The empirical material was analyzed and interpreted by Content Analysis by Bardin[14], which provides complementary information to the critical reader of a message, guided by the steps: pre-analysis, exploration of the material, treatment of results, inference and interpretation.

After exhaustive readings for a better understanding of the data under analysis, the registration units that mean 14 units to be coded were identified, which could be a theme, a word or a sentence, which guides the researcher in the search for information contained in the text. The choice of this technique was due to the valorization of the meaning of the content of the messages according to the objectives proposed by the research.

For that, the speeches and notes of the field diary were considered, bringing reflections that emerged for the adequate grouping of data in the construction of categories and the characterization of the research participants.

When advocating research ethics, patients with high blood pressure were represented by emotions and feelings, such as joy, lightness, sympathy, concern, among others, according to the conditions in which they found themselves at the time of consultations. The professionals were identified by the use of the acronyms (N - Nurse) and (D - Doctor).

The research was carried out with a favorable opinion from the Research Ethics Committee, of the Universidade Estadual do Ceará (UECE), under Opinion No. 1,506,165/2016, respecting the ethical precepts that guide research[15] in human beings established in Resolution nº 466/2012, of the National Health Council/Ministry of Health.

RESULTS

Characteristics of research participants

14 patients and two professionals from the team participated, a doctor and a nurse. Among patients with high blood pressure, there was a predominance of females (86%), with an average of 59.5 years of age. Regarding marital status, 57% were married. 71.4% of respondents were illiterate.

From the data, it was noticed the predominance of women during observations, due to the fact that they were housewives, with more time available to go to the health unit, as well as for presenting greater health care.

Due to the low level of education, there is a higher frequency of risk factors for cardiovascular diseases, arterial hypertension, and a need to strengthen the production of care and intersubjective relations to minimize health risks arising from uncontrolled blood pressure , as well as preventing other cardiovascular problems.

Health professionals were aged between 20 and 30 years old, single, with graduate and postgraduate degrees. The time of work in the FHS varied from two to four years, representing a significant time for understanding the territory, creating a bond and recognizing the specificities and needs of the coverage area.

Two categories emerged: "*Production of care in intersubjective relationships: welcoming, dialogue, listening, bonding*" and "*Elements emanating from interpersonal interaction: empathy, mutual respect, trust, accompaniment in reflections*".

Production of care in intersubjective relationships: welcoming, dialogue, listening, bonding

This category presents the practice of care and its implication with intersubjective relationships, allowing the experience of welcoming, dialogue, listening, bonding and interaction of those involved in the communication process. Throughout observations, an expression of emotions, doubts, anguishes and suffering established in the relationships with the other was noticed, being revealed by the reports:

[...] *it is taking a lot of hard work* [...]. (Concern)
Do you want to talk more about it (...). (N)
I suffer from it [...]. (Anxiety)
What causes so much suffering on you? (D)
The doctor gives me attention [...]. (Peace)
You can continue [...]. (N)

Through the speeches, there was a space for the production of care contemplated by a clear and understandable communication, allowing to express emotions, feelings and anguishes in the health professional-patient with high blood pressure relationship, essential for the development of a more humane care and adequate to the needs of these patients. Another fact that deserves to be highlighted is that the population calls the nurse a doctor, both for showing respect and for the leadership ability within the health team.

However, in the unit studied, in the care process, the use of light-hard technologies prevailed, watered by respect, bond and trust in the interactions of professionals with patients with high blood pressure. It was observed, then, the need for these professionals, when expressing inter-subjective relationships, to strengthen the use of light technologies to encourage live work in action in health. This improves the relational ambience and creates spaces in the production of new possibilities in care practices.

It seems a reality so far, but it is very close to health professionals, therefore needing a greater commitment in actions directed to communication, reception, accountability and listening that are peculiar to the human dimension, considering that patients with high blood pressure are the focus of attention and the recognition of their subjective expressions is essential to the effectiveness of care.

Elements emanating from interpersonal interaction: empathy, mutual respect, trust, accompaniment in reflections

This category privileges the elements emanating from interpersonal interaction, through dialogical relationships and encounters in the different spaces of care, emphasizing a welcoming and humanized care. In the observations, a care permeated with elements that contributed to the quality of care provided to hypertensive patients was manifested, as apprehended in the records:

[...] *I'm going through a difficult situation* [...]. (Hope)
You can tell me what's going on [...]. (N)
You can talk [...]. (D)
Stays quiet for a while "[...]" then, smiles [...]. (Sympathy)
I don't want to take these medications anymore [...]. (Charisma)
Can you tell me why you don't want to take these medications anymore? (D)
I don't feel well [...]. (Charisma)

Despite the above, harmonious, welcoming and humanized relationships were identified in the practice of care. Health professionals show attention, affection and concern, showing solidarity and being sensitive to the problems reported by patients with high blood pressure. In addition, elements that strengthen the therapeutic relationship were perceived, allowing greater professional interaction between health and high blood pressure that positively favors the treatment and care of these users, being represented in the following expressions:

Look at the patient while talking. (N)
Give the patient space to speak. (D)
Listen carefully to patients. (N)

I smiled [*...], offer help.* (N)
Care about what the patient says. (D)
Change medication and guide appropriate measures for disease control. (D)

It was evident in these speeches that the singularities of each patient with high blood pressure are reflected by the relationship of empathy, mutual respect, trust, receptive listening and monitoring in their reflections, mainly by the Nursing professional who establishes being-with, looking, listening, through their sensitivity and humanization in caring.

In the meantime, it was perceived an attention centered on the disease, based on prescriptive measures and guidelines for adequate control of hypertension, therefore needing to overcome these gaps to advance the dimension of health care. Despite this, situations of "*irony*", "*contempt*", "*judgment*", "*blame*" and "*inattention*" were not manifested by health professionals when approaching patients with high blood pressure, favoring a greater understanding of the needs of these patients.

DISCUSSION

This research was carried out in the PHC scenario, presenting FHS as a space of attention, which favors teamwork, seeking to assume the primary function of welcoming, listening and developing constructive interpersonal relationships, which favors the expansion of the care vision.

In the analysis of the sample profile, it was highlighted that arterial hypertension increases with advancing age, and people aged 50 to 59 years are 5.35 times more likely to suffer from high blood pressure than those aged 20 to 29 years old[16]. Adults with lower education levels (no education and incomplete elementary education) have a higher prevalence of self-reported AH[17]. This fact is worrying, as it is proportional to the level of knowledge about prevention of risk factors for the development of diseases, in general, and especially, of arterial hypertension[18,] demonstrating the need for a greater increase in the production of care in the perspective of valuing the singularities and subjectivities that permeate interpersonal interaction, in order to trigger changes in lifestyle to adequately control the disease.

With regard to health professionals, length of service and qualifications become a driving force in the production of care, contributing to meet the needs of individual and collective health. In the empirical field, the importance[19] of postgraduate studies for professional qualification and changes in practice in FHS is evident, with reflexes in the improvement of services provided to the population.

Thus, the resolutive work[20] in health is based on co-responsible care, in which the role of the multidisciplinary team prevails, in order to deepen the knowledge and practices in the health field. This action presupposes the production of interpersonal and contractual bonds, in addition to autonomy in the work process in primary care.

Patients' acceptance brings with it great potential capable of developing and strengthening affections in the context of health, especially at the level of primary care[21], user embracement and bonding are fundamental tools for establishing trust with the user[22].

Patients' acceptance is an action that must exist in all care relationships, in the bond between health workers and patients, in the practice of receiving and listening to people, and must be established as a tool that: enables the humanization of care; expand the population's access to health services; ensure the resolution of problems; coordinate services; and link the establishment of relationships between professionals and patients[23]. In view of this, it is necessary that health services organize themselves to welcome, tend to, listen to and solve most of the health problems of the enrolled population, taking responsibility for this population, making the necessary referrals to other points of care in the network .

During the observations, there were communicational exchanges that allowed people with high blood pressure to express their anxieties, fears and doubts, being based on listening and respect, culminating with care. However, health professionals need to strengthen the dialogue in the field of light technologies whose focus is directed to live work in action, to improve the production of care and the relational ambience, expanding the communication process from the perspective of intersubjectivity.

The production of this type of technology happens at the moment of meeting between the professional and the patient in the provision of health services, calling this production as live work in action[11]. Therefore, it is necessary to make FHS professionals realize the essentiality of care[24], integrality and primary care in the Unified Health System (*Sistema Único de Saúde - SUS*); its articulation for a health production process that rescues human beings as the focus of health practices.

So, PHC is a fertile environment for work that provides social interaction, which makes it possible to build health with the participation of different knowledge, valuing construction and establishing relational technologies[11]. For this, ESF professionals must be open to changes and strengthen relational technologies for greater effectiveness in everyday practices in health services. The potential of these technologies in line with the live work in action is a fundamental foundation for the production of care, being substantial in the health work process so that relationships become more welcoming, humanized and integrated.

The emphasis on the realization of the light technologies of live work in action in health, strengthens the bonds of trust and bond, positively interfering in the affectivity and effectiveness of intersubjective relationships, contributing to improve quality of care produced by all who are part of the team mainly by the nurse who, due to frequent contact[11] with patients who arrive at the health units, especially in primary care, has within her profession the theoretical and technical capacity to establish the applicability of the principles defended in the construction of relationships , as well as bonding, autonomy, accountability and welcoming, as measures that reorganize health care and quality.

In addition to the affective aspects, observations showed relationships of attention, help, support and concern in interpersonal interaction, reflected by elements essential to the weaving of care, such as empathy, mutual respect, bonding, trust and monitoring of the hypertensive in their reflections.

The capacity for empathy is related to feelings of trust, emotional involvement and mutual respect that occur in interpersonal relationships, creating spaces for more horizontal care relationships[23].

An empathetic attitude is a key factor in interpersonal relationships, contributing to quality care, permeated by bonds of trust and adequate monitoring of patients with high blood pressure in their reflections. Care requires from the professional who wants to provide it some necessary attributes, which are: ethics in human relations, solidarity and trust, which allow the person to learn to deal with the world, solving problems, including respect, honesty, conscience, faith and hope, and monitoring implies providing a reflection process that produces the autonomous decisions of users[24,25].

In the space of the health professionals' practices, the presence of these elements emanating from interpersonal interaction was evidenced, mainly by the nurse, who empathizes with relationships, trust, mutual respect, qualified listening and bonding, in the perspective of care welcoming and humanized. In addition, practices[11] exercised by nursing in the field of PHC, point to a differentiated approach capable of valuing the individuality of each being.

However, care focused on the disease, prescriptive measures and guidelines for disease control was still seen, therefore needing to overcome these gaps to better target care practices in the FHS. For this, it is necessary that health professionals strengthen interpersonal

relationships from the perspective of light technologies of live work in action in health, devices essential to the production of care.

Based on this premise, it is essential to create collective spaces for discussion in health teams and to build care actions that are mobilized to meet the demands of the community, considering that changes in the work process are essential. health, seeking the implementation of SUS principles and the use of appropriate health technologies for each care station[26].

The effectiveness of health care refers to real solutions for urban living and full access to health care[27]. Thus, FHS health professionals and patients with high blood pressure, while accompanying and being accompanied, take care and are cared for, emphasizing the subjectivities of care, should boost in the work process the light technologies of live work in action in health, which strengthen the bond , autonomy and co-responsibility, contributing to the achievement of promising results in health actions and services.

CONCLUSION

In this study, care practices are permeated by welcoming and harmonious relationships, emanating from elements that contribute to the quality of care offered to patients with high blood pressure, especially by the nurse, due to her potency in the dimension of care. Despite having as basis these experiences in the daily work of health, it appears that these practices are still centered on attention to the disease, on prescriptive measures and on the information necessary to control blood pressure levels.

Therefore, coping with chronicity requires investments in health promotion, permeated with effective communication that allows a multiprofessional approach with greater interpersonal interaction, so that a better understanding of arterial hypertension and its complications occurs. Therefore, it is necessary that the various subjects involved in the therapeutic relationship have an enlarged and human look, understanding that the production of care must go beyond an established therapy, opening up possibilities for an emancipatory health promotion.

With this, it is necessary for FHS professionals to revive the use of light technologies in live work in action in health, as they revitalize the care practices and tone the team's work, producing changes in the subjects and in the issues related to subjectivity. The recognition of the importance of these technologies enhances acting and doing in health, concentrating potentialities that consider the subjectivities and singularities of these subjects in the interpersonal relationships established in the health work processes.

The limitations of the research are the fact that it was carried out only in a health unit in the municipality, and it is not possible to have a greater understanding of this problem in the dynamics of work processes in other primary care territories, nor to make comparisons with other studies of larger dimension. But the importance of this study is pointed out in the understanding of the researched team that can be found in other realities.

It is suggested, therefore, that further research be carried out, as reflections on this theme need to be deepened in order to achieve more effective and efficient results in the context of SUS.

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CONTRIBUTIONS
Geanne Maria Costa Torres and **Maria Irismar de Almeida** contributed to the study design, data collection and analysis, writing and review. **Inês Dolores Teles Figueiredo**, **José Auricélio Bernardo Cândido** and **Antonio Germane Alves Pinto** participated in the writing and review.

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