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PRACTICES OF NURSES IN PRIMARY HEALTH CARE: REPERCUSSIONS ON PROFESSIONAL IDENTITY

PRÁTICAS DE ENFERMEIRAS NA ATENÇÃO PRIMÁRIA À SAÚDE: REPERCUSSÕES NA IDENTIDADE PROFISSIONAL

PRÁCTICAS DE ENFERMERÍA EN LA ATENCIÓN PRIMARIA A LA SALUD: REPERCUSIONES SOBRE LA IDENTIDAD PROFESIONAL

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Objective: to analyze how the practices of nurses in primary health care affect professional identity. Method: qualitative research, from a dissertation. The research was carried out in the second half of 2020 through a semi-structured interview with nurses who worked in Primary Health Care in a small municipality in the interior of Bahia. Data organization used the software N vivo 10 for Windows, and for theoretical analysis, the notion of habitus presented by Pierre Bourdieu. Results: three subcategories of analysis were identified: Prevention Practices, Clinical Practices - Individual and Assistance Standardization. Final considerations: there were conflicts and fragility in the professional identity of the nurse, with normative practices and processes that mark the professional choice by real possibilities and not by the interest of being, thus forming the habitus of the nurse of Primary Health Care.

Descriptors: Professional Practice. Nursing. Identity Recognition. Nurses. Primary Health Care.

Objetivo: analisar como as práticas da enfermeira na Atenção Primária à Saúde impactam na identidade profissional. Método: pesquisa qualitativa, oriunda de uma dissertação. A pesquisa foi realizada no segundo semestre do ano de 2020 mediante uma entrevista semiestruturada com enfermeiras que atuavam na Atenção Primária à Saúde em

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um município de pequeno porte do interior da Bahia. Para organização dos dados foi utilizado o software N vivo 10 for Windows, e para análise teórica, a noção de habitus apresentada por Pierre Bourdieu. Resultados: foram identificadas três subcategorias de análise: Práticas de prevenção, Práticas de Clínica - Individual e Normatização da Assistência. Considerações finais: percebeu-se existência de conflitos e fragilidade na identidade profissional da enfermeira, com práticas normativas e engessadas, permeadas por processos de socialização que matriciam a escolha profissional pelas possibilidades reais e não pelo interesse de ser, formando assim o habitus da enfermeira da Atenção Primária à Saúde.

Descritores: Prática Profissional. Enfermagem. Reconhecimento de Identidade. Enfermeiras. Atenção Primária à Saúde.

Objetivo: analizar cómo las prácticas de la enfermera en la atención primaria de salud impactan en la identidad profesional. Método: investigación cualitativa, derivada de una disertación. La investigación se realizó en el segundo semestre del año 2020 mediante una entrevista semiestructurada con enfermeras que trabajaban en atención primaria de salud en un pequeño municipio del interior de Bahía. Para la organización de los datos se utilizó el software N vivo 10 for Windows, y para el análisis teórico, la noción de habitus presentada por Pierre Bourdieu. Resultados: se identificaron tres subcategorías de análisis: Prácticas de Prevención, Prácticas de Clínica - Individual y Normalización de la Asistencia. Consideraciones finales: se observó la existencia de conflictos y fragilidad en la identidad profesional de la enfermera, con prácticas normativas y La socialización de los procesos que se han impregnado de la elección profesional por las posibilidades reales y no por el interés de ser, formando así el habitus de la enfermera de la atención primaria de salud.

Descriptores: Práctica Profesional. Enfermería. Reconocimiento de Identidad. Enfermeras. Primeros Auxilios.

Introduction

The professional identity has been used to understand how the subject is inserted in the world, social, personal and professional relations. It is known that the identity is built historically and socially based on the individual's experiences, connected with the experiences and representations linked to the perceptions of oneself and of others about oneself[1].

The professional identity linked to the habitus should not be restricted to the development of certain roles, since it is the result of similarity and union of ideas, functions, historical, economic and cultural aspects. These elements have the function of assigning to the nurse unique adjectives that aggregate impressions of herself, as a legitimate professional category and primary member of the health team, present at all levels of assistance[2].

Bourdieu, theoretical reference used in this research, brings in his theoretical framework the notion of habitus linked to a system of individual practices and incorporated by nurses, dialectically, influences and is influenced by the field of professional identities. This research aims to discuss the nursing practices system in Primary Health Care (PHC), based on the theory of habitus[3].

The system of practices arises from a tangle of historical relations, generated and generator of actions that are conditioned and conditioning, and derive from the double imbrication between subjective structures and objective structures constituted by social agents. This reciprocity in the relationship generates an infinite, generative and self-conditioned movement, the habitus, which seeks to rebalance, recreate itself and reproduce itself always[3].

It is possible to find in individuals the principles that generate and organize the practices and representations of actions and thoughts. For this reason, Bourdieu does not work with the focal concept of subject, he prefers the term agent, because social beings are agents as they act and recognize that they are endowed with practical sense, acquired system of preferences, classifications and perceptions[4].

As for the justification of this study, there is the significant contingent of nursing professionals in Brazil, around 570,000 nurses, and 1,341,428

nursing technicians and about 470,000 assistants, totaling 2,333,767 nursing professionals. In Bahia, there are 135,486 professionals, among nurses, nursing technicians and assistants, occupying the fourth place in the national ranking, according to data from the Federal Council of Nursing.

However, even with this significant contingent and being this profession in all the care levels, there is a weakened identity process leading to the decentralization of nurses' knowledge, expressed by care practices distanced from their real role in primary care. Thus, this lack of value infers in the care/work practices of these professionals; therefore, unveiling about the object of study, professional identity, affects the assistance provided.

After understanding the systems of practices and habitus, the following research question was delimited: How does the practice system affect the professional identity of nurses in Primary Health Care? Thus, this study aims to analyze how the nurse's practices system in Primary Health Care affects professional identity.

Method

This is a qualitative study, derived from a master's dissertation entitled *Bourdesian Analysis of the Professional Identity of the Nurse in Primary Health Care*. Qualitative research is related to the way of approaching the construction of knowledge on social and educational issues. It aims to offer plausible answers and, for this, refers to a wide range of perspectives, modalities, approaches, methodology, techniques and drawings, social situations and solving problems of the social authors, protagonists in this type of research[6].

The research site was the Primary Health Care of a municipality in the interior of Bahia, chosen due to the precariousness of employment links and working conditions in the health sector. The study population was composed of nurses who worked in this PHC.

The inclusion criteria were: to be a nurse working in the unit in question, as generalist and/or assistance, with minimum performance of six months in the field. The exclusion criterion were nurses who were absent from the service due to health problems or holidays.

Moreover, one of the eligibility criteria of the theme, field and subjects of the research, was due to the scarcity of studies aimed at small municipalities, proven by the lack of research, which makes it relevant to research and analyze how the professional identity of nurses is constituted in these types of space[7].

The data collection was carried out through a semi-structured interview, guided by a script divided between sociocultural issues and central questions, directed to the objective of the study and formulated after deepening the theoretical framework, in the period from January to February 2020. This interview allows an informative description, since it is guided by a widely informative style, with its structure containing semi-structured questions that allow a subjective guide, including perceptions, feelings, opinions, beliefs, among other characteristics that the patient can put. In addition, the researcher has an opportunity to make clarifications associated with dynamic segments of questions and answers, and thus strategically minimize the occurrence of errors[8].

The interviews were recorded with the help of two recorders and, after the completion of transcripts of the interviews, these were sent by e-mail for validation of the participants. In the analysis of the interviews, method used was the one proposed by Minayo for thematic content analysis[9].

The technique of thematic content analysis aims to identify the nuclei of meaning that make up a communication, and whose presence or frequency mean something for the objective of an analyzed study, using it in a more interpretative way, instead of performing statistical inferences[9].

The data were organized in N vivo 10 for Windows software, and the speeches were grouped by record units. This software is widely used in research in the various areas of knowledge, including health, as well as anthropology and similar, especially in qualitative approaches. It is a facilitating tool that assists in the exploration of

interviews concerning their structuring, resources to signal the material, association with other materials, association of words, categorization of data and consolidated managerial analysis[10].

After data organization, the floating reading of the transcribed interviews was carried out, respecting the representativeness, homogeneity and documents to the object of the work, making their categorization.

The categorization was initialized and the final analysis was performed with articulation to the sociological reference of Bourdieu and the authors' own perceptions. Based on the aforementioned concepts about the system of practices and the discursive corpus, three subcategories were generated, which dialogue with each other in what concerns the individual, collective and social aspects of the nurses' identity.

All the procedures adopted in the research are in conformity with the ethical guidelines provided for in Resolution n. 466/12, of the National Health Council, that defines the researcher as responsible for the integrity and well-being of the research participants, respect for their dignity and autonomy, recognizing their vulnerability, ensuring their willingness to contribute and remain, or not, in the research through expressed manifestation, free and enlightened[11].

Furthermore, all participants signed the Informed Consent Form (ICF) in two copies. This term includes the reports on the survey, as well as the acceptation for participation, ensuring anonymity of the participant's identity.

Thus, to ensure the confidentiality of the interviewees the codename Cactus flower was used, followed by a sequential numbering. This research is authorized for execution by the Human Ethics Research Committee (REC), of the *Universidade Estadual de Feira de Santana*, Opinion n. 2.998.614, approved in 2019.

Results

Data collection was performed with a total of nine nurses, aged between 20 and 30 years [6] and between 30 and 35 years [3]. After searching the system of practices of nurses in discursive statements, three subcategories were identified: Prevention practices, Clinical Practices - Individual and Standardization of Assistance (Chart 1).

Chart 1 – Corpus and subcategories of the Nursing Practice System in Primary Health Care. Feira de Santana, Bahia, Brazil – 2022

(continued)

CORPUS
Subcategory: Prevention practices
I really like educational activities, continuing education too, it is an area where we do a lot of cool things there. [...]. (Cactus flower4).
The basis of primary care is prevention. Prevention through vaccination, a regular check-up, and prenatal care. For me, the word that sums up primary care is prevention. [...]. (Cactus flower6).
We work with prevention, primary care is the gateway, that is why we work with prevention. In my work, we give educational lectures with the aim of trying to prevent diseases or promote changes in certain habits that could cause some disease or harm to people. (Cactus flower7).
Subcategory: Clinical Practices - Individual
About Primary Health Care:
We listen to what the patient has to say, with qualified listening. And from there we guide the patient. So for me, listening and embracement are very significant in Primary Health Care. (Cactus flower2).
I really like the person-to-person care, I identify with the users, in the care provided to the users. So, for me, there is a connection between me, as a nurse, and my patients. So for me, this is wonderful, this issue of being able to get to know the other person a little, of knowing, of following along, that for me is great.. (Cactus flower3).
I also identify with the relationship aspect, being close to the patient, being able to make a home visit, talk to the patient, listen to him during the hiperdia and prenatal consultation. And the nurse has this time [...]. (Cactus flower4).

Chart 1 – Corpus and subcategories of the Nursing Practice System in Primary Health Care. Feira de Santana, Bahia, Brazil – 2022 (conclusion)

CORPUS
In Primary Health Care, we can develop a bond with person to person, because I like this bond. [...] *The nurse in the unit can be making several connections in relation to the population, educational activities, nursing consultations, from childcare, prenatal care. Preventive care, so there is a range of things that we can be doing in the unit* [...]. (Cactus flower5).
Subcategory: Standardization of Assistance
I arrived there in May and the programs were not clearly defined in the schedule, it was all more spontaneous demand. So I try to recover, because the ministry always asks us to work according to the programs, so we do hiperdia, childcare, prenatal care, family planning. There are preventive issues, continuous spontaneous demand and emergency vacancies that have to be kept separate. The professors spoke clearly, the issue of laws, because primary care always follows the policy issue, the Ministry of Health. [...]. (Cactus flower1).
In my day-to-day work, we work with the programs of the Ministry of Health. On a certain day, we have prenatal care, preventive care, childcare, family planning, and hiperdia. It is held weekly. There are activities that are developed throughout the week. There are also extramural activities, where we leave the health center and go to the farms, where the people who cannot come. Then we go to them, the nurse and the doctor, and we take the medication from the pharmacy, the medication is dispensed there. [...]. (Cactus flower2).
You know you are going to have to follow the programs. You are going to see that patient. You already have three, four times a month, the same patient, the daily dressing, that chronic dressing. [...]. (Cactus flower3).
Those of us who work in primary care follow the Ministry of Health's schedule, which requires consultations in childcare, family planning, hiperdia, and preventive care. [...]. (Cactus flower9).

Source: created by the authors.

Discussion

Health prevention is signaled as something specific and guiding the system of primary care practices. This is due to the invisibility of health promotion, the hegemonic medical model and the professional identity of the conflicting nurse, as seen in the aforementioned speeches. These characteristics structure the field and resignify it.

Health prevention actions are linked to the process of preventing illness, fighting the emergence of specific diseases. Its purpose is the prevention of diseases, avoiding the increase in incidence rates and their prevalence[12]. The preventive strategies are directed, in a certain and persuasive way, to high-risk population groups (affected by specific comorbidities). Therefore, they constitute programs focused on individual and personalized topics and contextualization groups. In addition, there is still a difficulty in attending to the spontaneous demand associated with curative practice[13].

Prevention in PHC is divided into four levels: *primary prevention*, which is action aimed at removing the causes and risk factors of a health problem (individual or population); *secondary prevention*, which relates to the detection of an initial health problem; *tertiary prevention*, which is the implementation of actions aimed at reducing, in an individual or in the population, functional losses resulting from an already established acute or chronic problem; and *quaternary prevention*, which corresponds to the detection of iatrogenic disorders in individuals who are at greater risk of interventions, whether diagnostic and/or therapeutic, to protect them from inappropriate medical interventions[14].

The primary level, according to the phrases of Cactus flower 4, Cactus flower 6 and Cactus flower 7, highlighted in the first category, is related to prevention, immunization and educational activities. The secondary level, for Cactus flower 7, comprises prenatal and hiperdia consultations as a form of prevention. The other levels were

not identified in the nurses' speeches, which denotes misunderstandings in understanding the term prevention and lack of knowledge of their levels and of the basic principles of PHC.

It is evidenced the low number of studies in Brazil that problematize or discuss the nature and effectiveness of disease prevention and health promotion actions developed in PHC, which demonstrates the incipience regarding the reflection and conceptualization of the theme. The lack of clarity of professionals who work at this level of assistance shows that many professionals have difficulty conceptualizing health promotion, sometimes seen as absence of disease, which makes even more clear the fragility of these professionals with regard to concepts and techniques[15].

The PHC, with its particularities, integrates a network of services and is set as a subfield of health, permeated by conflicts and rules, that develops its system of practices with a population delimited and that combines from a social habitus. Thus, it is essential to think assistance under two aspects: the needs of each individual and social logic.

It was possible to identify a polysemy in this subcategory, because even if the nurses sustain the discourse of prevention, they contradict themselves when they say that people only seek the service for medical consultation and/or when they are sick, which demonstrates the perpetuation of curative practices. Understanding that within the Unified Health System (UHS), and based on what is governed by the National Primary Care Policy, the nurse must play a crucial role in perpetuating preventive practices and biopsychosocial. Nevertheless, when it is stated that the population only seeks the service for medical consultation, it brings to light a lack of awareness among the population about the importance of nurses' work.

The traditional and hegemonic biomedical model still perpetuates itself in the daily practices of the nurse in PHC, perceived by actions aimed at curative prescribing practices, focused on the disease process and unrelated to health promotion activities and prevention of diseases, mainly because population needs demand the opposite of biologist practices, which generates a distortion of the practices that represent the professional identity of the nurse[2].

A relationship present in the discursive corpus, derived from the speeches of Cactus flower 4 and Cactus flower 7, was that of educational practices and prevention. Education is understood as the use of pedagogical processes and techniques for the socialization of knowledge and training of social actors, having as foundation the numerous human relations. Thus, this action is constituted as a practice that leads to social intervention policies and can be linked to a problematizing methodology[16-17].

Health education is a space of practices and knowledge that aims to build links between health services and the way people think and act in everyday life. It is a mixture of political strategies aimed at the Unified Health System correlated to the work process of the nurse, since health education is a possibility to expand knowledge, contributing to the user, family and community, articulating between knowledge and practices in favor of life, the respect, dignity, awareness and comprehensiveness of health actions[18].

It was possible to observe educational practices disguised as informative practices. The purpose of the practices was exclusively to pass on information, which is a limiting factor for creating dialogical spaces with the population. The informative practices reduce the opportunities to know in detail the territorial reality, treating the population only as a repository of knowledge.

This vertical mode of education can be linked to the equally vertical way of managing the unit. The educational practices developed by nurses show that there is still a strong tendency to pass on knowledge through lectures, which was also observed in this research. This methodology highlights the traditional pedagogical practice, which is not interactive and uses scarce resources.

The nurse can mitigate the negative effects of sociocultural and structural conditions in which users live. To do so, she needs to associate its habitus with the practices and representations of Primary Health Care, with educational activities

and dialogue, with community participation and with action-reflection-action. This means that, by developing a dialogic and participatory practice, the aim is to modify the health reality of people and social groups in that territory[2].

The individualized care practice is notorious, focused on the clinical aspects of individuals, which reinforces the distortion in the health model and causes reflections in identity. The models of health care are the way in which health care is reproduced and structured by services, aiming to meet population needs. Based on these findings, the second subcategory emerged: Clinical Practices – Individual.

In the work process, it is necessary to relate and articulate the subjects (professionals/managers/users), the object (the one in which the work will be applied) and the instruments (physical or non-physical materials that facilitate work), aiming to intervene on collective and individual health problems in a socio-historical context[19].

The search for reorientation of the care model is not solved only by incorporating new perspectives, knowledge, information and technologies. It is also necessary to mobilize new knowledge about the user's life condition and family history (family constellation, territorial and household structure, social network and biopsychosocial aspects); immerse intensively and in a targeted way in the context of users' lives (home visits and community facilities); articulate new actions based on individuals and the community, with group activities, playful or not (celebration of important dates and campaigns)[19].

These changes add essential elements to the production of therapeutic projects, however, without the development and application of relational technologies, the narrowing of links and listening, this range of tools can only serve to strengthen and maintain the operationalization of a biomedical territory, prescriptive, hierarchical and disciplinary[19].

Bourdieu's conceptions about the field, when in dialogue with the concept of Models of Health Care, contribute to another conjecture, which is to think of PHC as a social space, where knowledge is built and practices developed around the objects that justify their existence, but at the same time as spaces of disputes[20].

The care model is intrinsically related to understanding the nurse's work process, since her identity is influenced by the context surrounding her, and, in particular, through the articulation of institutional, ethical, clinical, political and socio-cultural elements, which are the pillar for structuring the current care model[2].

It is in this game that the construction of the professional identity of the nurse occurs, in which she influences and is influenced by the current health model, based on the curative model and disease, distancing from the focus of PHC, which is the prevention of diseases and health promotion. This distance results in the nurse's identity fragility, for only reproducing the current model without producing an extraction, what Bourdieu brings as being the breaking of patterns that affect the visibility of care.

The link is an essential principle for the development of care between the nurse and the population, since it promotes the identification of health demands of the territory and generates the possibility of planning care, the singularity and multidimensionality of the subjects under their responsibility. Thus, the link is a basic element in the formation of the professional identity of the nurse, consistent with the reality and health problems of this care level[2].

In the discursive corpus, it was possible to observe that nurses cited the creation of a link with users as a way of person-to-person approach. They highlighted the creation of this link through consultations, home visits and qualified listening (Cactus flower 3, Cactus flower 4 and Cactus flower 7), which demonstrates the incorporation of light and light-hard technologies.

The link is understood as a light technology, because it constitutes the relational mode of action associated with health acts and actions. Light technology allows establishing such close relationships, to the point of being able to encourage, to sensitize and make the professionals responsible for the demands of individual or population health, able to see the other in his/her singularity. It aims to stimulate

and encourage the autonomy of users through therapeutic projects with low bureaucracy and that guarantee accessibility and problem-solving[21].

According to the foundations and guidelines of the National Policy of Primary Health Care, from the Ministry of Health, the link consists in improving relationships of link and trust between the health worker and the user. This situation makes possible the consolidation of the co-responsibility process for health, formed over time, and also carries within itself a therapeutic potential[11].

The PHC space allows the continuous development of care and, consequently, the closer links of the nurse with the population of the territory. This approach makes possible the construction and or reformulation of links between these social actors, by providing a discursive environment in which health needs are seen, and understood, with the appreciation of the construction of autonomous and socially valued subjects, being the user perceived as someone with emotions and speech power[2].

According to the discursive corpus of nurses Cactus flower 1, Cactus flower 2, Cactus flower 3 and Cactus flower 9, it was possible to see that the current model of health care is linked to a process of automation of care and anchored in protocols. Therefore, after this perception, the subcategory *Normalization of assistance* was delimited.

Surveys with PHC nurses also found that the actions performed by these professionals are mostly carried out with support and focused on a fragmented schedule of care, directed to specific groups, such as children and pregnant women, diseases (mainly hypertension and diabetes) and procedures, usually small, showing limited practices to the care protocols, which excludes other health production spaces[22-23] .

In this scenario, the programs and ministerial rules, based on the technicality of the work and on the distancing from criticality, are limiting for the Nursing and health care and contribute to the devaluation of the profession, labor cheapening and professional overload, which affect the modulation of habitus and professional identity.

In Brazil, the activities that the nurse develops in the field of primary care could be carried out by an institutionalized agenda by the Ministry of Health, but with autonomy in its various functions, including the planning and execution of their work process, analysis and understanding of the vulnerabilities present in the territory assigned. Centralizing actions only in the guidelines and regulations guided by the Ministry of Health generates fragility in identity configuration[2].

Therefore, the nurse must think and analyze the practice in a critical and reflective way for the construction of the agenda, considering that, even encompassing the ministerial programs, she must expand her care options based on the pillars of PHC and focus on autonomy, taking into account the particularities of individuals/community, which provides alternatives that reflect the essence of her professional identity[2].

A study limitation concerns the several interruptions during the interview, considering that these were carried out in the residences of the interviewees or in the work environment. Nevertheless, there was no compromise in the quality of the interviews.

Thus, it should be thought that the construction of the identity of the nurse in what permeates the associated practice system is a long way to be developed. Because of this, this study contributes to encourage knowledge about the practices, understand nurses' identity and thus provide quality care.

Final Considerations:

The results of the research indicated, based on the sociological framework adopted, that, in the system of practices of PHC nurses, there are conflicting models of health care, alternative and hegemonic, represented in an individualizing prevention, based on informative practices and linked to the model of curative and medical-centered care.

The discursive corpus allowed the perception of the existence of conflicts and fragility in the professional identity of the nurse, seen through her system of practices based on individualized prevention and informative practices disguised by educational practices. It is a system of practices developed in a model of curative and

medical care, centered on normative practices and processes of socialization that mark the professional choice by real possibilities and not by the interest of being, thus forming the habitus of the nurse of the PHC of the city studied.

Finally, the field of primary health care covers actions of promotion, prevention, cure and health rehabilitation. Health promotion should be the main focus of attention, understood here as a space for interdisciplinarity and appreciation of knowledge. Therefore, the nurse should seek to identify the power of this system for her work process and for the redefinition of her professional identity, based on scientific evidence and performed in a particularized way and according to the health demands of the community she assists.

Collaborations:

1 – conception and planning of the project: Nívia Vanessa dos Santos Carneiro, Denise Lima da Silva Brasileiro and Deybson Borba de Almeida;

2 – analysis and interpretation of data: Nívia Vanessa dos Santos Carneiro, Denise Lima da Silva Brasileiro, Deybson Borba de Almeida, Maria Talita Cruz Silva Oliveira Maia, Sélton Diniz dos Santos and Igor Ferreira Borba de Almeida;

3 – writing and/or critical review: Nívia Vanessa dos Santos Carneiro, Denise Lima da Silva Brasileiro, Deybson Borba de Almeida, Maria Talita Cruz Silva Oliveira Maia, Sélton Diniz dos Santos, Igor Ferreira Borba de Almeida and Lucas Souza Almeida de Araujo;

4 – approval of the final version: Nívia Vanessa dos Santos Carneiro, Denise Lima da Silva Brasileiro, Deybson Borba de Almeida, Maria Talita Cruz Silva Oliveira Maia, Sélton Diniz dos Santos, Igor Ferreira Borba de Almeida and Lucas Souza Almeida de Araujo.

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