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CASE REPORT ARTICLE

INTERNSHIP IN THE BASIC CARE AS INSTRUMENT TO THE MEDICAL TRAINING: EXPERIENCE REPORT

ESTÁGIO NA ATENÇÃO PRIMÁRIA COMO INSTRUMENTO PARA FORMAÇÃO MÉDICA: RELATO DE EXPERIÊNCIA

ETAPA EN LO CUIDADO PRIMARIO COMO INSTRUMENTO DE FORMACIÓN MÉDICA: RELATO DE EXPERIENCIA

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ABSTRACT

Objective: to present the lived experiences by a Medicine academic related to the Health Care internship as medical training instrument. **Method:** a descriptive study, in the experience report type. Were made six home visits to a family previous chose, living in Varadouro, João Pessoa, Paraíba, from Augusto to November 2014. **Results:** creation of a link with the family let the right identification of the patient index, considering the bio psychosocial in which he is inserted and the Care Plane choice. **Conclusion:** practices turned to the link creation should be indispensables in the training Medicine. **Descriptors:** Home Visit; Community Medicine; Humanization; Public Health.

RESUMO

Objetivo: apresentar as experiências vivenciadas por uma acadêmica de Medicina relacionada ao estágio de atenção à saúde como instrumento da formação médica. **Método:** estudo descritivo, tipo relato de experiência. Foram realizadas seis visitas domiciliares a uma família previamente escolhida, residente na comunidade do Varadouro, em João Pessoa, Paraíba, de agosto a novembro de 2014. **Resultados:** a criação do vínculo com a família possibilitou a correta identificação do paciente índice, considerando o contexto biopsicossocial no qual ele está inserido e a escolha do plano de cuidado. **Conclusão:** práticas voltadas para a criação do vínculo devem ser indispensáveis na formação médica. **Descritores:** Visita Domiciliar; Medicina Comunitária; Humanização; Saúde Pública.

RESUMEN

Objetivo: presentar las experiencias vividas por un académico de medicina relacionada con la etapa de atención a la salud como una herramienta de formación médica. **Método:** estudio descriptivo del tipo relato de experiencia. Sés visitas a domicilio fueron hechas a una familia que hayan elegido anteriormente, residente en la comunidad Varadouro en João Pessoa, Paraíba, desde agosto a noviembre de 2014. **Resultados:** la creación de un vínculo con la familia permitía la correcta identificación del índice de lo paciente, teniendo en cuenta el contexto biopsicosocial que se inserte y la elección del plan de cuidados. **Conclusión:** prácticas destinadas a la creación de la unión deben ser indispensables en la formación médica. **Descriptores:** Visita al Hogar; Medicina de la Comunidad; Humanización; Salud Pública.

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INTRODUCTION

According to the national curriculum guidelines of medical school ¹, graduate in medicine have general, humanistic, critical, reflective and ethics, becoming able to act at different levels of health care, from health promotion, prevention, recovery and rehabilitation, individually and collectively, with social responsibility and commitment to the defense of citizenship, human dignity, integral health of the human being and with the mainstreaming in their practice always the social determinants of health and disease process. The activities associated with the medical student's integration into the primary health care practice setting, such as home visits, enable the same perception of the reality of the people, their living conditions and customs, allowing the construction of the design process health- disease, trying to understand the determinants and constraints of disease with the way of life and work of people. Thus, caution is no longer facing the disease and is now focused on the disease process with the family and the individual focus.²

The association of medical education with the primary care environment allows the insertion of the student in a more participatory way, in a reality that can form the technical medical professional, more humane, ethical and committed to the community. This integration enables the educational institution to fulfill its function of producing knowledge and strategies in new ways of operating in health, they being more careful, paid up, with accountability and solvability of ties to collaborate to build a health care system more active, fair and, above all, ethical.³

Home visits are important tools in the process of training more humane professionals; since analyzing the reality of the individual and the family can observe the health-disease process and think of health measures that take into account the user's reality. The home visit is important for learning medicine, because many doctors are prepared to take care of the ideal patient, which can be found in the teaching hospital, where the student spends most boarding time. In contrast, the home visit the student learns to see and treat real patients in their home, in their community, with the interaction of family members living with him.^{4,5}

In addition, home visits stress by living a term widely used in the Family Health Strategy: the bond. He is a close and lasting personal relationship between the health

professional user and family, allowing, over time, that ties to narrow and even get to know more and more, enabling continuity of care is facilitated and consultations and unnecessary hospitalizations are avoided.^{6,7}

One of the methodologies that can be given to understanding and familiar approach, building relationship and continuity of care is the production of family genogram. It enables the recognition of present interactions among members, positive emotional ties or not, behavior patterns that repeat across generations, thereby identifying the biological, social, emotional, cultural processes that make up a family for several generations.⁸

The genogram is therefore an instrument used in the family study in general practice because it allows combining biomedical and psychosocial information of its members, understand the individual in their family dynamics, locate diseases presenting it in its historical context, evidence standards transgenerational disease, behavior and use of health services, but also allows the clinician and the patient to identify and interpret the familiar myths and change their scripts, and enables counseling on marital conflict and parent/child. Thus, it is concluded that he has both diagnostic value as a therapeutic.⁹

From the foregoing the study aims at presenting the experiences of an academic of Medicine related to health care stage as a tool of medical training.

METHODOLOGY

A descriptive study type experience report, performed by students of the second period of the Graduate Course in Medicine, Faculty of Medical Sciences of Paraíba, during the horizontal module for Health Care II, from August to November 2014. The students were divided into four groups corresponding to four Family Health Units in the city of João Pessoa/PB. The choices of the groups occurred randomly, with about 10 students per group, since each subgroup would be divided in pairs, chosen by the responsible teachers.

The families visited were previously chosen by the health team in a meeting with each teacher responsible for the group. The criteria used for choosing the families were the vulnerability and situations that need a closer follow-up of health professionals, where students could draw a plan of care to improve the quality of life of families together.

It was used as a dynamic evaluation method of each family to build the family

genogram. Theoretical knowledge to build this family assessment tool was taught in the classroom by teachers for the Care module II health and practical knowledge were built by the family with the information acquired during the visits.

The study was divided into six visits to the territory, five of them for families and one for the presentation of the genogram to teachers and health professionals of their Family Health Unit. After each day, students reported in the field of daily situations experienced; these should contain an account of the events during the visit, a theoretical depth on a subject that has drawn attention, being relevant to the study of the family and, finally, a free nature of reflection to present a critical analysis of what was experienced and what has been studied, which allowed the expression of anxieties, fears, joys, in short, all experienced emotions. At the end of the period, they should be delivered to teachers.

The activities were developed by objectives to be achieved at each visit, and these previously determined by the module teachers. The first visit was held on 13 August 2014 and aimed to the first contact with the family, to start the link. The second, held on August 27, 2014, had the intention to meet all family members. The third meeting, on 10 September 2014, was the family identification of the type of family, life cycle and functionality, and the fourth, on 24 September 2014, aimed to return to households for construction genogram family. The fifth visit, on 29 October 2014, was aimed at mapping the necessary and available resources, thus building a care plan, it was also held to farewell the family play and the last visit, on 12 November 2014, the territory was the presentation of the family genogram near the reference health team.

RESULTS AND DISCUSSION

On the first visit, the group was divided and accompanied by Community Health Agent of the Family Health Unit and the module teacher to their residence to meet members and thus have the first contact with the family who would be accompanied by its double during all home visits. Throughout the conversation with family, it was possible to know a little of the family structure noninvasively, since it is essential to maintain the privacy and freedom of the members, not requiring the presence of students. Some questions such as name of the residents, age, marital status, profession, existing or past conditions and family relationship with the Family Health Unit.

In the studied home, live six people, three of whom are women and two men and a child, and form four generations of the same family. The matriarch, 76, is a widow, hypertension, and is responsible for almost all the domestic activities of the house; in addition, he took care of the child throughout the fight against cancer. She reported that during the conversation was too afraid to undergo a mammogram because there was near witnessed the suffering of her daughter, and a warning sign for students. The daughter is 48 years old, a widow, and worked as a maid for years. She removed the left breast because of cancer, choosing not to rebuild it; It is hypertensive and has high cholesterol. A fact that drew attention was the revelation that had sinus problems, but that their religion was the healed. Due to cancer, initially it was considered the patient's work index.

Also live in the house the two grandchildren, her husband's granddaughter and one great-grandchild. The granddaughter is 23 years old and mother of the newest male member who is 4 years old. She works as a manicure and it was not possible to talk to the same during the experiment, not with his brother 21 years single and unemployed and her husband working.

During the visits, they were usually the matriarch, her daughter and grandson. In the begin, we asked them about the family contact to the Health Unit Family, and they said they have ties with the Family Health Unit and the Community Health Agent, whose assistance was praised by both. They said they liked the neighborhood and the community where they live, because it is very quiet and have family living in the houses.

The first visit was very important for the development of the bond, it was possible to know the members of the family, talk briefly about them and start watching the family dynamics. Moreover, it was a crucial time for students, since it was their first contact in medical school with families in their homes without Hospitals and routines, there are observed and learned.

The main difficulty was no doubt due to the existence of a method or model to be followed for the construction of the link. Contextualizing with the principles of Paulo Freire¹² about Popular Education in Health for the construction of the link is important to listen, respecting the rights of others to express themselves, speak "with" and not "to", it is also essential to undress and dress with the masses, that case, with a family that has a

history of life, principles and different customs.

Undoubtedly one of the great challenges of the Unified Health System is to prepare future doctors to work in Primary Health Care (PHC), whose learning is linked to the real health needs of the population. For this, it is essential to the integration of students in the scenarios of PHC from the earliest periods of graduation. The feedback is positive, since this contact provides the construction of a new insight into the process of health-disease, a closer relationship with the patients, the link establishment and a comprehensive health care community, and a greater Unic Health System living.¹³

The second visit took place two weeks later in order to know the other members. Before going to the home, the students were the Family Health Unit to view the records of the families together and watch some relevant data, with the purpose to confirm the views information in these documents with the passed by the family.

Arriving at the family home, they were present the same people from the previous visit. They are more at ease, and spoke of illnesses, surgeries and other facts about their health, but also talked about the dynamics and family histories and about themselves. The questions gave way to a spontaneous dialogue and from the addition, it was revealed some important points. One was the simplicity and the existing mutual care between the matriarch and her daughter, as well as mutual respect among members.

The third visit was intended to identify the family as to the type, life cycle and features. However, it was not performed because, due to a mismatch of information, the members usually provided the pair were not present, and the granddaughter of the matriarch who was in residence did not accept dialogue. No doubt this was the most difficult time throughout the course developed on visits, because the refusal was totally unexpected for the pair, which believed that bond was steady; developed thus mixed feelings and doubts about the relationship built. Sadness, frustration and the feeling of not being welcome at home were inevitable. It was unclear whether errors had been committed or if they felt uncomfortable with the visit to the questionings carried out, making it necessary critical reflection of the experience to date, revealing postures and attitudes.

The occurred points to a big question surrounding the medical training: emotions. Some researchers say it is possible to learn from the doctor's daily work the need for

control over the emotions, since there is no room to share or express them, and often to hide them for fear of being 'accused' of being very fragile, sensitive, and, finally, 'not used to be a doctor'.¹⁴ They believe that the debate would not be the right way to deal with them, since students must learn to repress them, strengthening it and creating a shield with which to become immune to such affection. They believe that the practice allows the acquisition of both manual skills such as emotional ability.¹⁵ However, especially in the Primary Health System, in which dealing with families and vulnerable people, restrict the emotions would be detrimental, since the emotional sensitivity of the professionals have a key role in the conduct, whether to detect conflicts, to form bond or to correctly choose the patient index.

On the fourth visit, insecurity made it difficult to return to the double, but the challenges and fears were resolved to reach the residence. The visit was one of the most rewarding, since it was possible to see the joy and the receptivity of the members present, highlighting the link that was increasingly established, and, therefore, it was concluded that no error had been committed. On this visit, one can see the development of affection and trust; they talked about the lives of residents spontaneously house and into increasingly in the family intimacy, which helped a lot in the perception of affective relationships that surrounded her.

The purpose of the day to be completed was the family ID from the life cycle and functionality besides the collection and confirmation of the latest data for the construction of the genogram itself. One of the difficulties was due to the absence of the matriarch, since his daughter was not aware of some of the facts. From this, it picked up as much information as possible and the genogram began to be built.

From the observations and dialogues, it was possible to classify the family as extensive functional and sixth stage of Durvall lifecycle. According to the Child and Adolescent Statute (Law n°. 12.796/2013, Art. 25), extensive or extended family is one that extends beyond the drive parents and children or family unit, consisting of close relatives with whom the child or adolescent lives and maintains bonds of affinity and affection. So the family studied can be classified as extensive as it contains four generations living together, whose members are extremely united, respect each other and care for each other. Regarding functionality, the functional families respond to conflicts and complex situations seeking

emotional stability, coordinating them from own resources (known or potential) and solving the problem appropriately. In addition, members are able to harmonize integrated, functional and affective way.¹⁶

The family life cycle can be divided in 8 steps¹⁷ the first is characterized by the marriage where there are no descendants, the second when the couple has children, the eldest of up to 30 months. The third step is classified when there are pre-school children, the higher of 30 months and 6 years old, as the fourth stage is represented by family with school children, whose eldest son has between 6 to 13 years. The fifth step is defined as a family in which there are teenage children (oldest child between 13 and 20 years old) and the sixth is composed of the family phase "launch" the children, or when there is output from the first to the last son from home. The seventh step, in turn, is the mature family, retirement to the empty nest and the last step is formed by elderly family from retirement to the death of both spouses.

Throughout the meeting room some information to the attention of the students. The matriarch had 15 pregnancies, over five of its six relationships, of which three were miscarriages, and was twins, who were stillborn, and ten were born alive. Of the children born alive, one was given up for adoption, five died in infancy and four of them were created by it, including the oldest daughter who lives in the house, which reported such events. In one of the relationships, she said her mother suffered domestic violence and that it still has body marks of aggression.

The most impressive facts along the visits were undoubtedly when he was mentioning the deaths of some of the children who were born alive in childhood, because it reflects the reality that the family is inserted and the lack of information is a risk factor, especially in the poorest communities. One of the deaths occur due to medication given by the mother, through information obtained with neighbors, which caused a lethal intoxication, for the other deaths, she could not say concretely and did not want to continue talking about it.

The fifth visit was aimed at mapping the necessary and available resources to build a care plan and playful families' farewell. In addition to the farewell, he took advantage of the meeting to confirm some data because the matriarch, who was absent in the previous visit was in residence. Initially, she was quite embarrassed when talking about spouses and at times found it difficult to relate the children to their parents. Therefore, it is

necessary to review the number of children to confirm if it had not forgotten any of the 15 pregnancies. From the reports, it was chosen as the patient's index family genogram.

The playful farewell marked the last meeting of students with family and was an opportunity to thank the host and collaboration for the realization of the Genogram. They were presented with yellow flowers buttons and a handwritten card, in addition to telephone contact, if needed. It was certainly one of the most memorable and exciting moments since the academic goals had been completed and therefore the contact family-student would be finalized. Throughout the course, the theory administered simultaneously in the classroom stressed the importance of the link creation, but the students were not prepared to break this bond, so the duo was 'bombarded' with a sense of accomplishment by success of the work and at the same time, extreme sadness for the family farewell.

The index patient selection criterion was not a disease or physical disturbance, but was chosen according to the family and social role, and, moreover, were also considered psychological factors related to this in front of his family and its history. The correct choice of the index patient was only possible through a delicate analysis of the accounts of members. So how care plan, was chosen to raise awareness about the importance of prevention against breast cancer and to score mammography, as well as being a way of preventing breast cancer, and would also serve to help her overcome fear developed from the daughter of disease trauma. For this, the students, to expose the context of the unit professionals, requested from the Family Health Unit, medical mammography and, therefore, the realization of the examination was about the responsibility of Family Health Team.

The link made during home visits is achieved with an appropriate form of treatment, respecting the individuality, differences in language, culture, values and, above all, through attentive listening, in which you want to understand what is being said and share the feeling that is present at the time.¹⁸

The health professional and you have your intentions, interpretations, needs, reasons and feelings, but they are in a state of imbalance, whose expectations and abilities are different; the user search assistance due to physical and emotional state weakened, as the professional is able to meet and take care of this fragile. From this, it creates a bond, or

rather creates an emotional connection and ethics between them, in which there is a help coexistence and mutual respect.¹⁸ The establishment of these relations is what the work flow naturally and thus, you feel more respected and valued, collaborate more easily with team.^{18,19}

O genogram was built from information reported by the family, in addition to the data accessed by the chart, which is available by the Family Health Unit. It is expected that the work can help to improve assistance to the family in question and thus improve the health conditions of the same.

The genogram gathers information about the identified patient's disease, the pathologies and family disorders, network psychosocial support, genetic background, the death of family members, in addition to psychosocial aspects presented, which, together with the information gathered in history, further enrich analysis to be made. Thus, health professionals are better able to perform a more comprehensive service and thereby detect the care needs of the patient, taking into account its psychosocial context.¹⁹

It is therefore necessary to have a full view of the human being, including family relationships with the community and with the responsible health unit, so that in this way, can be made an effective care plan.

The last visit was marked by the presentation of family genogram with the Familiar Health Unit team. What drew attention to the academics was that the staff ignores several situations presented about the families. While it is understandable that the Health Unit has no structure to keep families in such a particular way as that carried out by the students, the establishment of links is essential so that there is the understanding of the dynamics of both the residents concerned and the community as a whole, so that effective care plans can be built, guaranteeing individual solvability, family and community.

FINAL REMARKS

From this study, it was concluded that the practical experience of home visits is indispensable for the understanding of the relationship by medical students and thus to the formation of more humane doctors, so this experience was unique, it is not possible to be taught in the classroom space.

Unconventional reality for students in Medicine of the second period allowed them to acquire a huge load of knowledge not only for the medical profession, as well as for

growth as human beings, through the opportunity to meet, socialize, listen and help the families territory.

At times, the students were faced with quite shocking and unimaginable information which needed their sensitivity and interpretation of the conditions in which the family was inserted. It is very important that graduate students in medicine, when faced with situations that do not have in common, have good sense to listen and not judge them.

The study provides an understanding of the importance of the link to the knowledge of the most intimate weaknesses of users, such as their relationship with the other members of the family and the community in which it is inserted. In addition, he noted the importance of the genogram as a tool in the family health, since it allows a deeper study of the family in pathological aspect, as in the relationships between the members.

It is noteworthy, then, the importance of preparing students and future physicians to the various situations to be faced, such as the non-acceptance of these by the users, as referred to in the study because it does not use just teach them how to deal with patients, with families and the community, but also of primordial form, help them deal with the pressures, emotions and demands which accompany the profession.

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