Original Article

Performance of primary health care nurses: a phenomenological approach

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ABSTRACT

The objective of this study was to identify the performance of Chilean primary health care nurses. This was a qualitative study based on the approach of social phenomenology. Data collection was conducted between January and April 2013 through interviews with 13 nurses. Nurse performance showed that they experience greater professional autonomy and are closer to users; however, they suffered from professional burnout. Their expectations included the desire to be recognized for their work and better service management. Contributions of this study include the possibility of considering new designs for professional management practices in primary health care from the perspective of Chilean nurses. These designs should be based on the reorganization of work processes and by occupying spaces in macropolitics, influencing the professional performance of nurses at this level of health care.

Descriptors: Community Health Nursing; Primary Health Care; Qualitative Research.

INTRODUCTION

Health system reforms have been taking place worldwide. These changes are based on the implementation of a model centered on primary health care (PHC), in which nurses play an important role. Studies conducted in different countries ratify this statement [1-5].

In Australia, a study assessed Nursing practices and explored trends in their role over time. The results showed that government initiatives to strengthen primary care had contributed over the last decade to the quick expansion of Nursing practices at this level of care[1].

A literature review about Nursing practices in the context of primary health care in Brazil identified practices within the scope of community services and those related to management and education. The study highlighted advances in the implementation of PHC work reorganization policies, however, Brazilian Nursing needs to adopt extended clinical practice as an ethical-political imperative in the organization of services and professional interventions[2].

In Canada, a literature review showed that it was possible to transform PHC practices, even with the country's pluralistic system of private health care delivery. This required strong government and professional leadership, working together to improve the quality of the system[3]. Another Canadian study identified the impact on the outcomes of nurse practitioners in collaborative practices with other PHC professionals. The results showed improved quality of patient education, with a greater emphasis on health promotion and disease prevention and additional time spent on in-depth patient visits or more comprehensive care[4].

One study with the aim to learn about how countries in Latin America, especially Chile, incorporate the legal norms and aspects that generate health care emphasized that the role of nurses must be well defined by managers, both in terms of practice and management, to make their daily work effective and their performance assessed. This enabled the development of competence and professional autonomy[5].

In Chile, a study described how nurses perceived the implementation of the family- and community-centered comprehensive healthcare model, which occurred in 1995. The results showed barriers to implement the service and comply with the family healthcare strategies and norms, and the emphasis on policies based on health processes in detriment to respect, empathy, and commitment of health professionals with the community[6].

Soon after the implementation of PHC in Chile, in the 1990s, nurses had to reformulate their practice in light of this model. Considering that the work of PHC in Chile requires the redefinition of health practices, conflicts and difficulties may emerge in the performance of their professional activities if they are not adjusted to this specific context.

The literature has shown contradictions in how nurses perceive their professional performance in light of the autonomy conferred in PHC[7]. This shows the need for more studies about how these professionals perceive themselves when working at this level of health care.

Given these considerations, the following questions emerge: How do Chilean nurses perceive their daily work in primary health care? What do they expect in terms of their professional performance? These questions culminated in the aim of this study: to understand the performance of Chilean nurses who work in primary health care.

Understanding this phenomenon will point to aspects of the experience of nurses who work in PHC, invoking them to reflect about their practice in the field of public health. It can also underpin education in the field of PHC, fostering continuing education of these professionals in this context, in addition to increasing knowledge about the performance of nurses in PHC.

METHODS

This was a qualitative study based on Alfred Schütz' social phenomenology. This framework seeks to understand relationships based on the actions of specific social groups. Conceptual assumptions such as social relationships, intersubjectivity, stock of knowledge, motivation, and social action were used to underpin the discussion of the results[8].

Human actions in social relationships are guided by the biographical condition of individuals, which consists of a sedimented history of previous subjective experiences. This experience is rich in knowledge that is available and accessible according to the biographical situation. This stock is made up of information transmitted through parents, educators and experiences that structured it[8].

The biographical situation and stock of knowledge available and accessible serve as the basis to project action into the social world. Actions are interpreted by individuals based on existential motives derived from their experiences, which are inscribed in subjectivity, forming common threads of action. Those that are based on history, on the stock of knowledge, and lived experiences in the biopsychosocial domain are called "because motives", while those related to objectives, expectations, and projects are called "in-order-to motives"[8].

The actions considered in this study are inscribed in a context of motivation, composed of the previous and current experiences of nurses who work with PHC (because motives) and the projects that help reify action (in-order-to motives).

The target population of this study was 45 PHC nurses. The selection criterion was being part of the PHC system.

Participants were approached at the nurse's monthly staff meeting. The study was explained and professionals were invited to participate. Those who showed interest and met the selection criteria were contacted by phone to schedule the interview at a place and time of their convenience.

The number of participants was not set beforehand, as the interview phase was concluded when the researchers perceived data saturation, enough to answer the study objectives and questions[9]. Between January and April 2013, 13 nurses volunteered participation in the study, meeting the selection criteria and signing informed consent forms.

The interviews were recorded with the nurses' consent, lasted an average of 40 minutes, and were conducted and transcribed by the researcher. The guiding questions were: How do you rate your current performance in PHC? What are your expectations regarding your work? The material was classified, categorized, and analyzed according to the steps proposed by researchers of social phenomenology[10].

The interviews were analyzed through careful reading and rereading of the transcribed interviews, with the aim of capturing the essence of the experiences of the Chilean nurses working in PHC. Next, significant aspects extracted from the interviews were grouped according to thematic convergences to grasp the meaning attributed by the nurses to their own actions. These categories were analyzed with the aim of defining "because motives" and "in-order-to motives" of the actions of PHC nurses, and the results were

discussed based on social phenomenology and other frameworks.

The interviews were identified with the letter N (nurse) followed by the number of the interview (N1 to N13). The Research Ethics Committee of the School of Nursing of the Andrés Bello University approved the study through protocol L1/CECENF/71.

RESULTS

A comprehensive analysis of the activities already carried out as part of the PHC routine resulted in the following categories that reveal how nurses perceive their work (because motives): "Greater autonomy in professional actions", "Relationship with users" and "Professional burnout". The categories related with the "in-order-to motives" express the expectations of PHC nurses working: "Expect to be recognized for their work" and "Expect better management in PHC."

Category 1: Greater autonomy in professional actions

According to the interviews, PHC nurses conduct their activities with greater autonomy:

[…] *I like working in PHC because here I am an autonomous person, I do not depend on others to make decisions.* (N5)
We are more independent, we have never been subordinated to doctors, we share decisions […] it's the doctor's decision and the nurse's decision and both of theirs when necessary, that's what I like about PHC. (N10)
[...] *It's the best place to work […] greater ability to develop professional autonomy, here in PHC we can plan and solve problems.* (N11)

Category 2: Relationship with users

The nurses considered that PHC work allows them more opportunities to develop good relationships with users:

It's gratifying, because I like being with people. I can't imagine myself in the hospital, because it's more impersonal. […] I like PHC, I wouldn't trade it. (N2)
[...] *If they have problems with their family they always tell me because I spend so much time with them that we develop close relationships, there's more trust.* (N7)
They realize if we are close, if we are saying something in earnest, and this gives us more credibility. (N4)

Category 3: Professional burnout

The declarations of PHC nurses showed signs of professional burnout, a factor of demotivation:

[…] *We sometimes feel our energy coming to an end, like we don't have the necessary means to do so many things, but that's the daily routine, we rely on self-motivation.* (N9)
[...] *They burden us with more and more things, this frustrates me and demotivates me a bit.* (N6)
[…] *I have 15 patients with diabetic foot and vascular dressings and I work a lot. I dedicate the entire afternoon to dressings and recording the charts of chronic patients on the computer, every day.* (N13)

Category 4: Expect to be recognized for their work

The nurses expressed the desire of being valued and recognized for their work in PHC, feeling frustrated and often invisible to the health team:

[…] *I don't feel I'm important to the team anymore, I think that nurses are becoming more and more invisible [...] I feel invisible.* (N12)
We are pressured and receive no recognition, I'm not asking for a lot, but just knowing that people recognize your work, that's the most difficult […] and it's not just me, we all feel the same. (N3)
[...] *Suddenly I feel that the frustration is coming from me, obviously. [...] I believe I have good ideas, but I keep hitting a wall, I don't feel recognized for what I do.* (N6)

Category 5: Expects better PHC management

The desire to improve PHC management and the hope of counting on competent leadership were expressed in the interviews:

[…] *At this level of care, there are people with so much potential, but because of the structure of the system, it is not tapped into (N1).*
[…] *My expectations are that some areas can change their management so that things can be done better. Management is poor in terms of administration; those in the background are making all the decisions […] and sometimes they are not good decisions […].* (N4)
Our superiors don't always back us up… here nobody wants to take on more responsibility by leading a work group […] *there is no support for professionals.* (N10)

DISCUSSION

Regarding professional performance in PHC, the nurses in the present study highlighted that this healthcare scenario provides nurses with greater autonomy. Studies have shown that the autonomy desired by nurses must be considered when assessing their work performance as one of the advantages provided by this work setting. The main reason for this finding is that Nursing interventions are more independent than those in other healthcare sectors, enabling more autonomous care[11].

An integrative review of the literature showed that many studies highlight the autonomy of PHC nurses, even if it is not fully consolidated due to professional profiles and adverse conditions of the work process. However, some studies showed that such autonomy is real and results from the joint efforts of Nursing professionals[7].

In Portugal, a study analyzed PHC teamwork, showing that autonomy regarding technical and operational matters was one of the factors that contributed to greater motivation and satisfaction, which led to improved ability to solve health problems[12].

In Ontario, a study conducted with Canadian nurses showed that autonomy of PHC nurses is developed through their capacity to exercise their practice, make decisions, and manage health care actions. This generated a higher level of job satisfaction[13].

Another factor highlighted by the Chilean nurses about their performance in PHC was the possibility of establishing closer relationships with users. A literature review showed that the technical/healthcare

dimension of PHC in Brazil, which has been re-organized by the Family Health Strategy, has obtained better outcome than the traditional PHC model. This is due to family-centered interdisciplinary work that values embracement, rapport, and community orientation[14].

In corroboration with the premise that embracement fosters the creation of bonds with the community, the results of a study conducted with users of the Brazilian Unified Health System (SUS) in Belo Horizonte indicated that they perceived nurses as health professionals capable of providing embracement that favors intimacy and values dialogue, and that it is easier to express their health needs to nurses. The users considered that this attitude of nurses helped them to establish trusting relationships with these professionals[15].

Thus, Nursing work is more than an activity, it is a form of social relationship called “face-to-face” and considered by Schutz to be the most authentic of human relationships[8]. It is intersubjective because through it humans create bonds, understanding the meanings involved in social relationships[8].

Even though the nurses perceived themselves as having more autonomy and focused on intersubjective relationships with health system users, they emphasized professional burnout caused by work overload.

A study revealed positive and negative factors relative to the expansion of nurse functions in England’s National Health Service, in PHC. On one hand, nurses reported feeling greater professional recognition by patients and other professionals, increased technical power and professional body of knowledge, in addition to greater job satisfaction, related to increased decision-making ability in their practice. On the other hand, they expressed work overload, as nurses were now responsible for additional tasks[16].

Also in Chile, research conducted with PHC nurses showed that in the consolidation phase of implementing the family health model, burnout due to work stress emerged, generating work absenteeism and professional turnover[6].

The nurses’ stock of knowledge[8], demonstrated by the categories above led them to reflect about the PHC context and express expectations about their performance at this level of care (in-order-to motives).

The need expressed here by PHC nurses to feel recognized by professionals, managers and the community shows that being valued and recognized facilitate care provision and contribute to personal and professional accomplishment.

A study conducted with Spanish nurses showed that the recognition of Nursing is related to the value of care, and that both technology and the bureaucracy involved in care reduce time invested with patients. In this sense when care becomes invisible, the profession’s autonomy and recognition are threatened[17].

Another study conducted with PHC nurses in Brazil showed that greater social visibility takes place through the diversity of care practices they deliver and the different work places. Nurses are constantly searching for novelty, carrying out practices that are aimed at comprehensive care and commitment with problem-solving and the needs of the population[18].

The Chilean nurses who participated in the present study expected not only recognition, but also

better PHC management. Similarly, a study conducted in Scotland with community nurses showed that they expected management to eliminate bureaucratic practices that did not contribute to the work routine, desired leaders with proved managerial abilities who are familiar with PHC, who are accessible and provide room for participation, i.e., transformational type of leadership.[19].

The findings of a study conducted with Brazilian PHC nurses corroborate those of the present study. Special mention goes to the finding that factors that contributed to job satisfaction were related to a more organized management policy in public institutions, ongoing improvement of the health system, and better definition of nurse functions by managers[20].

Change processes needed in PHC occur gradually, requiring investment in different areas, especially in the development of management, education, and ongoing health education, strengthening social control, participative assessment in the healthcare system, and improvement to management and care technologies[21].

CONCLUSION

The professional performance of PHC nurses, based on the social phenomenology of Alfred Schütz, was expressed as consisting of an autonomous practice, with closer relationships with patients, but causing burnout. These professionals expect recognition from their team, managers and the community, competent leadership and to end work overload.

Limitations of this study include the fact that, as in any qualitative investigation, the phenomenon is never fully unveiled, and thus is a matter of perspective. The results were generated from and can be applied to this specific social group, which takes place in a concrete local reality, with specific geographical, cultural, and administrative characteristics. Thus, further studies can complement this knowledge and compare the performance of PHC nurses in other realities.

Contributions of this study include the possibility of considering new designs for professional management practices in primary health care from the perspective of Chilean nurses. These designs should be based on the reorganization of work processes and by occupying spaces in macropolitics, influencing the professional performance of nurses at this level of health care.

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