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A singular therapeutic project and home visits in the training of health professionals: An experience report

Projeto terapêutico singular e visita domiciliar na formação de profissionais da saúde: Relato de experiência

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ABSTRACT
This article reports the experience with home visits of students of an undergraduate course in Medicine in a higher education institution in the interior of the state of São Paulo. With the growing demands for the implementation of comprehensive health care and humanization of care, promoted not only by current legislation but also by discussions in health sciences, it has become essential to offer increasingly early in the training of health professionals opportunities to experience realities that contribute to the development of skills necessary for this. For this reason, disciplines such as Integration Practices and Health Care – FUNEPE and Community V, offered to third-year students of the Medicine course of the Educational Foundation of Penápolis (FUNEPE), should be the target of research and studies. Thus, the objective of this work is to shed light on a pedagogical model that gives students the opportunity to experience Home Care (HC) and Singular Therapeutic Project (PTS) practices.

Keywords: Singular therapeutic project, Home visit, Experience report, Genogram, Ecomap.

1 INTRODUCTION

Since the last decade of the twentieth century, health care has shifted from a purely biological, disease-centered approach to a more integrated, person-focused approach. Within the scope of the policies that go in this direction, there is the National Humanization Policy (PNH), of 2003. In it, three basic principles are established: that of transversality; the inseparability between care and management; and that of protagonism, co-responsibility of autonomy of collective subjects (BRASIL, 2013).

> [...] recognize that the different specialties and health practices can speak to the experience of those who are assisted. [...] Health care and assistance are not restricted to the responsibilities of the health team. The user and his/her socio-family network should also be co-responsible for the care of themselves in the treatments, assuming a leading position in relation to their health and that of those who are dear to them. [...] Users are not only patient, workers not only carry out orders: changes happen with the recognition of the role of each one. A humanized SUS recognizes each person as a legitimate citizen of rights and values and encourages their performance in the production of health. (PNH, 2013, p. 6-7)

Starting from what is established by the PNH guidelines themselves, it is necessary to leave a clinical conception focused only on the disease and consider the individual as a whole and in his interaction with his surroundings (family, friends, community, territory and health services), which leads to the concept of expanded clinic. Based on this assumption, the expanded clinic "seeks to integrate several approaches to enable an effective management of the complexity of health work, which is necessarily transdisciplinary and, therefore, multiprofessional" (BRASIL, 2010, p. 14). Some strategies have been developed to ensure that such an approach is guaranteed in the Health Care Network (HCN) – among them, the Singular Therapeutic Project (PTS) and Home Care (HC).

The PTS was first developed in mental health care centers, and began to be used as a therapeutic tool in the RAS, especially in more complex clinical cases. This is the framework of therapeutic treatment proposals established from discussions with a multidisciplinary team, and that starts from the collection of information not only on health, but also on the socioeconomic and family conditions of the patient (BRASIL, 2010, p. 39). Its unique character is related to the fact that it aims to meet the needs of each subject, taking into account the particularities of each case, without establishing *a priori* therapeutic lines based only on the diagnosis of the pathology (VIANNA; ROBERTS; FRAMES; SAINTS, 2022. p. 3).

The elaboration of a PTS implies four stages, not necessarily sequential, and that can be revised or repeated throughout the process: diagnosis, goal setting, division of responsibilities and reassessment (VIANNA et al., 2022. p. 4). In the stages of defining the diagnostic hypotheses and

short, medium and long-term goals, the involvement of the subject and their families is paramount, and one of the strategies that have been used to ensure this protagonism is the AD.

The AD was incorporated into the legislation related to the Unified Health System (SUS) in 2002 through Law n. 10,424, and has its definition updated by Ordinance n. 825, of April 25, 2016. According to the legislation, it is a service characterized "by a set of actions of prevention and treatment of diseases, rehabilitation, palliation and health promotion, provided at home, ensuring continuity of care" (MINISTRY OF HEALTH, 2016). It is a tool to guarantee the principles and guidelines of the PNH because it is based on the ideas of welcoming, equity and integrality of care, in addition to taking into account the territory, the community and the family in which the patient is inserted (BRASIL, 2020, p. 8).

> The provision of care at home should perceive the family in its social space, approaching the person in an integral and individualized way in their socioeconomic and cultural context. The health professional should have an evaluation of the dynamics of family life, with an attitude of respect and appreciation of the characteristics peculiar to each family and of human coexistence [...]. The integral approach is part of home care because it involves several factors in the health-disease process of the family. The health professional must take into account, using the concept of care that we saw earlier and of autonomy, that it serves not only to cure diseases, but to take care of health, considering the sick person in his vital context. (DAYS; LOPES, 2015, p. 25-26)

Despite research in the health area, all the legislation and the establishment of policies to establish a more personalized PHC that takes into account the autonomy of the RAS user, as well as the expansion of the HC, there are still many challenges to be faced. One of the main ones concerns the formation of the team that should provide this care. Resolution No. 569, of December 8, 2017, provided important guidelines in this regard, establishing the common assumptions and principles that should guide undergraduate health courses. Among them, it is worth mentioning four:

(i) health education committed to overcoming the inequities that cause the illness of individuals and collectivities, so that future professionals are prepared to implement actions of health promotion, education and community development, with social responsibility and commitment to human dignity, citizenship and defense of democracy, the universal right to health and the SUS, having the social determination of the health-disease process as a guide (CNS, 2017, art. 3, item Ia);

(ii) professional training focused on work that contributes to social development, considering the biological, ethnic-racial, gender, generational, gender identity, sexual orientation, inclusion of people with disabilities, ethical, socioeconomic, cultural, environmental and other aspects that represent the diversity of the Brazilian population (CNS, 2017, art. 3, item Ic);

(iii) the approach of the health-disease process in its multiple aspects of determination, occurrence and intervention, to enable the performance of future professionals to transform and improve the reality in which they are inserted (CNS, 2017, art. 3º, item IIb); and

(iv) the insertion of students in the practice scenarios of the SUS and other social equipment from the beginning of the training, integrating education and health work (CNS, 2017, art. 3, item IIIa).

Authors have emphasized the importance of including in training courses – not only at the levels of specialization or residency, but already at the undergraduate level – disciplines and internships that lead students to have contact with the dynamics of the UBS and with humanized and home care practices (SOUZA, 2023, p. 41). It is within this scope that this account is inserted and justified. It presents the experience carried out with undergraduate students of the medical course of an institution in the entire state of São Paulo with home visits aiming at the creation of a PTS for patients of UBSs of the municipality.

The general objective of this article is to report an experience of orientation of medical students in home visits with the objective of developing a unique therapeutic project. From this report, we aim to discuss the importance of this type of approach both for the training of future health professionals and for the improvement of primary health care.

2 METHODOLOGY

The present text starts from the report of the experience of students of the third year of the Medicine course of the Educational Foundation of Penápolis (FUNEPE) enrolled in the curricular extension discipline Practices of Integration and Health Care – FUNEPE and Community V. The objective of the discipline is to give students the opportunity to know in practice the process of developing a PTS from the realization of home visits to users of the RAS of the municipality of Penápolis and microregion / SP.

2.1 OPERATION OF THE DISCIPLINE

Those enrolled in the discipline receive a first theoretical class, in which they receive the schedule of the semester, and in which the principles of PTS and AD are presented and clarified. Students are divided into groups, each of them tutored by a professional.

The clinical cases to be treated are chosen in the UBSs of the municipality, and every three weeks the students change units. The calendar of visits is weekly and, after three weeks, a PTS for

that clinical case is presented in the classroom to the teacher responsible for the discipline. In the fifth week, students begin a new service in another UBS.

The first visit to the BHU is the one in which the medical record of the user to be attended is studied. With it, students learn the information necessary to make the first contact: personal data (name, age, gender); marital status; socioeconomic stratum; tests already performed and medications prescribed; and how long he has been attending the unit, among others. On this first day they also make the first visit to the family of the attended, always accompanied by the tutor.

During the visitation, there are a number of procedures that must be performed in order to collect the necessary information. As a way to prepare them for this task, an instructional roadmap is delivered to each group.

2.2 INSTRUCTIONAL SCRIPT FOR THE ELABORATION OF A FAMILY CASE STUDY

The script is composed of the objectives of the activity and the description of the stages of elaboration of the PTS, including the tasks to be performed during the visit and those related to the Calgary Model of Family Assessment (MCAF) (WRIGHT; Leahey, 2002). Its elements are presented below:

2.2.1 Objectives

Recognize the family as a context in primary care practice; evaluate a family with a view to identifying strengths, problems and the indication of intervention; consider that the family forms a network of relationships and that the interventions are interactive, materializing in relationships that aim at welcoming and changes; To find a way to briefly document the evaluation of the families and the proposed intervention.

2.2.2 Steps

And choose a family, as indicated by the UBS; collect data from family records, including all members (at home); to study the illnesses presented by family members; build genogram and ecomap; conduct a comprehensive interview; apply the scales for assessing family relationships (APGAR and Coelho-Savassi Scale).

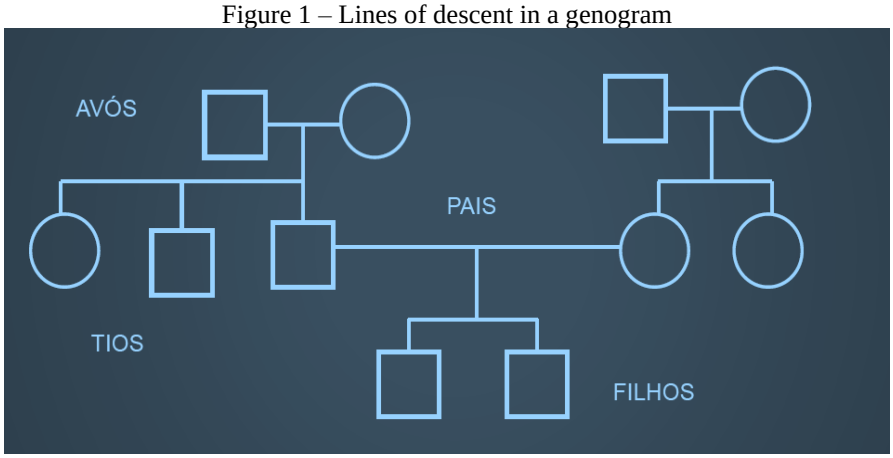
2.2.3 Comprehensive interview

It seeks to know the family structure; health history; habits; the insertion of the family in the territory; interaction with the BHU and the family health team; the dynamics of family relationships; the family life cycle; and family beliefs about health and disease.

2.2.4 Construction of the genogram

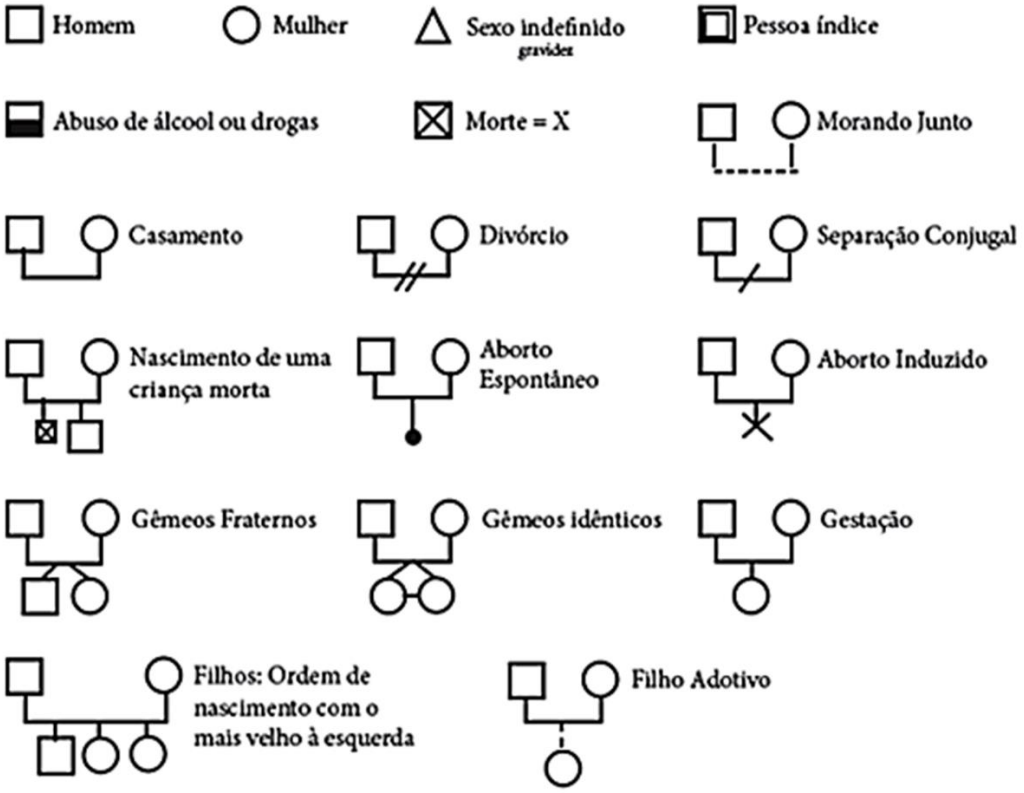
The objective is to offer data on family functioning that can be used by both families and the care team. At least three generations must be included, and family members must be placed in horizontal lines, representing each generation (parents – first line; children – second line) in order of birth, the oldest on the left and the youngest on the right (see Figure 1). Data collection begins with inquiries from the nuclear family, with information from those who live in the house – these members must be circulated so that they are distinguished from other family members; asks about the previous relationships of the spouses – if there have been other marriages, if there are children from that relationship or from extramarital relationships; probe whether there have been separations or divorces and when they have occurred – especially important for complex families with multiple parental figures and siblings. It should be followed for questions that portray the extended family, of maternal and paternal origin – parents of the parents (grandparents), siblings of the parents (uncles), name and age of the individuals. This information should be noted on the inside of the square representing the man to which it refers, or the circle in the case of women (see Figure 2). On the outside should be noted other information that may be significant, such as some illness or health problem etc. The year of death of a family member should be noted above the square or circle that represents it; and, in case of abortion, the specific symbol should be used, indicating the sex of the child, if it is known (MCGOLDRICK; GERSON; PETRY, 2012).

Figure 1 – Lines of descent in a genogram



Source: Prepared by the author based on McGoldrick, Gerson and Petry (2012).

Figure 2 – Symbols used in a genogram.

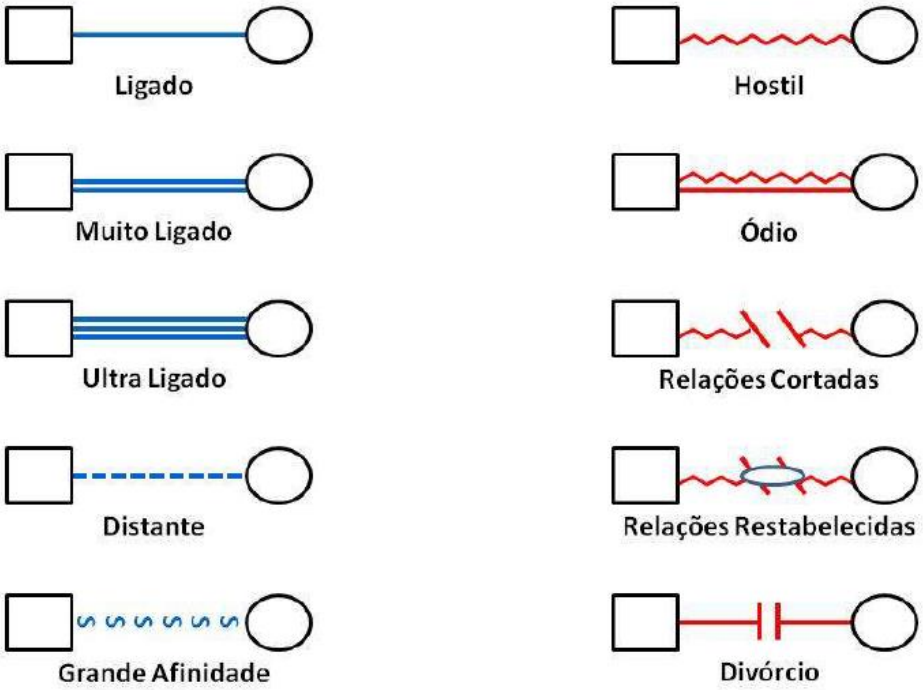


Source: Prepared by the author based on McGoldrick, Gerson and Petry (2012).

2.2.5 Construction of the ecomap

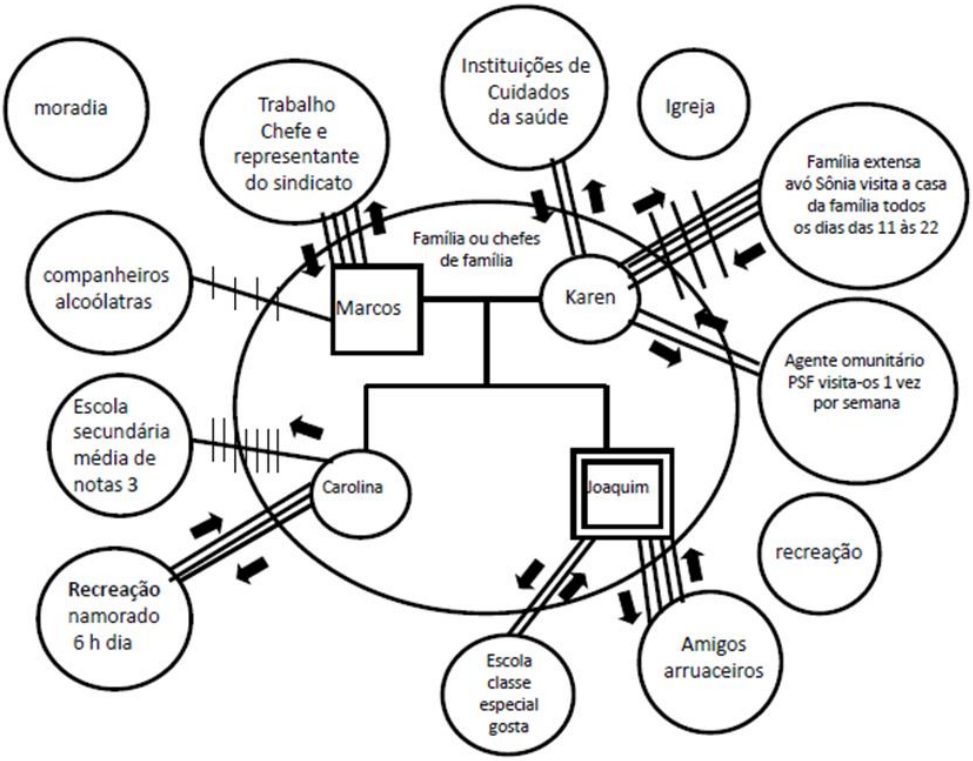
It serves to complement the genogram with information about the functioning of the family, the bonds established between family members and with the territory and the community, including health care services. It gives an overview of the support network of the subject assisted and the resources mobilized for conflict resolution. The degree of proximity or estrangement is given by the shape of the lines connecting the individuals on the map (see Figure 3). To indicate the flow of energy between the parts, arrows are used. Elements unrelated to the family context should be placed in external circles (see example of ecomap in Figure 4) (AGOSTINHO, 2007).

Figure 3 – Symbols of evaluation of the relationship between family members in an ecomap.



Source: Elaborated by the author based on Agostinho (2007).

Figure 4 – Example of an ecomap



Source: Elaborated by the author based on Agostinho (2007).

2.2.6 The family APGAR scale

Acronym for *Adaptation, Partnership, Growth, Affection*, and Resolve, the APGAR is an instrument that assesses the degree of satisfaction of family members with their relationships; it can reflect the perception that each one has of the role they present in the structure and detect if there are dysfunctions (GOMES, 2019). It is composed of five questions that probe the degree of satisfaction regarding aspects such as communication, support, affection and complicity, which can be answered on a three-level Likert scale (2 – always; 1 – sometimes; 0 – never). The total score ranges from 0 to 10 and can be interpreted as: score from 7 to 10, good family functioning; 5 to 6, moderate family dysfunction; 0 to 4, high family dysfunction (DUARTE; DOMINGUES, 2020).

2.2.7 The Rabbit-Savassi scale

It is a scale created to assess the situations of vulnerability to which the family may be exposed in their daily lives, choosing some information from Form A of the Primary Care Information System (SIAB) as markers, for which scores are given (Table 1). The classification of family risk will be according to the total score, with scores 5 or 6 (R1) classified as indicators of lower risk; scores 7 or 8 (R2), medium risk; and scores of 9 or more (R3), maximum risk (COELHO; Savassi, 2004).

Table 1 – Data from SIAB Form A and risk score

Data from Sheet A		**Scores**
Bedridden		3
Physical disability		3
Mental disability		3
Low sanitation conditions		3
Malnutrition (severe)		3
Drogue		2
Unemployment		2
Illiteracy		1
Under 6 months		1
Over 70 years old		1
Systemic arterial hypertension		1
Diabetes mellitus		1
Resident/room ratio	If greater than 1	3
	If equal to 1	2
	If less than 1	0

Source: Coelho and Savassi (2004)

After each visit, the groups return to the BHU to discuss what was done and collected. After three weekly visits in which data are collected and the family's situation is monitored, students take the PTS, taking into account the family structure and the role of each family member

will have in the suggested intervention. The proposal of each group is presented in the classroom to the responsible teacher, when it is discussed and undergoes interventions and corrections, if necessary. The approved project will be applied by the UBS team, and the students start a new cycle in another unit.

3 DISCUSSION

Since the National Humanization Policy (BRASIL, 2013 [2003]) and Resolution n. 569 of the National Health Council (CNS, 2017), many efforts have been made to transform the way medical teams have provided care, especially in PHC in the HCN of the Unified Health System (SUS). The Ministry of Health has incorporated in its regulatory framework measures that aim to humanize care, using as guiding principles the welcoming, interdisciplinarity and autonomy of the subjects served. In addition, it has sought to stimulate a more integrated approach to the patient, focusing on the individual and no longer on the disease.

PTS and AD are fundamental tools in this process. However, there are still challenges to be faced so that these instruments are incorporated in a more organic and daily way in medical practice. Therefore, it is important not only the continuing education of health professionals in this sense, but that they have contact with these practices since graduation.

Research, reports and case studies have been carried out in this area, some more specifically on the use of home visits and elaboration of PTS with patients of UBSs by residents and specialization students in the health area. However, there are not many reports of experiences with undergraduate students, although the disciplines that work in this direction already exist in some universities, such as the Botucatu Medical School (FMB), the Federal University of São Carlos and the Penápolis Educational Foundation (FUNEPE) – the latter, the object of this report.

The Community Service University Integration Program (IUSC) was an important program implemented at FMB in 2003, meeting the need for students to experience practices aimed at the integrality of health actions. Renata Maria Zanardo Romanholi (2010) put this experience into perspective in her master's research at this institution. The activities of the IUSC, according to the author, seek to break with the biomedical model of approaching the disease and the patient, privileging the home visit (HV) as a pedagogical instrument. The objective is to promote the reflection of the student on the social determinants in the illness, as well as to show diverse realities of his daily life. The exchange of knowledge and the strengthening of ties with the population served is also one of the intentions of the program.

According to the students followed by the researcher, the visits provided several learnings: (i) they developed the skills of listening, communication and ethical commitment; (ii) contributed to a qualified listening of the other and to the understanding of the situation in its singularity; and (iii) promoted disinhibition, among other aspects. The contact with diverse realities and with the daily dynamics in the SUS are essential in the training of health professionals and reinforce the theoretical knowledge about integrality of care learned during the course (ROMANHOLI, 2010).

For Romanholi (2010, p.101):

> In this teaching-learning process, there is a rupture of the dichotomy that existed between what is taught in colleges and the reality that professionals would encounter in their daily lives; the HV [home visit] is an opportunity for the student to experience the organization of the SUS in the practice of its realization and to appropriate the various dimensions that the integrality of care can assume.

In another study, conducted at the FMB School Health Center, and which analyzes the training of health professionals in AD (SOUZA, 2023), residents reported the need to be better prepared for the complexities found in the reality of care in a UBS, in which cases are found that require greater attention, a greater interdisciplinary effort and more understanding of the singularities of the subjects served. According to the researcher, they believe that these skills were learned from home visits and all the practice involved in them – such as applying scales and building genograms and ecomaps. The experience was seen as even more enriching because this group of residents had not had a similar opportunity during their undergraduate internships.

Canuto et al. (2019) report experiences of home visits with a focus on qualified listening carried out at the Family Health Unit (FHU) of Vila Altina, in the municipality of Marechal Deodoro/AL. They occurred during the mandatory internship of fifth year students of the Nursing course of the State University of Health Sciences of Alagoas. The authors conclude that home visits enable the approximation with the families, a central element when seeking humanized care, as well as making the team see other factors, emotional or socioeconomic, that may be hindering the prevention or treatment of diseases. For them, the visits provided opportunities for learning not only for the undergraduates, but also for the users. From the point of view of the patients, it was an opportunity to develop observation, necessary for better care, as well as to understand the importance of creating bonds for humanized care.

Another experience, reported by researchers from the State University of Rio Grande do Norte, goes in this same direction (BESSA et al., 2020). Students of the fourth period of the undergraduate program in Nursing at the university, enrolled in the discipline Collective Health Nursing, made a home visit chosen by the Community Health Agent (CHA) of a UBS in the city

of Pau dos Ferros/RN. During the visit, several aspects of the situation of the patient were raised, not only related to their health status, but also to their socioeconomic and family situation. From the data collected, the group of students elaborated a proposal for intervention. However, what the authors highlight most from the experience is how the use of home visits is still little, being performed more by the CHA than by a multidisciplinary team, as requested by the guidelines of Primary Health Care (PHC) and humanized care of the Ministry of Health. The students were able to see that it is necessary to find new approaches, always with the objective of providing integrated care, taking into account the social, economic and family context of RAS users, as well as the individuality of each case.

Students of the second, third and fourth periods of a medical course, enrolled in the discipline Primary Health Care, were divided into small groups, accompanied by a tutor responsible for their guidance and evaluation. These teams conducted home visits to users of the local HCN. The experience is reported in a 2019 article (SILVA et al., 2019). During the visits, the students evaluated the environment as a whole, recognizing the territory in which the family served is inserted, the presence or absence of public power, the housing situation and other socioeconomic data. Genograms and ecomaps were also constructed, as well as questionnaires/scales were applied to assess the degree of vulnerability. In each period, the students changed the UBS for which they performed the HC, which made it possible for them to know different situations and environments. The authors highlight as potentialities of the experience lived by the students the possibility of accompaniment of the family in the place where they live, which facilitates a more accurate knowledge of their reality. According to them, this factor would represent an important opportunity to expand learning, combining theory and practice, as well as an incentive to teamwork.

The home visit was also used as a supervised internship learning strategy in a study conducted by the Bahia School of Medicine and Public Health (RIBEIRO et al., 2019). The objective was to stimulate the Physical Therapy students to reflect, thanks to the visits, on the concrete problems experienced by those attended, becoming able to improve communication and intervention inside and outside the outpatient environment. The students reported feeling that the tasks related to AD present a high degree of complexity, requiring them to mobilize theoretical and practical contents. The experience, they report, made them improve competencies and skills important to the area and contributed in a relevant way in the process of professional learning.

This article is part of this line of research of experience reports with undergraduate students, and focused on the curricular extension discipline Practices of Integration and Health

Care – FUNEPE and Community IV, offered to students of the third year of the Medicine course of FUNEPE. The course aims to make students have contact with different socioeconomic realities and with the day to day of a UBS. The experience has proved to be very enriching, like other researches. Students can experience the daily life of the RAS in the region, as well as different socioeconomic and family contexts often different from their own, in addition to applying in practice knowledge acquired in the theoretical disciplines, not only in relation to the pathologies themselves, but also regarding integral health and humanized care.

4 CONCLUSION

The importance of daily experiences in the SUS network for undergraduate students in health sciences has been shown to be relevant and essential if one wants to achieve the goals given by the current legislation and by the increasingly hegemonic conception that care should be integrated and focused on the subjects, and no longer on the disease. Therefore, the provision of disciplines and internships such as those reported here become urgent, as well as research that probes their effectiveness, tests their formats, and suggests new instructional and educational approaches.

This work is an account of an educational experience, but it does not propose to make a critical analysis of the format adopted or the effectiveness with the students. Other research in this sense should still be developed so that teaching and learning instruments can be continuously improved in the health area that guarantee the training of professionals better prepared to meet the challenges of health in the country, even more so when thinking about the public network.

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