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Does permanent health education walk alone towards interprofessionality? A dentist's perspective

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ABSTRACT

Introduction: Permanent health education (PHE) is a strategy for qualifying work to improve patient care. **Objective:** To analyze dentists' perspectives on the PHE actions in the context of Primary Health Care. **Methods:** This qualitative case report study conducted through semi-structured interviews with 26 dentists in primary health care and five managers of PHE actions in the city of Sobral, in the Brazilian Northeast. **Results:** Data analysis was performed using the Collective Subject Discourse anchored in the following social representations: characterization of PHE actions as educational actions through theoretical-conceptual moments, with an emphasis on technical-scientific approaches and transmissive methodologies of an unprofessional nature; critical reflexivity in indicating improvements for these actions through the incorporation of interprofessional education in PHE actions. **Conclusion:** The involvement of continuing education actions in PHE has the potential to problematize work and develop strategies for the qualification of patient care, without losing the technical and scientific characteristics of each profession.

Keywords: education, continuing; dentists; interprofessional education.

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INTRODUCTION

Health education consists of the production and systematization of knowledge related to training and development for health practices and involves teaching practices, didactic guidelines, and curriculum guidance. Health education presents two modalities: continuing education and permanent health education (PHE)[1].

Continuing Education contemplates activities that have a defined period of execution, and uses the assumptions of the traditional teaching methodology, for example, formal offerings at the graduate level. It is also related to educational activities that aim to promote the sequential and cumulative acquisition of technical-scientific information by the health practitioner[2].

PHE is configured as "learning at work," in which learning and teaching are incorporated into the daily life of organizations and the workplace. PHE takes place in the daily work, and its purpose is to find alternatives and solutions to real and actual professional problems, prioritizing the work process as a central axis of learning[3].

In the Brazilian Unified Health System (SUS), PHE gained institutional space in 2003 when the Ministry of Health instituted the Secretariat of Labor-Management and Health Education (SGTES), responsible for formulating policies for the training, development, distribution, regulation, and management of health practices. The SGTES devised the proposal for the National Policy of Permanent Education in Health (PNEPS), with the main objective of defining a national plan for training and development for all health professionals[4].

In 2007, the SGTES approved Ordinance No. 1996, which proposed the regionalization and decentralization of PHE to the Permanent Commissions for Teaching-Service Integration (CIES). Thus, after local agreements and the structuring of PHE plans, states and municipalities could request financing for their regional projects[5].

Considering the need to resume financing and the planning process for PHE actions at the state and local level, Federal Management launched PRO PHE-SUS in 2017, with the objective of stimulating, accompanying, and strengthening the professional qualification of health practitioners, for the transformation of health practices. This initiative is characterized by financial allocations from the Ministry of Health directly to the municipalities to conduct PHE actions in the different territories[1].

The inclusion of Dentistry in Primary Health Care (PHC) occurred at the end of the year 2000 with the inclusion of the Oral Health Teams (ESB) in the Family Health Program (PSF), later called Family Health Strategy (ESF)[6], model of PHC organization in Brazil. Despite the continuous increase in the number of dentistry courses in the last decades, it is necessary to understand the relationship that the dentist makes with the PHE processes in PHC, focusing on the integration between categories[7].

The PHE leads the dentist to reflect their practices in face of new health approaches, thus making them a professional capable of learning to learn, of working in a team, and of taking the social reality into account to provide ethical, humane, and quality care[8].

Bearing in mind that dentistry was the most recent professional category to join the minimum PHC team, which, prior to the publication of the new National Curricular Guidelines (NCG) for health courses, had an educational background focused on health care market models, we noted a need for the studies that would qualitatively analyze PHE actions from the perspective of dentists in PHC, complementing the view of managers who participate in the organization, execution, and evaluation processes, to understand the extent to which PHE contributes to improving the health work process and integral patient care.

Thus, the objective of this study was to analyze dentists' perspectives on the PHE actions in the context of PHC in the Brazilian Northeast.

METHODS

The present survey considered a qualitative study, of the case report approach, using the Consolidated Criteria for Reporting Qualitative Research (COREQ)[9]. The empirical field of study was the municipality of Sobral, located in the northwest region of the state of Ceará, 235 kilometers from Fortaleza (the state capital), which had an estimated population of 208,934 inhabitants in 2019. The municipality is more densely populated than the state of Ceará as a whole[10].

According to data from the Primary Health Care Information System (SISAB), Sobral had 35 Family Health Centers at the time of data collection, 19 at headquarters and 13 in districts. In order to conduct the present study, the Family Health Centers (FHC) of Sobral that had at least one dentist used as the study scenario. The Visconde de Saboia Public Health School (ESP-VS) organizes the municipality's health education processes. Sobral also has a Health-Education System composed of the municipality's health services in partnership with educational institutions and health services[11].

All dentists who work in PHC in Sobral were invited to participate in the present study and 26 accepted. Also, it included a representation of the managers of PHE processes because they participate in the organization of education actions in Sobral. Data collection was conducted through semi-structured interviews with participants[12,13]. The script was prepared considering the study participants' profile, whether it was a licensed dentist from the FHS or a representative of PHE management in Sobral.

Semi-structured interviews are those in which the researcher presents questions to each subject with the possibility of addressing some unforeseen theme of interest to the study[13]. The interviews were conducted in the dentists' and managers' work environments, without interrupting their work activities, from May to June 2016, and recorded and later transcribed in full.

The responses to the conducted interviews were organized and analyzed using the Collective Subject Discourse (CSD) technique. This method proposes the organization and tabulation of qualitative data of a verbal nature, obtained from statements based on the theory of Social Representation and its sociological assumptions. These representations are the result of social interaction, being common to a specific group of individuals[14].

The proposal consists of analyzing the verbal material collected, extracted from each of the interviews[15]. In order for the CSD to be produced, the following elements are required: key expressions (KE), selected excerpts from the verbal material of the individual testimonies that best describe their content; central ideas (CI), synthetic formulas that describe the meanings present in the testimonies of each answer and also in the sets of each answer from different individuals, which have a similar or complementary meaning, *i.e.*, the same interviewee may have more than one CI;

and the CSD itself. Using the KE material from similar CIs, synthesis discourses or CSDs constructed, in the first person singular, with a varied number of participants, in which a group's thought or collectivity appears as if it were an individual discourse[15].

In order to tabulate and organize the testimonies, the Qualiquantisoft® software, which helps in this stage of collected data analysis, used, rendering it more agile and practical and increasing the reach and validity of the results. The discourses were prepared based on the professional category with which the interview conducted, considering the profile of the study participant.

The present study approved by the Research Ethics Committee of the State University of Vale do Acaraú (UEVA), under protocol No. 1.318.972.

RESULTS AND DISCUSSION

Participant characterization and synthesis of central ideas per professional segment

Among the total 42 dentists from PHC, 26 (61,9%) agreed to participate in the survey, as well as 5 PHE managers (1 Oral Health Coordinator, 1 Health Care Coordinator, 1 PHC Coordinator, 1 PHE-VS Permanent Health Education Coordinator, and 1 FHC Manager), totaling 31 participants.

The organization of central ideas regarding the PHE actions is summarized in categories presented in Table 1.

The first and second most prevalent categories brought together central ideas related to characterizing the moment and suggesting improvements for the moments, respectively. The characterization and needs of the PHE moments constituted the PHC dentists' CSD, as can be observed in the categorization of central ideas shown in Table 2.

The results organized through the social representations: "The formality of PHE for dentists: are the meetings sufficient?" and "Characterization of unprofessional knowledge in developmental moments: paths to interprofessionality," presented below.

The formality of PHE for dentists: are the meetings sufficient?

The discourse analysis shows the characterization of the PHE moments with unprofessional predominance, and the transmissive methodologies performed externally to the work environment. The CSD of Category A characterizes the periodicity, composition, and method:

> *"The action takes place monthly after a meeting with all of the municipality's dentists, where classes or lectures are carried out, given by guest university professors and specialists in the subject. The speakers share their knowledge with us so that we can learn about specific topics and capacitate ourselves for the work. In it, we can better understand the health system and clarify some questions and exchange experiences with colleagues. That is what happens, lectures given to us so that we can "update ourselves," but to me, it is not actions but rather the action" (CSD A - Dentist).*

In this discourse, the methodology used in the PHE actions is criticized in order not to be configured only as expository classes, highlighting the need for facilitators from other fields of work. Since it is more prevalent, it relates to the professionals' understanding that PHE is something larger that requires different pedagogical and interpersonal approaches[16].

The dentists' CSD characterized the PHE actions as formal moments of technical-scientific updating. A previous study obtained similar data, in which the participants only partially knew the PNEPS, despite understanding its objectives and the target audience[17]. The analysis of this discourse implicitly demonstrates a positive perception of PHE resulting from the democratic management that the municipality promotes, given that the elements necessary for the improvement of these actions are present in the identified problems[18]. The predominance of expository and transmissive methodologies renders it difficult for the subjects to participate and constitutes an obstacle when used exclusively[19].

Table 1: Distribution of categories related to permanent health education (PHE) actions by PHE Managers at the primary health care in Sobral, Brazil, 2020.

	Category	n	%
A	Demands of the territory discussed in the group of dentists	6	85.72
B	Need for flexible planning	1	14.28

Table 2: Distribution of Categories related to permanent health education (PHE) actions by dentists at the primary health care in Sobral, Brazil, 2020.

	Category	n	%
A	Scheduled monthly meetings	15	37.50
B	It should happen more often	9	22.50
C	Should involve other professionals	6	15.00
D	Should include issues beyond oral health	10	25.00

Upon identifying the developmental needs, the reflection regarding their practice was able to go beyond an exclusively technical aspect, despite the valorization conferred by PHE as a Continuing Education activity. It is noteworthy that the latent potential of the discourse to break with the verticalization of knowledge and its practices provides the professional with a sense of belonging that allows them to adhere to PHE actions[20].

Public health schools assume a strategic role in this regard by enabling the planning and execution of PHE actions using problematizing pedagogical approaches that involve the target audience and qualified facilitators, with faculty development programs to capacitate the teacher in this new role as the mediator of the learning process[19].

A systematic review revealed that educational meetings alone or combined with other interventions could improve professional practice and clinical care outcomes for patients. However, the effect is more likely to be small compared to educational meetings using interactive formats and mixed didactics, which demonstrated greater impacts on professional practice and patient care[21].

It is important to contemplate the specific characteristics of clinical dental care in the planning, organization, and execution of PHE actions. Educational activities must have the equipment and supplies necessary for clinical practice, and use clinically relevant, high-quality evidence for decision-making[22].

The second most prevalent discourse suggests the need for a higher frequency of theoretical-conceptual moments, focusing on biweekly periodicity for those moments that until then only occurred monthly:

> *"Permanent education needs to continue being carried out every fifteen days, the activities have been much less present than in the past due to the low frequency with which they are taking place. Even with the reduction in frequency, it works satisfactorily here, but I miss it, in that we could really be exchanging these experiences more often" (CSD B - Dentist).*

Through discourse analysis, we were unable to identify another type of PHE format that would narrow down the occurrence of these moments, such as distance education activities. The World Health Organization (WHO) advocates the use of Information and Communication Technology (ICT) to support online learning (by virtual means) as a way to promote the development of technical, programmatic, managerial, and administrative skills in health practitioners and the constitution of cyberspaces as a locus for learning[23].

The insertion of distance learning strategies in PHE programs is considered innovative, as it facilitates learning inside or outside the health institution[24]. The *Telessaúde Brasil Redes* (ICTs that not mentioned herein as representations of PHE spaces) support PHE and minimize the discrepancy between what is taught and what is expected from their performance in the services offered by SUS[25].

A survey conducted in a small municipality evaluated PHE through the Program for Improving Access and Quality in Primary Care (PMAQ-AB) revealed weaknesses in the PHE action assessment[26] regarding the promotion not only of the improvement of care but also of the professional understanding of the PHE's fluid logic.

Characterization of unprofessional knowledge in developmental moments: paths to interprofessionality

The most prevalent discourse characterizes the *modus operandi* of the actions and highlights the need to enable access regarding the planning and execution of PHE actions in Dentistry to other professionals who also participate in the oral health care process in the FHS:

> *"Permanent Education is restricted to Dentistry; oral health demands are discussed in the dentists' group after being identified in the territory. There is a need to carry out these discussions more frequently in the territory, broaden these discussions to other professional categories so that the team as a whole understands what these demands are and how they dialogue with the service, because discussing something very specific to dentistry without talking to other professionals ends up segmenting the category" (CSD A - Manager).*

The manager's discourse indicates the need for educational moments in the PHC's own territory with the involvement of other professional categories. Such interaction is favored by the set of NCG for courses in the health area, which evidence competencies in health care, decision-making, communication, leadership, administration/management, and permanent education, aspects that are consistent with Interprofessional Education (IPE)[19].

IPE consists of occasions where members or students of two or more professions learn from others, among themselves, and about others to improve the collaboration and quality of care and services[1]. IPE actions reinforce the role of each profession, prepare professionals for teamwork, and develop positive attitudes for the benefit of patients, improve work experiences, and a significant level of collaboration[19,27].

The less prevalent discourse values planning the flexibility of the themes chosen for the moments. Due to the logic of work in PHC being dynamic and characterized by the diversification and peculiar characteristics of each health service, the themes intended for the moments must arise from practice:

> *"We need to keep in mind that the demands will arise from practice, thus, most of the time, I will not be able to pre-determine the theme. The logic of permanent education is very fluid, so I will*

not always predict what will be discussed one year in advance. For this to happen, we need to analyze the predetermined themes in groups. The idea is that, in addition to dentists, other categories be heard during planning so that the most relevant issues and problems in the service be identified" (CSD B - Manager).

The demands, even though necessary to PHE processes, may, in this discourse, refer only to those related to the management's view. However, their views are required to meet the learning needs felt by health practitioners in order to improve the services provided at SUS. It is noteworthy that the demands of health workers are often related to their own personal needs, thus reflecting their individual learning needs throughout life[28].

It was identified that working in a private dental clinic is considered a restriction factor for adherence to educational activities[28]. Motivation for work reflects the profile of valuing workers, seeing that professionals in precarious working conditions and relationships remain dissatisfied and without motivation. Educational actions that balance professional needs to improve patient care and service qualification in the context of work valorization achieve successful results[29,30].

Given that learning needs are transcendental, category C of the dentists' CSD emphasizes the little involvement of the dentist with other professional categories of PHC and suggests the need for multiprofessional educational approaches, with themes beyond the clinical dental practice:

"There is a lack of involvement of other professional categories, sometimes the moment manages to bring together dentists and oral health assistants, but I would like to see more and of different categories, why? Because when we begin doing this inside the unit, the other professionals don't understand, they don't know why you are changing this or that, or why you are working in another manner. The actions end up being individualized by professional category, there is Permanent Education for dentists, and the qualifying actions that are directed to other health professionals, include us dentists" (CSD C - Dentist).

The need for interprofessional moments is due to the lack of knowledge of the oral health work process by the other PHC components and vice versa. PHE programs focused on IPE should consider these issues in their planning, since most professions do not have curricula that address this type of interactivity[19,31].

The discourses of the dentists and managers presented in this study have an avant-garde nature since they advance in the context of interprofessionality. They recognize the need to amplify voices and thoughts, contributing to a more effective reflection on practices and health care[20].

In this understanding, international studies suggest that the feasibility of offering interprofessional training of extended skills to dentists and other health professionals should reinforce their monitoring and evaluation using different methods[32,33], keeping in mind the challenging character of these methods, with examples such as interprofessional screening in the United States[34], inter consultations in Canada[35] and London[36].

The planning of educational actions was a landmark in the collective subject discourse, where the choice of themes for the moments also highlighted as a point that needs improvement according to category D of the CSD, suggesting the insertion of themes related to public health that integrate the dentistry professional in global situations that occur in the FHS itself:

"I believe that it is necessary to study broader health problems, such as situations that require the involvement of different professional categories, such interaction promotes joint growth among professionals through the exchange of experiences. The themes are more focused on more specific themes in dentistry, clinical themes, not broader themes of primary care" (CSD D - Dentist).

These learning needs reinforce the shortage of educational programs with an exchange of experiences and patient-centered care. However, the work process of professionals can block these moments, as can be seen in the perceptions of PHE by PHC nurses. The professionals stated that the assistance activities added to the managerial and administrative attributions (common to all PHC professionals) can render PHE actions unfeasible[37].

The discourse presents a description of strongly characterized PHE actions from specific areas of dental education. In this sense, the presence of public health schools in each regionalized locus of PHE actions provides substantial support, which can contribute to the "break" of unprofessionalism, since the latter constitutes one of the pillars of the Brazilian Network of Public Health Schools (*RedEscola*)[20].

Based on the present study, it can be inferred that PHE requires a broader evaluation of its primary determinants, especially those related to the management of health practices since the purpose of its policy is that, once the health service is identified as a space for learning and provoking educational actions[23], professional valorization strategies be used in order for the professional to be satisfied when working in SUS and feel motivated to learn.

The creation of municipal health-school systems could enable such valorization[17], enabled the implementation of the teaching-service-community and IPE integration processes, expanding the dialogue with the workers and educational institutions[1,24].

Although the concept of PHE focuses on meaningful learning in the context of the reality of services and Continuing Education on intellectual (formal) knowledge, the complementarity between both comprises an essential element for the development of PHC workers. Thus, PHE and Continuing Education can serve in the process of training professionals, opening the possibility of

dialogue and, therefore, of understanding and collaborative work for the consolidation of SUS[37,38].

This study used a qualitative approach in its design and execution, inherent to subjective and particular contexts that render it partially limited, despite the choice of using the CSD, the anchoring of the discussion in the organization of PHE actions, and the need for the IPE approach, since it includes the dentist as a part that internally validates the profile of other health professionals in educational processes.

In conclusion, the social representation of PHE actions for dentists in PHC still restricted to theoretical-conceptual moments, with an emphasis in technical-scientific approaches and unprofessional transmissive methodologies. Factors such as this make these professionals feel unmotivated to study training strategies to work in a service that does not offer security regarding employment relationships and causes dissatisfaction with professional practice in the Family Health Strategy.

Work management and health education policies that have an emphasis in professional valorization and relationship strengthening are tools that, by transforming the subject into a critical, reflective, and active being, allow the dialogue and participation of those involved in the educational process, in a way that promotes the development of skills and competences through the dissipation of knowledge.

From the dentist perspective, this study also identified latent social representations in the discourses regarding the need to improve these actions, to have more moments of PHE, to strengthen the relationship between the different professional categories of PHC, and to approach broader themes of collective health that integrate the dentist with human resources in health care services. IPE presents itself as a favorable path to achieve such improvement. Actions considered in the literature as continuing education can merge with the problematization to improve work and patient care, balancing themselves through interprofessional PHE macro planning.

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