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RESEARCH

Modelos explicativos do setor profissional em relação às plantas medicinais

Explanatory models of the professional sector in relation to medicinal plants

Modelos explicativos del sector profesional en relación con las plantas medicinales

Josiane Santos Palma ¹, Marcio Rossato Badke ², Elisa Vanessa Heisler ³, Rita Maria Heck ⁴, Sonia Maria Konzgen Meincke ⁵

ABSTRACT

Objective: Recognizing the explanatory models of the professional sector in relation to medicinal plants. **Method:** The study was conducted with nine professionals between May and July 2011 in the rural area of Pelotas/RS, with self-application of semi-structured questionnaires, participant observation and focus group. All ethical guidelines for research involving human beings were respected and each professional has been identified by the name of a medicinal plant. **Results:** According to the thematic analysis of data, health professionals use medicinal plants for care of their health and are able to mention the use of plant resources in the context of primary health care in times of self-care and palliative care. Aside from these moments, they encourage the exclusive use of allopathic resources. **Conclusion:** The strength of the professional sector with regard to medicinal plants may reflect the biomedical training, consisting of a critical node of semantic networks. **Descriptors:** Health team, Primary health care, Medicinal plants.

RESUMO

Objetivo: Conhecer os modelos explicativos do setor profissional em relação às plantas medicinais. **Método:** Estudo realizado junto a nove profissionais entre maio e julho de 2011 na zona rural de Pelotas/RS, com auto aplicação de questionários semiestruturados, observação participante e grupo focal. Os preceitos éticos para pesquisas envolvendo seres humanos foram respeitados e os profissionais foram identificados pelo nome de uma planta medicinal. **Resultados:** De acordo com a análise temática dos dados, os profissionais de saúde utilizam plantas medicinais no cuidado da própria saúde e mencionaram haver possibilidade para a utilização de recursos vegetais no âmbito da atenção básica em momentos de autocuidado e cuidados paliativos. Afora estes momentos, incentivam o uso exclusivo de recursos alopáticos. **Conclusão:** A resistência do setor profissional com relação às plantas medicinais pode ser um reflexo da formação profissional biomédica, consistindo em um nó crítico das redes semânticas. **Descritores:** Equipe de saúde, Atenção primária à saúde, Plantas medicinais.

RESUMEN

Objetivo: Conocer los modelos explicativos del sector profesional en relación con las plantas medicinales. **Método:** Se llevó a cabo con nueve profesionales entre mayo y julio de 2011 en Pelotas rural/RS, con la auto-aplicación de semi-estructurados, observación participante y grupos focales. Todas las pautas éticas para la investigación con seres humanos se respetaron y cada profesional ha sido identificado por el nombre de una planta medicinal. **Resultados:** De acuerdo con el análisis temático de los datos, los profesionales de la salud hacen uso de plantas medicinales en el cuidado de su salud y son capaces de mencionar el uso de los recursos vegetales en el contexto de la atención primaria de salud en los momentos de auto-cuidado y la atención paliativa. Aparte de estos momentos, fomentar el uso exclusivo de los recursos alopáticos. **Conclusión:** La fortaleza del sector profesional en relación con las plantas medicinales puede reflejar la formación biomédica, que consiste en un nodo crítico de las redes semánticas. **Descriptor:** Equipo de salud, Atención primaria de salud, Plantas medicinales.

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INTRODUCTION

The use of plants along the health-disease process permeated the whole of human evolution, being questioned. Its use was for years the only option to solve basic needs, consisting of records and manuscripts of different civilizations.

While the perception of health and disease approached the mystical and religious character, the use of the plants was less denigrated. To the extent that science developed, criticism increased considerably.¹

Several plants were the basis for the production of allopathic medicines such as antimicrobial agents, and thus temporarily replaced the use of these industrial plants for drugs during the last century. However, the high toxicity and the high cost of production again aroused the interest in plants because of lower costs and time for their production.²

The advance and the scientific development were directly proportional to the human being the quantifiable aspects of mathematics, reflecting the interest in the disease and the parts of the human body. This mechanistic orientation triggered the biomedical model that guides the training of health professionals nowadays. Undeniable is its positive influences in contributions; however, the biomedical model does not cover the entire human being.

Unrelated to discussions of scientific nature, the population did not fail to appreciate the potential of plants. The popular use of plants, therefore, is not associated with evidence of its effectiveness, having connection with cultural aspects, supplying the space between the economic availability of the population and the demand of allopathic³ or related to self-care capacity with natural products. Once inside the modern science and the biomedical model, the plants are replaced value to the present active ingredients of pharmacological action that act directly or indirectly as a medicinal product to be considered medicinal.⁴

In tracing the characteristics that differentiate the prospects of the population, the perspectives of health professionals involved in the biomedical model, on the use of medicinal plants, emphasizes the culture as a set of full webs of socially constructed meanings and shared 5 different in both occurrence contexts.

It lies in the way Anthropology to mediate this discussion with health professionals about medicinal plants. The anthropological framework contributes to reflection on the meaning of social practices as the exercise of care. The authors⁶⁻⁷ provided key elements for analysis of cultural factors involving the health field.

Health professionals and the public realize the health-disease process in different ways, while sharing some aspects of the same culture. During the process of training, students go through the process called "endoculture" and acquire gradually a new perspective on health issues.⁸

In this way, the seizure of knowledge during the course of life and the incorporation of new concepts or dogmas along the training they strip the individual of this popular culture and is of the wisdom and power of scientific culture.

Culture provides templates "from" and "to" human behaviors related to health and disease, which can be studied as a cultural system that consists of three parts, which sometimes overlap or act simultaneously: the sector popular, the professional sector and the folk sector⁶

The popular sector, in general, the largest, is one in which the family and the closest social group play an important role. It is an eminently secular space in which the disease is being defined and are triggered various therapeutic coping processes. Have the professional sector is the official or formal organization of health practice, in most cases, and biomedicine as reference. It is the sector that in some countries, to focus greater technological apparatus, organization and power, submits all other health practices to their authority. For its great penetration and the power available in some societies, such as Brazil, the professional sector is imposed on other sectors; finally, the folk sector, which covers all other unofficial health practices, such as herbalists, healers, religious practices and other alternative forms of healing.

In each of these sectors, their representatives have different models to describe etiology, symptoms, pathophysiology, course and treatment of diseases. Each has values, beliefs, rules of conduct and specific expectations.⁶⁻⁸

It should be noted that this study focuses on the professional sector, with a view to gradually approaches the daily life in the search for evidence of popular knowledge from the National Medicinal Plants and Herbal Medicines Policy⁹ which, among its objectives, brings the encouragement of research and control the use of medicinal plants and herbal medicines in the Unified Health System (SUS).

Authors who follow the anthropological⁶⁻⁷ reference agree that culture influences the experience and expression of symptoms of disease, weaving a series of criticisms of the Western medical rationale and proposed a cultural model that values other knowledge, complementary to clinical practice.

The structures that connect the concepts of health and disease to cultural values are called semantic networks⁷, which support the speech and the professional behavior and patient as a web of words, situations, symptoms and feelings associated with a disease, giving meaning to both the person suffering and to the professional involved in the care.

Constituting a reflection of a different culture of the popular sector and the folk sector, due to their training model, the professional sector is generally insensitive and resistant to prospects and expectations of patients, and the clinical reality grounded on the biological level as unique. Therefore, the statements of individuals on health and disease need to be interpreted experienced in their social context and symbolic.⁷

It is noticed that, gradually, the impersonality of the professional sector has been overcome and live with the popular sectors and folk sees is a user logic of the approach and an interface between the professional and the client.¹⁰

Among the explanatory models of disease concepts, there are different interpretations.⁶ Illness is translated into the English language as the means by which

individuals understand, categorize, qualify and experience symptoms, articulating that feeling through its own forms of behavior and traveling special ways to find a cure. Apart from personal experience, the individual attaches meaning to the disease. Finally, illness is the individual's subjective response to the disease situation, a response that includes individual, social and cultural to the experience of being sick.

Disease refers to how the experience of illness (illness) is reinterpreted by health professionals in the light of their theoretical models and guides in their clinical work. It is therefore a definition dysfunction, seated in an essentially biomedical substrate, the abnormalities of structure or function of organs or systems.

Sickness is the process by which certain behaviors and biological signals acquire recognized meanings socially transformed into symptoms and socially significant consequences. Associated with the disease (sickness) are the macro social factors, such as economics and politics.

Given the above, this study aimed to assess the explanatory models of the professional sector in relation to medicinal plants.

METHOD

This study is a part of the research "Of health professionals shares on primary care in relation to medicinal plants", approved by the Research Ethics Committee of the Nursing School of the Federal University of Pelotas an opinion 217/2011, as set out in Resolution 196/96 of the National Health Council, which provides for the Research Standards in Human Beings.

It is the qualitative, ethnographic influenced by reference to the description of a system of cultural meanings of a particular group, aiming to understand the way of life, from the point of view of the informants. Its process included observation, description, thick, document and analyze lifestyles or cultural patterns in order to understand them.¹¹

The study was conducted with nine health professionals from a Family Health Unit (FHU) located in the rural area of Pelotas / RS, in which experiences in relation to medicinal plants in line with some official institutions have been developed. The professionals were selected from the interest in dealing with the study of the topic; work placement at USF for at least six months; to have total agreement on its participation in the study by signing the Consent Agreement and Informed (IC); of nod with the recording of the data collected and agree to the presentation and dissemination of results in academic and scientific circles. All were identified by names of medicinal plants chosen by them in order to preserve the anonymity of their true identities.

Data were obtained in three complementary phases: semi-structured questionnaire self-applied 11 focus group participant observation 12-13 and 14, between May and July 2011.

The semi-structured self-administered questionnaire combined closed and open questions, allowing know the identification profile, training, performance of each health professional, and the use of medicinal plants in their own health care.

The comments were divided into three distinct and growing stages: entry in the search field, beginning of the interaction of the researcher with professionals and active participation of the researcher in context. After three times there was intensified reflection on the data. The meetings were held in places where there were professional relationship with the user, as analyzed how people behaved, the duration of the interactions, the characteristics of the service and the presence of medicinal plants in the context of health practices. The meetings totaled 80 hours.

A focus group was conducted by prior arrangement between the researcher and the professional and registered in a field diary, lasting between one and a half and two hours. It occurred in the Family Health Unit, allowing for group interaction and opportunity to the interpretation of beliefs, values, concepts, conflicts, confrontations and views. Through group, there was the validation of the emerging data for the entire study period.

This information was used in tables and in a field diary that culminated in the thematic analysis.¹⁵

RESULTS AND DISCUSSION

The subjects of this study were made up of six women and three men, aged between 27 and 56 years old. The age is 50 years old. All meet the statutory labor regime established by the city of Pelotas/RS for at least three years. The health professional with more time in the function has to for over 30 years in this Basic Health Unit.

The level of education mentioned by individuals fits between the average level (5) and the upper level (4). Five health professionals live in the rural area where the study was conducted; the other moving daily to the urban area through public transportation, most of the time.

Among health professionals with tertiary education, training occurred between the second half of the 1970s and the first half of the 1980s already among the health professionals with an average level of education, training took place between the first half of the 1990s and the second half of the 2000s.

No health professional discipline attended or followed related approach to the use of medicinal plants for training in middle or upper level; however, two mentioned have obtained information about the topic after the end of training. As confirmed by previous study¹⁶, 79% of health professionals have had no contact with the subject medicinal plants and/or complementary therapies during their academic education. Despite the recognition

of herbal medicine by health professionals' advice as many Nursing professionals do not feel safe to talk on the subject and therefore use in their professional practices.¹⁸

For all health professionals were asked to inform the name of the medicinal plants they use in their own health care. 24 plants were cited by common name used for several purposes that are matched in the popular and are shown in Figure 1, can be repeated in different changes.

Digestive changes	Respiratory changes	Inflammatory changes
Burdock	Garlic	Lemon
Doldutree	Guaco	Linseed
Onion	Mint	Mallow
Lemon balm	Orange	Marcela
Tobacco plant	Lemon	Tansagem
Fel-the-earth	Mallow	
Fennel	Marcela	
Mint	Tansagem	
Marcela		
Lemon Balm		
Palminha		
Brazilian cherry		
Urinary changes	Psychosocial changes	Tegumentary changes
Avocado	Chamomile	Avocado
Burdock	Balm	Aloe
Mallow	Yerba Santa	Burdock
Paw-of-cow	Lemon Balm	

Figure 1 - List of plants used by health care professionals in self-care, according to purpose. Pelotas/RS, 2012. Source: a Field study.

The plants used are grown in backyards or in small gardens maintained by health professionals living in the countryside. Those living in urban areas admit the use of medicinal plants in the form of processed teas.

Health professionals say they have learned about the use of medicinal plants with the family. This knowledge is restricted to the context of family relationships and is not passed on to users. All say they would feel more comfortable asking and answer questions from users if they received information in the form of professional training.

With views of the theoretical framework that supports this study, data denoted that the explanatory models of the professional sector in relation to medicinal plants points to the possibility of use of medicinal plants in times of disease self-care at an early stage (illness) or in more serious conditions such as palliative care of serious diseases and prior to death (sickness).

Between the two extremes, the only accepted therapy and encouraged derived from allopathic resources whose effectiveness is known proven. Figure 2 sets forth the understanding of health professionals concerning the scope of use of medicinal plants.

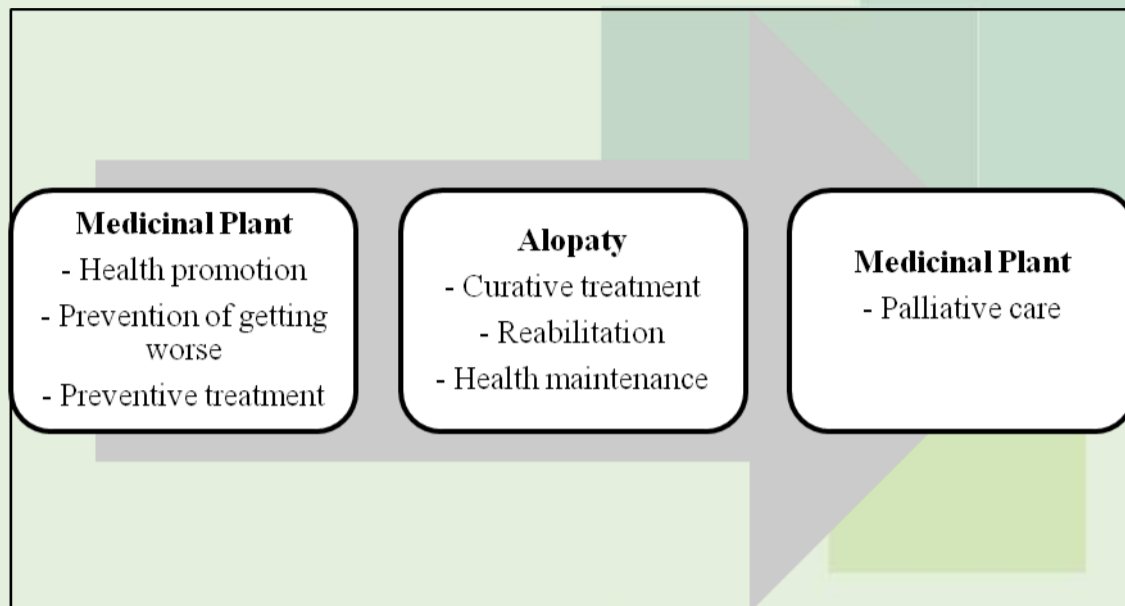


Figure 2 - Understanding of health professionals regarding the sphere of use of medicinal plants. Source: a Field study.

It shows the conception of health professionals that medicinal plants are effective, or at least not represent threats to the professional sector, while they remain restricted to the popular sector or industry folk.

The following statements legitimize the previous statement to disclose the meaning that medicinal plants remain with health professionals:

*People say, I think it will help me. And help. It is a matter of faith [...] (Mint);
[...] It is the placebo effect, if you believe that it will help you (Aloe).*

From the moment they occur health problems, the plants in its usual form of use as tea are replaced by allopathic medicines, such as tablets, whose presentation and expected results are validated by the erudite knowledge of the professional sector.

On this subject, we currently have the recognition of the use of medicinal plants, which are used for generations, with a manual, scientifically recognized, which teaches the correct use of the plant, its leaves, bark and roots.¹⁹ Because in this sense, plants, without proper pharmacological properties, mechanisms of action and known adverse reactions, remain outside the public health system. According to the professionals, this is an important point to be considered for the use of medicinal plants is recognized by the industry itself and prescribed to patients.

*Talking about plants is a step convincing. Recognize popular knowledge father brought child is the first step, and we are already convinced (Thorn Tree-Santa);
[...] The challenge now is how to use this knowledge in a consistent and scientific manner. It is important to have the validation of empirical use, which is not always confirms and gives security (Aloe).*

Most plants do not have the well-known toxicity profile and may cause serious problems. The belief in "harmless naturalness" is not easily contradicted because the scientific evidence of the occurrence of poisoning, adverse reactions or contraindications hardly come within reach of the population. There are justified, thus monitoring and

pharmacovigilance actions on medicinal plants as those that occur over conventional medicines.¹⁶

While restricted to the popular sector and the folk sector, health professionals do not interfere in the population's health-disease process, understanding that plants are sufficient at this stage confrontation or care.

The disease is a gradation. The plant works great in the early parts, not to let get too serious (Aloe).

Taking up the semantic networks, you can detect that the conceptions of health professionals about the disease differ radically the concepts of the user population of medicinal plants.

For the former, the disease is now considered when it reaches detectable levels of physical alteration/physiological, classified as biomedical diagnostics. In this case, the disease can only be treated with allopathic or quelled proceeds from the same model. Sickness takes on meaning for the professional sector as cause damage to the labor market, capitalist exploitation producer feeding the biomedical model. The last level is considered the illness; depending on the severity of disease and sickness, the resources used to date no longer accrue in restoring health. Goes up, then, the "allow" the use of medicinal plants in care prior to death, executed by the popular sector.

In contrast, the population considers illness as the first identifiable intervention locus of plants. The social significance of sickness becomes more consistency when it impossible to work and family maintenance. If the plants do not freak out intervention with the expected effect, the population relies on the professional sector to treat or eradicate the disease.

Given the above, the plots that weave semantic networks are private in each context and hence the explanatory models vary according to the professional sector of culture and the popular culture sector.

The results are corroborated by another study¹⁷ that investigated the way of structuring the knowledge network in the life trajectory of health professionals. Having as object of study the use of medicinal plants by health professionals, this study revealed that the plant has confirmed place in the private-home space.

As for the academic and professional space, the plants are tolerated by scientific evidence. The study justifies that students build their knowledge networks based on their social and family universes. Meeting with the academic knowledge, are to commit themselves to the dictates of this medium. The result is denial, ignorance or inhibition of common sense benchmarks.

It might come across the variability in the composition of the semantic network of the professional sector, which took shape from the oscillation between which resource (vegetable or allopathic) would be more efficient.

[...] There are people who would rather have tea instead of the tablet (Thorn Tree-Santa). Not recommended continued use of medicinal plants. It is recommended to take a few days and stop other days. It would be different, because the medicine always takes [...]. (Aloe).

The detected oscillation is able to further professional industry resistance with respect to medicinal plants, may be a reflection of biomedical training, prescriptive and normative.

It is much easier taking a little tablet and put it down, than catching and every day and tea, because even drinking tea for a while, but no one takes tea a lifetime. Except for pleasure, as the mate we make every day. This changes a lot (Aloe).

In the face unveiled, is no question that the ministerial guidelines for the use of medicinal plants in the Health System advance in relation to the training of the professional sector and the use of medicinal plants as complementary instruments to the biomedical model.

It is important to consider that education could (or should) support the professional practice also in the specific field of use of medicinal plants, as occurs in other areas of knowledge already legitimized academically.¹⁷ Is not here question the progress of the model or blame themselves health professionals, taking into account the impossibility to reproduce something that was not part of their constitutions.

The academic formation originating from a standard work and predominantly curative and rehabilitative activities does not allow the comprehensive care in primary care that incorporates educational health-promoting practices, not strengthens the relationship between user and professional and still restricts individual freedom in the name of health maintenance with behavioral requirements set by imperatives.¹⁰

CONCLUSION

The findings of this study imply address the use of medicinal plants consciously and proactively from the anthropological framework, asking that the popular knowledge may reveal an obscure reality in scientific circles. But not enough to overcome the known resources and validated by clinical studies.

Moreover, together with the implementation of public policies such as the National Medicinal Plants and Herbal Medicines Policy, this study considers that the main actors in the provision of care have been relegated exclusively to the performer plan certain actions at a higher level.

Because of this, one should seek to invest in sensitization that fruitful discussions on the implementation of local health programs, aimed at the cultivation, management and distribution of medicinal plants in primary health care.

In the guise of conclusion, a critical node of semantic networks needs to be undone: the essentially biomedical training. This way can be built ties involving different knowledge and different approaches that contribute to the quality of care, authentic and producer of autonomy, aimed to achieve the reorganization of the Brazilian health care model.

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