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Older Adults and Fall-Inducing Frailty: Bourdieu's Analysis of Field Narratives

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Abstract: The second external cause of death from unintentional injuries is falls in people over 60, a worldwide public health problem. Associated factors are identified early in Primary Health Care. Thus, we analyze professional narratives about older adults/old age and the organization of services in the presence of fall-inducing frailty. A structured narrative was applied under the following stages: understanding the context; setting/plot/character analysis; and interpretive synthesis. Data were collected from August to November 2022, distributing 21 health professionals in three Narrative Focus Groups. In the analyses, the collective conceptions dialogued with Bourdieu's Epistemology of field, habitus, and capital. Among the results, technical and common sense representations of older adults were simultaneously observed, along with the belief of old age as a problematic life stage. Care is centered on the installed disease/ailment. Encouraging autonomy and self-care emerges in integrative health practices, which older adults underestimate. Professionals access the lives of older adults according to their habitus, which, in turn, is structured (structuring) in the disputes for installed capital. Thus, the care provided disregards subjectivities and symbolic systems associated with falls.

Keywords: Aging; Primary Health Care; Postural Balance

1. Introduction

The demographic transition is a global event. It evidences the ongoing population aging [1]. Save for still possible adjustments, the 2022 Census recorded a population of 203,062,512 in Brazil, and people under 30 declined by 5.4% from 2012 to 2021, while the growth curve for the oldest old is very intense. The share of people aged 60 or over hiked from 11.3% to 14.7% in the same period, with 31.2 million in the last census [2], implying enormous social challenges [3].

The demographic change mobilizes many demands but mainly requires understanding the aging process [4]. Besides the prevalent diseases in older adults, facts intrinsic to the illness inflict molecular and cellular damage associated with the gradual loss of physiological reserves and the natural decline in the general capacities of these people to defend themselves against external agents, increasing the risks for all types and causes of accidents, including Fall from Standing Height (FSH) [5,6].

The postural control systems are being suppressed at increasingly higher ages, reducing the compensatory capacity. They can increase balance instability [7]. Clinical characteristics at advanced age point to greater or lesser functional dependence, cognitive impairment, higher frequency of health services, rehabilitation treatments, and permanent monitoring of chronic diseases [8]. Due to these chronic diseases, falls are also associated with older adults taking many medications [9].

Aging is an event of interest to baseline studies (insofar as they allow identifying historical trends and likely trajectories) in assessing the influxes of socioeconomic and cultural inequalities and social stratification in Brazil, the fifth-largest country in the world [10,11]. Clinical problems and social and economic adversities accompany the national population's aging. These ailments aggravate general life conditions, reducing the probability of getting help [12]. The consensus refers

to the longevity framework closely associated with the demand for healthier spaces, better quality of life, and broad access to life protection services in all their scope [13].

In Brazil, healthy aging actions provide for comprehensive care, primarily provided by Primary Health Care (PHC), articulated with care networks, respecting principles/guidelines of the Brazilian Unified Health System (SUS), without, however, underestimating vulnerable older adults' life contexts and existence conditions [14]. The Ministry of Health (MS) defends this premise through the Healthcare Secretariat, Department of Programmatic and Strategic Actions, which guides the implementation of the Line of Care for Comprehensive Health Care for Older Adults in the SUS. The body recognizes that the issue is a priority and declares the need to mitigate the inequalities of opportunities, establishing strategies for better implementation and adherence in monitoring functional ability to offer autonomous and healthy aging [15].

In the same vein, the United Nations understands that the Health sector is the most demanded, with an urgent need to adapt services and qualify professionals to work in primary care, health promotion, and comprehensive care for older adults. A specific UN agenda works toward reducing health inequalities on four strategic fronts: changing the ways of feeling/thinking about age and how social segments operate vis-à-vis older adults; promoting the skills of older people; offering older adult-responsive PHC services; and enabling access to (integrated/quality) long-term care for the older adults' demand [16].

The above justify conducting a survey based on three problem questions: how/what do primary care health professionals feel/think about "old men" and old age? How do services act/organize themselves regarding vulnerable older adults? From the perspective of responsive health services, what actions to promote people's skills apply to the senescent at risk of fall-inducing frailty?

To answer the questions in this article, we understand that PHC particularizes a specific field of economic, intellectual, and symbolic disputes and that, above all, this field does not exist without a habitus establishing it as such (and vice versa). Pierre Bourdieu [17] argues that a field is evidenced by the object of dispute and the power relationship between the stakeholders (or institutions) engaged in the struggle. Thus, PHC is a social and symbolic space, structured in and structuring the SUS, with its autonomous arrangement against other fields in which health equipment is installed. Bourdieu and his science of society provides the best tradition of questioning the reason for a given configuration of the field, bringing a "logic" of its functioning into people's lives, but which is not at the same time "logical" for the culture of the natural stakeholders of the place of the fought struggles, that the author calls habitus.

Research on this theme is relevant due to the motivation to give voice to healthcare stakeholders for older adults, contributing to infer potential structural, cultural, and intrinsic barriers to professionals imbued with the set of conforming PHC actions for older adults; and disseminating findings with the potential to add to the source of references that sustain the organization of practices and public policies to achieve goals in promoting old age with independence, autonomy, and quality of life.

This writing aims to analyze professional narratives about older adults/old age and promote older people's skills, according to the primacy of health services responsive to vulnerable older adults at risk of frailty that can induce falls from standing height.

1.1. The current state of the research topic

Individuals aged 60 or over are considered older adults under the primary documents in force in the country: Report of the World Health Organization (WHO) [18]; Federal Law 8.842/94 [19] and Law 10.741/2003 [20], and other documents that update the topic or that are conscientious.

The WHO [18] points out that this older adult age threshold must, however, be closely related to the socioeconomic conditions of each nation (and, therefore, the estimated life span) in such a way as to subscribe the age of 60 for developing countries, extending to 65 years (more) in the case of people living in developed countries [21].

A systemic growth in size, structure, and distribution of the elderly population is observed compared to other age groups. The population is becoming more urbanized while growing and

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becoming older. The implications of this migratory mobility dynamic from the inland region are catastrophic for urban centers, which still need to prepare themselves [16]. In an article [3], José Eustáquio Diniz Alves, Ph.D. in Demography, declares that never before has the history of humanity registered such record figures and that, from now on, it will reach the total number of older adults in the world, with an aggravating factor that survival in a higher age group is unfavorable to productivity, with different nations needing to face the effects of high dependency ratio between economy and demography [16].

The new demography also triggers an epidemiological transition characterized by particular patterns of morbimortality, placing at the center of events of concern such as the typical disability of aging, geriatric syndromes, heart, and chronic degenerative diseases, and falls from standing height [22–24]. Significant here are the pandemic events that have disproportionately affected older adults and exacerbated any logic attributed to the demographic/epidemiological transition by how the needs of this population segment are responded to, requiring changes [25,26].

Accordingly, gerontology (and social gerontology) is a multidisciplinary science that studies longevity in all dimensions and values and considers qualitative interactions in family and community as a pillar of healthy aging [27]. Thus, efforts based on institutional concepts are anchored for solving public problems more aligned with these movements toward sensitizing the world, achieving social and economic improvements, and, consequently, the health indicators specific to the places where people in the age groups considered older adults live or begin to live [28].

In this context, in its General Assembly report aimed at building inclusive societies for older people, entitled "The United Nations Decade of Healthy Ageing (2021–2030)", the UN called for global and multisectoral collaboration towards concrete actions that promote, in a sustainable way, healthy lives in longevity [16].

What is effectively intended from the health sector are care structures and practices (re)oriented towards close and realistic monitoring of the growing demand caused by the fact that many more people are living longer without necessarily being able to live physically, socially, and economically better [29,30]. In this context, Primary Health Care (PHC) is particularly crucial, given its essential role in mapping risk and vulnerability situations, strengthening/benefiting households/populations in the localities, minimizing existing intercurrences and articulating new targeted public policies, and implementing the already existing apparatus [31,34].

From this viewpoint of resources and public care apparatus, researchers Jesus et al. [35] wrote about the greater frailty of older adults given the context of social vulnerability, suggesting that social assistance and health segments are highly demanded in old age in the presence of vulnerability, besides any other life stage. The term frailty is used as a synonym for older adults, which is why we seek to explain the functional decline and instability that trigger events harmful to health, such as falls, for example [35–39].

Especially when people who age experience their biological decline in poverty, difficulty in accessing information and services, and suffering from other logics of non-inclusive societies [40], an outlook of significant vulnerability emerges among older adults living in communities [37] – This condition profoundly marks the city of Caucaia [41], the primary locus of the present research.

Etymologically speaking, the word "frail" is associated with the extreme weakness of a considered whole, referring to what is easily breakable. The cultural universe is designed so that vulnerable older adults can be assumed frail or at risk of "breaking", becoming a target person of hasty evaluations in the sense of diagnoses and consequent prescription of their guardianship by specialized medical services. There is a tendency to consider that the life context of the vulnerable exacerbates their frailties, adversely affecting human aging [42]. Thus, falls among the oldest old are considered a true clinical-geriatric syndrome of multifaceted origin [39,43].

The event of falls in older adults is described in the field of the greatest frailties of this age group. Reasons for its understanding regarding social harm and family dynamics [44] are listed. Moreover, the intercurrences associated with prolonged hospitalization stays, with a very high risk of death, are of great relevance and interest – classifying falls as a global Public Health problem [45].

We should underscore that one-third of Brazilian older adults fall at least once a year [38,46]. The prevalence of falls tends to increase by around 50% [47] as the years go by and reaching the age of 80. The risk of falling again is around 60 and 70% among older adults who have already suffered a fall, and approximately 20% of this population with a history of falls evolve to death [48] – which has been the object of interest of several studies [9,49,50] with different approaches [39,51,52].

The prevalence among Brazilian older adults is of falls involving fractures, followed by total or partial physical disability [53], requiring closer monitoring of family members and escalated evaluations/follow-ups beyond PHC, overloading institutions of greater technological density of the hierarchical network of health services in the country [54].

1.3. Pierre Bourdieu's Epistemology

Pierre Bourdieu's approach to social facts is unique: the thinker postulates as an epistemological exercise the general reflections around things and events from a broader magnifying glass, which uses different areas of knowledge and varying authors without contaminating oneself [55].

Regarding his epistemology, Ribeiro Valle [56] concluded that a characteristic of Bourdieu's works "is that the critical perspective is very much developed, marked by a deep political conviction, resulting from the following scientific finding: "one cannot explain the social world from old and rigid theoretical models" (p.124). Patrick Bonnewitz [57] argues that no sociology manual refrains from dedicating pages to Pierre Bourdieu's approach and his contributions to the renewal of scientific questioning.

That said, visit Bourdieu's theory of practice or praxeology aims to study social realities from concepts such as field, habitus, and capital [58]. The method is flexible to the association of any instrument and scientific practices to understand the invisible mechanisms underpinning social dynamics and build analysis systems [59,60].

Besides several analyses of institutions [60], Bourdieu developed analyses of social relationships in the most diverse fields (sport, fashion, religion, education, language, politics, and economy) [59]. He realized that no social event occurs in isolation, and the understanding of stakeholders (individuals and people) is only made possible by the "interiorized exteriority" and "exteriorized interiority" – which imply society and the subject in a constant exchange relationship. The interiorized social world changes the individual but also interferes with the social structure, externalizing what its interior is. One understands the individual, understanding society and vice versa [58].

Praxeological knowledge mediates through the dialectical method this dichotomy of the constant relational process between the individual and society – a kind of "epistemological surveillance" of these relationships, conducted under the following basic rules: questioning what is already consecrated and mistrusting classical norms [59].

Regarding practices, "ideas" have interpretative potential, hence the wide acceptance/use of Bourdieu's concepts in different domains of knowledge about contexts and societies [61]. He thus idealized his concept of "field" to generalize social spaces, that is, to make this abstract social world and made, at first, of representations, recognized and studied.

Bourdieu conceives the social world as a multidimensional space that, in turn, is differentiated into relatively autonomous fields, depending on the autonomy of the stakeholders who occupy positions within the field [56]. The struggles/disputes between these field stakeholders are understood, and the trend of reproduction/perpetuation of the mechanisms of domination by the relational type between stakeholders and field can also be attested [59].

As for the concept of habitus, Bourdieu says that it structures from and structures the social field. A body in this social field is historically contextualized, so it can be structured from the "inculcation" of cultural arbitraries (family, school, church, and political parties), also meaning that the past is in the stakeholders' habitus, surviving in a non-crystallized form because it can continuously be molded [59]. The habitus is a system of durable and transferable dispositions, which is defined regarding a field in the sense of what to do or say within it, still at the onset of the "actions" objectively organized

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by field stakeholders, per their specific capitals – thus, not necessarily the product of true intentions [58].

The (economic, cultural, social, and symbolic) capital allows for structuring the field as a social space differently. Somehow, it relates to authority and power. For example, differentiations are relevant to its total volume (of capital), explaining the internal cleavages within the groups that circumscribe people holding the same position but verticalized regarding relational dimensions within the same field/social space [57].

Pierre Félix Bourdieu's concepts are thus endowed with a complexity/potentiality that traverses a wide variety of formal disciplines under the aegis of transversality. Also, given its analytical properties, it is consonant with the processing of narrative representations in this study. It should be used to cover the set of events addressed by it (the study) in analyses.

2. Material and methods

We adopted quality criteria from the COREQ (Consolidated Criteria for Reporting Qualitative Research) and SRQR (Standards for Reporting Qualitative Research) checklists as supporting tools to ensure transparency and completeness of qualitative articles. While the SRQR allowed for evaluating the best synthesis for the results and overall report quality, COREQ describes the focus groups' field, recruitment, and implementation stages [62,63].

2.1. Study design

This is a comprehensive, quantitative, exploratory research [64] from the contribution of Pierre Bourdieu's Social Theory, where the language of "stakeholders" signifies the study participants. It describes part of the results of the thesis entitled Applications of Bourdieu's epistemology to narratives about longevity and primary health care, developed in a doctorate in the Graduate Program in Health Sciences, Collective Health Concentration, ABC University Center, Santo André-SP, Brazil, and is a self-funded study.

The proposed conversation topics allowed us to sensitize professionals to produce narratives close to the research objective. Data triangulation [64] was considered to articulate field strategies, data collection instruments, processing techniques, and theoretical frameworks for analysis [64,65].

2.2. Data sample and collection procedure

Primary Care in Caucaia, a metropolitan area of Fortaleza, Ceará state, Brazil, is organized into six districts, with 80 Family Health Strategy (ESF) teams, corresponding to 86.96% of population coverage. The research was conducted in two Primary Health Care Units (UAPS), also known as Basic Health Units (UBS), popularly called health posts. The UAPS defined for the research are located in districts IV and V of the Municipality. They were selected because they have a population of 22,855 people, 22.5% of whom are older adults [66,67]. The definition of these research sites also considered the easy access and the availability of people to participate.

The field phase occurred from August to November of 2022, considering different moments in which access to spaces and data collection were given to 21 health professionals. The approximation occurred in guided tours by the managers of the respective UAPS, when the professionals were consulted about their interest in participating in the research, and the location of the dynamic in each unit was defined. Next, the negotiation of the participation of professionals started, establishing the days and times that best reconciled with the availability of the greatest possible diversity of workers. The sample was selected by convenience, with representatives of doctors, nurses, physical educators, physiotherapists, nutritionists, social workers, and psychologists. Instead of "representativeness" [64], recruiting these participants prioritized a driving diversity of insights within the group/population under study.

When selecting health professionals, we attempted to hear the voice of the "other" with legitimacy to manifest the world that is his/hers, unveiling of his/her representations [68]. The

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research's eligibility criteria [64] were higher education professionals with experience in PHC, one year or more of practice, and working in direct care for older adults during the research period.

Supported by the principle that people's cultural formulations can be communicated from the narrative [69], several publications [70–72] in the broader area of health – and in Nursing, mainly – make use of the triangulation of Narratives with the Focus Group (FG) to collect qualitative data. In this case, a variation of the Narrative Focus Group interview technique was used [73] when collecting this type of indicator, an innovation based on participatory research designs [71,74].

The literature is very divergent regarding the number of people per discursive session [75], opting to divide the contingent of 21 participants into three groups of seven health professionals and adopting a meeting for each group, which lasted one hour and thirty minutes each. The dynamics of the meetings involved the introduction, the debates per se, and the closing of the works.

The phases of the narrative discussion consisted of preparation, which involves exploring the field and formulating research questions; introduction, presenting topics to start the narrations; central narration, encouraging without interrupting the statements; question phase, without giving opinions or making value judgments, nor making oppositions; concluding statements, when the recording is finished, and "why?" questions are allowed [76].

The portable recording device was placed in a strategic location to capture the voices with the highest quality and that the researcher assumed the moderation of the debates, adopting a guide-roadmap that mirrored the research questions and fulfilled the role of offering the same bases of discussion for the three groups. A new stimulus was given to the group whenever the exhaustion of each subject was perceived. The dynamic that built on the FG characteristics [77,78] allowed all the approached themes to be complemented by many voices [75], creating a space of discussion and substantial exchanges – according to the agreed rules: all should participate; speak one at a time; avoid dominating the discussion; keep the answers within each topic posted for debate.

Acknowledgments to the participants ended the discussions, and it was still time to commit to future feedback on the results. It is also convenient to say that this phase of the data collection work in the field was exhausted when it was possible to establish the investigated empirical framework, considering the criterion of saturation of significant statements when the answers to the research questions were repeated [65], that is, the data were sufficient to support conclusions [69].

2.3. Data analysis

Regarding the recordings and organization of the analysis corpus, verbatim transcription was preferred, faithfully recording everything said [64]. The transcription of the interviews took 25 hours, with unique processing in retrieving the original lines from the researcher's "linguistic filter", avoiding or not allowing slang and dialects that could hinder understanding, noise that did not represent speech, and repetitions due to vices of the language.

Two verification reviews were performed to ensure the reliability of the audio-recordings, and acronyms identified the participants to protect their anonymity from the establishment of the corpus in written text in the second verification. We opted to apply the letters PS to represent all Health Professionals, followed immediately by a differentiating Arabic numeral, so that the first identification received PS-01, in the ascending sequence up to PS-21, per the order of the initial statement of each participant.

The corpus was processed for analysis according to the Gomes theoretical-methodological framework [79–82]. In Gomes' proposal [82], narrative analysis is a method in itself. It was developed to unveil meanings from the world of health care and people's experiences with illness. Therefore, organizing contextualized data around the sociocultural elaborations of disease and health is typical.

In this method, it is crucial to work with meaningful statements, meaning that they are explanatory, purposeful, and comprehensive enough to verify/describe the experienced/perceived reality; or even those that express problems/needs, contradictions/conflicts, and other significant situations from the viewpoint of the "investigated" [68]. The analysis text is narrated in the third person, and the researcher is the "observer-narrator" who (re)tells the stories of the narrators-

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stakeholders (research subjects) and intervenes in them. In other words, narratives are organized in time and space, making connections and building meanings, thus unveiling the narrative web [82].

Interventions should not signify the personal opinion of the narrator-observer. Thus, when inferring, the interpretive lens or reading key is indicated [65,74]. From this perspective, the interpretative syntheses were made through the possible dialogue between the organized narratives and the main concepts formulated by Pierre Bourdieu (field, habitus, and "capital"), complementing the understanding of the context by the various authors who address the theme.

2.4. Ethical aspects

Risks were minimized and benefits reported, and the research followed the process of its ethical implementation protocols under specific parameters [83,84], with authorization from the Research Ethics Committee (CEP) of the Terra Nordeste-Fatene University to enter the field and implement the project, with protocol registered under N° 5.752.849/2020.

3. Results

The sociodemographic profile of the 21 health professionals who formed the focus groups consists of (02) doctors, (09) nurses, (02) physical educators, (02) physiotherapists, (02) nutritionists, (02) social workers and (02) psychologists; (17) were female and (4) male; with a predominant age group of 20-30 years; most of the training occurred in the last two to five years, coinciding with the referred PHC experience. Regarding titles: (08) mentioned specialization, (02) mentioned a complementary elderly health training course, while alluding to the title of master. The fact that only two men participated in the sample suggests a gender bias due to the high degree of female adherence to higher education health courses.

Below are the results supported by the themes that originated the conversations, referring to each issue-problem: the meanings about being old and aging triggered by the professionals' narratives; the organization of work at the UAPS related to vulnerable older adults; and health services responsive to risk factors for falls among older adults.

3.1. Being Old and Aging - senses triggered by narratives

For the stimulus offered to the FG, the professionals were invited to talk about their previous knowledge, everything that was apprehended or experienced, and that made them create or recreate representations. In this regard, the following narratives are retrieved:

Old age is a natural course of human beings. The person is born, becomes a child, teenager, young person... Until old age. It is a stage of development with its specificities and that, within society, this stage receives much attention from the health field. Many academic works focus on this phase of life. (PS-06).

In graduation, at least in nursing, we see the stages of life a lot, and in one of these stages, we have disciplines on elderly health. In these, we see a lot about the diseases of this stage of life. We don't usually see or study healthy older adults. So, the graduation course focuses on treating pathologies in older adults. (PS-03).

We should say that one narrative influences another in group dynamics, shaping representations and favoring or prevailing plots whose vocabulary is technical/academic, or refers to the time of higher education, to what they learned from older adults through specialized literature, referring to the representation of old age as a pathology.

As they keep talking and listening, professionals tend to migrate the discourse and, in the examples of narratives below, they signal that they will detach themselves from this academic universe to delve into common sense representations – which is what this study pursues:

About old age... When you look and listen to the typical person talks, you hear that the old 'is no longer good for much'. Now, as a physiotherapist – and I already have a perspective that may differ from other professionals

– I learned not to look at older adults as if they 'were no longer any good'. I was taught to look at his capabilities and work with this. (PS-08).

I think that, to a certain extent, before graduation, the perception is very negative (referring to older adults) because old age already brings this nomenclature of old, outdated, that is no good any longer, that which you no longer use because it's old and worn out. We work on this new perspective of old age and aging throughout our graduation in psychology. (PS-10).

In this regard, some health professions can produce favorable representations, especially those that understand the comprehensive being, while others, disease-focused, tend to maintain stigmatized representations. Complementary lines emerge, and the highlight below shows how the narrators start to detach from them this negative perception about older adults and old age, starting to infer it as a problem brought by the older adults into the therapeutic relationship:

What I see in my office is that, for many patients, aging is synonymous with suffering. I see a feeling of hopelessness. I see this older adult with very negative statements: "My life doesn't matter anymore, my children don't care about me anymore, and society doesn't care... And I've done everything I had to do". It's as if, for him, life is already over. (PS-18).

There is a considerable stigma related to older adults and old age. It (referring to old age) is considered negative [...]. Because people don't want to reach that age, and it's because they feel the weight of negativity that accompanies representations: becoming dependent on other people, start moving less... (PS-12).

We interpret from the statements that the common sense representation impregnates older adults with its negative burden and because it conforms to a thought in elderly patients with some health impairment. That being the case, when formulated critically and reflectively, the representation expressed by the health professional will likely help the patient reframe this harmful self-representation. In the highlight below, the nuance modifies or reclassifies the narrative under the protection of social slogans:

Old age is a stage that could be healthy, which could be the "best age"... As they say. However, in my practical experience, I see that little (PS-18).

It is called the 'best age' but is rarely perceived that way [...] (PS-19).

This mode of representation is said to conceal a real/personal feeling, that is, one is facing (pre)understandings consciously or unconsciously inserted in the narratives [68,85]. Furthermore, the content of this representation denotes a belief that there is greater potency/power of other age groups regarding old age, so being old is understood as a disadvantage from this viewpoint.

3.2. Perception of PHC and organization of work related to vulnerable older adults

Due to this classification system, the data block related to the PHC services is available: how they are organized and the perception of effectiveness, considering the older adults' demands. The analysis follows the logic of the order of data produced according to the stimuli: "talk about the professions in place and involved in care; address the available services/resources; and which strategies are used in health education and promotion":

We are a multidisciplinary team with different emphases. So, each emphasis contributes according to its specificity in elderly care. We organize ourselves, therefore, to perceive their demands in a way that each professional category will have a perspective and, through listening, will perceive the main demands that each professional participates in (PS-11).

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It is very enriching and advantageous to have a whole team to assist older adults because they (older adults) listen to various subjects, and they learn, absorb and pass on to their families and neighbors. Furthermore, like it or not, we bond with that user, and the user starts to trust the professional more. When guidance stems from a professional that is fine-tuned with the older adult (the bond), they end up absorbing it and starting to put into practice what they were educated, taught to do (PS-04).

I'm from the multidisciplinary residency. We can see the importance of each knowledge and how much knowledge complements each other. There is no way to talk only about nutrition with older adults with a whole life behind them... It's not just food. So, we complement each other a lot. That is why the multidisciplinary residency program is so essential (PS-15).

When narrating about the modality of multidisciplinary care, the agents recall the importance of complementarity of knowledge, besides mentioning some of the pillars of the therapeutic relationship, such as creating bonds and establishing a relationship of trust between professionals and older adults. However, only the former narrates about listening to older adults, whereas the vector is the authority of health professionals toward older adults in the others. Moreover, FG workers hold a uniform type of discourse regarding the purpose of the teams. They continue to expose the most known/disclosed design of multidisciplinary practices and the meanings attributed to the need and reason for the teams' existence. Again, regarding the organization of their work with older adults, the workers remember their respective actions:

I also work in the guidance of rights. In some cases, the older adult is sick and suffers from property violence, sometimes without even knowing it: this is violence in which older adults do not access their money, although they are oriented/aware. We also have moral violence and negligence – even negligence that occurs in a specific institution and, therefore, they need to know their rights and where to claim them. (PS-07).

My professional knowledge can sometimes help with the most essential nutrition information. So, I believe that the basics that I talk about food already interfere a lot with their health and diet… They start to understand. (PS-08).

Since the Alma-Ata declaration, one of the greatest references in primary health care, Brazilian health reform scientists have concentrated on the need to project the role of health teams [86]. The very SUS was established as a project not limited to a single sector, incorporating the ideas of integration, territoriality, and social participation, to guarantee rights in the context of an expanded concept of health. Given the complexity of real life, one would assume joint work with other areas and fields of knowledge to think about/implement changes impacting the causes of illness [87].

From a somewhat myopic perspective of health professionals, no reference has been made to the intersectoral network and the cross-sectoral approach in integrating knowledge/experiences for case management [88]. Thus, the statements reflect the services in the better-known and consolidated format: fixed structures, local stakeholders, and strict care protocols. Only two narratives come closer to describing what human complexity is in primary care:

Regarding nursing, you end up seeing everything. That is, you will be able to access more information and that patient more and more in its most comprehensive form as you interact with that patient: the social issue, the issue of medication use, diseases, family history, the relationship with the partner, anyway. [...] We gradually realize these things with the office practice or bond with the family/patient. You try to clarify and start directing the care to the specificities of a patient... Furthermore, understanding that one person's need is not another's, right? (PS-12).

In primary care – especially when working with the same community for a long time, serving the same population and families – you can look at a family core. It is not just looking at that patient sitting there, but you remember that the day before, you served the pregnant granddaughter of that older woman. You know that the granddaughter lives with her... So, you will understand how the network works, which even favors your

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understanding of that patient's family and social context. […] As you exercise this knowledge in your clinical practice, you become more and more prepared to identify certain issues and (try) to solve them. (PS-06).

We should remember that the field occupied by PHC, in its larger Family Health Strategy (ESF), proposes that the work be developed to promote ordinary people to the condition of reading realities so that they can assess what is best for them. They decide based on the best consensus (considering personal and community resources), and that is what autonomy is about, whose most evident strategy is encouraging people's self-care in health. However, this was only heard of now.

Continuing with the FG, in the stimulus given to address the strategies used in education and health promotion, there are the following examples of narratives:

Primary care should have a lot of this prevention, health promotion perspective... (But) It doesn't have much of a preventive perspective. (PS-14).

This health promotion and prevention issue is in the background, and we serve a tiny audience of older adults for this purpose. (PS-17).

It's hard for us to find someone here, an older adult who comes here purely for health promotion, right? I see more already in the part where we have to solve something. (PS-20).

Derived from these narratives was the insight for the FG to address older adults' representations regarding PHC spaces. The narratives produced will reveal that, besides PHC not remembering to use intersectoriality and partnerships with other social equipment in the region to offer health promotion activities for older adults, its professionals will complain that they should know/do prevention or the movement to seek help – with little or superficial understanding of the condition of vulnerability to which older adults are exposed.

Most people seek the Health Center more often when they already have a health problem. It's more about medication. [...] the hypertensive, the diabetic... who come more for medical appointments. (PS-14).

In primary care, older adults seek the service more from a more curative perspective, more for recovery when they already have a health problem. (PS-17).

When he comes, he often comes with depression, anxiety, and dependence on psychiatric medications. (PS-18).

I've been following that, increasingly, people look for the PHC Unit, the health service, when they already have something acute. It's much more problematic. When people get here, it's already an emergency. So, the people who followed up here only look for the health center when they have urgent needs. Then, unfortunately, we have to work on this demand, always trying to guide. Sometimes, it even frustrates us because it's almost as if we were trying to solve something that wasn't in the past. (PS-20).

The perception is that patients "do not perform" the promotion/prevention actions, only seeking PHC when "they are already sick". Still, in the health care spaces, the patient, the older adult, is a character seen as accumulating doubts, someone who is unaware or does not know (about his illness and care and medication use), needing the health professional to behave better.

We should remember that PHC is part of the larger field of Collective Health, which, in turn, dates back to the founding principles of Social Medicine practices [89], through which it is considered to broaden the vision of older adults, to alleviate the weaknesses/vulnerabilities of this population group in the face of adverse events, with measures to monitor social and economic conditions so that they live with better quality, have healthy habits, and interact with social networks for more autonomy and independence, reducing the biological harm that incapacitates older adults [90–92].

Next, the narratives add the "ingredient" of vulnerability, talking about older adults' lack of formal education, local violence, and other risk indicators for illness. Everything comes to the detriment of the more coherent frequency routine of older adults to health services:

Due to a lack of formal knowledge (I think this is a striking factor in this population), these people often do not know that they need to undergo a routine examination; they do not know how to relate a headache to high blood pressure... Thus, they end up in the emergency room. (PS-07).

I think aging here is more complicated due to vulnerability. I think that's it: a tiresome and suffering aging, full of violence; therefore, more passive aging in self-care, less active in the presence of support groups... (PS-11).

Due to social conditions, society and the family do not offer support... So, they only come to the health center when they already have something chronic. (PS-12).

At the very least, these statements bring potential reflections to subsidize lines of necessary changes and (re)orientation of clinical work in Public Health aimed at older adults. Regarding the excerpts reproduced, one habitus function is to account for linking the practices and intangible consumer goods of the individual stakeholder or the group of stakeholders [93], and this is not precisely related to formal education but stems from previous experience. Thus, what happens with the problem of the consumer good represented by health is that it is more like a discourse in the moral-cultural scope than it can express a concern accompanied by practical actions by public power entities to transform it into possible mass consumption [94–96] – and the general population assimilates this. Older adults who experience several other needs can also accumulate negative experiences with healthcare in such a way that not seeking the post early is just a hesitant behavior in the face of obstacles.

It is difficult to argue in favor of a Universal Health System in the context in which it is reduced to a mechanism for caring for people experiencing poverty [95]. It is not uncommon for health posts to experience problems (some of them chronic) lacking professionals, medicines, devices, and essential services. There needs to be more bureaucracy and significant delays in performing services. Jairnilson Paim thus speaks of the "risk of dismantling the SUS" when, in government policies, health is a peripheral issue [95]. Regarding health service shortcomings, we should note two particularly revealing narratives:

We have from very active older adults [...] to the bedridden patient who cannot come to the unit. We have those who come and report a fall: they fell in the street, on the way to the doctor's office... Or they complain of some other problem. We access and intervene as the patient shows himself to us as he talks about his difficulty. (PS-06).

That time and the number of people we serve do not allow us to sit down and discuss everything with them. We attend 17 in the morning and 17 in the afternoon, plus triage. We need to find a way to sit and talk about everything. Our time is rushing. Furthermore, it's not getting any better. (PS-21)

With these narratives, professionals reveal the prevalence of problem-based care and make clear their working conditions and demand, showing that they also need to deal with their yoke and limitations. The narratives of professionals who addressed the theme of older adults in their relationship with their families remember that every family lives the reality of the vulnerable. The plot built was that older adults are found in the settings (homes and communities) taking care of relatives, children, and grandchildren, always with a bias towards family contexts that are fewer partners and more incomprehensible:

Older adults are there supporting the family financially and with food. They support raising their grandchildren, too – they take care of them so their children can work and have a productive life. (PS-08).

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Sometimes, older adults are the only provider in the family, and they sacrifice/neglect their care. (PS-09).

Some older adults are overloaded: they must cook food for their children and grandchildren. Sometimes, other relatives come in for lunch. They feel responsible for this... (PS-12).

Some older adults are there with a child on drugs, and they must put up with it. (PS-20).

Besides the older adult issue, what transpires in these narratives is a sick social system with no perspective and little capacity for self-elaboration. Perceptions about the low presence of men (and male older adults) looking for care will be elucidated in other narratives:

I attend to older adults and see a gender bias: women look out for me. (PS-12).

It is infrequent to see a man. [...] They only come to seek treatment when the disease is already settled (PS-13).

Men voluntarily seeking the post is almost inexistent and is very rare indeed. (PS-19).

According to surveys [97,98], women (including older women) are concerned with general care practices for several reasons, but mainly for resolving the health of other family members. They also accept invasive exams better and are more responsive to the biomedical discourse as a device for controlling "the sick body". Whether this is recognized as cultural, it is still demarcated by professionals, besides gender bias, ethnicity, social class, and education as variables that deserve attention from PHC professionals:

Within the range of women I see, we should add that they are also poor, less educated Black women. (PS-13).

Women with a vulnerable profile living in Caucaia suffer daily from public disrespect and the most diverse violence forms, and it is the municipality with the highest occurrence of femicides in the State of Ceará [99]. We should ask the health services to mention which measures are taken towards the empowerment of these women since the combination of factors and contours of structuring poverty produces oppressive contexts and a specific type of historical racism, very intertwined with stereotypes, highlighting, of course, invisibility as its social capital.

3.3. Responsive health services and risk of falls among older adults

The following narrative is highlighted regarding the factors associated with systemic imbalance with risk of falls among older adults:

The problem in old age begins with the motor issue, walking alone. Because some will have Parkinson's, others may get diseases in their hands, including Chikungunya – many are in much pain, unable to do simple manual activities. We have motor difficulties, the issue of the senses (vision, hearing, smell). Sensitivity is reduced in all of this with advanced age. So, to chew, they lack teeth; vision is lacking to see things well; hearing is also poor. Walking alone is complicated: they don't hear a car horn or may not feel other dangers. If they fall, they have other problems walking, moving, and preventing them from falling again. (PS-17).

When it comes to falls, the architectural factor of the city was remembered along with others that make sense to address the affected systemic balance, including socioeconomic factors:

The architectural issue, the city, the place where he lives, and the issue of sidewalks. All this has to be considered when talking about falls in older adults. The path that they take to solve their activities is difficult to access. This will interfere with possible falls. (PS-07).

These older adults are not taking care of themselves. They don't exercise. They don't eat right – they are eating poorly. Many of them are eating instant noodles and junk food. (PS-08).

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Lack of food or poor quality can cause weakness, muscle pain, inflammation, and even increased blood pressure. (PS-20).

According to the statements, it is possible to state the narrators' reaffirmation of old age as a phase of life to manage cognitive and physical weaknesses/limitations in the face of their environment, food and economic difficulties/deficiencies, and complex family relationships. Other representations come as voices from the field: they are professionals with home-visiting practices and will approach the theme from the perspective of this universe:

Numerous factors interfere with balance and the possibility of falls in older adults. When visiting the family, we have to see the physical and human structures inside the home: if the home has a built-up area at the bottom and the top; if there are any rear areas (backyard); how many people reside; if we have children who will leave a toy on the floor; whether it has bathrooms with facilities; anyway... Sometimes, older adults do not control their blood pressure with medications. They only take them when their pressure increases and they still eat inadequate things – according to them, because 'the money is not enough'. (PS-20).

Older adults at home may slip and fall in the bathroom. Even food, because not eating well, can make you feel dizzy and have an imbalance. The use of medications is also a problem. With the increase in anxiety and depressive disorders, patients start taking a little medication to sleep and become number, which can contribute to that. (PS-07).

Among the central points pointed out as risks of falling are the "non-adapted" housing conditions for older adults, the intergenerational "care overlap" of grandchildren, besides the side effects of the concomitant use of medications. Regarding primary health services responsive to older adults, therapeutic groups are remembered as strategic actions to determine a "healthy aging", as the stakeholders-narrators point out:

The issue of healthy aging… I want to mention the issue of groups held to keep balance in older adults and avoid other complications. The CRAS (referring to the Social Assistance Reference Center) and us here have physical activity work. In short, this type of more bodywork and health education can be done to help prevent it. (PS-13).

In socialization groups, we usually do many health education actions besides interprofessional appointments, where we help each other and complement each other to observe this older adult holistically. (PS-12).

The specific literature [89–101] discloses the fact that each profession in primary health care, with its particular knowledge, underpins or forms the pillar of therapeutic plans or expanded projects of "interventions", which insinuates that all knowledge is cross-cutting and interchangeable in these interventions [102]. From this perspective, most of the narratives that address "therapeutic groups" reinforce the characteristics that they originate from the sum of professional talents to diagnose risk and initiate cycles of promoting a healthy life or minimize harms associated with morbid events, anticipating their effects on the daily life activities of older adults. Thus, the workers' FG were urged to address interdisciplinary interventions and integrated therapeutic plans from the perspective of institutions responsive to healthy aging:

Older adults come for more than just lectures here, but for therapies: Reiki, auriculotherapy... They manage to relieve their anxiety. [...] It's even a way to leave the family environment, where there is so much stress, to arrive in an environment where they can talk, feel welcomed, and be well cared for. (PS-05).

We have a group here called Healthy Life. Older adults feel more alive in this group, with the power to speak and use their widespread knowledge... This group gives them a voice and nurtures their social and community relationship. (PS-08).

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We have projects here: Pilates, Yoga for ladies, for example, which greatly help. They won't cure, but they will help somewhere. (PS-12).

Some do Pilates groups, and others also participate in NASF older adults' groups or attend CRAS elderly groups... So, many have this engagement spirit (PS-20).

We note narratives suggestive of integrative and complementary health practices in PHC, suggesting an openness to understanding older adults in their entirety, including considering the context of receptive coexistence so that they can express themselves in a safe environment.

The PHC philosophy itself provides for the achievement of some independence and autonomy for older adults by promoting the inclusion of these people in therapeutic groups or unconventional practices, characterized by being distinguished from biomedicine by not focusing on medication, being low-cost, integrated with family and society, and put the subject in an active position regarding his care [103].

4. Discussion

Mainly Bourdieu's General Theory of Fields[104] – since the analysis of health events still lacks theories from the social sciences –, applied with Gomes' analysis method [79–82], underpinned the type of dialogicity/debate of the narratives, safely addressing the theme of aging, making clear the intellectual capital for each professional within the PHC [105]. It should be stated that local disputes stand behind all intellectual capital, expressed by the offices and positions of power that demarcate the field where the hierarchy of authorities/power is made explicit[106].

In their narratives about how they feel and what they think of older adults, at first, the professionals speak based on what they learned in disciplines in the training courses – and for this reason, the type of narrative established is impersonal and precautionary against setbacks of any expression likely to offend, exclude, or marginalize this group of people. We understand that the universe of formal learning allows stakeholders to safely address the issue of aging while making clear the intellectual capital set for each one, also delimiting respective powers (or lack thereof).

However, it was necessary to overcome this FG phase, encouraging the narratives to migrate to subject (or group) conceptions about old and old age that were closer to the social relationships investigated – the statements had to reflect the set of opinions/values of the stakeholders-narrators who, in turn, determine their conduct/behaviors vis-à-vis older adults. Narratives about old and old age closer to the investigated social relationships emerged from the stimulus to the group. That is when the narratives in which old age is referred to as a bad phase of life emerge when people lose their usefulness for the family and social life. There seems to be (consciously or unconsciously) a perception accompanied by the stigma that being old is not good or "no longer good for anything", in such a way that older people may prefer not to identify with the old or will try to hide the marks of age in every way. In the narrated PHC setting, it can be said that this habitus structures (and is structured by) a mental mode of representation, enabling to perpetuate non-positive practices toward promoting skills in senescence.

From the preceding, we should remember that elaborating an identity involves different sociability processes, serving as an example the social self-elaboration [107], and all healthcare workers should be concerned with any view of older adults as "no good".

Furthermore, the perspective of a health service responsive to the frailty of older adults also comes toward the sustainable promotion of changes in the ways of thinking about age, including acting upon the older adult author-prejudice [16]. In order to debate, we should remember that people have already lost almost everything they could capitalize on in terms of power (job, income, possessions, relationships, and socially recognized knowledge) in the older adult life phase, which will condition their lifestyle and opportunities [17] – this should be included in the structured (and structuring) plan of the necessary social changes.

The narrator stakeholder will also stand out for statements about old age such as "it's called the best age, but it's not perceived that way" and "it could be healthy, but I don't see it that much". At

this point, we observe contradictions, as evidenced by affirming something denied in the same argument. When contradiction or opposition occurs in a discourse, linguists say that it (the contradiction) will be seen as a failure. Thus, a principle that governs the choice, vision, and representation of the world under the tendency of this type of conclusion (so-called monologic) is the expression of one's thoughts aloud [85]. Therefore, for this research, it is crucial to identify the narrators: Who are they?

Of the variables listed during the characterization of the agents participating in this study (category of health workers), in the composition of the Narrative FG, young women aged 20-30, with an average of five years of training and a minimum of two years seniority in the PHC prevailed. These data and the directions taken by the discussions lead us to assume a line of interpretation that the entire set of statements on the agenda should be considered more for what the narrators hide and less for what they reveal: the tendency of this younger, female professional contingent to prevail in PHC elderly care, influencing the social order of this field and implying a new attitude/perception of the sick body and interpersonal relationships, since women are more culturally dedicated to caring for others.

On the other hand, if it is a young woman's choice to train in a health field, it is not necessarily her aptitude or even a choice to start her work activity assisting the human segment of older adults age group, which may trigger dissonances [108] by the gestalt that the care relationship facilitates.

The dissonance between personal values and work tasks is one of the leading causes affecting the mental health of health professionals [109]. It stems from the stress of professionals believing that the work environment somehow threatens their status quo with excessive demands or that they (workers) do not identify or have cognition contrary to the impending demands [108].

Complementing this reasoning, we also see a growing number of young people from underprivileged families [110] taking higher education courses. Pierre Bourdieu understands that it is how the popular classes compensate for their disadvantage in the face of class culture [17].

Concerning the meanings attributed to the professions present and involved in assisting older adults, workers recognize and value the strategy of sharing cases and knowledge in multidisciplinary health teams. The public policy prescribes multidisciplinary work for Primary Health Care [111], including visits to homes and communities – both the suburban environment, when it comes to cities, and the most remote corners of access in the country – imbued to solve the most frequent and relevant issues for the populations of the territories where they settle [76]. They pursue indicators and variables that imply combating the emergence or deterioration of morbid cases, thus preventing populations from needing institutions of greater technological density in health, where care is depersonalized, with high risks (in particular for older adults), and with costs much more significant for public coffers [15,94].

We take here, as a reference, the reading made by Ecléa Bosi [112] in the context of the research and adapt it to the subject at hand in order to think that professional interventions (and the experience of the care relationship) are all the more valid for older adults as if the professional (observer) does not make "sanctuary excursions" in the situation of the older adult (observed). Collective Health [113] addresses the subject as "an honest dive" into the universe of clients, which in this study refers to (re)visiting with an ethical attitude the fields of PHC practices and the daily life of older adults to absorb their knowledge and customs, real-life conditions, participating in experiences, getting closer to the local culture, creating bonds and consolidating an understanding of "which", "how", "with whom", and "when" to solve or mitigate problems.

However, returning to Bourdieu [114], when he addresses those "included in the field", this author speaks of stakeholders as being favored individually by the volume of their capital (which is of the most diverse natures). In the name of this capital, these stakeholders tend to perpetuate dependency relationships to preserve the field, representing domination modes: fixing stakeholders in a pattern, creating and keeping the idea of a "need" for some vis-à-vis others. Referring to PHC spaces, each stakeholder is taken by this logic intrinsic to the position/profession in such a way that all, under their intellectual capital, act to preserve their position or status in a field of practice. The more stakeholders occupy a hierarchical space in the field, the greater their power, the more they will

work (they will be willing to fight and exercise dominance and control) to create dependencies, tame (develop acceptance) others who occupy more disadvantaged positions of the structure, sustaining the chain of submission, and this process is, to a certain extent, unconscious.

However, they demarcate a change in the knowledge-power paradigm, strategies such as therapeutic circles, foreseen to take place within PHC – as spaces for the democratization of knowledge, with users and professionals, in general, participating in them under the prerogative of the case study, formulating an integrated healthcare project [89,100,115,116]. The professionals in this study brought this theme to the FG when they addressed professions in PHC, adding potential and sharing knowledge within therapeutic groups and integrative/complementary health practices, the PICS [103].

We should demarcate the realities or examples narrated in the FG of this study. However, the stakeholders do not exceed the conscious knowledge, finding the ways of thinking/organizing (each according to a particular symbolic capital) the collective health practices [117] in the more traditional and structured practices. Hence, the strategies mentioned for PHC (with the nature of help groups, therapeutic groups, or even alternative practices) prescribe actions of the same "formula" for different people, anchored on the assumption that "each" experiences similar situations and life content.

Most stakeholders-narrators remember the therapeutic groups, but, above all, think about the modus operandi prescribed for this health field, circumscribed by the PHC. Furthermore, the list of interventions listed by health professionals to work on promotion and prevention, and those interventions envisaged for the interior of the older adults' homes, tend to disregard or not listen, not consult this target population about their preferences, beliefs, knowledge and practices, and even their belief or symbolic systems. Therefore, professional practices can be understood as arbitrary, reflecting the limited scope or non-adherence identified/declared.

We consider that the structure (with all functions) of the culture of one field does not have to be reduced from any universal (physical, biological, or spiritual) principle by the culture of another. If the opposite occurs, there will be a field where older adults live, not where UAPS professionals work. This will also be a source of eternal disputes, regarding which only the PHC as an entity would promote the encounter between the fields, making them (con)fuse.

Thus, the examples of strategies mentioned were designed to bring older adults into the service, with fixed facilities and scheduled times, service protocols, and an object demarcated, originating from each individualized perspective: of the physical educator, the physiotherapist, the social worker, and the psychologist. In this way, aging for health professionals in the UAPS is defined by biofunctional and form changes [118]. While the functional capacity of older adults can be approached per the difficulties or even lack of skills to perform certain activities of daily living, the morphology informs bodily changes, resulting in instability, decreased strength, and postural changes that affect gait and balance.

The systemic effects of biochemical aspects of aging are also implicated in mobility due to the neural regulation of the center of gravity and, among others, the reduction of bone and muscle mass [119]. Thus, fragility and vulnerability were associated with difficulties in accessing prevention and treatment services (involving the city's architectural problems and economic, cultural, and physical/biological factors), abandonment of older adults, lack of family and social support (social/relational dimensions), and medication side effects.

The apparently rigid structure behind this behavior forces some to adapt to what is predestined for the health field. In other words, care and actions are prescribed for the health of older adults. However, they do not necessarily consider all the conditions of the life dynamics of this specific population, with their intrinsic frailties, in households with modern and diversified designs and, in particular, living in communities more vulnerable to mobility (through alleys and bumpy streets), access to resources (scarce and in dispute), physical risks (associated with parastatal power disputes)[99,120,121] – of which the Municipality of Caucaia is an example, but not the exception in the country.

5. Conclusion

The narrative focus group achieved its objective of giving voice to stakeholders and establishing an understanding of settings, plots, and characters. They also began to reflect on the mechanisms that move the PHC context while leaving clues of their perceptions of older adults, beliefs about the organization of services, and more ingrained practices.

The negative reification of the representation of older adults by most health professionals participating in the research is closely related to the apprehended, experienced, and projected representations of themselves. Instrumentalized by this bias, the stakeholders-narrators can perceive, making associations with the causes of the primary suffering of the elderly population – including concerning older adults' needs to adapt to their new reality and demands of modern family arrangements. However, health services continue to focus on resolving "complaints".

From the tradition of behaving and presenting themselves in response to walk-in demands, PHC professionals treat patients and illnesses. The offered therapeutic spaces (or groups) function as a formality, thus perceived as a political locus for the control of all bodies and submission of all lives, with little margin for moving stakeholders within the field given by the institutionalized field.

Although the field comprises many intellectualities (multidisciplinarity), primary care is not structured according to the stakeholders but encompasses all the stakeholders of that specified field. So, diseases related to longevity, the risk of falls, and other conditions progressing to death are treated by stakeholders according to the incoming demand and in the context of routines and access protocols, approaches, and treatments.

This type of analysis, also based on Pierre Bourdieu's key concepts, allows other interpretations of the PHC view as a primary space of power relationships and permanent disputes for better positions in a given hierarchy. The very criterion for organizing the services consolidates a general formula of domination, while the interventions on the sick body give rise to status and power. The health field is designed as disciplining spaces full of valuable and docile bodies to produce political responses to "diseases" as social ills.

We should point out the need for new (longitudinal) studies that also involve older adults to understand the influences of this growing trend of young women being attracted to health courses, graduating, and starting to work with older adults in PHC without necessarily having an aptitude that defines their best practices. Thus, historical verification studies are also very relevant to understand the cultural aspects involved in creating and transforming the concept of health that governs practices.

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