HEALTH-DISEASE PROCESS AND QUALITY OF LIFE OF THE MULTIPROFESSIONAL RESIDENT

PROCESSO SAÚDE-DOENÇA E QUALIDADE DE VIDA DO RESIDENTE MULTIPROFISSIONAL PROCESO SALUD-ENFERMEDAD Y CALIDAD DE VIDA DEL RESIDENTE MULTIPROFESIONAL

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ABSTRACT

Objective: to reflect on the relationship of the Multiprofessional Residency in Health in the health-disease process and in the quality of life of the resident health professional. **Method:** this is a qualitative, reflexive type study. Refers to the collection of data to a documentary research and literature review with search in the databases PUBMED/MEDLINE, LILACS, and SCIELO virtual library with 16 articles submitted to the analysis. **Results:** the categories "Legislative conditions of residence and the interface in workers' health" and "Residence versus quality of life" stand out. **Conclusion:** negative conditioners on residence can be seen that can influence the resident's illness. It is hoped, however, that this research will contribute to generating subsidies for both public policies on residence and material to improve the internal regulation of the courses, policies that offer guidelines that favor the development of good practices in training and health. **Descriptors:** Non-Medical Internship; Worker Health, Quality of Life; Professional Exhaustion; Professional Training; Specialization.

RESUMO

Objetivo: refletir sobre a relação da Residência Multiprofissional em Saúde no processo saúde-doença e na qualidade de vida do profissional de saúde residente. **Método:** trata-se de um estudo qualitativo, do tipo reflexivo. Refere-se a coleta de dados a uma pesquisa documental e à revisão de literatura com busca nas bases de dados PUBMED/MEDLINE, LILACS, e biblioteca virtual SCIELO com 16 artigos submetidos à análise. **Resultados:** destacam-se as categorias "Condicionantes legislativos da residência e a interface na saúde do trabalhador" e "Residência versus qualidade de vida". **Conclusão:** percebem-se condicionantes negativos sobre a residência que podem influenciar o adoecimento do residente. Espera-se, porém, que esta pesquisa contribua para gerar subsídios tanto de políticas públicas sobre a residência, como de material para aperfeiçoar o regulamento interno dos cursos, políticas essas que ofereçam diretrizes que favoreçam o desenvolvimento de boas práticas em formação e saúde. **Descritores:** Internato não Médico; Saúde do Trabalhador, Qualidade de Vida; Esgotamento Profissional; Capacitação Profissional; Especialização.

RESUMEN

Objetivo: reflexionar sobre la relación de la Residencia Multiprofesional en Salud en el proceso salud-enfermedad y en la calidad de vida del profesional de salud residente. **Método:** se trata de un estudio cualitativo, del tipo reflexivo. Se refiere a la recolección de datos a una investigación documental y a la revisión de literatura con búsqueda en las bases de datos PUBMED/MEDLINE, LILACS, y biblioteca virtual SCIELO con 16 artículos sometidos al análisis. **Resultados:** se destacan las categorías "Condicionantes legislativos de la residencia y la interfaz en la salud del trabajador" y "Residencia versus calidad de vida". **Conclusión:** se percibe condicionantes negativos sobre la residencia que pueden influenciar la enfermedad del residente. Se espera, sin embargo, que esta investigación contribuya a generar subsidios tanto de políticas públicas sobre la residencia, como de material para perfeccionar el reglamento interno de los cursos, políticas que ofrezcan directrices que favorezcan el desarrollo de buenas prácticas en formación y salud. **Descriptor:** Internado no Médico; Salud Laboral; Calidad de Vida; Agotamiento Profesional; Capacitación Profesional; Especialización.

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INTRODUCTION

The Unified Health System (UHS) was instituted as of the Federal Constitution of 1988 and it was regulated by Laws 8,080/90 and 8,142/90. By its principles and guidelines, it aims to ensure that the population has access to health in an integral, egalitarian and resolute way. In the effective development of the UHS, however, many obstacles are faced, and reorganization of the entire health system is required, mainly requiring changes in training and professional qualification.¹ In the various attempts to approximate education and health policies, multiprofessional residences in health, or non-medical residences, were created in diverse formats.²

The Multiprofessional Residence was created based on Law No. 11,129 of 2005, recognizing it as a *Lato sensu* specialization and considering it as one of the proposals for education through work,² since it is a cooperation between the Ministries of Health and Education designed to favor the qualified insertion of health professionals in UHS.⁴ The objective of this study is to establish regular funding for the Multiprofessional Health Residency Programs in Brazil and to invest in its pedagogical and political potential, to enable both the training of professionals and to contribute to the change in the technical design of the Unified Health System (UHS).³

The Multiprofessional Residency is organized by a Multiprofessional Residency Commission (COREMU), which presents autonomy for the production of an internal regiment, but it must comply with Law 11,129/2005. In this way, characteristic conditions can be presented in each region or institution. According to Resolution No. 5 of 2014, the multiprofessional residence has a total workload of 5,760 hours, of which 1,152 hours (20%) are intended for theoretical or practical-theoretical activities and 4,680 hours (80%) for activities 60 hours a week with at least one weekly day of rest and duration of two years, in addition to requiring exclusive dedication.⁴ Therefore, the value of the fellowship to the resident health professionals of R\$ 3,330.43.⁵

The Multiprofessional Health Residency program is based on the interaction between the subjects and on practice-based learning, which promotes and produces meanings in the world of work.³ It is known, however, that working conditions are strictly related to the process of sickness of the health worker.⁶ For this, work can be used as a mediator for health when it brings to the professional a construction of achievement for itself, thus

increasing the subject's resistance to the risk of psychic and somatic destabilization. Work, however, can also work to destabilize health when the work situation, social work relations, and managerial choices permeate suffering in the pathogenic sense.⁷

It is believed that suffering occurs when the expectations of the worker are not considered, that is, when, in the result of the relation of the man with the work activity, the shock occurs between the personality of the individual, his individual project and the prescription imposed by the organization of work. Happiness, however, occurs when spaces exist for the expression of subjectivity, creativity and the development of potentialities of the worker.⁷ It is now realized that the denial of psychic suffering in the world of work is still quite evident and interventions often have the objective of making up the suffering and psychic issues, either they are disregarded, or they are embedded in a logic strictly medicalizing.⁸

The Multiprofessional Health Residency is generally centered in a hospital approach and, thus, the degree of requirement to which the resident is subjected is very large, in addition to the various circumstances in which the resident is exposed in daily life. Therefore, in psychosocial, environmental and family matters, physical and mental balance of the students.

It is understood the importance of this balance and, therefore, the choice of the theme arose from the experience as a resident professional multiprofessional in health, affected by this daily, which is educational and at the same time, a fact that made the researcher of this study to look at the other colleagues and formulate the following guiding question: How can multiprofessional residency influence the health-disease process of these health professionals and what are the possible impacts on the quality of life?

Therefore, it is proposed, through this research, to generate a critical-reflexive discussion about the Multiprofessional Residency in Health and its conditioning aspects in the quality of life of the resident, thus offering subsidies of both public policies on residence and material to improve the internal regulations of the courses, which offer guidelines that favor the development of good practices in training and health.

OBJECTIVE

- To reflect on the relationship of the Multiprofessional Residency in Health in the

health-disease process and in the quality of life of the resident health professional.

METHOD

This is a qualitative, reflexive type study carried out from December 2017 to February 2018, based on the experience of the Multiprofessional Health Residency of the Comprehensive Attention Program in Functional Health in Neurological Diseases, in a Hospital University in Manaus, capital of Amazonas.

It is intended, through this type of study, to know or deepen knowledge and discussions of a topic or a subject of inquiry of reality.⁹ Thus, in this type of production, the material collected by source is organized and, based on its analysis, allows the researcher to prepare essays that favor contextualization, problem-solving and a first validation of the theoretical framework to be used in the research undertaken.⁹

The research was based on a literature review and documentary research approaching the legislations and regulations of multiprofessional health residency in order to better discuss and reflect on the tenuous line of work-study binomial with the health-disease process and to understand its possible impacts on health and its quality of life involving the resident health professional.

Data collection was developed in electronic format in the databases: Medical Line (MEDLINE), Latin American and Caribbean Literature in Health Sciences (LILACS), US National Library of Medicine, National Institutes of Health (PUBMED) and Scientific Electronic Library Online (SciELO). We proceeded to search from the keyword (1) "Multiprofessional Residence" and the descriptors (2) "Non-Medical Internship", and (3) "Worker's Health", with their respective English terms.

Only a search strategy was used, with the Boolean operators "OR" and "AND": (1) OR (2) AND (3). The following inclusion criteria were selected: article, availability of the full text in electronic format, in Portuguese and English, published in the period from 2005 to 2018. A total of 41 articles were found, of which 16 were submitted for analysis.

Data was analyzed through the reading and categorization of documents divided into scientific sources (articles and books) and legislative aspects (laws, decrees and ordinances) that regulate the practice of multiprofessional residency in health, address constraints on workers' health and correlate with the process of sickness of this resident.

RESULTS

Refer to the results presented after the literature review, which was divided into two subtopics in order to, in a didactic way, sensitize a better discussion and reflection, thus stimulating a reflexive-critical thinking about the exposed subject. The following subtopics will be addressed: Legislative conditions of residence and interface in workers' health and Residence versus quality of life.

Legislative conditions of residence and the interface in workers' health

It is known that the Multiprofessional Residency in Health is one of the modalities included in the Scholarship Program for Education through Labor, as previously described, and according to art. 20, of Law 11,129/2005, multiprofessional residency in health does not imply the characterization of any labor relationship, that is, it does not generate an exempt bond². It is inferred, however, that one of the great problems faced is the labor institutionalization to which the resident ends up being imposed in his daily life.

On the one hand, it is possible to notice that, on the one hand, the residents empower the Brazilian population in the various scenarios and levels of health care, improving services linked to the Unified Health System. great interest that the student is not characterized as "responsible for the service", since the in-service training denotes a set of teaching activities mediated by tutors and preceptors and not restricted to the services themselves.¹⁰

It is understood that one of the proposals to train professionals for a differentiated performance in the UHS is education in and by work, however, research shows that the different insertions in the system, during the formation in the residences, can put the subjects of the educational process in differentiated power and knowledge relations.¹¹ In this context, a discussion of the importance of a manual or protocol that can be a reference for both the resident and the tutor, punctuating well-defined activities of the resident's daily life is done so as not to generate doubts about the student's role residing within the work environment and, therefore, no activities are required that go beyond their attributions.

Another characteristic about the residence was mentioned, previously, punctuated as of extreme relevance for the discussion in this research, which is the hourly workload of 60

hours per week established by art. 1 of Interministerial Ordinance No. 1,077, dated November 12, 2009. It is known that the hospital is a context that presents with numerous challenges and occupational risk for health professionals because it already presents day labor, often generating excessive load of work, in addition to the presence of situations that cause conflicts and a high level of tension. Imagine this context in front of the resident with 60 hours per week or 5,760 hours in the two years?

It is evidenced by the researchers that the conflict between the organization of work and the psychic functioning can lead to illness,¹² which highlights the importance of a readjustment of these resolutions with a more humanized look. It is proposed to soften this

problem by reducing the workload for residents, a fact that already occurs in several countries.¹³

It contains, in the organization of work, biopsychosocial aspects that can be determinant in the manifestations of the health-disease process of the workers, especially the resident professionals, because they are placed within a chain of authority that presents the COREMU coordinator at the top of this hierarchy and , and finally, the resident (Figure 1), thus generating: greater probability of internal conflicts; divergence in commands; excessive request of activities to the resident by all the authorities; failure to communicate between the chain of command, among other situations.

Figure 1: Hierarchical flowchart of the Multiprofessional Residency in Health. Manaus (AM), Brazil, 2017.

It should be noted that the above figure was developed based on Resolution Num. 2 of April 13, 2012 and the Internal Rules of the Multiprofessional Residency Committee on Health of 2017, showing the scenario of practice experienced by the resident health professional.

Some studies point to factors related to psychological suffering at work: the rigid control of time (work done without many pauses, requiring constant alertness); the way the industry is organized (with lots of equipment and little space); lack of materials, adequate equipment and personnel; excessive noise in the unit; conflicts in the relationship between team members; the critical health

condition of the patient; the moral suffering of workers, especially when care involves terminally ill patients; work on weekends and holidays; the inadequate or insufficient use of Personal Protective Equipment (PPE's).¹⁴

It is recalled that, in addition to these factors, the need to care for the patient's family becomes more of a care that is often not computable or considered, and this fact, combined with overwork and psychic somatizations of the resident, difficulty in relationships between residents and the patient's family/guardians/caregivers.

The resident is usually involved in all these aspects, so it is the reflection of what kind of resident health professional is being trained to

act in the day-to-day care within the Unified Health System and to what extent training is the main influencing factor of the sickness and quality of life of these residents.

In terms of the vocational training of multiprofessional residents, two axes were defined by Resolution num. 5 of November 7, 2014: Practical and theoretical-practical educational strategies and Theoretical educational strategies.⁴ It is explained that the practical Educational Strategies are those related to in-service training for professional practice, according to the specificities of the areas of concentration and the professional categories of health. It is detailed that theoretical educational strategies are those whose learning is developed through individual and group studies, in which the resident health professional counts, formally, with the guidance of the faculty.⁴

For the first axis, the preceptors are responsible for the direct supervision of the practical activities performed by the residents in the health services where the program is carried out, by a professional linked to the training institution, with a minimum specialist training.⁴ It should be noted that in a study carried out in São Paulo with multiprofessional residents, the criticism fell on these preceptors, since the residents negatively evaluated the knowledge and experience of those who assumed this function. It was mentioned the lack of theoretical and theoretical-practical mastery of the professionals involved in the achievement of the training, which made it difficult to learn.¹⁵

It can be concluded, when comparing medical residency to multiprofessional residency, that no professor specializing in any medical subarea will be accepted in a postgraduate program if he or she is not competent to perform that function,¹⁶ then becomes a prerequisite training in the specialty.

Residency versus quality of life

Quality of life is brought to the interior of large companies, as it is already proven that a professional with a balanced personal life, with a high degree of happiness, generates greater workforce and profits for the companies. The QoLW (Quality of Life at Work) is thus aimed at humanizing the work environment. In the process of training of health professionals, these approaches can be observed in theory, however, the practice constitutes a great challenge to educators due to the complexity in stimulating at the same time, professional, interpersonal and humanistic abilities of the student.¹⁷

It is warned that the health care of the resident should not be neglected, since this one, usually, is exposed to situations of stress. It is noted that when the stressor is persistent and the event is not resolved, it is common for Burnout Syndrome to be understood as a stress chronification with negative consequences at the individual, professional, family and social levels.¹⁸

The syndrome is recognized as an occupational risk for occupations involving health care, education and human services.¹⁸ The syndrome is considered by the World Health Organization (WHO) as an endemic problem worldwide corroborated by studies reporting a high level of stress in resident students and in hospital staff.¹⁹

A prospective longitudinal study was conducted with 46 residents of a multiprofessional residency program, 75.0% of the participants presented Burnout Syndrome and 72.5% had some degree of depression,¹⁸ which is reflected on those residents who, early in their careers, where many are newly graduated, may develop or have already developed a chronic syndrome.

The level of stress and the quality of life of the resident students during the two years of training were investigated at the University Hospital of the Federal University of Mato Grosso do Sul. According to the result, the residents' quality of life and univariate analysis showed a worsening of the physical, pain, vitality and mental health scores of these residents.¹¹

It is added, according to this research, that the overload observed in the residents is explained, in part, by the profile of the students, usually recent graduates and with little assistance experience, besides the academic-professional transition with the natural insecurity before the changes, the which may have interfered with residents' health indexes. There is also mention of the residents' fear of making mistakes, because, not always, the resident is close to the preceptor in the practice scenario, as well as the increasing charges and responsibilities imposed on residents are factors commonly associated with stress levels and emotional exhaustion.⁷

Among the physical consequences associated with dissatisfaction and increasing stress, there are commonly painful somatizations with a direct influence on the quality of life of the resident. In the literature, the presence of muscular fatigue and the increased risk of the appearance of work-related osteomioarticular complications have been demonstrated in the literature, often

due to excessive efforts and inadequate postures associated with psychological shocks.²⁰

In another study, the objective of this study was to evaluate the stress and quality of life of multiprofessional residents in health, that the majority of residents surveyed presented indicative of stress at an unhealthy level and that the symptoms they present, such as physical exhaustion, the will to escape from everything and the daily anguish, are signs of psychic suffering and general health deficits. The quality of life of health professionals residing in the city was negatively affected by about one-third of the residents and, in addition to the high level of people with stress, it is necessary to pay more attention to the health of these professionals, especially those who are in final phase of the training process.²¹

It is reiterated that work is never neutral in relation to the health of the worker, and the dynamic articulation of the experiences of pleasure and suffering can be positive and balancing or result in the destabilization and fragilization of the health of the individuals.⁷ It must be recognized who works, so that it is a source of health, in order to give meaning to the suffering experienced by the workers and as a possibility of conversion of this suffering into pleasure, seeking to lead the individual to the construction of their identity and self-realization.⁷

In a systematic review study on the factors that influence residents' work satisfaction during participation in residency programs, recognition as one of the elements that have positive impacts on satisfaction throughout the training process.²² Recognition constitutes a central element for the constitution of the psychic integrity of the worker, allowing the attribution of meaning to the suffering experienced and, therefore, its conversion into pleasure.²²

It can be seen, however, that the situations of suffering seem to stand out in relation to the possibilities of pleasure in the professional formation of the multiprofessional residents in health.⁷ It is believed, therefore, that to identify the situations of pleasure and suffering during the process training of residents can help Multiprofessional Health Residency Programs in qualifying this experience and reduce negative impacts on their quality of life.

CONCLUSION

It is possible to establish the Multiprofessional Residency in Health and

Professional Health Area through the articulation between the following health professions: Biomedicine, Biological Sciences, Physical Education, Nursing, Pharmacy, Physiotherapy, Speech Therapy, Veterinary Medicine, Nutrition, Dentistry, Psychology, Social Work and Occupational Therapy.

Based on this context and the analysis presented, one of the major limitations identified is the fact that multiprofessional health residency presents several professional areas involved in this training process and several specialization programs, which makes it difficult to construct a manual reference to the daily activities for each profession, in addition to the different practice scenarios where the resident can be inserted, many of them in other institutions.

It was observed the need for training of the professionals involved in the training process, from the management to the good practice of organization, by the Multiprofessional Health Residency Committee (COREMU), and for the preceptory that often have no idea how to behave in the context of the professional/student where the resident is inserted interfering, in a negative way, in the quality of the training.

One also needs strategies for the prevention and control of the stressors imposed on the resident's daily life in order to minimize the negative consequences in the learning process, in the quality of life of students/workers and in the care provided to the patients/family members.

It is possible to identify the resolutions that they have on the guidelines for the residence programs; guidelines for COREMU; duration, program hours, evaluation and frequency; on the housing scholarship program; on license, lock-outs and other occurrences of removal, however, all these resolutions are only aimed at the proper functioning of the residence. It is intended, however, to involve residents with a science and a care that are transformed to the extent that the certainties and immobilizations of concepts on crises, illnesses, disorders and mental illnesses cross the gaze of those who seek a living in everyday life.

It is understood, therefore, the importance of deepening research on the object of study and the reflection on intervention measures to improve the quality of life of residents. It is understood that multiprofessional health residency is still a recent field of professional training, and few researches have been done on the difficulties in this field. It is hoped, therefore, that this research will contribute to generate subsidies of both public policies on

residence and material to improve the internal regulations of the courses, policies that offer guidelines that favor the development of good practices in training and health.

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