

## FORMAÇÃO DE RESIDENTES MULTIPROFISSIONAIS EM SAÚDE: LIMITES E CONTRIBUIÇÕES PARA A INTEGRAÇÃO ENSINO-SERVIÇO

### TRAINING OF MULTIPROFESSIONAL RESIDENTS IN HEALTH: LIMITS AND CONTRIBUTIONS FOR TEACHING-SERVICE INTEGRATION

### FORMACIÓN DE RESIDENTES MULTIPROFESIONALES EN SALUD: LÍMITES Y CONTRIBUCIONES PARA LA INTEGRACIÓN ENSEÑANZA-SERVICIO

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#### RESUMO

**Objetivo:** analisar os limites e contribuições na formação dos residentes multiprofissionais em saúde para a integração ensino-serviço. **Método:** pesquisa qualitativa, realizada com 13 docentes vinculados a um Programa de Residência Multiprofissional em Saúde, os quais participaram do estudo por meio de entrevistas semiestruturadas. Os dados foram analisados mediante análise temática de Minayo e os princípios éticos foram respeitados. **Resultados:** a formação dos residentes é permeada por limitações envolvendo a falta de trabalhadores nos serviços de saúde que contemplem todos os núcleos profissionais propostos pelo Programa e o estranhamento do papel dos residentes ao serem integrantes provisórios das equipes de saúde. Para tanto, a valorização das atividades realizadas a partir da inserção dos residentes tem contribuído para a atenção à saúde e para os serviços de saúde. **Conclusão:** salienta-se, como contribuição, a discussão da temática de formação profissional, tendo em vista a importância de refletir sobre as transformações das práticas em saúde na perspectiva multiprofissional e de acordo com as necessidades locais e regionais.

**Descritores:** Saúde pública; Prática profissional; Pesquisa qualitativa; Internato não médico; Capacitação Profissional; Serviços de Integração Docente-Assistencial.

#### ABSTRACT

**Objective:** to analyze the limits and contributions in the training of multiprofessional residents in health for teaching-service integration. **Method:** qualitative research carried out with 13 teachers linked to a Multiprofessional Health Residency Program, who participated in this study through semi-structured interviews. The data were analyzed through Minayo's thematic analysis and the ethical principles were respected. **Results:** Residents' training is permeated by limitations involving the lack of workers in the health services to cover all the professional centers proposed by the Program and the estrangement of the residents' role when serving as provisional members of the health teams. To that end, the valuation of the activities performed through the residents' insertion has contributed to health care and to the health services. **Conclusion:** as a contribution, the discussion about vocational training is highlighted, considering the importance of reflecting on the transformations of health practices in the multiprofessional perspective and according to local and regional needs.

**Descriptors:** Public health; Professional practice; Qualitative research; Internship nonmedical; Professional training; Teaching care integration services.

#### RESUMEN

**Objetivo:** analizar los límites y contribuciones en la formación de los residentes multiprofesionales en salud para la integración enseñanza-servicio. **Método:** investigación cualitativa, realizada con 13 docentes vinculados a un Programa de Residencia Multiprofesional en Salud, los cuales participaron del estudio por medio de entrevistas semiestruturadas. Los datos fueron analizados por medio del análisis temático de Minayo y los principios éticos fueron respetados. **Resultados:** la formación de los residentes está impregnada por limitaciones que involucran la falta de trabajadores en los servicios de salud que contemplan todos los núcleos profesionales propuestos por el Programa y el extrañamiento del papel de los residentes al ser integrantes provisionales de los equipos de salud. Para ello, la valorización de las actividades realizadas a partir de la inserción de los residentes ha contribuido a la atención a la salud y a los servicios de salud. **Conclusión:** se destaca como contribución, la discusión de la temática de formación profesional, teniendo en vista la importancia de reflexionar sobre las transformaciones de las prácticas en salud en la perspectiva multiprofesional y de acuerdo con las necesidades locales y regionales.

**Descriptores:** Salud pública; Práctica profesional; Investigación cualitativa; Internado no médico; Capacitación profesional; Servicios de integración docente asistencial.

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## INTRODUCTION

Health practices reveal ongoing initiatives to bring vocational training closer to different local-regional needs and health priorities. These initiatives are more evident in the last ten years, based on the articulation between the Departments of Education (MEC) and Health (MS), and take form in the proposal of the National Curricular Guidelines (DCN) in the area of health, implementation of policies, programs and projects in the search to approach educational institutions and health services<sup>(1)</sup>.

In this context, Multiprofessional Health Residency Programs (MHRP) emerge as a strategy for education in the world of work and for work. Resting on the process of in-service teaching, learning and work in health institutions, they are characterized by the training of professionals according to the local needs, that is to say, with specific skills and specialties according to the regional deficiency<sup>(2)</sup>.

These programs aim at vocational training focused on differentiated activity in the Unified Health System (SUS), in the perspective that the workers are instituting beings in the health work process, promoting collaborative construction, teamwork, Permanent Education in Health (PEH) and the reorientation of the technical care logics promoted by the changes in pedagogical practices<sup>(3)</sup>. In order to strengthen the movement of changes in health education in Brazil, MHRP have been an example of a link between training and work<sup>(4)</sup>.

The teaching-service integration can be considered as collective, agreed, articulated and integrated work among the people who are involved in the training courses in the health area, with workers who constitute the service teams in that sphere<sup>(5)</sup>. Thus, this study is justified because, understanding that the relationships established among people can contribute to quality health care and, therefore, to the consolidation of SUS principles, the aspects that interfere in the training of multiprofessional residents and health services need to be acknowledged<sup>(6)</sup>.

In addition, the transformation of teaching, care and management practices in health implies that the teaching-service integration occurs in order to facilitate the professional training process in the health area, in accordance with the guidelines and principles of SUS<sup>(7-8)</sup>. Therefore, we ask: what are the limits and possibilities in the training of multiprofessional residents in health for the teaching-service integration? It is in this

context that this study is proposed, whose objective is to analyze the limits and contributions in the training of multiprofessional residents in health for the teaching-service integration.

## METHOD

This is an exploratory and descriptive study with a qualitative approach, carried out in a Multiprofessional and Integrated Health Residency Program (MIHRP) in the South of Brazil. The MIHRP is linked to a federal higher education institution and its emphases and concentration areas are: Primary Care/Family Health Strategy; Chronic-Degenerative Care; Maternal-Infant Care; Onco-Hematology; Mental Health and Health Surveillance. It includes the professional centers: Physical Education, Nursing, Pharmacy, Physiotherapy, Speech Therapy, Nutrition, Dentistry, Social Work and Occupational Therapy, affiliating 141 health residents during the research period.

The total number of MHR teachers was 25. Of these, only 17 met the inclusion and exclusion criteria. Thus, we aimed for a minimum representation of each professional center and concentration area, selected through a draw. Thus, 13 teachers participated in the study, who met the following inclusion criteria: to be a teaching staff member of the higher education institution and to be a tutor (function characterized by academic orientation of preceptors and residents) or preceptor (function characterized by direct supervision of the practical activities performed by the residents in the health services where the program is developed) in one of the six emphases/concentration areas of the MHRP. It is noteworthy that, as there were shortages of preceptors in the health services sometimes, the MIHRP teachers performed these activities and should be working for at least a year during the data production period. The time criterion of at least one year of experience in the MIHRP was established considering that, during this period, the teacher understands the reality and the training of the residents better, being familiar with the educational practices. And, as exclusion, those who were on any kind of leave or on vacation during the data production period were considered. The choice of teachers occurred randomly, by means of a draw. The selection of the teachers is justified because, in the program studied, these serve as mediators in the

relationships in this teaching mode, besides being accountable for the theoretical and theoretical-practical axes of the MHRP.

The data production took place between March and July 2015 through semistructured interviews. These involved a trigger question: "tell me how you perceive the teaching-service integration in the training of health residents". Other questions were asked in the course of the interviews, such as: "which difficulties and facilities do you face in working with teaching-service integration in the MHRP?".

To execute the interviews, the researcher previously invited the teachers via e-mail and/or telephone contact. After the participants' confirmation, more convenient timetables and locations were agreed upon. The interviews had an average duration of 40 minutes, were audio-recorded with the authorization of the research participants and fully transcribed by the principal investigator. All the participants were informed about the objectives of the study and signed the Informed Consent Form. The data production was closed off when there was saturation, determined by the repetition of responses and the satisfactory achievement of the proposed objectives<sup>(9)</sup>.

The data were submitted to thematic content analysis according to Minayo's operational proposal, characterized by two operational moments. The first corresponds to the exploratory phase of the research. The second, called the interpretative phase, was carried out through the encounter with the information, which was divided into the ordering and classification of the data and the actual

analysis, which was based on a multireferential perspective<sup>(10)</sup>.

The research received approval from the Ethics Committee on Research involving Human Beings of a higher education institution under Opinion 932528 and CAAE 40246414.4.0000.5346. All Brazilian legal standards for research involving human beings were complied with, Resolution 466/2012. In order to preserve the participants' anonymity, the discourse was identified with the letter T (Teacher), followed by Arabic numerals (T1, T2, T3 and so forth).

## RESULTS AND DISCUSSION

From the qualitative analysis of the data, two categories emerged from their themes and discourse: Category 1. Limits of teaching-service integration in the training of Multiprofessional Residents in Health, based on the themes "Lack of workers in health services to cover all professional centers" and "Temporariness of the resident". And Category 2, Contributions of the teaching-service integration to the training of Multiprofessional Residents in Health, with the themes "Contributions in health services" and "Contributions in health care".

Regarding the first thematic category, limits of the teaching-service integration in the training of the Multiprofessional Residents in Health, it was evidenced that this training is permeated by limitations involving the lack of workers in the health services to cover all the professional centers proposed by the MHRP and the estrangement of the role of residents as temporary members of health teams.

Figure 1 – First thematic category, themes and discourse according to the thematic analysis.

Thematic categories	Themes and discourse
Limits of teaching-service integration in the training of Multiprofessional Residents in Health	Lack of workers in health services to cover all professional centers
	"They are technical. Their activity is as if it were a technician, despite their very strong will not to be merely technical and that this training should take place. But, without pedagogical monitoring of the center, sometimes, this gets difficult". (T3)
	"Putting new professions in place where they had never worked, without that professional there inside the service, it was difficult [...] and, therefore, there's the estrangement, there's a charge, there's lack of knowledge of what one does". (T4)
	"There is a lack of professionals. The residents complain a bit that there's no field/center preceptor so, some things are missing, but we know that, over time, they adapt, but I believe that, in that sense, this integration has worked, but with some difficulty". (T7)
	"At first it was very difficult [...]. There are some centers you simply do not see at the hospital" (T9).
	"I believe that the difficulty also strengthen, despite several structural weaknesses and public, let's say municipal policies, such as the lack of workers in some centers of certain services. But I think it gets strengthened within the actual difficulty of the service itself". (T10)
	Temporariness of the resident
	"What I feel is that there's always this whimpering that "it's difficult to be understood as someone from the unit". And I always have to discuss that with them: "you have to understand that you are temporary" and, in that temporary condition, she (resident) creates a protection" (T5).

	<p>“There’s a difficulty in the service which is to understand the residency in there, and the feeling I have is that the people do not open up sufficiently. So everyone gets wary: “you come here and do it, but you do not experience what I do” and the other is: “I come here but I cannot experience it because I am here temporarily”. (T6)</p>
	<p>“What happens is that the residents go to the services and end up setting up situations, activities, actions, stimulating new activities within the services and I am afraid that the Residency will leave... and the service? Will that activity me maintained? It is very temporary and the service do not always see that positively” (T12).</p>

Source: Elaborated by the researchers, 2017.

Based on the results, it was evidenced that the residents have some limitations during their training process in the MHRP, such as the lack of workers in the health services related to their training center. The main characteristics of the MHRP are the integration among the different occupations present in the SUS scenarios, seeking to develop and enhance the work and comprehensive care in the team, with due attention to what is common to all areas and to what is a specific professional center, considering both knowledge and practices. Therefore, the resident needs to develop the knowledge, attitudes and abilities to act in an interdisciplinary way, that is, in the field of thinking-acting common to all professional areas<sup>(11)</sup>.

The actions of the residents need to be supported by the epistemological base of each profession, that is, its specific professional center. In order to do so, pedagogical monitoring focused on the center is necessary in order to help, in practice, the commitment to a certain knowledge and to the set of responsibilities, functions and practices of each professional in order to indicate a professional identity. Thus, by adding the knowledge of specific knowledge to what is common to all professions, we have the situational expansion of the center, guided by the need to fulfill objectives agreed upon in a given body of interdisciplinary know-how<sup>(12)</sup>.

In applying these concepts, the MHRP can help in the training of professionals with the skills to migrate from the one-professional vision to a more extended stage, that is, the construction of health that is well-integrated in the perspective of integration among people. Thus, when working in multiprofessional teams, one has to value the role of each professional, thus favoring collective work and the opportunity for new knowledge about other areas<sup>(4,13)</sup>.

The training of professionals who work as a team is a way to enhance the collaborative performance, as the construction of these actions needs to contain a characteristics of transformation and progression of care practices in view of the care provided to the health service users. In this sense,

the development of activities allows residents to understand that interdisciplinarity can contribute to the improvement of user satisfaction that employs public health services, also improving their way of observing and knowing healthcare practices<sup>(14)</sup>.

The limitation evidenced in this data analysis may raise questions about the way the training of health residents is valued at the national level, the lack of human resources in SUS health services, and the fact that the resident is sometimes seen as workforce in health teams, aspects that may impair the accomplishment of field activities with the other residents<sup>(15)</sup>. On the other hand, the insertion of the multiprofessional residents in the field of practice permits the theoretical-practical articulation, the ability of reflection and contextualization in view of the obstacles of the care experiences, which favor the achievement of positive outcomes for the training. In addition, the role of the residents as provisional members of the health teams in the care actions enables them to recognize different scenarios of practices, besides benefitting the oxygenation and maturation of the management and care practices to be developed<sup>(16)</sup>. These benefits can be triggered through collaborative actions, such as PEH practices<sup>(11)</sup>.

Teachers emphasize that this relationship of temporariness is an aspect that may influence the development of teaching-service integration. In a way, this situation hinders the relationship among the health worker, the resident and the contact with the teacher. The resident does not "let it run in the vein" what he is experiencing in everyday practice. Moreover, when they are inserted in the services, at the beginning of their activity, they arrive with willpower and desire for change, which leads to solitary work, limiting collective activities.

The temporariness of the resident has a direct influence on the development of the teaching-service integration, as the main operation of this relationship is to draw a central axis in the training, with a view to converging the actions of each and strengthening the cooperative work. Therefore, there is a need to clarify

the health teams and the pedagogical supports, in view of the training objectives in an MHRP and the importance of their performance for the qualification of these professionals in training. Improving the ways of insertion of the resident in the professional practice scenarios can contribute not only to the optimization of the PEH process, but also to improve the multiprofessional care provided in the institutions<sup>(17)</sup>.

In order to do so, the valuation of the activities carried out based on the residents'

insertion has contributed to health care and health services, as joint possibilities among service workers, users and pedagogical supporters, that is, preceptors, tutors and teachers. In that sense, the thematic category Contributions of the teaching-service integration to the training of Multiprofessional Residents in Health was evidenced, whose themes and discourse that produced these categories were described in Figure 2.

Figure 2 – Second thematic category, themes and discourse according to the thematic analysis.

Thematic categories	Themes and discourse
Contributions of the teaching-service integration to the training of Multiprofessional Residents in Health.	<b>Contributions in health services</b>
	“Beyond the support book, that is a production of life, of subjectivities, of complexities, we are building that quality. The network is not established [...] it is flawed [...] but the residency staff is helping us. We are stopping to think about those flaws” (T1).
	“We help to set that in a way that attends the service better, because the workers, they are unable to, sometimes, we organize that part of the data, to get a publication, that time is not available. So, for example, health indicators, indicators to assess some actions in certain sectors, the residency tries to observe how those actions will be assessed through the use of some indicators, because that is important”. (T2)
	“In general, the service gained considerable qualification through the residents’ insertion, to the extent that I’ve worked with the residency for six years and we are recognized” (T8).
	“We are being recognized as residency, our profession exists in the hospital now, we are being recognized” (T11).
	“The residency came to contribute to the services here in the city, because it ends up affecting the comfort zone” (T12).
	<b>Contributions in health care</b>
	“Health is not produced in any other way, no transformation is produced, no network is constructed. [...] I have some certainties, of course with the clinical experience, I’ll have some certainties, but I need to have other doubts. The more we can share and build new ideas together and reinvent new ideas through the Residency. (T1)
	“It’s difficult for you to break these walls that separate the professions to work on the health team, but people are understanding what that is now. You cannot work on health without a health team. There’s no gain for anyone without the multiprofessional: not for the user, not for the professional, for nobody.” (T2)
	“The resident got those guys and called: “we’ve got a guy in common here, let’s meet, let’s talk and set up a plan?” What is different today and, I think it’s an advance of the expanded clinic: bring the community inside and the residency helps a lot with that”. (T6)
“We organized a holiday colony in the village for the children there. So, the resident came with the idea and we set up a time plan, an activity plan. She got the space there from a church nearby and I brought the idea for the undergraduate students, I brought a resident here and she invited them”. (T13)	

Source: Elaborated by the researchers, 2017.

It should be noted that, in this study, some contributions were made by residents in the health services and in health care, such as the exchange of knowledge, the strengthening of the care offered to users and the possibility of networking. The multiprofessional resident is provoked to participate in the improvement of the team in its daily activities like the other field workers, involving the team in the educational activities<sup>(18)</sup>. In this sense, the MHRP encourages and triggers the learning processes, establishing the teaching-service integration, as it provides actions to exchange knowledge and experiences based on their daily work.

Based on the residents' actions in health care, it is possible to strengthen the Teaching-Service Integration and, consequently, to contribute to health services in achieving success in actions that intensify the user care, enhancing the population's health conditions. As an example of these gains, we can mention the collaborative work, in favor of user care in Health Care Networks. This is considered to be one of the MHRP proposals, as it seeks to establish a relation between practice and theory, with education-service integration serving as a transformation strategy in health care. In addition, it attributes

actions that have influence the work process of the teams and the training courses<sup>(19)</sup>.

Therefore, as observed, the MHR departs from a theoretical context allied to the immersion of the practical context for the construction of knowledge in an integrated and collective way, in view of everyday experiences. The analysis on the elaboration of new ways that offer professional qualification is fundamental, with the oxygenation of health practices through PEH offered by the city and health service managers, in order to promote care improvements<sup>(11)</sup>.

According to the teachers, one can notice that the health practices have become broader, aiming at the accomplishment of activities to collaborate with the users' well-being through multiprofessional practice, thus favoring collaborative action among the health professionals promoting the integrality of care that is fundamental to strengthen the SUS<sup>(20)</sup>.

In this sense, based on this kind of strategies, greater advances are possible towards a strengthened health system, involving the health and educational instances in the consolidation of public health policies, consistent with local demand and aiming for improvements in vocational training. In addition, as the teachers indicate, the insertion of the professionals who were residents in the services provided an immeasurable gain in the improvement of the care practices and in their involvement in the MHR Program.

These scenarios of care production and pedagogical production attribute new meanings to health education and propose it as a relationship beyond teaching and learning. In this spectrum of dimensions of the integration process, the relations between teachers, students and health workers are narrowed. The relations that are established among the people can contribute to quality health care and, consequently, to the consolidation of SUS principles. All the elements involved in the processes of changes in the training are not neutral, but permeated by struggles between positions and interests. They also involve a way of preparing those responsible for the implementation of these changes, that is, primarily the teachers and professionals who work in health care<sup>(21-22)</sup>.

## FINAL CONSIDERATIONS

Teachers linked to the MHRP of this study perceive the teaching-service integration in the

training of the residents as a process with limitations, such as the lack of workers of the different centers in the health services and the temporary status of the residents. But, at the same time, residents contribute significantly to health services and user care due to the integrative actions they develop in their work settings.

It is emphasized in this study that, in view of the complex conditions that involve the teaching-service integration in the context of the training of multiprofessional residents in health, it is essential to invest in strategies that facilitate this relationship, as expanded spaces for discussion and agreement on the activities focused on the residents' training.

This study was limited by the fact that it was carried out in a MHRP of a certain geographic region, limiting itself to a specific social context. As a contribution, the discussion on the theme of vocational training is important, considering the importance of reflecting on the transformations of health practices in the multiprofessional perspective and according to local and regional needs. Further research is suggested to strengthen activities in health education.

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