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TEACHING-SERVICE INTEGRATION IN THE TRAINING OF HEALTH RESIDENTS: THE TEACHER'S PERSPECTIVE

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ABSTRACT

Objective: to understand the development of teaching-service integration actions in the training of residents, from the perspective of teachers linked to a Multiprofessional Health Residency Program.
Method: qualitative research, of the exploratory and descriptive type, carried out between March and June 2015, with 13 teachers from a semi-structured interview and a systematic observation. Data was organized and analyzed through the operational proposal of thematic analysis.
Results: the construction of new spaces for the development of the teaching-service integration in the Multiprofessional Residency in Health is evident, coming from the effective relationship between the university and the health services, besides the insertion of the professionals who were resident in those services, besides challenges that permeate this proposal.
Conclusion: the Multiprofessional Health Residency, as a training strategy, tends to broaden health practices by providing residents with the opportunity to participate in a collaborative, dynamic and active process in their professional training. However, the teaching-service integration requires a continuous reflection of the role of each one, in order to stimulate co-responsibility in the pedagogical process according to public health policies and local reality.

DESCRIPTORS: Public health. Professional practice. Qualitative research. Teaching. Internship Nonmedical.

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INTEGRAÇÃO ENSINO-SERVIÇO NA FORMAÇÃO DE RESIDENTES EM SAÚDE: PERSPECTIVA DO DOCENTE

RESUMO

Objetivo: compreender o desenvolvimento das ações de integração ensino-serviço na formação dos residentes, na perspectiva dos docentes vinculados a um Programa de Residência Multiprofissional em Saúde.
Método: pesquisa qualitativa, do tipo exploratório e descritivo realizada entre março e junho 2015, com 13 docentes a partir de entrevista semiestruturada e de observação sistemática. Os dados foram organizados e analisados mediante a proposta operativa de análise temática.
Resultados: evidencia-se a construção de novos espaços para o desenvolvimento da integração ensino-serviço na Residência Multiprofissional em Saúde, advindo a partir da relação efetiva entre a universidade e os serviços de saúde, além da inserção dos profissionais que foram residentes nos referidos serviços, além de desafios que permeiam essa proposta.
Conclusão: a Residência Multiprofissional em Saúde, enquanto estratégia de formação, tende a ampliar as práticas de saúde oportunizando aos residentes a participação em um processo colaborativo, dinâmico e ativo na sua formação profissional. No entanto, a integração ensino-serviço requer uma reflexão contínua do papel de cada um, a fim de estimular a corresponsabilidade no processo pedagógico de acordo com as políticas públicas de saúde e a realidade local.

DESCRITORES: Saúde pública. Prática profissional. Pesquisa qualitativa. Ensino. Internato não médico.

INTEGRACIÓN DE LA ENSEÑA Y EL SERVICIO EN LA FORMACIÓN DE RESIDENTES EN SALUD: PERSPECTIVA DEL DOCENTE

RESUMEN

Objetivo: comprender el desarrollo de las acciones de integración de la enseñanza y el servicio en la formación de los residentes, en la perspectiva de los docentes vinculados a un Programa de Residencia Multiprofesional en Salud.
Método: investigación cualitativa, del tipo exploratorio y descriptivo, realizada entre marzo y junio de 2015 con 13 docentes, a partir de una entrevista semiestructurada y de observación sistemática. Se organizaron y analizaron los datos según una propuesta operacional de análisis temático.
Resultados: es notable la construcción de nuevos espacios para desarrollar la integración de la enseñanza y el servicio en la Residencia Multiprofesional en Salud, que proviene a partir de una relación efectiva entre la universidad y los servicios de salud, además de insertar a los profesionales que fueron residentes en los servicios señalados, además de los desafíos que atraviesan esta propuesta.
Conclusión: la Residencia Multiprofesional en Salud, como estrategia de formación, tiende a ampliar las prácticas de salud, dando a los residentes la oportunidad de participar en un proceso colaborativo, dinámico y activo en su formación profesional. Sin embargo, la integración de la enseñanza y el servicio requiere una reflexión continua del rol de cada uno, a fin de estimular la corresponsabilidad en el proceso pedagógico, de acuerdo con las políticas de salud pública y la realidad local.

DESCRIPTORES: Salud pública. Práctica profesional. Investigación cualitativa. Enseñanza. Internado no médico.

INTRODUCTION

From the movements that culminated in the creation of the Unified Health System (Sistema Único de Saúde - SUS), the organization of health personnel training became the responsibility of the Ministry of Health (MS), in order to recognize health services as a field of practice for teaching and to seek to improve the quality of care for the population.[1–2] To this end, the training of health personnel over the last thirty decades has been constructed, operationalized and redesigned by reflexive strategies that transcend the vision of training centered on technical procedures, without considering the structuring aspects of personal relationships and practices, according to SUS principles and guidelines.[1–3]

Among these strategies, the creation of the Multiprofessional Residency in Health (MRH) is a partnership between the Ministry of Education (MEC) and the, in reference to postgraduate studies *lato sensu*. As a central objective, this type of training seeks to provide the transformation of health practices according to the reality of health service users, through multiprofessional work.[4]

As regards the supervision of activities in the MRH Programs, these should be carried out under the supervision of teaching and health care, with joint responsibility of the education and health sectors.[5] Teachers are those linked to the training and executing institutions that participate in the development of the theoretical and practical-theoretical activities foreseen in the Political-Pedagogical Projects (PPP). Regarding teaching work, it needs to articulate, together with the (or in the role of) tutor, mechanisms for stimulating the participation of preceptors and residents in research activities and intervention projects.[4]

In addition, it is expected that this teacher will support the coordination of the programs in the elaboration and execution of projects of Permanent Education in Health (PEH), characterizing, in this way, the central support for the actions of teaching-service integration to the team of tied preceptors health services.[4] These actions need to be central to the PPP of the program, since in this aspect the integration between university and health services is evidenced. Thus, planning of the pedagogical activities is elaborated according to the practice in real situations of teaching and with the working environment, with a view to enabling the protagonism of the resident, their knowledge, expectations and experiences in the teaching-learning process.[5]

Teaching-service integration can be constituted from the collective work agreed, articulated and integrated of residents and teachers of the health area with workers and preceptors that make up the teams of health services. The purpose of such integration is to promote quality of care for the individual and collective health of the population, excellence of professional training and development/ satisfaction of service workers.[6–7]

This idea is in line with the initiatives committed to the articulation of the university and the services, which have not yet been implemented, as this requires a transformation in the training of health professionals. The changes include reflection on the teaching-service interface, which can corroborate in the transformation of the relationships that permeate teaching and health services.[6] Despite the fact that these political and institutional strategies are feasible, the link between teaching and service is still fragile and limited.[1–2]

Most of the studies available in the literature focus on teaching-service integration in undergraduate studies.[8–9] This fact evidences the need for research in this area, with the possibility of knowing the development of the teaching-service integration in the training of residents, a fundamental aspect for the formulation of MRH programs for in-service education.[10] Thus, it is necessary to broaden the debate about teaching-service integration, in order to encourage and stimulate the commitment of teaching with the SUS and to plan the pedagogical practice in an integrated way.[9] For, by understanding health services as potential learning scenarios, it is possible to redefine and re-signify these spaces as privileged for the incorporation of teaching-service integration into health training.[10]

In this sense, this study was guided by the following research question: How do teachers of a Multiprofessional Health Residency Program develop teaching-service integration in the training of residents? It aims to: understand the development of the actions of teaching-service integration in the training of residents from the perspective of teachers linked to a Multiprofessional Health Residency Program.

METHOD

It is a research of the exploratory and descriptive type, with a qualitative approach.[11] Among the reasons for choosing this option, we highlight that the qualitative approach has as its focus the experience of relationships and the meanings that individuals attribute to certain phenomena.[11] In this way, understanding teaching-service integration in the training of residents of an MRH Program requires a proposal that brings the researcher to immersion in the universe of meanings expressed by the subjects, without the pretension of reaching absolute and definitive conclusions, propose a narrative circumscribed by the time, space and circumstances in which such subjects are inserted. Thus, this approach seeks to accompany the intense social transformations in the contemporary context, which affect individuals as well as collectivities.[12]

The present research was developed in a Multiprofessional Residency Program Integrated in the Public Health System, located in the inland of the state of Rio Grande do Sul (Brazil). The interest of the research arose from the need of the MRH Program, in agreement with the Research Group to which the main author is linked, in understanding the relation between teaching and service and how this relationship permeates the formation of the residents from the speech of teachers, who, in the program studied, have an important role of mediation between teaching and service and other pedagogical practices.

To that end, the participants involved in the research were the teaching staff of a higher education institution, who played the role of pedagogical supporters (tutors/preceptors) with the MRH Program. They are teachers of different health care settings who, after previous contact, showed interest and willingness to participate in the study. The total number of MRH teachers was 25, of which only 17 met the inclusion and exclusion criteria, thus, a minimum representation was sought for each professional core and area of concentration, with selection by lot. The total number of participants was 13 professionals and closure of the collections occurred due to saturation of information.[13]

In order to select the participants, the following inclusion criteria were established: to be a teaching staff member of the higher education institution and to be a tutor (his/her function is characterized by academic orientation of preceptors and residents) or preceptor (his/her function is 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 areas of concentration of the MRH program: chronic-degenerative, maternal-infant, onco-hematology, basic care/family health, health surveillance and mental health; have completed at least one year of performance at the beginning of the data collection period, implying that these teachers better understand the reality and the training of the residents, and are accustomed to educational practices. And, as exclusion criteria, those who were on leave of any kind or on vacation during the period of data production.

In order to operationalize the research, seeking to meet the ethical precepts recommended by Resolution 466/12 of the National Health Council, the insertion in the field was carried out through an initial contact with the coordination of the MRH Program to present the research project and to know the relation of the teachers linked to the program and their contact. Prior to contact with teachers, an e-mail was forwarded through coordination of the Program so that the teachers knew that there was science and acceptance of the coordination to carry out the research. Following, by means of telephone

contact with the teachers, the invitation to participate in the research was made. It is worth noting that there was no refusal or withdrawal by teachers after the invitation to participate in the research.

Subsequently to the acceptance, personal contact was made for scheduling the data production stage, which was carried out by the main researcher from systematic observations and semi-structured interviews, during the months of March to June 2015. For systematic observations,[11] they were developed with eight of the 13 teachers who answered the interviews, selected by a second draw. Thus, we opted for the possibility of observing the context of the research participants in greater depth.[11] Observations were made in spaces where teachers were included, such as Field Tutoring meetings (different professions, equal concentration areas) and Core Tutorials (same professions, but different concentration areas), theoretical classes, practical classes and pedagogical meetings, totaling 50 hours, which were guided by an observation script and described in a field diary.[11]

In relation to the semi-structured interviews,[11] they were developed with 13 teachers, in an individualized way, with prior scheduling and private placement. The timing of the interview was not previously delimited and happened according to the availability of the participants, and the average duration was 40 minutes. Prior to the beginning of the interview, participants were asked for authorization, registered by consent form, to record the meeting on a digital recorder, and then transcribed in full, by the main investigator.

Interviews began with the reading of the Term of Free and Informed Consent and then questions were asked according to the proposed objective. Participants were mentioned in the text with the letter “d”, being the initial letter of “docentes” (“teachers”), followed by an Arabic numeral from d1 to d13, guarding the identification of the subjects. Also, at the moment of data analysis, it was sought not to reveal the characteristics of the speeches that could evidence the professional nucleus of each participant, since this is not the objective of the study.

After data production, a thematic analysis was performed,[11] being operationalized in three stages: data ordering, which included the moment of transcription and organization of the interviews and the field diary. Data classification, in which an orderly and exhaustive reading of the data was carried out and, thus, enabling the apprehension of the relevant structures of the central ideas. Finally, data analysis, which corresponds to the formation of the thematic categories, transversal reading of the material, in order to answer the research question. The central ideas/units of meaning guided the identification of two thematic categories: the production of meetings and the challenges in the daily life of the formation, generated the following guiding framework (Figure 1):

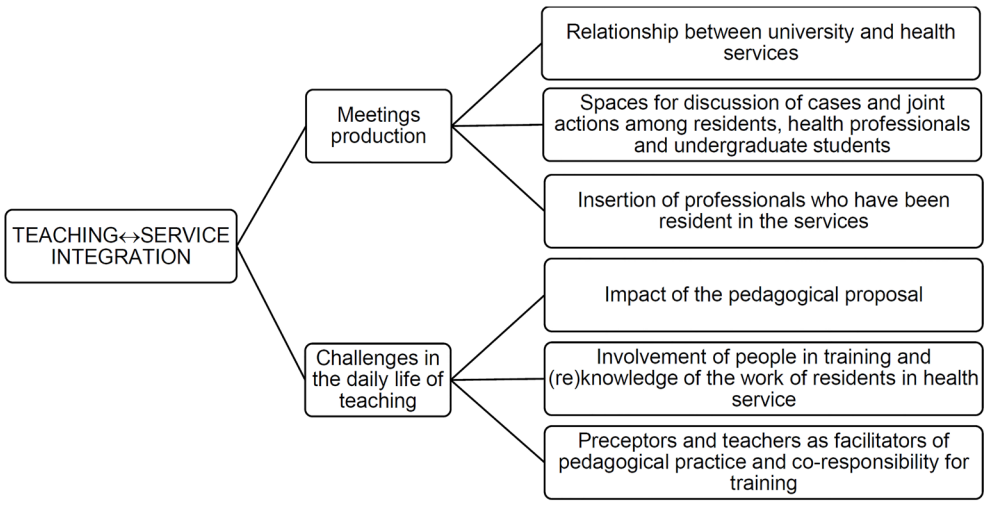

Figure 1 – Central ideas that guided the formation of thematic categories.

RESULTS

Thirteen teachers participated, with predominance of women (12) and an average age group of 43 years old. As for the university's working time, it was found from two to 33 years, with eight teachers being linked to the activities since the consolidation of the MRH Program in 2009, and the rest having carried out the activities in the residency from one to three years. Regarding education, all had a Doctorate degree in their area of formation or in collective health.

Production of meetings in the development of teaching-service integration

In the interviews with the participants, it was evidenced that, for the effectiveness of the development of the teaching-service integration, teachers promoted meetings operationalized from pedagogical practices that aimed to enhance reflection compared to the experience in practice. Among these meetings, we highlight the creation of spaces for discussion among professionals linked to the university and health professionals, according to the teachers, enabling collective involvement in the construction of knowledge, according to the local need.

[...] *residency oxygenates the service. Because you enable, not only the resident to be producing knowledge, but also people to be involved in this process. I think it is also positive because it instigates the public manager to think about some questions and the role of the university within the service. I think that the university assumes this responsibility with the municipal government, in the sense of intending all this* (d10).

In addition, the accomplishment of activities that linked undergraduate academics, professionals and users of the health services and professionals of the MRH Program was observed. It can be observed that in several field and/or core mentoring meetings, students were participating in the activities, as well as in the decision-making in which the residents worked together with the work team.

I think that's what you must do: you have resident-professionals and you have undergraduates. So, I try to go where they have Residency, to go with the graduation so they can get involved with doing it a bit more advanced than simply recognizing territory, identifying demand (d6).

We have built subjects that can bring the student closer to the Residency. I have opted for the core residents to do this activity along with undergraduate students. We have been doing group study and research movements from the nucleus as well. [...] *It is the production of knowledge that reaches the undergraduate student so that this reality is not far* (d10).

Teachers indicate that, based on the relationship between the service professionals who perform preceptory activities, as well as the pedagogical support from the training institution in which the MRH Program is linked, there is a possibility of constituting the teaching-service integration effectively.

The academy, she must leave the comfort of the classroom to go to the territory [...] *Classes do not happen in the university, they happen in the services and the preceptors are part of the didactic body of these disciplines* (d1).

You enable not only the resident to be producing knowledge, but also that people are also involved in this process (d10).

In addition, according to the teachers, to the extent that the insertion in health services of the professionals who were residents, there is an important gain in the effectiveness of the teaching-service integration. This is because, from the experience of the professionals as residents, they can help tutors and the current residents in improving the pedagogical practices offered in the MRH.

New professionals have already been residents. [...] *I'm very happy with the people who are coming in, are having a better partnership, some spaces are being covered for us to innovate* (d2).

Already have two professionals within the service who have passed through the residency and are working in the hospital, which has made things easier for us. For, the moment I had students who started the Residency and now they are acting as professionals and with a multiprofessional vision that I did not have before, this will make a difference. It's not any professional who has entered (d5).

Challenges in the daily life of teaching

This category refers to the teachers' understanding of the confrontations of teaching-learning experiences that permeate the daily life of the MRH formation and directly interfere in the development of teaching-service integration. Among the units of meaning, we find the impact of the pedagogical proposal offered by MRH. As observed in the field tutorials and in the excerpts below, teachers questioned the changes in training in front of the Curricular Guidelines that dissociates from the articulation between theory and practice.

There is a curriculum directive since the beginning of the 21st century, since 2002. It places theoretical discipline, but then has no practice, places a theoretical-practical discipline that later will not link with the territory, will not link in the service [...] *rigid technical teaching, the one that gives money and once they are graduated, what is going to happen? Goes to public service and will make the most restrictive technique* [...] *and what happens is that they arrive at the Residency and do not know how to articulate theory and practice* (d6).

In addition, teachers point out that the lack of involvement of the people who are inserted in the process of teaching and learning is a factor that directly jeopardizes the effectiveness of the teaching-service integration. This aspect corroborates with what was observed because, from spaces such as tutorials and preceptories, there was a demand for clinical cases and discussion of the work process in which residents were involved. However, limited opportunities for discussion between pedagogical supporters and program coordination were sought to strengthen teaching and learning activities.

The biggest difficulty, as I see it, is people. [...] *The point is that people do it in a minimized way in an uncomplicated way. It's more talk than it should be, of what is advocated* (d6).

I miss the tutors very much, to harmonize, I do not say that they reach a consensus of unanimity, even by the differences of our formations. But, I feel a certain lack of harmony between the purposes of each of us, we have not met to discuss together (d12).

According to the interviewed teachers, for the development of the teaching-service integration it is necessary that the actors who participate in the training (re)know and (re)think the role of the resident within health services. The time that the resident stays in service causes him to be seen simultaneously as a member of the team and as a provisional subject of these spaces, because the team does not understand him as a being involved and co-responsible in the practices of care.

The resident has a double role there (in the service). He must do his training while a resident. Therefore, he must leave a specialist and he has no other way if he does not perform the tasks of his area and do the activities of his profession but do and at the same time be a student. And, at the same time, being critical of the service in which he is. So this integration has a very thin threshold because either the resident falls into the routine of service and becomes a server, or he walks away and becomes a stranger (d4).

Another element that teachers signal is their relationship with the preceptor, and this preceptor, who understands the daily life of health services and who is involved in the learning process, tends to assist the resident in their learning. In addition, teachers indicate that when they are immersed in contact with health services, their practices become more consistent with the reality of health work.

We end up knowing the reality of the municipalities, how services are structured, how it has worked. This helps us a lot to mature bringing you into the class, because by following you have real information to bring into the academy (d2).

It's a relationship, a matter of trust. Preceptors are working there (in health service), *I'm acting here* (at the university), *when we have some doubt we talk, we contact each other through social networks, email, phone and it works* (d9).

DISCUSSION

Training of health professionals was strongly marked by the assistential vision, under the influence of conservative, fragmented and reductionist approaches, in which curativist knowledge was privileged, to the detriment of proactive practices aimed at the protection and promotion of health.[14] Despite some advances and strategies aimed at training in the health area, such as the reformulation of the current National Curricular Guidelines and the development of projects, such as the Health Education Program (Programa de Educação pelo Trabalho para a Saúde-PET-Saúde), PEH, among others that foster teaching-service integration, there are still challenges that hinder the educational process.[15]

To train professionals who work in the health area with the desired profile means to enable an innovative approach and a critical-reflexive approach. In this way, the lived reality is reflected, being able to direct the transformation of the practice, through criticism and self-criticism.[15] Thus, professionals with different health formations, willing to move between the specific areas of training, articulate their specific knowledge with that of their colleagues in the work organization, which makes it possible both to share actions and to delegate activities to other professionals, in the collaborative practice.[16] This movement tends to increase the resolubility of services and the quality of health care.

With the complexity of the needs in health services, there is an emergency of professionals who act in these ways of the practice of care, and these occur in the scope of human relations.[3,16] Insofar as the relations of conviviality with the other are understood as conditioning factors for the dynamics of collaborative health practices in the teaching-service integration, the complexity of the relationships resulting from the experience of each one tends to produce knowledge. For this, it is of important relevance to consider the experience of the other for the understanding of teaching and learning to do.[17]

With this understanding, when performing actions to carry out teaching-service integration, with the process of approaching and constructing commitments, with education at work or through an educational work, the possibility is opened that they focus on the quality of this integration, the educational values of requalification and of thought, of reflection. This is because one has in mind the quality of life of those who depend on their work to have a better life.[1] To do this, it is important that there is openness on both sides (teaching-service) and a reflexive and critical dialogue so that one understands the role of each one and emphasizes the need for a whole.

The teaching-learning process through the implementation of teaching-service integration requires the understanding of those involved as unique and global beings. In this way, permanent spaces for dialogue and awareness can be operationalized by the relations of the actors involved in this process.[18] Therefore, it is understandable that these actors identify the needs of the services and make collective contribution pacts, in addition to the contribution of the teacher and the participation of service professionals in the discussions about the teaching-learning process.[6,19]

Therefore, in order to change health practices, according to teaching-service integration, it is important that the social actors linked to RSM programs restructure and resignify the process of teaching and learning to be and do in health in another way. However, privileging teamwork, which is permanently encouraged, aiming at integrality in the training of health professionals.[10] In this dynamics, there is the possibility of effecting the integration, through collective and agreed spaces, both in health services and in the university, environments in which the social actors are linked. Therefore, MRH can be considered a device capable of provoking improvements in the training of health professionals, because it is possible to work in an engaged way based on an expanded health concept and not only focused on biological aspects that determine the health-disease process.[20]

The proposal of integration in the MRH enlarges spaces of discussion for a cooperative, collective and integrated production. With the involvement of pedagogical supporters (teachers, tutors and preceptors) and undergraduate students, there is a mutual benefit for the construction of knowledge, modifying the logic of health services: they are no longer just practice laboratories for professional training. They should also be understood as a *locús* for the transformation of shared knowledge.

This shared commitment corroborates the challenge of complexity, which lies in the double challenge of reconnection and uncertainty. It is necessary to reconnect what was considered separate and, at the same time, to learn to make certainties interact with uncertainty, that is, this process implies, among other principles, the dialogical relationship to face deep realities that, precisely, unite truths apparently contradictory.[21] The MRH are presented as an important strategy to enable teaching-service integration in order to rethink the process of health production, through the formation of critical subjects and the creation of spaces for professional representation in the construction process of SUS. For, as well as MRH, lived in the daily life of health services, teaching-service integration is based on experience, and knowledge is not limited to the content that is in theories, but in the relation that is established between this and the practice and the reflection that is made on each action that allows to perfect the actions.

Therefore, the need to clarify the teams that will receive the residents is evident, as well as the objective of the MRH programs in health services and educational institutions. This is due to the hybrid relationship of the resident in this form of training through work, when residents are sometimes not treated as professionals by the other actors of the residency or, still, seen as passengers and do not assume their functions completely. For the development of teaching-service integration, as well as for the ideology of SUS-oriented training, the lack of understanding of the roles of the subjects involved in this process is an interfering aspect.[15] For this, it is necessary that the residents are seen as actors in formation who need monitoring and pedagogical supervision, even though they are already trained professionals.

Moreover, residents' lack of autonomy and their direct dependence on supervision reveal the dilemma of seeing the resident as a professional (once a graduate) or student (since he is in the process of specialized training). This way of observing the insertion of the resident in the scenarios of professional practice can contribute not only to the optimization of the process of PEHPEH but, mainly, to the improvement of the care provided in the institutions and to the training.[22]

CONCLUSION

The results of the present study emerged from the perspective of teachers in the development of teaching-service integration in the training of residents. Among these, on the one hand, the construction of new spaces for the development of teaching-service integration in MRH is evident, coming from the effective relationship between the university and health services, besides the insertion of professionals who were residents in the services. And, on the other hand, the impact of the pedagogical proposal by the residents when they come across different teaching-learning arrangements, in which they are considered as protagonists of their formation.

In MRH, there is the possibility of a unique learning experience, expanding health practices through the opportunity to participate in a process of dynamic and active collaboration of the actors involved. However, the implementation of teaching-service integration requires constant critical reflection. For the experiences underwent by the teachers highlight the intensity of this relationship and its effects and possible reflections on the training of residents and, consequently, the training of workers linked to health services.

Although limited in the complexity that permeates training in MRH, this study makes it possible to show that, in order to develop the integration between teaching and service, it is also necessary to work with the subjectivities of the relationships that encompass the involved instances. The importance of rethinking ethics in interpersonal relations, commitment, responsibilities and, above all, dialogue is also observed. This interaction between health services and educational centers can become more effective once the role of each one of them is understood and, above all, the importance of the relationship with the other constructed as a support network. And so, one can think of all the actors as powers for the development of the actions together.

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NOTES

CONTRIBUTION OF AUTHORITY

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Discussion of the results: Mello AL; Terra MG; Arnemann CT; Nietsche EA
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ETHICS COMMITTEE IN RESEARCH

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CONFLICT OF INTEREST

There is no conflict of interest.

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