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articles

Preceptor's best practices in a multiprofessional residency: interface with interprofessionality

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In this article, based on Appreciative Inquiry, we present and discuss the best practices of a group of preceptors from a multiprofessional health residency program in Brazil. The best practices we identified are the multiprofessional consultation, the reception given to residents, and the integrated actions among different majors of the residency. In addition, we identified their strategies to develop the practices in health settings. The practices follow the presuppositions of interprofessional education, as they promote the reflection of different actors on the construction of practices that aim at the provision of better healthcare for users of the Brazilian National Health System (SUS).

Keywords: Interprofessional education. Permanent health education. Multiprofessional health residencies. Appreciative inquiry. Professional practice.

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Introduction

Health professionals' education has been widely (re)discussed across the world. According to the World Health Organization, health professionals' education is still considered fragmented and decontextualized when the dynamics of changes that occur in this area is evaluated[1]. Moreover, the WHO argues that it produces a static curriculum. In Brazil, we highlight the Permanent Health Education (PHE) movement, assumed in 2004 as a public policy that aims to promote changes in health professionals' practices[2]. PHE is part of a political project that proposes to change health professionals' education. One of the changes that have already been implemented was the creation of *Residências Multiprofissionais em Saúde* (RMS - Multiprofessional Health Residencies). The RMS were created with the objective of stimulating practices that meet the demands of *Sistema Único de Saúde* (SUS - Brazilian National Health System), and constitute spaces for the development of PHE actions[3].

Thus, residencies have become a possibility of problematizing reality in the daily routine of the health services and connecting the services with teaching institutions, with the aim of integrating residents, teachers, users, managers, and health professionals. In addition, the RMS tend to enable the permeability of educational actions in the daily routine of the health practices, fostering the development of PHE among professionals working in the health services[2-4].

Multiprofessional residencies can also be appropriate spaces for the development of interprofessional education, as they function under a perspective that seeks to promote integration among different professionals[5]. Interprofessional education offers opportunities of joint learning with other health professionals, aiming to develop attributes and skills that are necessary in collective work[6]. This type of work recommends that professionals from different areas should develop their activities and learn jointly, in an interactive way, enhancing collaboration and the quality of healthcare[1]. Therefore, interprofessional education complements and strengthens the set of ideas of the SUS, providing subsidies for the construction of a project of society that includes the amplified conception of health[7]. Designing interprofessional curricula, adopting disciplines that are common to different courses of the health area, and implementing interprofessionality in RMS are movements that contribute to reformulate the education of professionals[7].

In this scenario, we have the figure of the preceptor, who has been playing an outstanding role in healthcare institutions by providing residents with learning situations in such a way that interventions and conducts are satisfactorily performed, analyzed, transformed and apprehended during the education process. Therefore, preceptorship has become an educational practice[8].

Studies about the preceptor have shown the importance of this actor in the pedagogical process and educational practices of the RMS, as well as difficulties regarding aspects of the didactic process[8-10]. In this direction, considering this professional's visibility and the importance of their practices, we propose to investigate and present successful practices developed by a group of preceptors, showing the residency's potential as an education modality.

Methodology

This study is characterized as an Appreciative Inquiry. The Appreciative Inquiry is a methodology used to identify the best practices developed and employed by the people who work at an institution. This methodology enables the participation and engagement of health professionals in research related to their area of activity, and it can be applied to multiple areas[11].

The Appreciative Inquiry was chosen for this study because it is a methodological approach that has been increasingly used in the scenario of qualitative research, as it explores positive points and common points developed in the environments where it is applied, and it has started to be used in studies that investigate the area of health in Brazil[11]. Furthermore, the Appreciative Inquiry stimulates participants to carry out reflective and critical debates and establishes a discussion space to foster the occurrence of changes[11-12]. The methodology was organized in four stages that form a 4D cycle: Discovery, Dream, Design and Destiny.

In this article, we focus on the first stage of the cycle - the Discovery stage[13] - due to the study's central objective, which is to identify the best practices developed by preceptors. The study was carried out in the Integrated Multiprofessional Residency Program of *Hospital de Clínicas de Porto Alegre*, located in the southern region of Brazil. The participants were seven preceptors representing the majors of the above-mentioned residency: Critically Ill Adult, Cardiovascular Care, Comprehensive Care for Drug Users, Hospital Infection Control, and Onco-Hematology. Regarding professional categories, we had the following professions: Nursing, Pharmacology, Physiotherapy, Physical Education, and Social Work.

We adopted the following inclusion criteria: preceptors who had been working in the multiprofessional residency for at least one year and who were interested in reflecting on and discussing about PHE. Each preceptor could be absent from one meeting, at the most, throughout the data collection period. Preceptors from all the professions were included in order to have at least one representative of each profession. The exclusion criteria were: preceptors who were on holiday or on a leave in the data collection period.

As strategies for data production, discussion groups were conducted with the preceptors. An audio recorder was used to record and transcribe the data. In addition, field notes were used to complement what was observed in the meetings.

In the Discovery stage, we conducted three meetings with the group of preceptors, each one lasting approximately two hours. The objective of this stage was to identify the best practices developed by the preceptors. To achieve this, before the first meeting, the preceptors received a reflective task that asked them to recall a positive experience they had had as preceptors. We called "reflective tasks" the activities that the participants performed before each meeting, with the aim of enabling them to reflect on the object of study. They functioned as a strategy to prepare the group's meetings[11].

In the first reflective task, we asked the participants to write a letter, addressing it to some colleague, to the coordination of an institution, or to the study's researchers, reporting on their professional history and describing a positive activity they had performed in the multiprofessional residency.

As it was mentioned above, the second and third meetings were also part of the Discovery stage, the first stage of the 4D cycle. This stage can be started with a dialog encouraging research participants to share experiences, so that they can discover or rediscover their strong points, no matter if they are active or emerged when they had their greatest achievements.

The Discovery stage involved the identification of the participants' best practices through the appreciation of what "gives life and energy" to individuals, to their work, and to the organization[12-14]. The questions that guided the discussion group were: What are the best practices this group develops? What gives life and energy to the work of the multiprofessional residency? What do you think has been producing good results in the multiprofessional residency?

Data analysis was performed according to Denzin and Lincoln's proposal[15]. The steps followed in the thematic process of data analysis were: immersion in the data, coding, categorization, and data generalization. To the study, Resolution 466/12 of the National Health Council was taken into account, and the research was approved in the Research Ethics Committee, obtaining a favorable opinion: *Certificado de Apresentação para Apreciação Ética* (CAAE - Certificate of Submission to Ethical Analysis) no. 35009014.5.0000.5327.

Results and discussion

In this article, we present the category best PHE practices in an RMS. This category originates from the dissertation "Permanent health education in the context of the multiprofessional residency: a critical and appreciative study". Appreciative Inquiry enables researchers to propose the creation of a collective scientific production with the participants, who become co-authors of the article. Thus, this category included the objective of producing a manuscript emphasizing the dissemination of the

best practices of this group of preceptors. The category was subdivided into two subcategories: "best collective practices guided by PHE principles" and "strategies for the development of interprofessional actions".

Concerning the first subcategory, "best collective practices guided by PHE principles", the preceptors mentioned the consultation at the Cardiology outpatient clinic:

> The two practices I highlighted are the planning and execution of a new multiprofessional practice, like the outpatient clinic in Cardiology. (P2)

> I thought about it and decided that it is the consultation at the outpatient clinic cited by her [a colleague], which is the multiprofessional outpatient clinic. (P7)

> It was interesting [the multiprofessional consultation in Cardiology] because it is a proposal that started from scratch, from the need to work based on this, and it seemed to me it was a successful experience. I think we have good experiences, like the cardiology outpatient clinic. (P4)

> The multiprofessional consultation is a practice that was mentioned by many people here and I believe it is possible to be executed. (P1)

> An issue of practice, of how you can put it into practice, is the Individual Therapeutic Project. Different people interfere in the practice, which refers to the patient's entire treatment, to the unfoldment of everything that is necessary to develop care. It is the multiprofessional inter consultation. (P2)

Based on the description of the multiprofessional consultation, we can relate its operationalization to the interconsultation, which is considered a facilitating strategy for professionals of interdisciplinary teams in the area of health. It promotes teamwork and action grounded on the biopsychosocial model. The interconsultation was implemented in the field of Medicine and consists of the presence of a health professional at a service unit, requested by a physician to guarantee a more global look at the patient[16]. Practices like this aim to solidify multiprofessional teamwork in order to improve the quality of care provided for users.

Another practice viewed as important in the scenario of multiprofessional residencies is the reception given to new residents as an integration activity in the RMS.

> I view many activities as positive experiences I've acquired in my work as a preceptor. However, one activity that I can emphasize was the field reception given to new residents at the beginning of the year. I was responsible for organizing the activities that would be developed in the field on the first days of the new residents. (P5)

The preceptors organized themselves to conduct the activity of reception and presentation of the services in which the residents were going to work in the RMS.

Multiprofessional rounds are also seen as best practices and have had an increasing presence in the scenarios of multiprofessional residencies.

> Multiprofessional round. We started to participate in rounds through the residency. (P6)

> At X, we have very positive experiences. There is also the daily multidisciplinary round, in which all the preceptors and residents participate, as well as the entire team, and it is called multidisciplinary round. (P5)

Rounds are multiprofessional meetings in which the residents present their patients' cases and exchange experiences. The multiprofessional residents started their participation in medical rounds. P2 analyzes the multiprofessional round in an interprofessional perspective, calling it "interconsultation".

> There is the consultation, but there are also other actions that can be thought of and carried out. Our field does not offer consultations. We can't provide a PTS (Individual Therapeutic Project). But the multiprofessional round is, in fact, an interconsultation, which favored us in this sense. (P2)

In addition to practices focusing on the residents' action, P1 argues that the visit to a non-hospital institution is a successful experience in his trajectory.

> [...] I write this letter to tell you about a very interesting and successful experience that we had in the RMS. Last semester, we had the opportunity of visiting, together with the residents from major X, Partenon Sanatorium, here in our city. This institution is responsible for tuberculosis treatment here in Rio Grande do Sul. (P1)

The preceptors discuss the importance of residents' experiences in other education areas of the RMS, the possibility of joint actions involving different majors, and experiences in other settings, highlighting the presence of preceptors together with residents and the inclusion of new professions in the residency, described by P2.

> And the presence of these preceptors, together with the residents, really is a positive practice in our RIMS (Integrated Multiprofessional Health Residency). The presence, the fact that we support the residents so that they don't feel alone and abandoned - we are careful about that. To me, these are the positive practices. (P2)

In this context, the preceptors aim to provide education with elements that promote a comprehensive care model. One of the strategies for this education is stimulating actions involving different majors, which the preceptors call "inter-major actions".

> Inter-major actions. I highlight one in which we engaged the areas X and Y. For example, in area X, there are many patients with an important cognitive deficit, a severe intellectual impairment in hospitalization, and the part of infection control is quite hard if you are providing care for patients. The issue of seasonal diseases, for example, is very common in summer. So, the residents asked the preceptors for authorization, took some time off from their weekly work at the Infection Control and went to the unit. (P2)

> More than a multidisciplinary work, the inter-major actions are an education proposal. An education proposal among majors. And we already have some experiences to share. (P7)

> An inter-field work [...] more than being a residency in mental health, critically ill adults, infection control, child health, alcohol and drugs, it is an integrated multiprofessional health residency. (P2)

The actions performed among majors, which the preceptors call "inter-major actions", are activities that aim to integrate preceptors and residents from the same area of activity. They propose to integrate different professional areas and nuclei, and have been present in discussions about professional health education. To integrate means to consider new interactions in teamwork, configuring exchanges of experiences and knowledges. Such exchanges, targeted at respect for diversity, cooperation and solidarity, constitute transformational practices that aim to obtain care permeated by dialog and collaboration.

The best practices brought by the group of preceptors, such as *Projeto Terapêutico Singular* (PTS - Individual Therapeutic Project), multiprofessional consultations, residents' reception, multiprofessional rounds, new professions in the RMS, and inter-major actions, are devices constructed in accordance with the biopsychosocial healthcare model. Thus, the best practices promote significant learning, as they are based on daily reflections and acquire meaning because they are aligned with the reality of the RMS preceptors. Significant learning in PHE refers to a pedagogy that proposes, to the health professional, an active role in healthcare related to the subject's previous experience, in opposition to the traditional models[17]. According to some authors[18], the space of the multiprofessional residency uses different active methodologies that aim to contribute to an education that gathers knowledge from all the professional nuclei, revealing the power of these methodologies in education processes that intend to reduce the distance among different actors involved in the SUS and to the SUS. We believe that the preceptor who articulates changes in health practices is an actor of the change process.

Consequently, it is possible to think that these practices can be enabling the collective thought and action of a group of professionals working in an education modality like the RMS. This leads us to think that, in spite of the preceptors' intense working day, they are willing to search for teaching modes based on a logic that aims at the provision of comprehensive care based on the biopsychosocial model. They intend to do a good job in residents' education, defending a proposal that makes a difference in human resources education[19]. However, they are also concerned about not letting the residency be understood merely as a problem-solving type of education that complements the problems coming from academia, as this might lead to a distorted view of residency and of the preceptor's role[20].

The subcategory "strategies for the development of interprofessional actions" presents strategies for teaching and integrating the RMS majors, such as the mapping of each resident's knowledge, conversation circles, theoretical disciplines, integration methodologies involving all the RMS areas, and collective encounters. Based on multiprofessional teaching strategies, we can ask ourselves: How can we deal with distinct practices and theories in a group with different professional nuclei, in which each resident has their singular knowledge deriving from their experiences and specific academic background? The strategy P2 employs is the mapping of each resident's knowledge.

> You asked about an instrument to provide field preceptorship. First, what we use is the mapping of each one's knowledge. In the first encounters, we map and survey the level of instruction of that area. (P2)

For the mapping strategy, P2 uses conversation circles, which enable to survey the individual knowledges that form the group of residents and to share the approached contents with the field residents.

> [...] I raise the topic and survey the content they (residents) have [...] and, based on this, I develop a conversation circle or a research on a topic [...]. All this through the instrument of initial mapping. (P2)

As for the development of multiprofessional teaching, one of the strategies that stands out is, once more, the mapping of the residents' knowledge, because each resident has their own knowledge and new knowledges are built in the preceptor-resident relationship. We believe that individual expertise values different knowledges coming from professional experience, tacit knowledge, or even from personal knowledge. PHE works in the perspective that every learner has an experience that should not be ignored[21]. According to Freire[21], with critical ethics, scientific competence and authentic tenderness, under the perspective of liberating political engagement, it is possible to teach learners to be more active and involved beings.

In relation to multiprofessional teaching, the identified practices reflect the preceptors' interest in creating learning spaces that are not restricted to the professional nucleus, promoting interfaces among different professions and converging on a multiprofessional action that aims at comprehensive

healthcare. With the initiative of multiprofessional teaching, the people involved grow, crossing the academic barrier, traditionally directed at an education that focuses only on the profession[22]. Furthermore, multiprofessional practice provides society with comprehensive care as people start to be seen in the biological, psychological and social spheres, feeling embraced and connected with the health team. The multiprofessional residency provides knowledge about all the areas involved, generating denser and more complex discussions and solving the problems presented by society more efficiently[23].

However, based on what was discussed so far, it is possible to notice that the majority of concepts that involve the RMS are linked to the principles of multiprofessionality. We argue that the multiprofessional residencies propose that the developed actions should be multiprofessional and interdisciplinary. Thus, how can we advance in discussions about interprofessionality in RMS spaces? The successful practices adhere to the interprofessional education proposal but are presented as multiprofessional initiatives, as they integrate the collective work of different professions and have similarities with some principles of interprofessional education. Interprofessionality is characterized by an intentional and collaborative articulation among different professions, resulting in more efficient and comprehensive actions.

In addition to these strategies, the preceptors highlight that the theoretical disciplines in which the residents participate could be reviewed to become moments for multiprofessional discussions that explore knowledges that are transversal and common to different professions.

> And as you have, at first, health policies, I think that the theoretical disciplines also function well and support the discussions that we've been having in the field. (P4)

> We needed to think a little bit on this process of constructing a multi-work and we created the strategy of including theoretical knowledge about multiprofessionality. (P2)

The preceptors highlighted the active methodologies used in the residents' education. The group approaches these methodologies as strategies for interprofessional teaching: through them, residents can take a stance and discuss their experiences.

> One of the classes was meant to promote a discussion precisely about professional identity, the position of X in the multiprofessional team. And a teacher from the X course told me by e-mail: I've planned a twenty-minute class and the rest of the time is for discussions. And I thought: How come? Doesn't she know that the class should last two hours? And, at least of the classes I attended, that was the most awesome! (P7)

> It's not because there's the traditional class that you must follow that type of class. Instead, you should think of new proposals that will enrich education, like the active methodologies. These methodologies help us think of other possibilities to the classes. (P5)

> And also the suggestion of modifying the proposal of classes that already have a nucleus [...] we had a workshop in March and the classes, at first, happened according to this methodology. We had plenty of interesting stuff, examples of practical things, a play, some really cool discussions. The residents' responses were timid at first, but they gradually got involved and participated more actively in the new proposals. (P7)

The active methodologies also become evident when the preceptors meet the residents to discuss themes that cross the areas of activity of each professional, by means of reflective triggers like movies, additional theoretical activities, collective presentations of projects and *Trabalhos de Conclusão de Residência* (TCR - Residency Completion Essays) in field classes, encompassing different RMS majors.

> One example was the work with the theme of drugs triggered by movies, as this theme receives a lot of attention from the cinema. We could develop four seminars and promote debates. We held meetings with patients, professionals and residents every 15 days about the theme of mental health [...] the patients themselves bring movies, make proposals, etc. (P4)

> I thought the colleague's proposal was interesting: Having a movie session for all the residency groups. Such a rich opportunity, coordinating an action like that. The preceptors being there as debaters. (P6)

> [...] another thing we're offering to the residents is a seminar for the presentation of TCRs and projects. We're letting students present their TCRs in the field classes, in the last three field classes. (P4)

Among the strategies to integrate the RMS majors, P6 suggests the RMS areas should be integrated:

> I think we can have events, as our colleague is saying [...] that we could organize integration seminars. One class, one discipline. He does this in the Bioethics encounter and it produces good results. Sometimes, cases are brought and discussed beforehand to see if they are fit for situations that, according to them, involved ethical issues and, sometimes, there are two fields involved. (P6)

Furthermore, the preceptors believe that collective encounters involving preceptors, tutors and residents strengthen the collective dimension in the multiprofessional perspective.

> [...] that we should have pervading subjects and themes. We could have one resident, one preceptor and one tutor composing the table, and we could organize residency encounters. Just to debate with the group. (P6)

The preceptors discussed how to develop the best practices in the RMS, listing strategies to advance multiprofessional teaching and to integrate the majors that compose the RMS.

The strategies mentioned by the preceptors value the resident's knowledge, and the active methodologies are a sign that the RMS fosters spaces that generate new knowledges and practices targeted at innovation in the provision of care[19]. Thus, these proposals can represent a point-of-departure to provide residents with a type of teaching that promotes interprofessional education. Corroborating this idea, Meyer, Félix and Vasconcelos[23] recommend the production of methodologies that allow to experiment with a collective action, by means of workshops, conversation circles, discussion of movies, reflections on discourses and scenes experienced in the service, songs, poems, literature, and other cultural artifacts. The RMS can be considered not just a space for the absorption of information, knowledge and models that result in specialists, but a period of time for the reinvention of oneself and of the world. In addition, it can be viewed as the capacity for being close to and caring for users in their territory[4].

Thus, in this text, interprofessionality was used focusing on the best practices developed by preceptors, even though these are related to multiprofessionality, as the elements brought by the group of preceptors reveal characteristics related to interprofessional education in the daily routine of the services and in the action of preceptors, residents, and service professionals. These experiences are opposed to those of interprofessional education that occur in classroom activities or clinical simulations, and that is why they deserve to be disseminated[24].

Interprofessional education can be adopted both in undergraduate programs and in the reality of the services[25]. Thus, multiprofessional residencies are a powerful space for the adoption of interprofessional education, as it is a strategy that enables the development of collective work with the aim of optimizing the quality of healthcare[8,25]. That said, we need to understand how residencies

function and if they are settings where interprofessional education can be developed, bearing in mind that merely gathering different professions in the same space cannot be considered interprofessional education. It is necessary to know which theoretical and methodological frameworks we can use to truly educate subjects who are able to collaborate with one another in the dynamics of health work.

In view of the results presented here, we can see that the preceptors' best practices, as well as their strategies to make them feasible in the RMS, show that the actors must develop interprofessional skills. The activities developed in the collective dimension disclose the elements that reorganize the preceptors' work practice and, due to this, the actors of this teaching and learning process are valued.

As for the SUS, the organizer of this education process, it is expected that these professionals are qualified beyond an insertion in this logic. These professionals' education should prepare them to act as participative articulators, identifying critical nodes, making decisions, and creating strategic alternatives in management and care, so that they can promote the necessary changes to act in their reality, being committed to improving healthcare[26].

The education of residents triggered by spaces where actors talk about PHE must be understood as a process, and not only as something isolated, dealt with under a certain perspective. By means of this education, residents will be capable of developing competencies. Stimulating questionings about reality, as well as analyzing the daily routine, are extremely important to reduce the distance between socially constructed knowledge and experience gained in the world of work[17].

Therefore, the responsibility of educational centers for instructing professionals in the area of health is fundamental, and this process must reflect the social, political and cultural reality, grounded on the principles and guidelines of the SUS[27]. It is known that the multiprofessional residency programs have changed the setting of the services that house them. The advances that these in-service education modalities have implemented in the SUS are significant and have the potential for fostering changes in education and work. However, only a few experiences have been documented, recording these changes and reaffirming the importance of this education device for the consolidation of interprofessional actions and collaborative practices.

In view of this, we can think that the identification of best practices can be connected with an indicative of change in RMS education, as residencies can be considered spaces for teaching and learning actions, for they combine the preceptors' daily routine in the service with the expertise of academia's professionals. Thus, the residency can be considered a two-way street where the service contributes to the education of qualified professionals, and the professionals contribute to the improvement in the service as a whole[10].

It is expected that interprofessional experiences are capable of better preparing future health professionals to act according to the SUS's structuring principles. In addition, it is hoped that professional qualification implies an increase in the quality of the care provided for the population, contributing to the development of the sense of social responsibility in the area of health education.

Final remarks

This study presents the best practices developed by a group of preceptors of a multiprofessional residency. The recognition of the preceptors' practices is performed under the perspective of interprofessional education, as we consider it a device to fulfil collaborative practices produced by teamwork. We highlight interprofessionality as a powerful strategy for health education, and multiprofessional residencies stand out, as they involve different professional nuclei in the creation of an integrative strategy.

The preceptors viewed these practices, considered by the group as the best practices performed in the RMS, as positive and remarkable in their action as preceptors. This made them realize that, although their work has countless problems, it makes a difference in the education of professionals. Disseminating the successful practices of a group of preceptors in a professional residency is fundamental to give visibility to these collaborative practices, which are significant and produce knowledge, aiming to foster interprofessional education in healthcare.

It is important to mention that, as this is a qualitative study, we do not intend to generalize our data. Our challenge is to disseminate PHE and interprofessional education proposals in multiprofessional residencies with the aim of contributing to discussions and to present possibilities that can be implemented in different multiprofessional residencies. In view of this, further studies that disseminate successful experiences in RMS including preceptors continue to be necessary.

Authors' contributions

All the authors participated actively in the discussion of the study's results, in the review and in the approval of the manuscript's final version.

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