Cogitare Enfermagem

ORIGINAL ARTICLE

BURNOUT SYNDROME IN PRECEPTORS AND RESIDENTS LINKED TO FAMILY HEALTH RESIDENCY PROGRAMS

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ABSTRACT

Objective: to identify the Burnout and its associated factors in preceptors and residents of Residency Programs.

Method: a cross-sectional study carried out with 64 preceptors and residents in the context of Primary Health Care, from October to November 2016. A socio-professional form and the Maslach Burnout Inventory questionnaire were used. For data analysis, Fisher's Exact and Kruskal-Wallis tests were applied. The significance level was set at 5% ($p<0.05$).

Results: the participants showed moderate feelings of Professional Incompetence, Emotional Exhaustion and Depersonalization, with averages of 23.1; 17.5 and 4.1, respectively. There was an association between the dimensions of the Maslach Burnout Inventory and the Health District variable.

Conclusion: Burnout among the participants was not found. However, moderate levels of feeling of professional incompetence, emotional distress and depersonalization can negatively influence the quality of care provided. This research contributes to the pre-existing knowledge by involving residents and multi-professional tutors.

DESCRIPTORS: Primary Care Nursing; Primary Health Care; Burnout, Professional; Internship and Residency; Burnout, Psychological.

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SÍNDROME DE BURNOUT EM PRECEPTORES E RESIDENTES VINCULADOS A PROGRAMAS DE RESIDÊNCIA EM SAÚDE DA FAMÍLIA

RESUMO

Objetivo: identificar a presença de Burnout e seus fatores associados em preceptores e residentes de Programas de Residência.

Método: estudo transversal realizado com 64 preceptores e residentes no contexto da Atenção Primária à Saúde, de outubro a novembro de 2016. Utilizou-se formulário socioprofissional e o questionário Maslach Burnout Inventory. Para análise dos dados, aplicaram-se os testes Exato de Fisher e Kruskal-Wallis. Considerou-se o nível de significância de 5% (p<0,05).

Resultados: os participantes apresentaram sentimento de Incompetência Profissional, Desgaste Emocional e Despersonalização moderados, com médias de 23,1; 17,5 e 4,1, respectivamente. Evidenciou-se associação entre as dimensões do Maslach Burnout Inventory e a variável Distrito Sanitário.

Conclusão: não foi identificada a presença de Burnout entre os participantes. No entanto, níveis moderados de sentimento de incompetência profissional, desgaste emocional e despersonalização podem influenciar negativamente a qualidade da assistência prestada. Esta pesquisa contribui para o conhecimento pré-existente por envolver residentes e preceptores multiprofissionais.

DESCRITORES: Enfermagem de Atenção Primária; Atenção Primária à Saúde; Esgotamento Profissional; Internato e Residência; Síndrome de Burnout.

SÍNDROME DE BURNOUT EN PRECEPTORES Y RESIDENTES ASOCIADOS A PROGRAMAS DE RESIDENCIA EN SALUD DE LA FAMILIA

RESUMEN:

Objetivo: identificar la presencia de Burnout y los factores asociados en preceptores y residentes de Programas de Residencia.

Método: estudio transversal que se realizó con 64 preceptores y residentes en el contexto da Atención Básica a la Salud, de octubre a noviembre de 2016. Se utilizó formulario socio profesional y cuestionario Maslach Burnout Inventory. Para análisis de los datos, se aplicaron las pruebas Exacta de Fisher y Kruskal-Wallis. Se consideró el nivel de significancia de 5% (p<0,05).

Resultados: los participantes presentaron sentimiento de Incompetencia Profesional, Agotamiento Emocional y Despersonalización moderados, con promedios de 23,1; 17,5 y 4,1, respectivamente. Se constató asociación entre las dimensiones del Maslach Burnout Inventory y la variable Distrito Sanitario.

Conclusión: no se identificó la presencia de Burnout entre los participantes. Sin embargo, niveles moderados de sentimiento de incompetencia profesional, agotamiento emocional y despersonalización pueden influenciar negativamente la cualidad de la asistencia prestada. Esta investigación contribuye para el conocimiento preexistente por involucrar residentes y preceptores multi profesionales.

DESCRIPTORES: Enfermería de Atención Básica; Atención Básica a la Salud; Agotamiento Profesional; Internado y Residencia; Síndrome de Burnout.

INTRODUCTION

The increase in the range of action and accountability of Primary Health Care (PHC) professionals in Brazil has been strengthened since the 2000s, as a result of the expansion of the Family Health Strategy (FHS). The care model, which was once hospital-centered and based on the disease, went from the core of medical professionals to the inclusion of different multidisciplinary knowledge, in line with the model of health care networks (RAS), which considers PHC as the organizer of the network. In this context, the responsibility of PHC professionals has gradually increased, involving assignments related to the opportunity for access, long-term and continuity of comprehensive care to the individual and the population[1,2].

Given the need to expand the performance and qualification of advanced practices of PHC professionals, Health Residency has been considered an ideal modality for training professionals for the Unified Health System (SUS)[3,4]. Professionals, usually recently graduated, seek residency in health to acquire experience, professional excellence and the title of specialist in the chosen area. The objective of the Family and Community Medicine (PRM/MFC) and Multiprofessional Family Health (PREMULTISF) Residency Programs is to train professionals through in-service education, under the logic of learning-by-doing, to work in PHC and other RAS care locations, seeking to qualify them for the performance of their activities in the SUS and aiming at achieving the technical, political and ethical competences of the FHS[4].

In Brazil, the residency programs suppose a minimum workload of 5,760 hours, divided in over 60 hours per week, of which 20% are committed to theoretical activities and 80% to practical and theoretical-practical activities. The development of the skills and competences supposed for the resident during the course is supervised by preceptors, tutors, pedagogical and internship supervisors, and other subjects co-responsible for the programs. The preceptors are health professionals inserted in the same workplaces as the residents, in this case, the Basic Health Units (UBS)[4]. In this sense, the student responsibilities expected for the resident and the supervisory assignments for the professional teacher add to the workload and assistance roles inherent to working in PHC.

The professional performance in the health area happens intensely, in which, in addition to the high workload and frequently the addition of another employment, there is also an intense emotional burden that comes from monitoring the health and disease process. Because of this, the potential for triggering occupational stress resulting from the work dynamics of health professionals in different contexts of practice has been widely discussed in the literature[5,6]. In this context, stress happens as a result of a situation that exceeds the individual's adaptation and resilience abilities[7].

The lack of strategies to overcome the stressful factors that involve work can result in several psychosomatic changes, including Burnout Syndrome (BOS)[7]. The most consolidated definition of BOS considers it as a reaction to chronic emotional tension motivated by direct contact with other human beings when they are concerned or with problems[8], having as main characteristics the emotional exhaustion, the depersonalization of the care provided and the feeling of professional incompetence[9]. In Italy, the structure, validity and reliability of the scale were tested. The analysis provided support for a 20-item version and kept the original three categories[9].

In Brazil and other countries, BOS has been studied in the context of health professionals, exploring the prevalence of the syndrome among PHC professionals[8,10-12], hospital context[5-7,9,13-15], and even among health residents[16,17]. However, the discussion about BOS among members of residency programs, including preceptors and residents within the scope of PHC, still represents a gap to be explored. Thus, the objective of this study was to identify the presence of Burnout and its associated factors in preceptors and residents of Residency Programs.

METHOD

This is a cross-sectional study, with data collection carried out from October to November 2016 in a PREMULTISF and a PRM/MFC linked to a public postgraduate education institution in the city of Florianópolis-SC, with residents as participants and preceptors of a PREMULTISF and a PRM/MFC.

The non-probabilistic sampling was used, in which all 41 residents and 51 preceptors who were part of the programs were invited to participate in the study. As inclusion criteria, residents from the 2015-2017 class, and preceptors linked to both programs were considered. Those who did not respond to the instruments sent by e-mail were excluded from the study.

The researchers initially approached participants at periodic meetings pre-established by the programs. In this approach, an attempt was made to explain the theme and objectives of the research, making the invitation to participate in the study and collecting the e-mail addresses of those interested. In a second step, the following documents were sent via Google® platform: Informed Consent Form (ICF), socio-professional form and the Maslach Burnout Inventory (MBI) questionnaire, version Human Service Survey (HSS)[18]. It should be noted that all instruments were self-applied. Of the total of 92 residents and tutors linked to the programs, 28 did not answer the questionnaire. Thus, the research sample consisted of 64 participants, being 34 residents and 30 tutors in the professional areas of physical education, nursing, pharmacy, physiotherapy, medical, nutrition, dentistry and social work.

The socio-professional form addressed the variables: age, sex, professional category, function (preceptor or resident), time of professional experience and Health District (DS) to which the UBS in which the professional was inserted belongs. The instrument chosen for the evaluation of BOS, the MBI-HSS, was developed by Christina Maslach and Susan Jackson in 1981 and was later adapted and validated for the Brazilian context[18,19].

The MBI-HSS is a Likert-type instrument, with a five-point scale, in which zero is for never, one for a few times a year, two for a few times a month, three for a few times a week, and four for daily. It consists of 22 items divided into three subscales, independent of each other, in which nine items refer to Emotional exhaustion (EE), five to Depersonalization (DP) and eight to Lack of Professional Achievement or Feeling of Professional Incompetence (PI). The first two dimensions, EE and DP, have a positive score, that is, the higher the score, the higher the SOB level, while the PI dimension is presented in a reverse way, so that the lower the score, the higher the SOB level[20].

The data were tabulated in an Excel® spreadsheet and, to interpret the scores achieved on the three scales, the cutoff points are shown in Chart 1[14] were presented.

Chart 1 - MBI-HSS scale values. São Paulo, SP, Brazil, 2015

Dimensions			Cutoff points
Emotional Exhaustion	Depersonalization	Feeling of Professional Incompetence	
≤ 10	≤ 2	> 27	Low
11 to 21	3 to 8	21 to 27	Moderate
> 21	> 8	≤ 20	High

Source: Ferreira, Lucca (2015)[14].

The data were processed using the Statistical Package for the Social Sciences (SPSS) version 23 and analyzed using descriptive and inferential statistics. To check the association between the variables, Fisher's exact test and Kruskal Wallis's nonparametric test were applied. The level of significance was set at 5% ($p<0.05$).

The research project was submitted to the Municipal Health Research Projects Monitoring Committee and the Ethics and Research with Human Beings Committee, being approved by the opinion 1,686,785.

RESULTS

The predominant characteristics of the participants were age less than 30 years, female sex and time in the profession between two and five years. The training areas with the largest number of participants were Nursing and Medical. The socio-professional characteristics of the research participants are shown in Table 1.

Table 1 – Socio-professional characteristics of preceptors and residents of the Multiprofessional and Medical Residency Programs in Family Health. Florianópolis, SC, Brazil, 2016 (continues)

Socio-professional characteristics	N	%
Age (in years)		
< 30 years	25	39.1
Between 30 and 35 years	21	32.8
Between 36 and 40 years	11	17.2
> 40 years	7	10.9
Sex		
Female	48	75
Male	16	25
Professional category		
Nursing	21	32.8
Medical	17	26.5
Dentistry	10	15.6
Physiotherapy	5	7.8
Physical Education	4	6.3
Pharmacy	3	4.7
Nutrition	3	4.7
Social work	1	1.6
Function		
Resident	34	53.1
Preceptor	30	46.9
Health district		
South	24	37.5

Continent	15	23.4
East	14	21.9
Center	6	9.4
North	5	7.8
Time in the profession		
2 to 5 years	36	56.3
6 to 10 years	15	23.4
> 10 years	13	20.3

Source: The authors (2016).

The BOS was not found among preceptors and residents. Participants had moderate PI, EE and DP, with a mean of 23.1; 17.5 and 4.1 respectively. The descriptive analysis of the dimensions of the MBI-HSS, referring to PI, EE and DP, can be seen in Table 2.

Table 2 - Dimensions of Burnout Syndrome in preceptors and residents of the Multiprofessional and Medical Residency Programs in Family Health. Florianópolis, SC, Brazil, 2016

Dimension	Dimensions level	N=64 (%)	Min-Max.	Median	Standard deviation	Variance
The feeling of professional incompetence	Low	19 (29.7)	9-32	23.1	5.9	34.3
	Moderate	29 (45.3)				
	High	16 (25)				
Emotional exhaustion	Low	14 (21.9)	4-34	17.5	7.6	58.3
	Moderate	33 (51.5)				
	High	17 (26.6)				
Depersonalization	Low	27 (42.2)	0-15	4.1	3.5	12.3
	Moderate	28 (43.7)				
	High	9 (14.1)				

Source: The authors (2016).

As for the associations between the MBI-HSS dimensions, there was a positive and statistically significant association between the PI and EE between PI and DP, and between EE and DP (Table 3).

Table 3 – Analysis of the associations between the dimensions of the Burnout Syndrome in preceptors and residents of the Multiprofessional and Medical Residency Programs in Family Health. Florianópolis, SC, Brazil, 2016

		IP			Total N (%)	P-value
		Low N (%)	Moderate N (%)	High N (%)		
The feeling of professional incompetence	Low	7 (10.9)	7 (10.9)	-	14 (21.8)	0.001
	Moderate	11 (17.2)	16 (25)	6 (9.4)	33 (51.6)	
	High	1 (1.6)	6 (9.4)	10 (15.6)	17 (26.6)	
	Total	19 (29.7)	29 (45.3)	16 (25)	64 (100)	
Emotional exhaustion	Low	12 (18.8)	10 (15.6)	5 (7.8)	27 (42.2)	<0.001
	Moderate	7 (10.9)	18 (28.1)	3 (4.7)	28 (43.7)	
	High	-	1 (1.6)	8 (12.5)	9 (14.1)	
	Total	19 (29.7)	29 (45.3)	16 (25)	64 (100)	
		DE			Total N (%)	P-value
		Low N (%)	Moderate N (%)	High N (%)		
Depersonalization	Low	6 (9.4)	18 (28.1)	3 (4.7)	27 (42.2)	0.005
	Moderate	8 (12.5)	13 (20.3)	7 (10.9)	28 (43.7)	
	High	-	2 (3.1)	7 (10.9)	9 (14.1)	
	Total	14 (21.8)	33 (51.6)	17 (26.6)	64 (100)	

Source: The authors (2016).

As for the associations between sociodemographic and professional variables and the dimensions of Burnout Syndrome, there was no association between the levels of PI, EE and DP concerning the variables age, sex, professional category, function and time of professional experience. Regarding the UBS health district, a statistically significant difference (p=0.031) was observed between the PI level and the different health districts in the municipality. The Southern health district stood out with a higher level of PI, as shown in Table 4.

Table 4 - Association between the feeling of Professional Incompetence and Health District. Florianópolis, SC, Brazil, 2016 (continues)

Health District	Feeling of professional incompetence			Total N (%)
	Low N (%)	Moderate N (%)	High N (%)	
Center	2 (33.3)	2 (33.3)	2 (33.3)	6 (100)
Continent	3 (20)	10 (66.7)	2 (13.3)	15 (100)
East	4 (28.6)	9 (64.3)	1 (7.1)	14 (100)
North	1 (20)	3 (60)	1 (20)	5 (100)

South	6 (25)	5 (20.8)	13 (54.2)	24 (100)
Total	16 (25)	29 (45.3)	19 (29.7)	64 (100)

Source: The authors (2016).

DISCUSSION

Among the study participants, a higher prevalence of members younger than 35 years was observed. In a study that sought to identify the sociodemographic and academic profile of 37 multi-professional health residents, it was observed that 51.4% of the participants were in the age group between 25 and 29 years old, corroborating the findings of this study. This may be related to the fact that recently graduated professionals identify an opportunity at the residency to acquire experience and technical skills in the area of choice, which results in frequent entry into residency courses right after undergraduate school[21].

The greater number of professionals in the areas of Nursing and Medical is due to the magnitude of the workforce of these professionals in health services and, consequently, to the greater number of vacancies supposed in the public notice for these professionals in the researched programs. Therefore, professionals in these areas represent the largest number of residents in the program and, as a result, have the largest number of preceptors in the same professional category.

The studied context presents the third-highest Municipal Human Development Index in the country, being the first among the capitals[22]. Also, the municipality represents a national reference model in good practices in the PHC setting[23], which may have contributed to the absence of BOS among the participants.

Even so, the participants presented moderate PI, EE and DP indexes, indicating the need for reflection on the training conditions of these professionals. It is inferred, therefore, that these values could be negatively influenced according to the work environment of the investigated scenario, given the heterogeneity of Brazilian municipalities and their responsibility on the primary level of care. In this sense, it is important to emphasize the need for further studies to assess the reality experienced by members of residency programs in different PHC settings.

Although there was no evidence of BOS in residents and preceptors, studies have shown its prevalence in professionals working in PHC settings[11-15]. Considering the organization of SUS according to the sense of RAS, which is ordered by PHC, the health conditions of professionals at this level of care have an impact on the quality of care offered throughout the network[8]. Recent changes in the approach of the FHS require preparation and training to face them satisfactorily. Along with this requirement, UBS is often inserted in dangerous and unsanitary territories, marked by social inequalities and poverty, which can favor the emergence of psychological distress for the professionals involved[24].

In some cases, in addition to the 60-hour workweek, residents are exposed to factors such as disrespect for the basic needs of the teaching-learning process, lack of tutoring, deficiency of time for study and rest[16,17]. Residents exposed to training stressors, in addition to those in the profession, can develop BOS when they do not use adequate strategies to minimize or eliminate the stressor. In this sense, personal, family, institutional and social damages are possible in this population[25]. Along with this, the requirement for a set of functions and tasks performed by the preceptors, in a context with influences of the social, economic and political situation, experienced at work in the FHS, contributes to different levels of stress that can lead to BOS[26].

In the analysis of BOS among the study participants, an association was identified

between the three dimensions of the MBI. The feeling of PI can be the result of a perception of failure in the face of the therapeutic possibilities of the assisted users, making the professional unable to discern the weaknesses of the health system from their limits of autonomy and governance[5]. It is associated with low self-esteem, feeling of inadequacy, flaw and demotivation, which reflects a decrease in engagement and commitment to the quality of the work performed, and negatively influences the care provided[27]. In this sense, we can infer that the feeling of PI identified in the preceptors and residents is a result of emotional exhaustion derived from working conditions, which can compromise humanized and individualized assistance, resulting in the depersonalization of care.

Thus, the prevention and treatment of BOS transcend the individual benefits of the professionals, reflecting in the work environment and better performance of organizations. As an example of this, the best service offer, fewer days off work and better economic performance[28] stand out.

The relationship between the feeling of PI with exhaustion and depersonalization of the care provided by residents and multi-professional preceptors in family health, linked to the workplace, suggests the interference of different management processes as a contributory factor for the triggering of BOS. A study carried out in five regions of Brazil pointed out that job dissatisfaction in this scenario is linked to factors such as inadequate physical structure, lack of material resources, management failures, excessive working hours, lack of work appreciation and low payment[29].

BOS has been understood not as a problem of the individual, but of the social environment in which work skills is performed, highlighting the influence of organizational management at work[17]. The lack of commitment and planning by managers in the continuity of health actions, linked to the political influence on services, makes it difficult to implement the National Primary Care Policy (PNAB). This reflects on the daily care by the FHS and hinders its resolution. There is also a high turnover of managers who are committed and trained for only political issues, hindering the continuity of good practices and the provision of better quality services[24].

The feeling of PI was identified as moderate in three health districts and high in one. Organizational environments are shaped by social, political and economic factors, and are constantly changing. When these changes result in high demands with few resources, they can impact professional exhaustion. Also, therapeutic relationships, which require continuous and intense attention of emotional and personal contact, in the case of PHC that aims to provide long-term care, can be both rewarding and stressful[27].

There was no association regarding age, sex, professional category and function with the feeling of EE, DP and PI. A study carried out with FHS workers in a municipality in the south of Brazil points out that common mental disorders were more frequent among professionals between 36 and 45 years old and nurses, without, however, showing significant statistical differences in comparison with the other age groups and professional categories evaluated. Regarding sex and BOS, there are divergences in the literature, with some authors observing a higher risk of burnout in women[30] and others in men, and even those who did not find an association with the sex variable[8,12].

Regarding the experience time in the profession, a study that analyzed the presence of BOS in PHC professionals showed that the longer the time in the profession, the lower the chances to BOS, since this factor favors the professional for providing more experience and familiarity with the context. On the other hand, the shorter the length of experience, the greater the insecurities regarding decision making and the difficulty in dealing with stressful factors, indicating that short time of experience in the profession is associated with BOS[10].

As limitations of the research, the use of a non-probabilistic type sample is pointed out based on the inclusion of residents and tutors of two residency programs in the same municipality, which compromises the generalization of the results. Despite this, the study's findings provide important subsidies for discussing worker health in PHC.

FINAL CONSIDERATIONS

No Burnout was identified in preceptors and multi-professional residents, however the participants showed moderate feelings of PI, EE and DP.

This study contributes to the multi-professional residency programs in family health and family and community medicine, as well as to the primary care setting. The research advances in the pre-existing knowledge by involving preceptors and multi-professional residents and pointing out factors related to the feeling of PI that can directly influence the care provided in this context.

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