Preceptorship in Multiprofessional Residency in Oncology: Between In-Service Training and Labor Precariousness

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A Preceptoria na Residência Multiprofissional em Oncologia: entre a Formação em Serviço e a Precarização do Trabalho

Precepción en la Residencia Multiprofesional en Oncología: entre Capacitación en el Servicio y Trabajo Precário

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INTRODUCTION

The Multiprofessional Residency Programs in Oncology (MRO) have the objective of qualifying professionals by and for the National Health System (SUS) because they are strategies of continuous education to produce new practices in health, being a modality of post-graduation *lato sensu* education focused to oncology and aimed to professional categories in the area of health, other than medical.

The importance to educate professionals in oncology is clear because according to the estimates of the National Cancer Institute José Alencar Gomes da Silva (INCA)[1], for each year of the triennium 2020-2022 in Brazil, 450 thousand new cases of cancer are anticipated, except non-melanoma skin cancer.

The formation in oncology needs to comply with SUS principles and with the guidelines of the National Policy of Continuous Education in Health, recognizing all the players involved (docent, resident, preceptor, tutor and manager) as subjects of the work-learning-teaching process.

The preceptor is an extremely important professional for the process of formation in health and must be able to articulate the practice with scientific knowledge and then, turn the professional field into a learning space through its experiences[2], like the resident who is a professional in formation who brings its potentiality required by the MRO while participating of this process[3].

Rodrigues[3] affirms that the residencies are potentializers capable to transform the practices, but also to press the components of social policy that materialize in the spaces of the daily life. The current scenario of dismantling of health public policies has not been favorable to improve the education in health within the perspective of continuous education. The precarization of the labor conditions and insufficient human resources for new demands of health services – because of accumulation of tasks – fragilize the dialectic relation among assistance, teaching, research and management[4].

It is advocated that MRO is a space of integration of wisdom and practices that allow the construction of new knowledge to consolidate the continuous education in the labor process and in other spaces of formation, dialogue, collective construction and social control (forums, councils, social movements and organization entities of professional categories), in order to develop a critical and reflexive attitude of the services provided by SUS within the perspective of integrality.

As a consequence of the authors critical reflections based in the experiences they lived in MRO, it is attempted in this article to discuss this modality of professional formation from the insertion in a conjuncture of regulation of the process of precarization of the labor market,[5] and within the perspective of problem-based education[6], understanding that MRO has a tenuous line between formation and work[4].

DEVELOPMENT

The consequences of labor precarization in MRO: tendencies and challenges of preceptorship

MRO develops in the hospital context of high complexity of SUS, which experiences the dismantling and privatization of health services, specially from 2009 onward. As a result of the health project designed in the market, what it is noticed is the materialization of a policy of adjustment targeted to reduce costs and rationalization of the supply[7].

In what concerns the management of the labor force, there is an attempt to break the Single Legal

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Regime proposing the creation of contract management with privatizing objectives[7], which is increasing labor precarization when it allows to engage workers under the Consolidation of Labor Laws and other forms of temporary contract.

These multiple contradictions found in the labor conditions and relations in health have been defined by the critiques[8-10] as elements of labor precarization. Precarization is understood from a double dimension: in the dimension of the actual labor as a commodity and in the dimension of the man-who-works as a generic human being with personal experiences of class in a context of labor rights, submitted to salary conditions of exploration/spoliation[8]. In a world characterized by the flexible accumulation radicalized through spoliation[9] or precariousness[10], there is no job offer protected to all – although the job is done under pressure of more involvement to achieve better results.

The precarization of labor nowadays is expressed as forms of commodification of the labor force, by the conditions and organization of the job, health and safety conditions at labor and collective organization and representativeness[11]. In health, the precarization has been triggered by the privatization of management in SUS, since the public server starts to be ruled by non-stability regimen, different salaries in the same professional and service category, in addition to binding part of the salary to criteria of productivity.

Despite being hugely important for continuous education, MRO is mirroring the flexibilization and diversification of SUS labor bonds. Surveys have been demonstrating double movement in MRO: from one side, the growth of offer of scholarships for health residencies and, on the other, reduction of public tender for tenure in SUS[4].

Budget shrinking for social policies and privatization of health public services to recover equity considering its cyclic crisis escalating increasingly[7] at each term, favor the recognition of MRO programs beyond their pedagogic feature and create a dilemma: in-service training or risk of creating another modality of precarious labor?[12].

In practice, the insertion of the resident in the activities of the program has a duality: of the professional capable for the practice in its profession but that cannot be considered a team member that must respond individually to the demands and requests of the service/institution[3].

The preceptorship must acknowledge the resident not as a professional belonging to the institution staff, that is, as replacement staff but follow a pedagogic project that establishes a differentiated nature for this participation that grants supervision, time for studies and meetings to favor a transforming education of ways to work in health[2] and not merely an engagement to meet the immediate necessities of human resources.

Residency presupposes a more reflective practice, however, currently, it is opposed to a 60-hours working routine that is satisfactory only in the institution environment[4]. The discussion about institutional fulfillment of an extensive work shift in face of the health professionals fight for the regulation of the 30 hours week workload is quite important for all the professionals involved in the process learning-teaching because despite the individuals occupy differentiated functions in the units, all are professionals and are exposed to the same consequences resulting from labor precarization.

Considering the pressure for productivity, work overload, especially in academic/scientific works that, mostly, materialize as a merit-based and productive-driven bias, it is noticed that this worker-student is in the process of sickening[13]. Specifically, the MROs present some potentializing factors of the work-related diseases, which are the process of attention to cancer and emotional exhaustion the worker-student is submitted to during its activities.

The study conducted by Cavalcanti et al.[14] analyzed the occurrence of the Burnout syndrome and depression among MRO residents and concluded they had high level of this syndrome and depression. In addition to the intense work overload and emotional tiredness, the professionals of the MRO are, in its majority, women who also have their household activities, a sign of gender inequality in our society. It is indispensable the recognition of residency as work and education, since this health education improvement environment is becoming a precarious work for the professionals[4].

In preceptorship, some general elements of precarization are clear through the fragmentation of the workers who have diverse contracts, salaries and work shifts, which affects their working conditions and political organization. A great dilemma has been the reduced number of professionals for preceptorship, in addition to the heterogeneity of health professionals with different employment bonds and lower salary than the scholarship for residents.

Furthermore, it is observed in the preceptorship the polyvalence and simultaneous practice of parallel activities and pressure for more results, agility/versatility that tend to lead to wearing, increased fatigue and personal impacts physiologically, mentally, emotionally and work-related.

Quite often, the preceptor assumes the positions of tutor and coordinator of programs/modules/disciplines simultaneously, revealing the polyvalence of the professional work, without relying on a defined institutionally work shift to perform the actions similar to professional specialization,

characterized by teaching in-service. Therefore, it must be recognized the activities of residency as inseparable from the professional job in health.

CONCLUSION

The discussion about MRO and its dilemmas in the formation and work have been the core of the debates among professionals, students and investigators of several areas, indicating the urgency of studies and researches that elucidate the residency as one of the strategies of flexibilization of the employers bonds in SUS. Therefore, the difficulties of the preceptorship cannot obfuscate the ethical-political commitment of defense of the residency in health as process of formation in-service and not as reiteration of different modalities of precarization of teaching and work.

CONTRIBUTIONS

Both authors contributed substantially for the conception and planning of the study; gathering, analysis and interpretation of the data, wording and critical review and approved the final version to be published.

DECLARATION OF CONFLICT OF INTERESTS

There is no conflict of interests to declare.

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