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The Teaching-Service Integration and the Multiprofessional Residency in Health: an experience report at a Basic Health Unit

A Integração Ensino-Serviço e a Residência Multiprofissional em Saúde: um relato de experiência numa Unidade Básica de Saúde

La Integración Enseñanza-Servicio y la Residencia Multiprofesional en Salud: un relato de experiencia en una Unidad Básica de Salud

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ABSTRACT: This study comprises an experience report that aims to promote reflections about the teaching-service integration in the context of the Multiprofessional Residency in Health, in the practice scenario of a Basic Health Unit (BHU). It sought to analyze the way the residents carried out the coordination of activities with the daily routine of the service at the BHU, as well as to describe the challenges encountered during the operation period in this scenario and the coping strategies developed to deal with such difficulties. In order to perform a critical and reflective analysis of the experiences, both the existing scientific literature on the subject of teaching and service integration, as the perspective of social constructionism were used. The experience of this resident team corroborates existing experiences in the scientific literature about the challenges faced in the context of teaching-service integration, pointing to the need for a closer relationship among the sectors involved in this process.

Keywords: teaching-care integration services, non-medical internship, health centers.

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RESUMO: Este estudo compreende um relato de experiência que tem como objetivo promover reflexões acerca da integração ensino-serviço no âmbito da Residência Multiprofissional em Saúde, no cenário de práticas de uma Unidade Básica de Saúde (UBS). Buscou-se analisar o modo como ocorreu a articulação das atividades realizadas pelos residentes com o cotidiano do serviço na UBS e descrever quais os desafios encontrados durante o período de atuação neste cenário, bem como as estratégias de enfrentamento desenvolvidas para lidar com tais dificuldades. Para realizar uma análise crítico-reflexiva das experiências vivenciadas, utilizou-se tanto a literatura científica existente sobre a temática da integração ensino-serviço, como a perspectiva do Construcionismo Social, na construção do conhecimento. A vivência da equipe de residentes corrobora com as experiências existentes na literatura científica acerca dos desafios enfrentados no contexto da integração ensino-serviço, apontando para a necessidade de uma maior aproximação entre os setores envolvidos nesse processo.
Palavras-chave: Serviços de integração docente-assistencial, internato não médico, centros de saúde.

RESUMEN: Este estudio comprende un relato de experiencia cuyo objetivo es promover reflexiones sobre la integración enseñanza-servicio dentro de Residencia Multiprofesional en Salud en el escenario de prácticas de una Unidad Básica de Salud (UBS). Se trató de analizar cómo fue la articulación de las actividades llevadas a cabo por los residentes con la rutina de servicio de UBS, y describir los retos encontrados durante el período de operación en este escenario y las estrategias de enfrentamiento desarrolladas para hacer frente a estas dificultades. Para realizar un análisis crítico y reflexivo de las experiencias, se utilizó tanto la literatura científica existente sobre el tema de la integración enseñanza-servicio, como el punto de vista del Construccionismo Social en la construcción de lo conocimiento. La experiencia de este equipo residente corrobora las experiencias existentes en la literatura científica acerca de los desafíos enfrentados en el contexto de la integración enseñanza-servicio, que apunta a la necesidad de estrechar los vínculos entre los sectores involucrados en este proceso.
Palabras clave: servicios de integración docente-asistencial, internado no médico, centros de salud.

INTRODUCTION

This study intends to reflect on the teaching-service integration within the scope of the Multiprofessional Residency in Health, in the context of the Basic Health Unit (BHU). This is an experience report of a group of residents participating in the Multiprofessional Residency Program in Adult and Elderly Health of the Federal University of Alagoas (UFAL), which develops the activities in two practice scenarios: a University Hospital (HU) and a Basic Health Unit. The report bases on the assumption that the Multiprofessional Residency is an important device to deal with changes in the health care model, fostering discussions about in-service training and improvement

of teaching-care integration.

The Multiprofessional Health Residency is a new strategy that favors the production of the necessary conditions for the change of the restrictive medical-assistance model still hegemonic[1]. It seeks, therefore, the integrality of the actions in health and not only the model centered in the procedure. However, in order to change the ways of doing health, it is necessary to take into account the different contexts and actors involved in this process.

As provided in item VI of article 2 of Interministerial Ordinance MEC/MS nº 1,077, of November 12, 2009, the Multiprofessional Health Residency should include as one of its guiding axes the "teaching-service-community integration, through Program partnerships with managers, workers and users".[2] Thus, there is no production of the necessary conditions for change if there is no dialogue among teaching, assistance, management, users and professionals in training.

The interest in this theme arose due to our experiences as residents in the second year of the Residency Program, when the change of the practice scenario, from the hospital context to BHU, takes place. During the first year, the residents work at the medical and surgical clinics of the hospital and, in the second year, they acquire experiences at the outpatient clinics and at the Basic Health Unit, one semester for each of these scenarios. In the semester assigned to BHU, there were concerns about the distance between residents and service professionals, in both the planning and execution of actions, as the absence of a representative of these professionals in the meetings of the residency program. Such concerns have raised interest in reflecting on how the articulation between teaching and service has occurred in the context of the Multiprofessional Residency in Adult and Elderly Health regarding this practice scenario.

The study bases on the narrative of the activities carried out by the resident group from the years 2013-2014, during the period of performance experienced at BHU in the year 2014. Professionals from the Psychology, Nutrition, Physical Education, Nursing, Pharmacy and Social Work areas, currently covered by the program, integrate this group. In order to do so, we sought to analyze the way the articulation of the activities we, residents, perform with the daily life of the service at BHU occurred, through our experiences recorded in minutes and reports, as well as to describe the challenges encountered during our performance in this scenario and the coping strategies developed.

Teaching-Service Integration and the Multiprofessional Residency in Health

Resulting from the Sanitary Reform and the movements seeking to expand the concept of health care based on integrality, the Unified Health System (SUS), a major achievement of the health movement, is currently a protagonist in the construction of several policies aimed at the operationalization of this new model of health production. Among these, the National Policy of Permanent Education in Health (PNEPS – *Política Nacional de Educação Permanete em Saúde* in Portuguese)[3] stands out.

The need to change the biological paradigm focused on the disease and the procedures into a comprehensive care model that responds in a more effective and humanized way to the health problems of the population has focused on the indispensability of modifying the practices previously used to respond to such issues. In this sense, training for the health area must go beyond the technical-scientific update. According to Ceccim, Feuerwerker[4], training encompasses aspects of the production of subjectivity, production of technical skills and thinking, and adequate knowledge of SUS. This training should prioritize the transformation of work practices and organization, thus problematizing work processes. Therefore, the training should not be remote from the reality of the services, but inserted and dealing with the problems of the routine of health units.

In the scientific literature and within the scope of health management, discussions on the devices that provide the necessary changes in the health sector have been occurring, and policies have been formulated to deal with the current demands of modifying the training of professionals to work in the SUS.

In 2003, with the creation of the Department of Health Work and Education Management (SGTES – *Secretaria de Gestão do Trabalho e Educação na Saúde* in Portuguese) in the structure of the Ministry of Health, the National Policy of Permanent Education in Health was established, as set forth in Administrative Rule No.198, dated February 13, 2004.[5] Permanent education "is learning at work, where learning and teaching are incorporated into the daily life of organizations and work[3]".

Following the perspective of permanent education, it is clear the importance of the integration between education and service for the consolidation of the policy and consequent realization of the new ways of doing health. The work environment becomes the ideal space for dialogue and joint construction between teaching and assistance and for the formation of a critical-reflexive professional whose competencies are solving current health problems and the ability to work as a team[6].

> Teaching-service integration is understood as the collective, agreed and integrated work of students and professors of health training courses with workers who make up the health services teams, including managers, aiming at the quality of attention to the individual and collective health, the quality of professional training and the development/satisfaction of service workers[7].

A dialogical and non-hierarchical relationship mong the actors that make up the scenario of the teaching-service integration is fundamental so that the discourses problematize the organization and the work processes and do not only blame one or another sector. Studies[8,9] have shown successful examples in health education through the new policies developed for this sector, such as the experiences of the Pro-Health and Pet-Health and curricular internships of graduate courses

in Primary Care. One example of this experience with Pet-Health and Pro-Health in Porto Alegre evidences the good articulation of activities of these two programs with Residency programs carried out in the same care units. An important point to highlight for the effectiveness of such an experience is the constant dialogue between the University and the Municipal Health Department, which is responsible for the basic units where academics and residents are inserted[8].

On the other hand, there are still many challenges described in the relationship between teaching and service, such as the fact that the university still does not take into account the services professional in the planning of pedagogical activities and, in return, this professional does not participate in such activities. Therefore, the university needs to invest in the sensitization of the professionals inserted in the teaching-learning scenarios, diagnosing the needs of these services and contributing to them, through teacher-student pacts. Such pacts should take into account the negotiation of spaces, schedules and technologies conducive to the adequacy and development of service activities and educational practices. Just as it is of the utmost importance that service professionals participate in the discussions on health education[7].

A literature review on the panorama of teaching-service integration in Brazil points out advances such as the reduction of the dichotomy between theory and practice and the approximation with the principles of the SUS by the Academy; the qualification of the professionals and the improvement of the quality of the care regarding the assistance. Regarding the challenges encountered, there are asymmetrical relations, distance among the actors, work overload and inadequacy of the physical structure of services[10].

Such asymmetrical relations and distancing among the actors involved in the process should be problematized, since the scenarios of practices in the field of permanent education, whose focus on the training of professionals privileges the critical reflection on the care and management practices, should allow opening spaces for intersectoral dialogue, configured as part of health work and not as something extra/disconnected from the field of practice.

Still within the context of the National Policy of Permanent Education in Health, the Multiprofessional Health Residency emerges as a possibility to change health care practices and is permeated by the same discourses, advances and challenges found in the other scenarios of teaching-service integration.

The Multiprofessional and Professional Health Area Residency was regulated by Law No. 11.129 of June 30, 2005. It is characterized as a *latu sensu* post-graduation in the teaching-in-service modality and its objective is to train professionals to work in the public health system, and should be guided by the guidelines of SUS[11].

This type of in-service teaching enables not only the qualification of the residents, but also of the professionals included in the services, since it encourages the process of reflection on the practice.

On the other hand, the conception that the program should fill the existing faults in the graduate course may detract from the focus of a reflexive practice for the application of decontextualized theories and techniques or prioritize individualized training[6]. The purpose of the Residency is not to fill the gaps of the previous training, but to promote the acquisition of competencies of another order and, for this reason, many programs do not have specific preceptor by professional category[12].

Some studies[13, 14] show the challenges faced by the Residency programs, such as the preceptor being responsible fot the training of the resident, as well as the task of sensitizing all co-workers and promoting team and residents mediation. This reality evidences the overload suffered by the preceptor, since his/her participation in the Residency does not exclude the activities in the assistance, which often causes absence from work with other professionals in his/her team, generating conflicts.

Other barriers encountered in the context of the Residency concern gaps in the training of preceptors who were not trained to deal with the pedagogical aspects of teaching. The work overload and the non-involvement of other professionals with the Residency, the lack of understanding of the managers in relation to the preceptory work as part of the prescribed work, as well as the precarious working conditions that end up generating dispute by spaces[14].

The experiences in the context of the Multiprofessional Residency have shown the importance of building a dialogue among teaching, assistance and management, since none of these sectors is capable of solving these impasses alone. If the management does not understand that spaces and conditions of possibilities are necessary for the integration between teaching and service, proposals such as the Residency become isolated or even impossible to be effective.

Taking into account the transformative nature of health practices attributed to the Multiprofessional Residency, as well as the fact that their implementation experiences are recent in the health area, studies[5,10,12] point out the importance of conducting researches that demonstrate the impact of the insertion of the Residencies in the health services, contributing to the evaluation of the programs, as well as to the improvement of the reflections about the teaching-service integration.

METHODOLOGICAL PATH

Records of minutes and reports by the residents of the second year class of the Multiprofessional Residency Program in Adult and Elderly Health were used as input for the experiences of BHU in the year 2014. These minutes and reports were part of the work processes of the residents in the practice scenarios and were produced during the two semesters when we were inserted in the BHU. This group was formed by eighteen residents: two physical educators, two social workers, two pharmacists, four psychologists, four nutritionists and four nurses. Due to the fact that we formed a relatively large group, we were divided into two teams, which worked in different periods at the BHU. Therefore, for this study, a minute and a report on each team were used, which included the period from May to August 2014, regarding the experience of the first team; and September to

December of the same year, concerning the experience of the second team. In such records, each team describes the activities performed weekly, as well as the planning of the following activities, in the case of minutes; and the final report, which describes the activities carried out throughout the period of practice at the BHU, as well as the advances and challenges faced.

Regarding the composition of the teams, each one counted on the participation of a physical educator, a pharmacist, a social worker, two nutritionists, two nurses and two psychologists.

We chose the reports and minutes of the two teams, because we understood that the experiences were an ongoing process initiated by the first team during their performance in the aforementioned practice scenario continued by the insertion of the second team. Thus, we experienced several moments of joint discussion on the challenges faced in the context of the BHU.

In order to perform a critical-reflexive analysis of the experiences of both teams in this practice scenario, we used both the existing scientific literature on the theme of teaching-service integration as the perspective of Social Constructionism.

Social Constructionism considers knowledge as an "artifact of social interchange", as Kenneth J. Gergen[3*] states in 1985[15]. According to the author, Construccionism does not understand knowledge as an absolute truth, but rather as a socio-historical construction based on human relations. Thus, the interest of science should not focus on the pursuit of unquestionable truths, but on the processes in which they occur.

The principle of the constructivist perspective is to question what is imposed. It starts from the assumption that it is necessary to question the way in which we conceive the reality around us[16].

The multiprofessional team of residentes and the Basic Health Unit routine

Our process of insertion into the BHU was, in the first moment, a week of familiarization with the local reality, with the objective of elaborating a planning of the actions the two teams would perform during the year 2014. Such planning was constructed with the participation of all residents of the second year. In order to do so, visits to the BHU were made so that we could know its infrastructure, the professionals' team, the daily service, as well as the main health demands of the population.

This Basic Unit has 100% coverage of the Family Health Strategy in its territory, divided into three areas of coverage, and, thus, it has a Family Health team for each area. Regarding the physical structure, the BHU was in very poor conditions, with reports of lack of material to make cytology, rooms with infiltration and electrical problems and the non-functioning of the dentistry service also due to lack of material.

3 * Gergen K. The social constructionist movement in modern Psychology. American Psychologist. 1985; 40 (3): 266-275 apud (15).

In the first contact with some professionals from the Basic Unit, we could observe through their reports their discouragement in the face of precarious working conditions, as well as the overload of activities that often made them prioritize the performance of some actions to the detriment of others. Given this scenario, we were able to see the expectation of these professionals in relation to our possibilities of action. Thus, at the first moment, the residents were received several demands for nutritional and psychological care, since the unit did not have professionals in these areas.

In order to start working at the BHU, we were divided into two teams of nine residents, and each team experienced a three-month period in this practice scenario.

Regarding the activities carried out, the two teams developed the same interventions, and the second team resumed the actions initiated by the first one. These activities consisted of a home visit, health education and guidelines for the participants of the group of people with hypertension and diabetes (Hiperdia); the Walk Club with the provision of physical activities to the population, aiming to promote quality of life, as well as prevent risks of falls and circulatory problems in the elderly population. And finally, the Best Day group, which has been set up as a specific orientation space for the care of patients with diabetes.

The home visit is a practice of the Basic Unit in which we accompany cases of the most serious users attended by the service and who were indicated by the BHU professionals. At first, community health agents or another professional accompanied us to the users' home and, in the following visits, we continued the follow-up of the cases. Still in this process of familiarization with the chosen users, we had access to the medical records of each one for information collection.

Both teams of residents were unable to promote moments of discussion of the cases with the reference teams responsible for the areas covered by the basic unit, occurring only informal conversations with some professionals. Although considering the possibility of establishing a moment for such discussions, issues such as the lack of availability of BHU professionals, due to the high demand of the service, as well as the incompatibility with the residency schedules of the residents of the unit, hindered this process. Also during this period, the Basic Unit faced some moments of strike in the municipal health system, which also hindered approaching the professionals, as they began to work based on the strike scales.

Another activity in which we entered was the Hiperdia group. Hiperdia is a program instituted by the Plan for Care Reorganization to Hypertension and Diabetes that works through the Health Services Basic Attention Network and aims to allow the monitoring of the patients enrolled in this plan[17]. In BHU, this activity occurred with one group for each area of coverage, being configured in three groups of Hiperdia. We only entered one of them. The group took place once a week with different users at each meeting, where they met in a community-given location because the basic unit did not have enough space. The activities performed by the professionals of the service were the monitoring of blood glucose rates and blood pressure measurement, as well as medical guidelines

and prescription of medications.

The objective of our participation in this group was to work on health topics that could allow strengthening the users' adherence to the treatment of diabetes and hypertension. The group primarily developed the health education activity performed by us, residents, and, later, the activities of BHU professionals.

The Walk Club, unlike the other activities already mentioned, was an activity that began with the group of residents of the Multiprofessional Residency Program from 2011 and has been maintained by the following groups to date due to the good adherence of the community dwellers. It occurred outside the BHU space and consisted of a moment of physical activities and another about health tips. However, it is an activity that has not managed to develop a systematic articulation with the professionals from the Basic Health Unit to date. One of the reasons for this difficulty is that BHU did not have a physical educator and the main function of the Walk Club was the provision of physical exercises, although the activity space is not reduced to that moment. It is also understood as a space of socialization among its participants and a space to create bonds between them and the teams of residents.

And lastly, the actions of the Best Day group were developed. This group arose from the articulation between the resident team that joined the BHU in the second half of 2014 with one of the nurses from this Unit. The idea came from informal conversations in which she told us about her need to clarify diabetes patients as well as their family members and caregivers about the treatment of the disease and self-care. She also told us that many users had doubts about the insulin administration, often using it in the wrong way. Based on this information, we planned the actions that would be developed and the group took place in three moments, in which the population received guidelines on the definition of diabetes, its complications, treatment, self-care and insulin administration.

Regarding the meetings held by the two teams of residents for planning and evaluating the activities, these occurred without the participation of any professional of the service. At these times, we discussed the planning of activities for the following week, taking into account the suggestions given by the users, as well as by the BHU professionals, when they indicated some themes to be worked on in the groups.

Although we have been inserted into activities already carried out by the Basic Health Unit, as in the case of home visits and the Hiperdia group, the work with the health team of the service occurred very timidly. However, taking into account the perspective of Social Constructionism, this study does not intend to point out mistakes, but rather to enable the problematization of such experience. In this way, the following topic will reflect on the challenges faced in the BHU practice scenario, as well as on the strategies used to deal with the difficulties in the context of teaching and service integration.

Challenges on the teaching-service integration in the BHU practice scenario and coping strategies

Our experience as residents of both teams at the BHU raised some questions about the integration between teaching and service, as well as the purposes of health education. Throughout this experience, we began to question the way the activities of the Residency were being performed in this scenario of practices and, especially, their contribution to the service.

One of the greatest challenges faced was the detachment and disarticulation of the activities carried out with the daily service of the basic unit. As already mentioned in the previous topic, even in activities such as the home visit and the Hiperdia group, characterized as actions inherent to the BHU routine, this articulation occurred in a fragile way, being restricted to the indications of cases for home monitoring or the suggestion of certain themes by the professionals from the service to carry out the groups. However, there were attempts to hold moments for the discussion of cases, as well as invitations for the participation of BHU professionals in the Walk Club. Nevertheless, the fact that such invitations did not have an effect has made us reflect beyond BHU's refusal and non-involvement in such activities.

Another difficulty faced was the lack of a field preceptor. This preceptor would not be for each professional category that composes the resident team, as it happens in the first year of the Residency in the hospital context. This preceptor would be a BHU professional in dialogue with all the residents inserted in the same context, allowing moments of reflection on the problems of the work in health found in that scenario of practices. In addition to this difficulty, there was also the absence of a representation of the BHU in the meetings of the Residency Program.

Over time, we found, as a strategy for such situation, the invitation of one of the professionals from the service, a person we had already developed a link due to the partnership in some activities, so that she assumed the function of the preceptory. However, she refused justifying she was alrealdy overburdened and, therefore, she did not want to commit herself to such activity, but would provide the necessary support when possible. Thus, it was clear that the work overload is a factor that contributed to the lack of interest of this professional to accept the function of preceptory. As Autonomo[13] reports, the service professional, who is already overwhelmed with the demands of the assistance, sees the role of preceptor as another task to perform.

In the experience as residents, we experience the reality of this precariousness of health work and understand that it impairs formation. Factors such as lack of physical space to hold meetings or case studies distanced residents from the basic unit as physical space. However, other strategies such as the development of activities in other spaces provided by the community were used. Nevertheless, summarizing the challenges faced by precarious working conditions would devalue their complexity.

We believe that one of the triggering situations of the problematic about the fragility of the articulation between teaching and service in the context of the BHU was the possibility of extinction of the Walk Club as an activity carried out in this practice scenario. This was due to the probability of changing residents' experience in basic care for another BHU, through the significant precariousness of physical space and functioning that the own residents reported as a problem. Therefore, we began to think that interrupting the provided service would be detrimental to users who participated in this activity. The disarticulation of this activity with the basic unit also became clear. It was an action developed by the residents, planned by them and that, if we left this scenario of practices, the activity would no longer be performed.

In view of this, we needed to question needs the Multiprofessional Residency would be responding to and what contribution it would make to that service. According to Nascimento, Oliveira[18], the Residency should seek not only the professional improvement of residents, but also promote changes in the health services that receive them, allowing spaces for reflection on the work developed there.

When entering the Basic Health Unit, we constructed a planning of the actions that would be performed in this scenario of practices. This planning used as a subsidy the policies, guidelines and priority actions of Primary Care that relate to the health of adults and elders, since this is the focus of this Residency Program. Epidemiological data on the health status of the community were also used. However, the BHU professionals did not participate directly in this construction, nor did users. In this way, we wonder if this would not be one of the reasons that contributed to the disarticulation of activities. What needs would the planning of these interventions be responding to?

According to Merhy, Feuerwerker[19], the way health acts are developed relates to the conception of what health work is and the technologies that permeate these actions. The authors point out that health work is a live work acting and occurring in the relationship between health professional and user, but that the quality of this relationship may be compromised according to the technologies involved in the production of this meeting. Such technologies can be hard, understood as those that allow performing procedures, diagnosis; light-hard, those related to well-structured and defined knowledges; and light technologies, which are linked to the relationship that occurs in the encounter between professional and user, which allow broadening the listening and the look to the real needs of the subject. Therefore, the professionals' conception of the health-disease process and the way they use these technologies will guide the method of identifying health needs. The standpoint of well-structured scientific knowledge often defines the legitimate object of intervention in the health service.

In this way, we could say that the planning based on the needs pointed out by the scientifically structured knowledge, whether epidemiological or normative, although they are of fundamental importance as part of this construction, since they are indicators of a more global reality. However,

it seems to have lacked a meeting with the singularities of the health service, as well as the users who enjoy it.

For example, health service professionals brought some demands focused on the specificity of some areas of knowledge that made up the resident team, as in the case of Psychology and Nutrition, in which, at fisrt, we observed the desire of these professionals that we developed an individualized service. At that moment, our unpreparedness to deal with situations that were out of the intervention plan for that scenario of practices became clear. The fear of developing an action that would corroborate practices that fragmented health work generated an insecurity in accepting those first demands.

These demands of the health service often come as a help request in the face of precarious conditions and work overload. However, meeting these requests does not mean implementing them as the request, but broadening the look and listening for such needs provides an opening to other possibilities for jointly agreed interventions.

However, this practice does not imply the extinction of works aimed at the specific areas of the professional areas that make up the team, but the approach to such problems can be done through devices that favor teamwork, as in the case of matrix support, the construction of the Singular Therapeutic Project (STP), which provide a joint decision-making process, but does not prevent the possibility of protagonism among the areas of knowledge. Nonetheless, in order for these devices to be used in the services, there must be spaces for dialogue on their importance to improve health care, as well as clarity by all those involved in its construction, regarding their proposals and objectives.

We consider that the lack of joint planning among BHU, Residency Program and residents regarding the actions to be carried out, as well as the lack of agreement of the responsibilities of each one of the actors involved in this process, is the core of this problem. The fact that the professionals from the Basic Unit do not appropriate activities such as the Walk Club or the preceptory function reminds us that the management of health services still cannot conceive permanent education as part of health work, being an isolsted activity. On the other hand, the Residency Program also showed that it did not realize the current fragility of the link with BHU and the need to reassess the way of carrying out the practices in that scenario and their effects on the health service.

Since this Residency Program occurs in its first stage in the hospital environment, as well as its coordination, meetings and classes are allocated in this environment, the impression we have is that this also contributes to a withdrawal from BHU in relation to the other practice scenarios, since the discussions on these other contexts turn out to be more frequent. Thus, although this is a Multiprofessional Health Residency Program, even the way the physical spaces are configured

often provides a greater approximation among the actors involved. This may be corroborated by the conception that the Program is a hospital residency and by the practices that affirm this place, as occurred through the reduction of the hours of the BHU practice scenario.

Thus, inserting the residents into the service does not guarantee the transformation of work practices[13]. This implies entering territories where certain health practices and ways of thinking about work in this field prevail. Inserting the Residency into BHU brings changes to the service routine. The way this insertion will occur will allow a greater or lesser approximation to the territory of the health work developed there and, consequently, promoting the transformation of the practices. The territory of health practices is always a political space, of multiple disputes, which permeate the interests and capacities to act of the actors involved in it. Such interests may converge or diverge in an attempt to seek a conformation of the health model that is meaningful to that place[19].

It is important to emphasize the need for a greater link between the Residency program and the BHU practice scenario, reflected in a cooperation pact among the different actors involved, namely: teaching, management, attention and social control. When these pacts do not occur, there is a risk that the presence of residents in the service resembles that of a stranger in another's territory and, therefore, there is no co-responsibility between service and health training.

The lack of a BHU representative in the Residency Program meetings, the lack of articulation of the activities carried out by residents with that practice scenario and the lack of field precepts are consequences of the way in which the dialogue among them has taken place, making possible or not the agreement of the needs to be achieved.

Another important point to highlight is the place that the resident occupies in this context and in what ways this contributes to the transformation of health practices or to the replication of those already existing. We speak from this place, because in our experience, we come across several times with the difficulty of conceptualizing what is to become a resident.

Fajardo[14] points out in his study with preceptors of a multiprofessional residency in health that there is a difficulty of health service workers in understanding the place of the resident. The author reports that this is because the residents are neither students, nor trainees, nor employees, and that the only category of resident hitherto known was the medical one, which also differs from what has become the multiprofessional resident. The researcher concludes by saying that this time of specialized training has not yet reached a clear definition of its specificity in the health work environment, because it is still referred to the 'not-being' this or that[14:29].

Despite so much uncertainty about this place, we can say that the resident is a professional

in formation who does not have a formal working relationship with the health service where he/she works, but must always have an ethical commitment to the health practices developed there. Therefore, we seek to have this ethical commitment to the BHU practice scenario, which implied in questioning our practices, as well as in an arduous work of denaturalizing the place of performance as a field of application of theories and techniques. We seek to understand health work as a territory of caregiving and Multiprofessional Residency as an effective device for the construction of this care centered on the user and their needs, not only on the procedure. This work in health, in turn, must be strongly related to the notion of this care continuity. For this continuity to occur, the actions developed need to be closely linked to the daily life of the health service.

Therefore, as we residents have been discussing about the problems faced in the BHU practice scenario, we have launched the strategy of bringing these concerns into the Program meetings. This initiative triggered a dialogue among preceptors, tutors, co-ordinators and residents about such issues, and enabled the involvement of these in this process. It is necessary to emphasize that this strategy allowed the meetings to cease being only a space for bureaucratic discussions, generating concern and reflections on the practices developed until then in the various spaces through which residents perceive their experiences. Thenceforth, we were able to construct moments to evaluate the practices that we were carrying out not only in the practices scenario of BHU, but also in other spaces, since previously this evaluation was restricted to the delivery of reports at the end of each passage through the scenarios. Just as it was possible to create spaces for dialogue between the Program and BHU so that we could present the final reports to the service professionals.

It is necessary to point out that some strategies did not have the expected effect, as in the attempt to present these reports to BHU professionals, mentioned above, since they did not attend on the scheduled date for such presentation, evidencing the needing of other forms of approach. It is also possible pondering that such an approach is done through a continuous process. However, we conceived the strategies used here as the beginning of this process, which, until then, were not discussed within the Residency Program itself, corroborating with the conception of the practices scenario as a place of actions replication without questioning its effects .

FINAL THOUGHTS

Our experience as residents in the BHU practice scenario corroborated with the experiences found in the scientific literature about the challenges in the context of teaching-service integration. Such experience points to the need for this Multiprofessional Health Residency Program to seek, together with the ones involved in this process, evaluating the impacts of their actions on the services where the residents are. In this way, it is possible to constantly rethink practices and use devices that enable the improvement of health work, bringing gains both to the health service and its users, and to the training of its professionals. One of the ways to promote this change would

be by strengthening practices based on matrix support in health as a direct form of contribution for the Residence to the BHU practice scenario, since the reference team of the Basic Health Unit does not have the professions that make up the Multiprofessional Residence. Therefore, this would be an opportunity to exchange experiences and knowledge among the different areas of knowledge.

On the other hand, it is of fundamental importance that BHU not only occupy the place of receiving the residents. For this to occur, the Residency Program must collude actions with the management of the basic unit in order to strengthen the Permanent Education as an essential part of health work, since the teaching-service integration requires the construction of common goals among the sectors involved. The clarity that the purpose to be achieved is to change the ways of thinking/doing health training so that there is, indeed, the integrality in the actions given to the users is of great importance to this integration.

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