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Impact of the insertion of medicine residency in units of primary health care: perception of family health strategy teams

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Abstract

Background: The insertion of residency in Family Health Stratey occurs at the core of the performance of the health care teams, where professionals in training learn to work in teams and with the team. This insertion also highlights the importance of real teaching-service integration, as the presence of resident physicians can lead to new forms of health work organization and enable changes in the qualification of care provided to the Community.

Aims: The objectives of this study are to describe and analyze the insertion of the residence of Family and Community Medicine in Primare Care Units (PCU) from the view of the workers of these teams.

Methods: The research model was descriptive, with qualitative approach. The participants were 27 professionals who are part of five teams enrolled in four PCU of the Mossoró municipality, Brazil. The interviews were carried out through the technique of the focal group, with audio recording, later transcription and content analysis proposed by Bardin, through the thematic analysis.

Results: The categories emerged were "medical residency and their presence in the team", "medical residency and the work process", "medical residency and Community" and "medical residence and management".

Conclusion: The research allowed an analysis of several aspects related to the insertion and performance of the residence in the PCU, highlighting potentialities and weaknesses in this process.

Introduction

The central theme of this study is the insertion of the residency of Family and Community Medicine, analyzed from the perspective of professionals of the Family Health Strategy (FHS) teams. The recognition of education in service in Primary Health Care (PHC), as essential in the education of resident physicians in the area, responds to changes in the work scenario in the Unified Health System (SUS), to promote the training of a health professional. critical, reflective and prepared to work in teams [1,2].

The FHS medical development program requires the integration of universities with health services, as well as the expansion of practice scenarios, which creates the need for discussions about the relationship between teaching-learning procedures. and the health work process in PHC. Within the scope of the formation of professionals for SUS, medical residency (MR) is a lato sensu postgraduate degree in which the knowledge, skills and attitudes of physicians are improved with a view to developing specific skills for better care, with education in health. service, which demands a teaching-service integration.

The insertion of residency in FHS occurs at the core of the performance of the health teams, where professionals in training learn to work in teams and with the team. This insertion also highlights the importance of real teaching-service integration, as the presence of resident physicians can lead to new forms of health work organization and enable changes in the qualification of care provided to the community [2,3].

However, the integration of health care services with universities brings demands, especially regarding horizontal relationships, joint work processes, common interests and alignment of needs and potentials [3]. The FHS team adopts as part of its work process the teaching of family MR "through an understanding of continuing education of themselves and learners who go through their history" [4]. Therefore, the importance of conducting research that appreciates the study of this insertion [4] is reiterated. There are studies addressing relationships between professionals from an FHS team, between professionals from different teams, as well as between professionals and Community [5,6], but the relationship between professionals and resident physicians inserted in in-service training in their work scenarios has not yet been focused. that is, in the interface between the world of work and the world of training.

Based on these considerations, the main research problem of this study is raised: how health professionals of FHS teams from the municipality of Mossoró, Rio Grande do Norte State, Brazil, perceive

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the insertion of the MR in the service where they work and in their own care work process the community?

The aim of this study was to describe and analyze, from the view of FHS team workers, about the insertion of the MR in their work scenario, as well as about their own contribution as an interprofessional team about the formation of residents.

Methods

Study Model

The research model of this study was descriptive with a qualitative approach, since it aims at describing the participants' perception, in addition to fitting the objective of describing characteristics of a given population or phenomenon [7].

Research Scenario

The basic health units (BHU) chosen as locations for this study correspond to the first five to receive Community and Family MR in the municipality of Mossoró, Rio Grande do Norte State, Brazil. These BHU are located in different neighborhoods of the city, but are geographically close to each other.

The city of Mossoró is a Brazilian municipality located in Northeast region of the country, with a population contingent of 259,815 people, constituting the second most populous municipality in the state. In the health area, which is the thematic context of this study, the municipality is part of the II Regional of Public Health Unit.

Data Collection

Data collection took place between July and August 2018 in the four referred UBS. The sample invited to participate in the study was composed of professionals who are part of five minimum FHS teams of the mentioned units, namely, the nurse, the nursing technician, the community health agents, the dentist and dental office attendants. One of the UBS had two teams selected for the study.

The inclusion criteria were as follows: (a) professionals from the FHS teams of the referred BHU; (b) professionals who have worked for at least two years in these teams; and (c) professionals who signed the Informed Consent Form. Exclusion criteria were: (a) servers of such teams who were recently absent from the service for a period of one year or more; and (b) non-acceptance of team workers to participate in the study; and (c) physicians of these teams acting in the preceptorship of MR.

The interviews were conducted using the focus group (FG) technique. The use of this exploratory data collection technique considers the purpose of capturing perceptions, attitudes, feelings and motivations in the face of a deliberate question in a place of dialogue between the selected people [8].

The groups had a moderator and an observer. The moderator with experience in qualitative research had the task of providing dialogue between participants, as well as operationalizing the discussion stages. The observer made notes on group dynamics and participants' statements, as well as providing support to the moderator in time management and discussions. These were recorded in audio and video and later transcribed in full by the principal researcher and the observer. There was also a third collaborator, undergraduate student of medicine, who cooperated with the recording of the video. Five focus group meetings were held in different shifts, one for each FHS team.

Before the beginning of the discussion in each group, the option of choosing a card containing the name of a bird was given, advising participants that during the FG, when addressing the others, this fictitious name should be used to avoid your actual nominal during audio recordings.

The groups took place in existing spaces within the territory of the four teams, using an Interview Guide prepared by the authors, seeking the search for clarifications that substantiate the objectives of the study, with the purpose of guiding the discussion. The first three questions in this Interview Guide addressed the process of inserting the resident into the FHS team, while the next six focused on aspects related to the role of resident physicians and their work process with the team. In the last question, we asked if the participants of the FG would like to add something that they considered pertinent. For all groups, the same guiding script was used.

Participants received prior clarifications on the purpose of the study. Prior to the discussion, the Participant Identification Questionnaire was distributed on a self-completion sheet to record information about participants such as age, gender, profession, education, length of work and time in the current team. Survey participants were cited in the results report in numbered form as Family Health Estrategy team (tFHE) / Participant (PART 1 FHSt 1, PART 1 FHSt 2, and so on).

The theoretical saturation criterion was used, because in the five FG performed, repetitions were observed that allowed the formation of groups and constitution of open empirical categories.

Data analysis

Thematic analysis and lexical content analysis techniques were used to complement each other in the work of interpreting the discursive data manifested by the FG participants.

The textual analysis was performed using the Bardin [9] content analysis technique, following the following order of procedures: pre-analysis, material classification and interpretation of results. In the pre-analysis phase, speech readings were performed to identify the converging points and establish a first classification. In the execution of the qualitative analysis, the statements were subjected to thematic categorization according to the semantic similarity of the clippings, establishing a set of equivalence classes, which were defined a posteriori, that is, after reading the transcribed material. Inference and interpretation were made by comparing the research objectives with the theoretical references on the subject.

Ethical approvals

The present study was approved by the Research Ethics Committee of Rio Grande do Norte State University in June 2018.

Results

Characterization of participants

Twenty-seven professionals from the five FHS teams selected from four BHU of Mossoró municipality participated in the research, being three nurses, one nursing technician, 21 community health workers, one oral health technician and one dental office assistant. Among the professionals who met the exclusion criteria for length of service at the BHU less than two years ago, there were two nurses, two nursing technicians and one dentist.

Demographic and working time characteristics in the FHS and teams are presented in Table 1.

Table 1. Demographic characterization and working time of Family Health Strategy professionals from five teams from four Mossoró municipality Basic Health Units, Brazil

FHSt	Age	Gender	Education	Professional Time	Time in FHS (years)	Current team time (years)
1	34	Female	3rd	CHA	5	5
1	33	Male	3rd	CHA	4	4
1	40	Female	3rd	Nurse	15	3
1	54	Female	2rd	CHA	21	13
1	47	Male	3rd	CHA	21	13
1	55	Female	1rd	CHA	14	13
2	35	Female	3rd	CHA	13	12
2	37	Female	2rd	CHA	13	12
2	39	Female	2rd	CHA	20	12
2	39	Female	2rd	CHA	12	12
2	42	Female	3rd	CHA	5	5
2	44	Female	3rd	Nurse	18	10
2	50	Female	2rd	CHA	21	12
3	36	Female	2rd	CHA	13	13
3	42	Female	3rd	Nurse	17	4
3	46	Female	2rd	CHA	15	13
3	48	Female	3rd	OHA	4	4
3	54	Female	2rd	CHA	20	13
3	56	Female	2rd	CHA	15	13
4	40	Female	2rd	CHA	13	13
4	45	Female	2rd	CHA	21	21
4	52	Female	2rd	CHA	4	4
4	57	Female	2rd	CHA	18	18
5	32	Female	3rd	CHA	4	4
5	33	Female	2rd	CHA	13	13
5	40	Female	2rd	CHA	13	13
5	41	Female	3rd	OHT	14	10

FHSt: Family Health Team; FHS: Family Health Strategy; CHA: Community Health Agent; OHA: Oral Health Assistant; NT: Nursing technician; OHT: Oral Health Technician; 1rd: primary school; 2rd: secondary school; 3rd: college school.

Thematic content analysis

From the reading and classification of the transcripts, the following categories emerged: "residency and its presence in the team", "residency and the work process", "residency and the community" and "residency and management", whose subcategories are presented in Table 2.

The process of insertion of residence and resident in the team occurred with the presentation of the preceptor, without manifest co-participation of local management. Regarding the understanding of the residence, it was observed that although the FHS works in the UBS, the residence has been inserted since 2011 in three teams, and since 2012 in one of them, lack of understanding of what was the residence by participants at the beginning of implementation of in-service training. In this initial insertion process, there was a reorganization of the team to this new reality, which was expressed in the speeches of the team professionals, as well as suggestive allusions of the emergence of many expectations among them regarding the arrival of residents.

Regarding the training process, professionals reported that some residents seemed to have a profile for Family and Community resident while others did not. Another important aspect that has been shown refers to the perception of professionals about their own contribution to the education of residents. Clippings of speeches referring to the preceptorship in the residence, both in the aspect of their presence and performance, as well as about its lack, especially in face of demands that arose in the accompaniment and formation of the resident, were also made explicit by the participants.

In the subcategories of the theme "residence and its presence in the team" there were talks about the understanding (or not) about what the residence was, as well as about the expectation about it:

"[...] last year I came to understand very well what was the family doctor's residence, what it was to be a resident doctor." (Part. 2, FHSt 1)

"I already knew the doctors were resident doctors, but I didn't know how it worked." (Part. 05, eSF 2)

"[...] the expectation was very high, really, as they said, what was going to be, how was this residence going to happen ..." (Part. 14, FHSt 3)

"I expected improvements with the arrival of residents, improvements, which in this case improved, now not as much as we wanted, the expectation was higher than what happened." (Part. 3, FHSt 16)

Regarding the contributions of the team to the training of residents and the resident profile of CFM, the following statements stand out:

"[...] they see how a team works ..." (Part. 1, FHSt 1)

"[...] the resident arrives here at UBS and will make the first home consultation, so let's help by telling how the family is, how is the patient's daily life ..." (Part. 10, FHSt 2)

"So until then the team feels and she notices when a resident arrives that has nothing to do with it there. It seems that he fell like this by parachute " (Part. 14, FHSt 3)

"[...] there are doctors who do not touch the patient." (Part. 16, FHSt 3)

"[...] there is the resident doctor and there is the resident doctor, who are two totally different people. There is one who proposes to work at the PSF, which is what he wants for his life, and there is one who goes just to fulfill it... " (Part. 20, FHSt 4)

The role and intermediation of preceptorship appeared in the following lines:

Table 2. Thematic categories and subcategories of the speech of the focus group participants

CATEGORIES	**Medical residency and their presence in the team**	**Medical residency and the work process**	**Medical residency and the community**	**Medical residenye and management**
SUBCATEGORIES	Understanding what the medical residency means	Repercussion for the basic health unit	Community acceptance	Lack of support
	Expectations about residency	Job qualification	Impact on the community	Precarious resources
	Team contributions to formation	Interpersonal Relationships		
	Family and Comunnity Resident Profile	Continuing / Continuing Education for the Team		
	Preceptorship intermediation			

Source: Field research primary data (2018).

"[...] thus, the resident at UBS is played. But who oversees these residents? Who sees how they are working? [...] Ah, there is the preceptor, but she comes once a week..." (Part. 20, FHSt 4)

"When you started with the residency, when you had a problem in the area, you would come to the parent doctor and she would say 'you have to talk to the resident, he who is seeing the care, you have to direct him'…" (Part. 10,FHSt 2)

The second defined thematic category was related to the work process at the BHU. A number of particularities were raised during the focus groups involving this aspect and with repercussions on the service provided to the community and on the teams themselves. As with other aspects previously portrayed, the favorable or non-favorable focus of these questions varied among the groups addressed. The idea emerged that the insertion of residence favors closer proximity to universities, making the local network more integrated with the network.

"The resident contributes to the qualification and resolute capacity of the team because it brings services to us, it is a bridge with the university." (Part. 1, FHSt 1)

According to the participants, the residency also allowed some work not previously performed by the team to be completed:

"[...] the prenatal program, the appointments and consultations, the hypertensive program of the child was implemented..." (Part. 21, FHSt 4)

"[...] the point of view of me is to always have the doctor at UBS, every day, morning and afternoon and the programs that were implemented." (Part. 21, FHSt 4)

Associated with the last subcategories, but constituting a separate thematic subunit, the "qualification of work" emerged in the following lines:

"Formerly the 30 tokens were like this, 30 tokens came, the doctor would attend ... The [doctor] of the PSF, his head was down ... [...] now, the [resident] doctor talks ..." (Part 22, FHSt 4)

"[...] I think it has changed a lot and, in my view, it was for the best, we started to work things that maybe because of the work overload we had, we couldn't work." (Part. 1, FHSt 6)

"If it were a doctor who was not a resident and had three days a week here we would not have been able to go to school, go to home visit ..." (Part. 25, FHSt 5)

On the other hand, there was reference to the discontinuity of work in the FHS with the insertion of resident doctors:

"We were used to the doctor he had at UBS, everyone was already used to him, and when he arrived at the residence ... the doctor spent two years, he left ..." (Part. 15, FHSt 3)

"Then the user's bond with the doctor was lost a lot. When it was the following year the other R2 arrived ..." (Part. 20, FHSt)

Interpersonal relations represented an important dimension in the speech analysis in relation to the work process of one of the teams. The dialogue between professionals also seemed to favor the direct resolution of the problems identified and shared among professionals, according to some of the professionals interviewed. In this sense, for them, team meetings collaborated for integration and conflict resolution. Depending on the team, the bond and relationship were considered good, persisting even after the resident left.

"When he [the resident] arrived, it was already passing as he wanted, and we had to adapt to his norms." (Part. 2, FHSt 1)

"[...] he [the resident] criticized me in front of the whole team for this kind of procedure I do." (Part 1, FHSt 1)

"[...] we have several examples of residents who have come and come while visiting us" (Part. 7, FHSt 2)

"With him [resident] we had 'that moment', they were all like that, 'it seemed' to 'Xuxa and the paquitas' ..." (Part. 22, FHSt 4)

"And maybe if there were more meetings, there would be more resolutions. And at the meeting itself sometimes conflicts occur, but it is in the clash of conflicts that the solution is found" (Part. 5, FHSt 1)

Still in the same category, we observed fragments of discourses alluding to continuing education:

"Yes, the team becomes more qualified with residency in relation to the qualifications that occur…" (Part. 5, FHSt 1)

"[...] I talk about continuing education of the team, we started to study more ..." (Part. 7, FHSt 2)

Other defined categories were "residency and community" and "residence and management", whose subcategories and clippings were presented in Table 3 and 4.

Discussion

To organize the discussion of the results, this section was divided into subsections according to the thematic categories constructed, after the characterization of the participants' profile.

Table 3. Subcategories of the theme "Medical Residency and the Community"

Category: Medical residency and community
Community acceptance
"[...] for the community it's confusing. To this day, some still get confused about who their doctor is in their community, because they have two general residents and it's a bit confusing for them. "(Part. 7, FHSt 2) *"[...] the community I think is according to what we are receiving and passing on to them, and they are having the same acceptance as us. Maybe if we had a lot more difficulty, surely the community would have a lot more. "(Part. 12, FHSt 2)*
Impact on the community
"By the time the house arrives, the number of vacancies has automatically decreased. So the population that came to get 16 tokens is a population that comes to get now 8 tokens, ready, we would arrive in the area was already a complaint ... "(Part. 20, FHSt 4) *"[...] there was something new that from then on would have other attributions, other activities, other possible referrals, referrals, with various other procedures that were going to do the welfare of the population." (Part. 6, FHSt 1)*

Source: Field research primary data (2018).

Table 4. Subcategories of the theme "Medical Residency and Management"

Categoria: Medical residency and the management
Lack of support
"I don't think management supports the residence, I don't think so. In what sense? It's not that management is against it, for management it's a hand in hand, it's wonderful to have professionals, but I don't see them doing more to make the resident feel more welcomed ... "(Part. 1, FHSt 1) *"And the resident being at UBS, he has a time to meet it, and it is not common for an effective physician ..." (Part. 24, FHSt 5)*
Precarious resources
"So I think the difficulty is often not so much the next residents, or the team, but the structure itself, the equipment, the room, the medication, the regulation of exams, these things, we have a lot of difficulty ... "(Part. 26, FHSt 5) *"If funds were to come for this, for residence, then it was to have set up an office or an office, for residence to attend that office." (Part. 20, FHSt 4)* *"For us, the residence brought no problem. Our problem is lack of structure in the unit to support "(Part. 10, FHSt 2)*

Source: Field research primary data (2018).

Participant Profile

The group of professionals participating in the study was predominantly characterized as a sample of women, aged between 40 and 57 years old, in the role of primay health care, with high school / college level and with more than ten years of work in the FHS. This profile is consistent with what was reported in a quantitative approach study that aimed to characterize the profile of higher level FHS workers in a capital of Northeast Brazil, showing that most of the sample (83,3%) was from women, with a mean age of 45,8 years and 20,4 years of training [10]. This profile also corroborates qualitative studies conducted in Brazil to evaluate collaborative interprofessional work in the FHS [11-13].

Thematic Category 1: Medical residency and your presence on the team

The reports in the statements of some professionals of the FHS teams about the lack of understanding of what the residence meant and the gaps in their supervision show the importance of knowing the aspects related to the insertion of residency in the BHU from the workers' own perspective. It is understood that the resident should start this training process with the team already informed about what is the medical residence and what are the residents' attributions and limits, as well as the exchange of information between them with the intermediation of the preceptorship, as they were mentioned. failures in communication and supervision.

The presence of the medical resident in the team, according to some reports, due to their temporary permanence, makes them perceived as passengers by the team professionals, which makes it difficult to establish trust relationships between them, as well as in relation to the lack of knowledge of the team. community. The resident's presence at BHU was initially felt by the fact that his activities in the service are articulated with the team's schedule and by the new actions that are established through the residence schedule in relation to BHU and the community.

Regarding the figure of the resident as a professional for Community and Family MR it was evidenced that they perceive when there is an expanded medical look, beyond the view of the predominant biomedical model. The Competency Based Curriculum, prepared by the Brazilian Society of Family and Community Medicine [14], expresses these issues, which should be discussed in the practice of residency and preceptorship with the residents themselves, so that they could be aware of the acquisition and development of these competences necessary for the practice of Family and community MR.

Thus, the challenge of inserting residence into the service also seemed to involve issues such as "who is the resident", what is their current profile and how does it need to be formed during the two-year period of residence. However, it should not be forgotten that the context of the resident's work, under the preceptor's accompaniment and the dynamics of the work process within the FHS, has an influence on this process and, consequently, on the training of professionals in Community and Family MR. More emphasis is needed on improving communication skills, both in patient and family care, and in teamwork, which could be mediated by the precept itself, which directly experiences the complexity of the context of training in primary care [15] .

The questions posed are not dissociated. They occur together, and in a way that also generate another product, as in addition to the medical resident, it is expected that a positive impact will be generated on the FHS team and its performance within the territory with repercussions on the assisted community. It is the expected teaching-service-community integration. When graduated as Family and Community doctor, a work team is also conceived with characteristics similar in many respects to the profile of the generated specialist, that is, with a resolving capacity, capable of working in a team, with a sensitive perception about the reality of the territory and the family and the impacts generated on the individual. In this sense, most of the findings of our study corroborate results of published research on the difficulties in developing teaching-service-community integration activities [2,3,5,19].

Testimonials about the contribution of primary health care to the residents' training process suggest that these workers also interact in the search for recognition of the capacity and valuation of their performance in the team. The way the health service is historically organized, that is, based on the "verticalization of knowledge", in which the physician's knowledge is considered the most important professional [13,16].

No studies with the same objective as the present research were found. But there are two similar studies, involving workers' perceptions about the insertion of medical students16 and about the insertion of multiprofessional residency in BHU [17]. Regarding the study on the perception of BHU professionals regarding the insertion of undergraduate students, the thematic categories defined from the speeches of the interviewed professionals were teaching-service-community integration, service functioning and medical education [16], which are consonant. partly with those found in this research.

In our study, it was observed that the statements contained the idea that the presence of residents in the BHU facilitated an environment of exchange of knowledge and practices between them and the team professionals, was also found in the study on insertion of medical students in services [16]. In another study carried out in a UBS, the insertion of medical students and residents has had a direct impact on the daily routine of health services, expanding the scope of care and contributing to the organization of work processes [18]. In this article, it is reported that the resident doctor of Family and comunnity assumes the role of doctor in the FHS team of which he is part, and is also encouraged to act as preceptor of the students of the boarding school of the university.

Medical residency and the Working Process

The conflicts mentioned by the participants were, in part, considered by them as what is called "positive conflict", framed as constructive interactions [19], but also viewed by other deponents as personal incompatibilities with certain residents, who exercised a power relationship in the team. or even harassment. On the other hand, some speeches that converged on the issue of interpersonal relationship with residents indicated the existence of positive integration, with some even expressing feelings of affection, reaching even an idealized view, an aspect that was convergent with the observation of a previous study that focused on however, interpersonal relationships in teams of FHS professionals [20,21].

The statements categorized as "interpersonal relations" between residents and workers of the UBS show that the theme of health education is inseparable from issues related to health work and expectations regarding professional practice [22,23]. In the speeches in this category, there was mention of the importance of dialogue and the need to hold meetings and periodic meetings with team members, which represents a positive perception to foster interprofessional bonding and the possible exchange of information relevant to collective work [21].

Considering the totality of the statements, it can be said that the actions of the CHA are the ones that seemed to be the most closely articulated with the team of professionals, which presents itself as a similarity to what other authors observed [22], in an observational study. participant in an FHS team. In line with the statements recorded in the FG, it is emphasized that it is essential that professionals recognize the importance of dealing with interpersonal relationships, as these end up significantly interfering with the care provided to the client and the Community [24].

The statements that suggested the positive influence on the qualification of work in teams due to the insertion of the Family and Community MR corroborate the assertion that residents favor collective work in the FHS, corroborating the results observed in a previous study in which the perception of the health worker was evaluated. on the contributions of the Multiprofessional Family Health Residency in five BHU [17]. In this sense, health education is considered one of the central issues related to the transformation of professional practices, so as to favor interventions capable of approaching the needs of the population and the health reality in which the professional is inserted.

A positive factor is also the view that the insertion of residence favors in the FHS teams the possibility of the growth of its members, encouraging them to seek knowledge and skills that they did not have before. This theme is of great relevance in the context of health services, although its scientific production is still considered incipiente [21].

It should not be stressed, however, that in regard to teamwork, although current curricula aim at training a professional able to act on the biopsychosocial model and teamwork, medical students are often not They are prepared to work in an interprofessional way and are usually not cognitively and affectively prepared to understand their role in the FHS [13]. Residents' disrespectful attitudes towards team workers eventually segregate the service environment from the teaching environment. Such attitudes, noticeable in some speeches of the deponents, seem to reflect an ideology of superiority of the still prevailing medical profession, perceived by other health professionals [25]. Although the work of the FHS is more horizontally structured than in other areas of health care, the physician is still the main authority figure, regardless of the positions held by other professionals. In this sense, there are still intense power-knowledge relations between the FHS members, which occur in a naturalized way without the majority of workers identifying them [25].

Medical Residency and the Community

It is assumed that the insertion of resident physicians in the FHS teams can improve the quality of health care of people in the territory where they are inserted, especially with the joint and integrated performance of health professionals and students in the team. The statements in this sense were scarce, in relation to what was focused on the repercussions on the service and the staff, being of a different nature, between the close and affective relationship of users in relation to residents and the low acceptance of the discontinuity of the bond inherent to the service. transient condition of resident physician. Community participation in the resident's formation process was also poorly scored, hardly appearing in the professionals' speeches. This situation makes it difficult to reach the intended changes with residence, which are supposed to have a direct impact on the Community [26].

Medical residency and management

Management appeared in the statements very tangentially and related to problematic aspects. For the presentation of the residents to the teams, it was the preceptorship mentioned as intermediary of the first contact with the team, without mentioning the managers. Another allusion made to management was to demonstrate that there was no support from residents and that the infrastructure was precarious and often no longer supported actors in that scenario in which residents were inserted. Managers are perceived as elements outside the team, sometimes seen as unrelated to the reality of the service, a fact reflected in their distancing from workers and their needs, including in relation to residentes [27]. There are several material challenges experienced

in this process of training in Family and Community MR, among which are the inadequate physical structure for the resident's teaching-learning process [28] and the scarcity of material resources that hinder working practices in the FHS and the experience daily life of residents in poor maintenance conditions [29].

Final Considerations

For the service professionals who participated in the focus groups of this study, with the insertion of residency in the UBS, there was an expansion of the theory-practice relationship and qualification of the team work, as well as initiating specific health policy actions that did not exist in the BHU, also strengthening health actions in accordance with the comprehensive care. Thus, the insertion of medical residency was perceived as positive for the FHS teams, for the BHU and for the community. Also noteworthy among the views displayed by professionals are those that refer to factors external to the FHS and residence that interfere with the integration with the service, in addition to the scarce support from management.

In this research were explained certain meanings that permeate the perceptions of FHS professionals about the insertion of residence in their daily work, which is a research question not yet empirically explored in Brazil. It cannot be presented as a work with well-defined conclusions, by its exploratory nature, but which raises questions that may compose new questions for further research on this subject. A possible impact of the observed results on the knowledge related to the training of Family and Community MR is pointed out, as well as on the teaching-service integration within the scope of the FHS.

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