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Quality of life at work and Burnout in Family Health Strategy teams

Fernanda de Oliveira*
Sandra Poncio Feltrin**
Rafael Zaneripe de Souza Nunes**
Marieli Mezari Vitali*
Lisiane Tuon**
Graziela Amboni**
Karin Martins Gomes**

Abstract

The aim of the present study was to analyze the Quality of Life at Work and Burnout Syndrome of health professionals who work in the Family Health Strategy program of a municipality in southern Santa Catarina. This was a cross-sectional study conducted with 145 health professionals. Data were collected using a sociodemographic questionnaire, Quality of Life Assessment Instrument - WHOQOL-bref, and Maslach Burnout Inventory (MBI). Pearson's chi-squared test was used to quantify the association or independence between Quality of Life and Burnout Syndrome and work-related variables. The results were analyzed using the SPSS Software and indicated the prevalence of depersonalization, emotional exhaustion, and average personal fulfillment, with the possibility of progressing to a Burnout Syndrome. Regarding the Quality of Life, most of the interviewees demonstrated physical, psychological domains, and environment as regular. These domains are directly related to professional occupation, and Community Health Agents are the professionals who most need to improve them, a fact that may be related to their insertion in the community and role assignments. This research points out the illness of health workers related to occupational suffering. The need to create reception strategies, as well as prevention and health recovery actions for these professionals, is highlighted.

Keywords: Quality of Life. Occupational Stress. Worker's health.

INTRODUCTION

The Brazilian public health model, proposed by the Federal Constitution of 1988 and consolidated as the Unified Health System (SUS), advocates a new paradigm of assistance to the population, which in turn leads health professionals to experience peculiar situations in their work routine. This reality is evident in the Family Health Strategy program, in which the performance of professionals is marked by involvement with the population of their territory of coverage, direct contact with the suffering of others, creation of affective bonds, among others[1]. For Tomasi *et al.*[2], these professionals are the basis of the health system and, therefore, are protagonists in the development and improvement of this system.

Moreover, these professionals are exposed to several challenges and work stressors that can cause physical and psychological exhaustion[3,4]. In the context of health professionals, studies indicate that quality of life is represented in a multifaceted way by professionals from

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* Universidade Federal de Santa Catarina, Florianópolis/SC, Brasil.
**Universidade do Extremo Sul Catarinense, Criciúma/SC, Brasil.
E-mail: fernanda.dlvr@gmail.com

the Family Health Strategy, encompassing social, psychological, and physical aspects[5,6]. Issues related to monetary factors, number of professionals in institutions, interpersonal relationships between staff and users, as well as, numerous other factors lead to professional dissatisfaction, stress, and emotional problems, which directly affect the quality of life of these individuals[7].

Quality of Life is defined by the World Health Organization (WHO) as the way in which the individual perceives their position in life, goals, expectations, and concerns regarding the culture, context and value system in which they lives[8]. The notion of Quality of Life at Work is complex and changing, covering physical, psychological, technological, and social dimensions of work[9,10].

Research on Occupational Health and Quality of Life at Work (QLW) reveals the systematic and growing illness of health workers[3,5-7,11]. Camelo and Angerami1 identified a higher level of stress in workers who provide assistance to communities, compared to those who work in the hospital environment. Fernandes, Miranzi, Iwamoto, Tavares and Santos[12] point out a relationship between the quality of life of nurses in family health teams and the level of independence, the type of employment relationship, the workload, and satisfaction with work. While the study by Paiva[13], which investigates the association between working conditions and the impact on health professionals' well-being and health, found an association between the presence of Burnout factors in the decreasing of the quality of life of such professionals.

In this context, to deal with work situations, health professionals who are already in a stressful state develop individual protection mechanisms[14]. Such strategies for individualizing suffering tend to naturalize the illness of workers in this sector. This naturalization leads professionals and managers to assume that this suffering is inherent in the profession of these workers[4,10-11]. This fact can result in an oversight of professionals who are dedicated to the health of the population and that as citizens have the right to proper health.

Burnout Syndrome (BS) concerns this process of chronic stress at work, resulting in impaired work activities[15]. Given the importance of the relationship factor in the development of this syndrome, there is a predominance of Burnout among professionals, such as: those in healthcare, teachers, and police officers[16]. In a sociopsychological conception, Burnout Syndrome has multidimensional aspects in response to chronic work stress involving three main factors: emotional exhaustion, depersonalization, and reduced personal fulfillment[15].

Emotional exhaustion is considered as the lack of energy and exhaustion at the worker's emotional level. With regards to depersonalization, there is a sphere of negative feelings towards work and emotional hardening, characterized by detachment from the environment and co-workers. Finally, still within the main aspects involving the Burnout Syndrome, the reduction of professional achievement involves the spheres of negative self-assessment of the worker, with a consequent reduction in performance and productivity[17-19].

As citizens and workers, health professionals are entitled to conditions to carry out their work activities without prejudice to health and with quality of life20. In this sense, from this primary right, the improvement of the working and living conditions of these professionals can generate positive impacts on their health and quality of life, in addition to offering subsidies for the improvement of work processes and practices and, consequently, on population

health[12]. Therefore, based on the literature on the subject, it is hypothesized that due to the high workload and unfavorable work environments, health professionals, specifically in the FHS, face high levels of stress on a daily basis that may contribute to their physical and psychological illness.

Thus, it is necessary to know the epidemiological profile of these workers, as well as the factors associated with their quality of life and job satisfaction, so that it is possible to build collective strategies to prevent suffering at work and promote health. The identification of these factors also helps to fill the institutional gaps present in the SUS, so that primary care professionals can exercise their right to decent working and living conditions. In this context, the present study aims to analyze the quality of life at work and Burnout Syndrome of health teams that work in the family health strategy program in a municipality in southern Santa Catarina.

MATERIALS AND METHODS

This is a quantitative cross-sectional study, carried out with professionals who make up the basic health teams of 21 institutions of the Family Health Strategy, in a municipality in southern Santa Catarina. 145 professionals participated in this study and met the inclusion criteria of the study, which were namely: being a health professional working in FHS in the municipality where the research was applied, and accepting to participate in the study by signing the Informed Consent Form. Regarding the exclusion criteria, the following stand out: professionals who were away or on vacation at the time of collection at their unit, professionals from other points of care in the network temporarily allocated to work in primary care, and professionals hired less than a month. This was a convenience sample[21], as professionals present at the institution participated in the research application, which took place from January to March 2016.

Three instruments were used for data collection, namely: a sociodemographic questionnaire developed by the authors, Maslach Burnout Inventory (MBI), and the Quality of Life Assessment Instrument - WHOQOL–bref. The participants' characterization questionnaire has the following information: age, gender, race, marital status, professional occupation, workload, time in the profession, time in the ESF, professional association, if you chose the job, leadership position, and study time. For analysis purposes, given the low representativeness of some professional categories in relation to other professions, professional occupation was divided into four categories, namely: "nurse", "nurse technicians", "community health workers", and "others ". This last category groups the occupations with the lowest number of professionals, namely: general services professional (10), doctors (6), dental surgeons (3), and oral health assistants (3).

The categorical variable, race, was collected according to the categories standardized by the IBGE: white, black, brown, indigenous, and yellow. Due to the absence of indigenous and yellow individuals, these categories were excluded from the analysis. A preliminary analysis with the race/skin color variable disaggregated in whites, blacks, and browns showed that the number of observations in these last two strata was low, which may interfere with the statistical power of the analysis. Thus, it was necessary to group these categories, resulting in a categorical variable dichotomized into blacks and whites.

Created by Christina Maslach and Susan Jackson in 1978, the MBI is the most widely used Burnout rating scale in research on the

syndrome[22]. It is a Likert-type self-assessment scale of five items ranging from "never", "annually", "monthly", "weekly", and "daily", to be attributed to a set of feelings expressed in twenty sentences[23]. MBI assesses how the worker experiences his work, according to three conceptual dimensions: emotional exhaustion, professional achievement, and depersonalization, which are categorized according to low, medium, and high levels[24].

The WHOQOL – bref is the shortened version of the WHOQOL – 100, developed by the Quality of Life group of the World Health Organization (WHO). This short version of WHOQOL was created in view of the need for a cross-cultural instrument to assess quality of life, which would allow satisfactory psychometric responses in a short time of application. This instrument has 26 questions, two of which are general on quality of life and the others represent the 24 facets that make up the original instrument (WHOQOL – 100), and are divided into four domains: physical domain, psychological domain, social relationship, and environment[25]. The questions in each domain of the WHOQOL-bref present answers on a Likert scale of five categories, which may vary, depending on the context of the question, in intensity ("nothing" to "extremely"), capacity ("none" to "completely"), frequency ("never" to "always"), and evaluation ("very dissatisfied" to "very satisfied", or "very bad" to "very good").

The data were collected by the researcher at the institutions participating in the research, during business hours and in a noise-free place. The interviews were conducted individually with the application of the instruments, starting with the sociodemographic profile. Each participating professional filled out their data in an available questionnaire, as well as the MBI and WHOQOL – bref tests. The data collected were transcribed in a table in the Microsoft Excel program and for the analysis, the software Statistical Package for the Social Sciences (SPSS) version 2.2 was used.

Pearson's chi-squared test was used to analyze the data quantifying the association or independence between Quality of Life and Burnout Syndrome and the variables: professional occupation, job training, living in the work district, having a leadership position, being a professional with a permanent or temporary association, time working at FHS, professional experience, and weekly workload. The adopted statistical significance of probability values was below 5%.

The research complied with the legal ethical precepts that govern research with human beings, as indicated in Resolution No. 466/12, of the National Health Council and passed approval by the Research Ethics Committee of the University of the Extreme South of Santa Catarina with CAAE 45679715.0.0000.0119 and Opinion No. 1.101.244. Participation in the study was dependent upon the signing of the Informed Consent Form (ICF) and the anonymity of the participants was guaranteed.

RESULTS

The sociodemographic and labor data of the studied population are described in Tables 1 and 2. Regarding the sociodemographic aspects, the female gender (92.1%), white race (85.3%), married (49.7 %), residents of the neighborhood where they worked (61.7%) were the most predominant. Data related to work aspects point to the prevalence of hired professionals (68.8%), with the occupation of Community Health Agents (53.1%). It was identified that most of the participants chose the job they perform (97.2%), and a little more than half (56.3%) claimed to have received training for the

work they do in the FHS.

The data obtained through the Maslach Burnout Inventory (MBI) in relation to Burnout Syndrome, are presented in Table 3, which shows the results of the scores obtained in the categories of depersonalization, emotional exhaustion, and low personal achievement that characterize the syndrome. Of the 145 questionnaires obtained in the survey, 38 were invalidated because they were not filled out correctly, making it impossible to correct them. Thus, 107 questionnaires were considered valid for analytical purposes.

Regarding depersonalization, the statistics point to a relationship with professional occupation. In this case, nurses are characterized as the most affected professionals, with 60% of high depersonalization in their category. Also, an association between depersonalization and working time in the FHS (p=0.038), time in the profession (p=0.007) are highlighted.

The results showed that there was no relationship between low personal fulfillment and the weekly workload, working time in the FHS, age, and weekly workload. There was a relationship between study time and low personal achievement (p=0.004). Finally, there was an association between emotional exhaustion and the weekly workload (p=0.006) and time of study (p=0.03).

Table 4 shows the data obtained in relation to Quality of Life through the WHOQOL-bref Survey. It is worth mentioning that 29 surveys were invalidated due to incorrect filling, making it impossible to correct them. Totaling 116 subjects analyzed in this category.

Table 4 shows that most of the interviewees have a good quality of life (68.1%), a good perception of health (48.3%), good social relations (44.8%), and regularity in the physical (50%), psychological domains (37.1%), and the environment (50%).

Table 5 shows the results of the cross-tabulation between professional occupation and quality of life, health perception, and the other domains that characterize Quality of Life in WHOQOL-bref.

The statistical analysis points to the relationship between professional occupation and the Physical Domain (p=0.039), Psychological Domain (p=0.031), and the Environmental Domain (p=0.025) as significant. In general, Community Health Agents were the professionals who showed the greatest need to improve these domains.

There is no statistically significant relationship between Quality of Life and age, time of study, professional experience, time working in the FHS, and weekly workload. With regards to the perception of health, there is no relationship between this domain and age, time of profession, FHS time, and weekly workload. Regarding the physical domain, there was no association with age, weekly workload, professional experience, and time working in the FHS. However, there was a relationship with the time of study (p=0.030).

No statistically significant relationship was found between the psychological domain and age, profession experience, and time working in the FHS. However, there was a relationship with the weekly workload (p=0.005) and time of study (p=0.040). With regards to the domain of social relationships, there was no association with age, time of study, professional experience, time working in the FHS and weekly workload. Finally, the domain of the environment was not related to age, professional experience, and time working in the FHS. However, there was a relationship with the time of study (p=0.002) and the weekly workload (p=0.040).

Table 1 – Distribution of sociodemographic and work data of the study participants. Criciúma, SC, 2019.

Variable	Distribution	
	n	%
Gender		
Male	11	7.9
Female	129	92.1
Breed		
White	122	85.3
Black	21	14.7
Marital status		
Married	72	49.7
Not married	41	28.3
Others	32	22.1
Professional Occupation		
CHA	77	53.1
Nurse Technician	31	21.4
Nurse	15	10.3
Others	22	15.2
Resides in the working district		
Yes	87	61.7
Professional association		
Permanent	99	68.8
Temporary	45	31.3
Chose the job		
Yes	141	97.2
Management position		
Yes	17	11.7

Table 3 – Data obtained from the Maslach Burnout Inventory (MBI). Criciúma, SC, 2019.

Burnout syndrome	n	%
Depersonalization		
Low	30	28.0
Medium	43	40.2
High	34	31.8
Emotional distress		
Low	41	38.3
Medium	39	36.5
High	27	25.2
Low Personal Achievement		
Low	11	10.3
Medium	40	37.4
High	56	52.3
Total	107	100.0

Table 2 – Distribution of sociodemographic and work data of the study participants. Criciúma, SC, 2019.

Variable	Distribution	
	Average	SD
Age (years)	37.0	(±10.6)
Weekly Workload (hours)	40.1	(±6.0)
Professional experience	7.2	(±6.5)
Time working in the FHS	4.7	(±4.9)
Time of study	13.3	(±3.8)

Table 4 – WHOQOL-bref Inventory data. Criciúma, SC, 2019.

WHOQOL	n	%
Quality of life		
Needs to improve	5	4.3
Regular	18	15.5
Good	79	68.1
Very good	14	12.1
Perception of health		
Needs to improve	20	17.2
Regular	27	23.3
Good	56	48.3
Very good	13	11.2
Physical Domain		
Needs to improve	14	12.1
Regular	58	50.0
Good	43	37.0
Very good	1	0.9
Psychological Domain		
Needs to improve	13	11.2
Regular	43	37.1
Good	36	31.0
Very good	24	20.7
Social relationships		
Needs to improve	14	12.1
Regular	45	38.8
Good	52	44.8
Very good	5	4.3
Environment		
Needs to improve	16	13.8
Regular	58	50.0
Good	19	16.4
Very good	23	19.8
Total	**116**	**100**

Table 5 – Data obtained in the Cross Tabulation between professional occupation and WHOQOL-bref domains. Criciúma, SC, 2019.

Domains WHOQOL-Bref	Nurse n(%)	CHA n(%)	Nurse Technician n(%)	Others n(%)	p-value*
Quality of life					
Needs to improve	0 (0.0)	1 (4.8)	4 (6.5)	0 (0.0)	0.284
Regular	1 (6.7)	5 (23.8)	10 (16.4)	2 (10.5)	
Good	11 (73.3)	12 (57.1)	42 (68.8)	14 (73.7)	
Very good	3 (20.0)	3 (14.3)	5 (8.2)	3 (15.8)	
Perception of Health					
Needs to improve	1 (6.7)	4 (19.0)	11 (18.0)	4 (21.0)	0.186
Regular	2 (13.3)	6 (28.6)	14 (22.9)	5 (26.3)	
Good	9 (60.0)	9 (42.8)	32 (54.4)	6 (31.6)	
Very good	3 (20.0)	2 (9.5)	4 (6.5)	4 (21.1)	
Physical Domain					
Needs to improve	2 (13.3)	0 (0.0)	11 (18.1)	1 (5.3)	**0.039**
Regular	5 (33.3)	12 (57.1)	30 (49.2)	11 (57.9)	
Good	8 (53.4)	9 (42.9)	19 (31.1)	7 (36.8)	
Very good	0 (0.0)	0 (0.0)	1 (1.6)	0 (0.0)	
Psychological Domain					
Needs to improve	1 (6.7)	1 (4.8)	11 (18.0)	4 (21.0)	**0.031**
Regular	6 (40.0)	12 (57.1)	30 (49.2)	5 (26.3)	
Good	8 (53.3)	8 (38.1)	20 (32.8)	10 (52.7)	
Social relationships					
Needs to improve	1 (6.7)	2 (9.5)	9 (15.7)	2 (10.5)	0.281
Regular	6 (40.0)	8 (38.1)	21 (34.4)	10 (52.7)	
Good	8 (53.3)	10 (47.6)	29 (47.5)	5 (26.3)	
Very good	0 (0.0)	1 (4.8)	2 (3.2)	2 (10.5)	
Environment					
Needs to improve	1 (6.7)	3 (14.3)	15 (24.6)	5 (26.3)	**0.025**
Regular	9 (60.0)	15 (71.4)	40 (65.6)	9 (47.4)	
Good	5 (33.3)	3 (14.3)	6 (9.8)	5 (26.3)	
Total	15 (100)	21(100)	61 (100)	19 (100)	

* p<0,05

DISCUSSION

According to ordinance 2.488/2011, the FHS must be composed of a multiprofessional team formed by at least one doctor, a nurse, a nursing assistant, and Community Health Agents (CHA's), in the proportion of one agent for, at most, 150 families or 750 people[26]. This can infer a large number of Community Health Agents (53.1%) participating among the professionals interviewed in this study, as well as in a similar study[1].

Regarding the prevalence of the female gender (92.1%), the historical and cultural predominance of women in the health field stands out, especially in nursing, in addition to the fact that most CHA's are women[27-29]. Elevated samples, respectively, 81% and 84.9%, were also found by other researchers, in the studies by Tomasi *et al.*[2] and Trindade[29].

With regards to Burnout Syndrome, the existence of a relationship between time of study and low personal achievement was observed in this study. In this case, it is inferred that the possibility that studying allows not only the choice of profession and work that one wishes to exercise, and the assurances that come from this work, but also the possibilities of insertion into the labor market and choice of work place. This option often does not occur for people with a low education, as in relation to CHA's. All community agents in the present study who experienced stress chose their occupation due to lack of options, advanced age, need for work and income. For many of these professionals, occupation represents entry into the job market, and age and education are factors that can influence the job opportunity, leading them to choose the CHA occupation[30,31].

Study time and weekly workload were also related to the emotional strain of the professionals surveyed. The literature, however, is divergent, pointing out studies that do not associate time of study and Burnout Syndrome[2]. Other researchers, in turn, describe that individuals with a higher educational level tend to develop higher scores of Emotional Exhaustion and Depersonalization and lack of personal fulfillment at work, which may be related to the recognition that some professions confer in relation to others[2,15]. The salary is also pointed out as a factor of job satisfaction, causing suffering and possible illness. This factor is directly related to occupation and education level, since the salary of FHS professionals varies considerably, according to the activities, responsibilities or workload performed by the professional[2].

With regards to Burnout Syndrome and professional occupation, the data obtained in the study point to the relationship between depersonalization and nursing professionals, corroborating with similar studies[32-36]. Depersonalization is a specific characteristic of the Syndrome, perceived as the loss of sensitivity to the problems of users, family members, and dehumanization of the care process[33,36]. Nursing is considered the fourth most stressful profession in the public sector, increasing the tendency towards depersonalization of the worker given the difficulty in delimiting the profession's roles as well as the lack of recognition among the public[37].

The depersonalization of nursing professionals is often associated with stress or risk factors, such as many hours weekly, conflicts with the team, double employment, and little free time for leisure and rest[34]. Furthermore, in some contexts, depersonalization is considered a defense mechanism for professionals to deal with

emotional exhaustion and low personal fulfillment[38].

In this context of depersonalization, emotional exhaustion and low personal fulfillment evidenced in the study by the instrument used (MBI), the quality of life at work is compromised by some existing problems in Primary Health Care. Among these factors, satisfaction with working conditions, availability of human, material and environmental resources, organization of the work process, ways of caring, and the result and recognition of work are highlighted[10].

In general, CHA's were the professionals who most needed to improve their quality of life, especially in relation to the physical, psychological, and environmental domains. With regards to the physical domain, it is noteworthy that work in health units is carried out in an environment with several occupational risk factors and community workers are the most affected by these conditions1. This is due both to the fact that these professionals represent the majority of the team, as well as the fact that they constitute the link between the community and health unit and are inserted within the territory. In relation to the psychological domain, it is noteworthy that, once inserted in the community, CHA's become a reference for the population in their area of coverage, consequently assuming various roles, such as listeners, counselors, reference point for problems in other areas, among others[14].

Another relevant factor in relation to these professionals, and which affects these domains, is that unlike the vast majority of FHS professionals, CHA's do not leave the community when they finish their workday, sharing in the same difficulties, vulnerabilities, and unhealthiness experienced in the environment. Thus, the researchers point to the need for greater attention to the domain of the environment in which these subjects live, intrinsically related to the other domains, in the development of actions for the quality of life of health workers[39].

CONCLUSION

This study aimed to analyze the Quality of Life at Work and Burnout Syndrome in health professionals who work in the Family Health Strategies of a municipality in southern Santa Catarina. It was possible to identify the high level of personal unfulfillment, medium level of depersonalization, and low emotional exhaustion, which influence occupational suffering. Depersonalization is a characteristic of Burnout, associated mainly with nurses.

With regards to quality of life, the data indicated a good quality of life, perception of health, and social relationships, but demonstrate regularity physical, psychological, and environmental domains. Community Health Agents were the most negatively affected by the domains in question. Still, with a view to prevention, the prevalence of depersonalization, emotional exhaustion, and personal fulfillment that point to an occupational suffering that can evolve to a profile of Burnout Syndrome, must receive necessary attention.

In view of the above, the illness of health workers in the studied municipality is evident, highlighting the need for attention to these professionals in a way that guarantees, not only their performance and commitment to SUS, but mainly, health and quality of life. It is essential that public management is attentive to the factors cited as interfering in the health of these workers, as well as developing actions aimed at receiving and recovering professionals who are already ill or in the process of becoming ill, in addition to preventing future cases.

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