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Health Evaluation and Worker's Health: the definition of the length of medical leave in focus

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Abstract *For the purpose of analyzing topics linking the health-disease-work process to medical evaluation practices under the scope of the federal public service and their interaction with Worker's Health, this article investigates the issue of determining the duration of the sick leave period that a worker is granted for caring for their own health, within the Subsistema Integrado de Atenção à Saúde do Servidor (SIASS). To that end, the parameters for granting time off work, as provided by the Manual de Perícia Oficial, and the speeches on this topic by the interviewees were analyzed. The importance given to the topic 'days off work' arises from the fact that it is related to the time it takes the worker to recover, which implies fewer days dedicated to being productive. Interviews were conducted with 32 professionals from 5 educational institutions, and this article highlights some analytical categories: days off work; Manual da Perícia and disagreement between medical evaluators and attending physicians. The results point to the usefulness of revising the Manual taking into account Worker's Health, identifying contradictions; the need for shaping an effectively interdisciplinary evaluation, so that the worker's health-related complaints can be handled from the perspective of the worker's care, and not simply concerning control and surveillance.*

Key words *Worker's Health, Health evaluation, Federal public service*

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Introduction

The Worker's Health paradigm aims to guide interventions in health-disease processes at work, and its assumptions constitute the operating principles in the Integrated Health Care Subsystem of Federal Civil Servants (*Subsistema Integrado de Atenção à Saúde do Servidor Público Federal* - SIASS), which, since 2009, when it replaced the previous system (Integrated Federal Civil Servant Occupational Health System - SISOSP) centered on the paradigm of occupational health, operates health care actions for federal civil servants in the Executive Branch. Considering the field of Occupational Health as the ideal one for thinking about health-disease processes at work, this article presents the findings on the decision-making moment by experts about the duration of medical leave (days on leave) for the treatment of their own health in the health evaluations carried out in SIASS units. The concept of treating one's own health is different from the one that refers to monitoring a family member undergoing health treatment and without autonomy, whose time implies a much shorter maximum leave period than the treatment of one's own health, showing the importance of time in expert decisions. The findings originate from semi-structured and in-depth interviews, carried out throughout 2019, with experts from five federal institutions in the state of Rio de Janeiro, Brazil. Inside this topic, we will analyze, based on the interviewed professionals' statements, the role of the SIASS Expert Manual and the experts' divergences in relation to the reports issued by other physicians who follow the assessed workers, the so-called assistant physicians. Investigating the criteria from the Expert Manual section on the granting of medical leave time off work, we analyzed how this period is evaluated by the expert and the health team, and what the margin for negotiation is between the expert's position and the demands expressed by the worker. This proposal originates from a doctoral thesis defended in 2020, whose objective was, in summary, to investigate the role of health evaluations by SIASS experts from the perspective of the practitioners.

Regarding the principles of Worker's Health evoked by SIASS, Machado[1], based on the analysis of normative texts of this system, observes the lack of certain conceptual cohesion regarding the adoption of the field foundations. The theoretical principles that appear in normative texts are often hybrids and get confused with the theoretical bias of Occupational Health, which considers the multi-causality in the production of the disease, but the risks or etiological agents are decontextualized, whereas on the other hand, the social and institutional relations regarding illness at work are not taken into account. This theoretical misperception, present in some SIASS guidelines, proves to be a problem as its actions extend across a vast population of federal civil servants and, thus, require an equally vast number of health professionals, whose approaches can be as heterogeneous as possible, in the negative sense that such heterogeneity can acquire during the health care practice aimed at the civil servant (a mixture of actions influenced by the three paradigms related to illness at work, which are: occupational medicine, occupational health and Worker's Health). To have an idea of the magnitude of SIASS, it is worth mentioning that it should cover a total of 1,051,580 (one million and fifty-one thousand, five hundred and eighty) active federal civil and military servants throughout the country[2], according to data from the Ministry of Health.

It is emphasized that the establishment of the Worker's Health principles within the federal public service still requires many developments[3,4], given that some of its principles are difficult to be carried out, and their connection with the Brazilian Public Health System (SUS, *Sistema Único de Saúde*) and health policies remain precarious, occupying a more marginal position regarding the effective actions in this area[5]. On the other hand, Lacaz[5] identified, in 2007, a setback in the Worker's Health field, due to three aspects: the fragility that was already affecting the Union movement, the attitude of scarce engagement of the academia and reductionist public policies, related to Occupational Health[6].

It is also worth recalling that, as Minayo-Gomez and Thedim-Costa[7] point out, Worker's Health is "a goal, a horizon" and requires "political, legal and technical action", in addition to an "ethical posture". Worker's Health incorporates principles of the Italian Workers' Model (IWM), according to which the health reform should allow the acknowledgement that the disease, in addition to personal suffering, is "the sign of a historical conflict between man, nature and society"[8]. Thus, if these principles indicate a horizon to be pursued, they can be used, in this research, as an ideal from which to analyze the data from the interviewees' statements regarding their understanding about the days of medical leave for the treatment of one's own disease, by the workers, and about the negotiations about the experts' decisions that involve the subject.

Ciência & Saúde Coletiva, 26(12):6069-6078, 2021

Method

The SIASS health evaluations are carried out in federal institutions by expert physicians and dentists who then issue technical reports containing the experts' decisions about the civil servants' health claims. Not all federal institutions include a SIASS units, and there are technical cooperation agreements for carrying out health evaluations. It is important to highlight that the concept of expertise in health is, in theory, distant from that of medical expertise, as it presupposes an expert's work that combines different technical knowledges. Therefore, SIASS provides for the existence of the so-called expert support team, consisting of professionals such as psychologists and social workers, who support the physician's decision. For the study that originated this article, 32 semi-structured interviews were carried out, with physicians (20), dentists (3), psychologists (4), social workers (4) and physical therapist (1), selected after previous contacts of the researchers and the snowball method. The interviews were analyzed with the aid of the qualitative research software, *Atlas.ti*, which helps to organize the categories obtained in the interviews. The script sought to be guided by questions related to the interviewees' conception of the role of expertise in health in federal public service, their academic training and professional experience, how to solve their doubts (thereby giving rise to the protagonism of the SIASS Expert Manual), the difference in their work when it occurs in the expert scenario and when it occurs in the care setting and, finally, the way teamwork occurs (when it exists). One of the findings of the interviews was the frequency with which the discussion about the length of medical leave arises.

The importance given to the topic of the expert decision regarding the days of medical leave allows us to highlight at least two points: 1) interests prioritized or not during the expert evaluation process, since the more days the server is in the recovery process, the fewer days they will be available for work and, 2) to what extent the worker's perspective is taken into account in this decision process or not. In this article, we will analyze the specific topic of "time off work" starting from how the topic appeared in the analysis of interviews with SIASS professionals.

Time off work: an angle of analysis

The issue regarding the length of medical leave may seem to be a minor issue; however, it is about thinking about the worker's time dedicated to oneself, to their recovery, and not to work. In other words, it is about what is the central object in the discussion about work: time. About that, Foucault states: "It is necessary that man's time be offered to the production apparatus; that the production apparatus can use the lifetime, the time of existence of men. It is for that and in this way that control is exercised"[9]. The quote reminds us that the issue of days off work might no longer be related to health itself but be linked to productivity.

The relevance of the discussion about time off – or days off – work lies in the relationship between time, work and capitalism. In the capitalist mode of production, the control over the time that the worker dedicates to working – and, therefore, to production – constitutes the core of work in this type of system. The added value, according to Marx, is precisely extracted from the time that is not paid to the worker, as recalled by Braverman[10]. Therefore, it is worth remembering that macro-social changes, especially those that took place from the 1970s onwards, with yet another structural crisis of capitalism, resulted in transformations that impacted the way of thinking about both work and time[11,12]. Also in this sense, Crary[13] analyzes the issue of time that is extracted from the subjects' lives so that they serve the work and consumption systems inherent in the capitalist logic. By pointing the US government research on the behavior of birds that do not rest over a course of days, the author highlights the objective of understanding this biological phenomenon that allows long vigils without loss of yield, for their subsequent reproduction in human beings. The idea would be to reach what the author calls a "sleepless worker", who becomes, in the end, the "sleepless consumer", in what would be an evident process of unrestricted colonization of the subject's time. It can be deduced that the breaks (daily sleep, rest and also days off) prevent continued productivity.

The issue of working time is so central that the legal regulation in relation to disability retirement, for instance, according to Law No. 8,112, which encompasses the rules of the Single Legal Regime at the federal level, in its article 188, establishes that such modality of retirement "will be preceded by leave for health treatment for a period not exceeding 24 (...) months"[14]. The length of service, fundamental for social security purposes, also places the time dedicated to work as a requirement for obtaining social rights and, according to each legal system, it will include or

not some types of leave, which are all very well specified.

The debate about time is still essential in terms of managing work behavior inside a given institution, and this seems to have been the case since the advent of the so-called Scientific Administration (or Taylorism), in which the workers' gestures should be mechanical so that they fit into the measured time (these were calculated in details for the purposes of productivity and optimization, reverted into capitalist gains)[15]. Once again, the discussion is relevant as perhaps the times of capital are not the same as those necessary for the health/disease processes. According to Canguilhem, "to be in good health is being able to fall ill and recover"[16]. Thus, the possibility of falling ill is part of the health state, and falling ill requires recovering, which entails a period that cannot be shortened. This recovery is also linked to Berardi's[17] discussion about the impossibility of expanding what is called 'cybertime', of which limits refer to the intensity of the lived experience. Therefore, the experience of illness (the intensity that is intrinsic to it, being one of its elements) is unique, and does not end in fixed tables. The recovery of an illness – health, according to Canguilhem – would be, according to what can be inferred from Berardi's contribution, the necessary moment of reservation, assimilation and processing of the lived experiences.

The issue of the length of medical leave in discussions about the health evaluation by experts brings to the scene the debate on absenteeism and its more specific conceptual development, the absenteeism-illness pair, according to the nomenclature of the International Labor Organization. A study carried out in public services in the city of Goiânia, state of Goiás, Brazil, reinforces aspects related to working conditions, deduced from absenteeism-illness indicators. The study indicates that their analysis, when associated with the medical leave profile, can generate not only information about the workers' health conditions, but also about the working conditions in which they operate[18]. The study results indicate a higher prevalence of days off work to treat one's own health related, in this order, to mental disorders, musculoskeletal diseases and injuries. As will be pointed out ahead, the number of days off due to psychiatric diagnoses generate divergences between medical experts and assistant physicians.

According to Santi et al.[19], there is an association between absenteeism-illness and the continuity of essential activities for the citizens with regard to public service, which would result in burdens to public resources due to non-productivity and expenses with worker's rehabilitation. The authors indicate a central point that tells us what the negotiation about the length of medical leave reveals: the days of absence are understood as absenteeism for the public funds. The concept of isolated absenteeism, without its counterpart related to the disease, seems to be imbued with a negative connotation due to the burden it would generate. However, we consider here that, from the perspective of the worker's health, the days of medical leave, even if they are more numerous than those indicated in the Expert Manual, may be the time needed by workers to recover their health.

Results

The results below focus on the topics that were directly related to the subject of time off work based on the interviews, that is, how the criteria that guide decisions regarding the granting of days of medical leave are brought up by the interviewed professionals (quantity, renewal or not of the period of medical leave, agreement or disagreement with what is indicated in the reports of the assistant physicians), how this period is evaluated by the expert and other health professionals and, finally, what the margin of negotiation is between their position and the evaluated worker's demands. Thus, we divided it into three central points: the Expert Manual, as this is the regulatory instrument that provides guidance on the length of the medical leave; leave days, which shows how ideas and values are taken into account by the expert in their decision-making process; Divergence from the Assistant Physician, to analyze how the image of the assistant physician appears in the interviews.

Expert Manual

The expert evaluation is the moment when the civil servant will have their health demand evaluated by professionals who have the power, making use of some legal argument, to agree to it, or deny it. If the civil servant falls ill, it is there that they will have their leave granted or not, as well as the definition of the time necessary to recover, and it is there that they can be retired due to disability. These are just a few examples of the types of evaluations that the experts have to perform, which is sometimes a decisive moment

Ciência & Saúde Coletiva, 26(12):6069-6078, 2021

in the worker's life. In our analysis, we observed that there are several aspects entwined in the conceptions about the expert professionals' practice, added to those that constitute the text of the Expert Manual, but, to facilitate the discussion, we can isolate two main aspects, knowing that there are numerous variables that can influence this process. Thus, the decision about the length of medical leave for a civil servant is intertwined with the expert's distrust, which is encouraged by the Manual, in relation to civil servants in general.

According to the Manual, there is a difference between the physician who treats a patient and the physician whose job it is to provide an evaluation as an expert. The description of these two relations places them at two extremes, as if there were not several possibilities of interaction between them. The relationship between the attending physician and their patient presupposes the patient's trust and interest in telling the physician everything about their illness, leading to total honesty. As for the relationship between the evaluated individual and expert physician, there would be mutual distrust. In this case, the employee's interest in obtaining some kind of benefit could lead them to simulate a condition and, therefore, lead to an *a priori* expectation of fraud on the part of the expert professionals, which places them in a situation that is far from the impartially that is claimed by the text of the Manual and in some of the interviewees' speeches. In addition to trust, "empathy" would be something present only in the treatment relationship, but not in the expert evaluation relationship. The text shows a constant reinforcement that the expert professional must be careful about the possibility of disease simulation, and that they must "stand up for the Federal Public Administration", a bias that can keep the workers from receiving their social rights provided by the Constitution, which makes all them of equal in advance, as if the evaluated civil servants were, for the most part, looking for secondary (illegitimate) gains that must be detected by the experts. These and other ways of defining expert evaluation relations end up placing this type of practice in a sphere of conflict. There is no mention, with the same frequency, of the relationship between illness and the organization of work in the Expert Manual.

Suspicion regarding the reports of the evaluated individuals can bring great suffering to the servants whose diseases are not recognized or do not fit the legal provision. In the cases of what Dumit[20] calls "illnesses you have to fight to get", that is, diseases that are characterized by the uncertainty about their diagnosis, treatment and prognosis and which do not have biological markers that attest to its legitimacy, the possible predominant description of the evaluated individual as someone who should be distrusted in advance is something even more problematic. These people have to fight to have a diagnosis, in the sense that they have the suffering and symptoms, but they are not recognized in their illness due to the fact that there is no name for what they have or, even if there is, it is full of uncertainties due to the fact it is an emerging disease

With the justification of granting "transparency to the evaluation acts"[21], the Manual has a table of medical leaves that correspond to the different diagnoses. To mention examples of Mental Disorders, 20 days are recommended for depressive episodes and phobic and anxiety disorders, 30 for schizophrenia and obsessive-compulsive disorder and 7 for somatoform disorders, dissociative or conversion disorders. But there are other correspondences, such as 3 days for torticollis, 2 for gastritis, 15 days for glaucoma, among others. What can be perceived is that the maximum time off work allowed for any of the mental health diagnoses is 30 days. These parameters of length of medical leave raise a number of issues that are also related to the expectation of fraud.

One of the main issues that appears in the decision-making process about the length of medical leave is the disagreement between the expert and the assistant physician's report. When the civil servant arrives at the expert evaluation with a report from their attending physician indicating a number of days longer than what the expert considers reasonable, there is a problem. The expert, as mentioned in some interviews, which will be seen in the next section, tends to disagree with the assistant physician, seeking to reduce the length of medical leave, but one must ask: on what basis does the expert judge that a given number of days off work is excessive? In cases of mental health and suffering, which are linked to the organization of work, for instance, even if the causal link is not established, the diagnosis is a fiction. Or an illusion of objectivity, of homogeneity. After all, faced with the same name – depression, generalized anxiety disorder – a myriad of reactions can arise, whose recovery time is impossible to predict. A depressive episode may have to do with bullying experienced in the work environment, with the lack of meaning related to deviation of function, with restructuring in the

institutional sphere. Does all of this lead to the same number of days off work?

Regarding the interviews, there does not seem to be a question by the expert as to why the attending physician may have decided to give "more" days than what was supposed to be reasonable. What has the worker told them that has not found an environment of "mutual trust" during the expert evaluation to be reported? What does the assistant physician know that the expert may not know? It is not possible to have knowledge of these issues without listening and searching for what, at work, in institutional relationships, may or may not be linked to that illness. The primacy of the suspicion towards the employee causes the expert to fall into a habit of suspecting everything, including the assistant physician.

As mentioned, the interviews led to the creation of several analytical axes, and in relation to the Expert Manual, only physicians (20) and social workers (1) mentioned it. Some of these references are mixed with those related to the length of medical leave. There are several citations to the aforementioned Manual as a source of reference in case of doubts. As there is a lack of training for working with expert evaluations in the experience of most of the interviewed physicians (out of 20 physicians, only 1 had had training akin to expert evaluation), the Manual also undertakes the training function and that is why it is so important, having a significant influence on the professionals:

[...] I have come to work at this function... I read the manual, of course I didn't absorb all the information, so I read the manual at home so I could understand and I was lucky to have someone here that already had the experience, [...] so, to this day, I solve my doubts with her, because we didn't have a training course, I think this is something that we should have had [...] (physician 4).

At other times it is referred to as a type of the "casting out nines" procedure, in the absence of a better term. This is what you see below:

[...] sometimes we have to go to the manual to remember if it matches what people are saying and everything (physician 2).

What stands out in the excerpt above is the fact that the Manual takes precedence over the experience report brought by the civil servant. It is used as a guide to the truth, so to speak, in which the worker's statements and the indications recorded there will be checked.

The Manual is also cited as a kind of source of expert etiquette: the expert evaluations, the ways of performing the evaluation, the prescription of the interaction at the time of the expert evaluation, everything is there. One of the characteristics of the relationship between the expert and the evaluated subject must be the impartially and the distancing, as we observed when talking about the absence of empathy in the description of this relationship. The text of the Manual is a justification for this type of behavior:

In the SIASS manual itself, there is a definition of the expert physician, how they must behave; we have to keep a certain distance (physician 5).

Finally, there are also more references questioning the rules of conduct offered by the Manual, as seen below:

Send an email, and then "wow, can you see this case", "call the civil servant", "wow, they called me", I don't want to know what's going on... And that outwits the manual. Even the health manual we end up outwitting. If strictly speaking, strictly speaking, we could not do any of this, but when we do it and see that the result is very good for the servant, it is worth it... wow... it is priceless... (physician 6).

In the example above, the expert had been describing the way they act with the servants, nothing distant or formal and, in this sense, they point out the transgression they commit against what the SIASS text suggests, identifying this transgression as their social role, in the sense of offering good support to the worker, treating them with dignity, caring for them.

Days off work

Regarding the topic of days of work, the way the expert deals with the Manual and the divergence that can occur with what the employee's physician recommends, some excerpts illustrate the discussion raised in the previous section:

[...] very often, we think that the assistant physician granted too many days of medical leave. I don't know, because their judgment is not our judgment, their judgment is 'look, they probably can't work for a certain number of days', they end up granting a little more time; I tend towards assistentialism, we tend to do this and we tend to comply... with the patient's wishes... but in the expert evaluation process, the definition of these days, depending on the type of work, [...] you can have alternatives, a gradual return, there are several options, then comes our legislation, right, and this gradual evolution is what constitutes a pleasure, in my opinion, and it is the differential (physician 1).

By chance, this physician, throughout the

Ciência & Saúde Coletiva, 26(12):6069-6078, 2021

interview, says some things through which they identify the expert's work as the one that can seek to connect the illness with the work processes. The descriptions they provide show approximations with the crucial conceptions of Worker's Health, making health expertise reconcilable with this field. However, here, there is an *a priori* judgment of the assistant physician, who becomes this abstract figure that fits all the cases.

Another example shows the same issue, linked to the idea of a decision-making power that belongs to the expert, to the asymmetry of the relationship between them and the other characters in the expert evaluation scenario, whether it is the civil servant or the assistant physician:

[...] a 3-month off work certificate arrives, a certificate for an indefinite time of medical leave arrives, there is no such thing, it is up to the expert to make this assessment, and as they can reduce the time, they can also increase, it is up to the expert because the expert has the final word, right [...] (physician 2).

In this example, it seems that, in the entire matter, what really matters is the "final word", which belongs to the medical expert. There is no other argument related to the decisions to increase or decrease the number of days of medical leave.

Below, we reproduce an excerpt that joins two units of meaning: days off work and the Expert Manual:

[...] the most common [diseases] we have an average estimate that they advise for any leave of absence, so, let's suppose, for depression... of course that is an average and we have to evaluate case by case, but, for example, they advise 30 days for depression, so, like, there have been cases of people who arrived here with a 90-day medical leave certificate for depression, so we can, so as not to cause upset too, show the length of time recommended by the Manual, that is 30 days and that can be renewed, but the Manual itself, for the most prevalent diseases, it gives you a suggestion so you can guide yourself and try to follow that, but of course this is very relative, I've already granted 60 days, but in some cases I granted 30... so that is kind of a guide for us (physician 3).

There is an excerpt from one of the dental professionals in which the length of leave is questioned but considering the servant deceptive or dismissing their claim as a fraudulent situation. The motivation for the suffering that may be behind this type of complaint can be perceived, which, from our viewpoint, reconciles health expertise with the principles of Worker's Health:

But I have been receiving cases that have caused me [...] and eventually the person comes to the expert evaluation and starts telling a story that permeates harassment, the need to get away from the work environment, as if they had sought all the possibilities and then: "I'll get a dental certificate". [...] And I'm starting to notice that people have started to articulate themselves more [laughs] to obtain this kind of leave. And I talk a lot with people, when it is logically possible, if it is necessary, I even extend the patient's recovery period, I am not necessarily obliged to accept what the certificate... if the certificate says 3 days and I think that the person needs 7 days, I'll grant the person 7 days [...] (dentist 2).

The dentist recognizes situations in which the certificate is deliberately used incorrectly, but the way they deal with it, the interpretation they attribute to this gesture, allows one to think more broadly about what work has been promoting, in terms of suffering and willingness to stay away from it.

Below, another excerpt shows the example of depression, mentioned by another physician, in the same sense used before: 90 days seems a lot, since it is three-fold what the Manual recommends:

But [...] if it's a question like, "ah, I don't know, I'm thinking it's a long time off work", then one of the options I sometimes employ is to use the SIASS manual itself, even to explain to the person, I don't know, that the suggested period is 30 days and the physician is asking for 90, I show them, "look, in general it's these many days, I'll give you these 30 days, but if you need to renew it, you can get a more detailed report with your physician, to explain why you need more time", [...] in general there is no problem, people understand it well, well, that there are some recommended periods of time that we have to more or less comply with (physician 4).

This is another example that joins the units of meaning of the Expert Manual and the duration of leave, with the Manual acquiring the function of a resource on which the expert will rely to avoid belligerence. The argument used, however, is that the "suggested periods" must be "more or less" used by the expert, raising the parameters to the category of a law, which is not true, having only a discretionary character.

One of the interviewed psychologists talks about the reduction of leave duration by the physician and the discussions that take place around it:

[...] sometimes they [the experts] try to ratify for less time and I suggest more, or they have already talked about retirement due to disability, I

say "hey, I don't think so yet, I think we still have to give them a chance", and they listen [...] (psychologist 1).

If we can think that one of the challenges of Worker's Health is manage to operationalize its principles also in the field of expert evaluation, we would say that the expert practice should be concerned, above all, with the relationship between illness/suffering and work and, therefore, the issue of the leave duration would perhaps be perceived and evaluated differently in the expert evaluation context.

Divergence with the Assistant Physician

As for the divergence with the assistant physician, this is also a unit of meaning linked to the duration of medical leave, as, in general, the mentions that appear by the physician (14) refer to this fact. Among the other professionals, only psychologists mentioned this category (4). Below, the speech of a psychologist who reproduces the deep-rooted discourse about the worker's intention to obtain a benefit is shown, although, in their interview, they refer to Worker's Health, as well as to the causal link:

And then [...] We clearly see that there are certificates that come, like, biased... that the assistant physician or another assistant professional, the assistant psychologist, etc., wrote things there that are very far from the reality that you you're seeing, right... and it's clearly like that... because as the expert valuation is going to be part of the possibility of obtaining a benefit, right, you have the person who may be interested, in fact, to stay off work longer and you there is also the opposite, the person who is very ill and does not want the medical leave... because they will be frowned upon by their colleagues, for everything, so [...] this is not easy... it is not so objective... (psychologist 2).

Some speeches relating to the "divergence with the assistant physician" have already been reproduced in the preceding sections, but there is still a last excerpt, in which the physician refers to a kind of complicity between the civil servant and the physician, or to the latter's *naïveté*:

But it's because we feel that sometimes things are 'loose' and want to check if it really is that complaint, if there's something important going on there or if it was just a certificate that was agreed upon with the physician... if they exaggerated it to the assistant physician and it's not all that... (physician 7).

Taking into account the case of mental health diagnoses and the parameters provided by the Manual, it is questioned how much these parameters were prepared to accompany transformations in disease classification manuals, such as the International Classification of Diseases (ICD), which has announced its 11th edition for 2022. We consider here that a parameter regarding the duration of medical leave can be important if it can be used as a starting point in cases of illnesses that experts do not see often or that are not part of the field of knowledge of their previous specialization. If used sparingly, it can be useful. However, this resource can sometimes gain prominence in expert decisions, ceasing to be a guideline to becoming a rule, as if what diverges, towards more (in terms of time for treatment and health recovery), than what is specified constituted an excess. Diagnoses and understandings about illnesses are transformed and a table containing the length of medical leave fixes what is changeable, crystallizes what is dynamic, makes general what is particular.

Final considerations

The analysis of part of the empirical material obtained from the professionals who work with health expert evaluation at SIASS and the examination of a certain aspect of the Expert Manual indicated that the establishment of the civil servant's length of medical leave to take care of their health was guided by the assumption that the fewer days away from work, the better it would be, from the institution's perspective. The decision regarding the length of medical leave was also guided by an attitude of suspicion towards the complaints of the evaluated civil servants. There was, to the same extent, no mention of harmful work situations by the interviewees. What was observed was a concern regarding leave periods that were considered to be longer than reasonable, without questioning what would or would not be reasonable. These positions, especially in their synergistic effect, distance themselves from the principles of worker's health, even though these are indicated as numbers to be maintained in SIASS.

Thus, as pointed out, the time needed to recover from an illness, included in the concept of health recommended by Canguilhem[16], ends up being categorized as absenteeism and understood as a burden to the public resources, as it would imply, according to management understanding, a pause in productivity. However, this period of absence from work activities would be necessary to re-establish the civil servant's capabilities.

Ciência & Saúde Coletiva, 26(12):6069-6078, 2021

We believe that one of the challenges regarding workers' health, at least within the scope of the federal public service, is to make the practice of health professionals more coherent with the guidelines in this field, making health-related aspects in the work context prevail based on a critical viewpoint. This might mean debating and, in a second moment, revising the Expert Manual from the perspective of worker's health, identifying contradictions.

On the other hand, we add the fact that, regarding the expert evaluation in health, if one takes into account that the worker's health constitutes a "horizon", an effectively interdisciplinary work is necessary. The Manual, despite recommending the presence of an interdisciplinary composition in expert evaluations[21], reveals a medical-centric emphasis by highlighting the sovereignty of the expert physician in the decision-making related to the health claim. In this sense, we observed, based on the obtained data, mental health cases in which the expert evaluation was carried out by physicians from specialties that were unrelated to mental health, without the presence of psychologists. This issue makes a difference in that, even if non-medical professionals give their opinions, if there is disagreement, it is the medical experts' opinion that will have the prominence, even if they originate from areas unrelated to mental health, and the opinion of a nephrologist will have more value than that of a psychologist, hypothetically. If a health expert evaluation does not include specialists in the area, the proposal of an interdisciplinary work, necessary for the establishment of Worker's Health in any institution, is not carried out, at the expense of the worker, since it is possible to reach an inadequate assessment regarding the duration of leave from their work activities.

Finally, there is a close link between the Manual's discourse and that of the interviewees, regarding distrust. The experts' listening, in general, tends to go hand in hand with the description offered by the Manual, that suspicion should be the main guide for understanding the demands. The duration of the medical leave evaluated by professionals is an example illustrating the values that are at stake in the practice of expert evaluation and that swing more towards the maintenance of the productive order than, in fact, towards the worker's vital state. In this sense, the suffering that the work can generate is overshadowed and light is shed on the imaginary aspects related to the alleged fraud that the worker is about to commit.

Collaborations

VH Pizzinga and RT Zorzanelli participated in the conception and design of the research project and analysis and interpretation of data, the writing and review of the manuscript. The first author carried out the data collection and the conception of the initial manuscript, and the article constitutes part of her Doctoral Thesis in Public Health (Human Sciences and Health), defended on March 20, 2020, at the Institute of Social Medicine at UERJ, and the second author is a professor and advisor of the present research.

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