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A gender equity approach as a management strategy for the settlement of physicians in vulnerable areas

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Although several government programs have contributed to significantly increasing the number of physicians in Brazil, remote and vulnerable areas that are difficult to access continue to lack a minimum number of professionals, and this hampers access to health care services and the population's health indicators. Government strategies, such as special financial incentives, have been able to attract physicians to these remote areas with special needs; however, the settlement of these professionals has not been effective. In view of the trend toward the feminization of Medicine and the increasing family and economic influence of women in decision-making in current society, this theoretical essay suggests the use of contemporary approaches aimed at gender equity in health services in order to favor the settlement of medical professionals in regions most in need.

Keywords: Physicians. Health services. Working women. Health management. Poor areas.

Introduction

Despite a linear and constant increase in the number of medical professionals in Brazil, the availability of quality and effective health services in remote and poor areas with special needs remains a challenge. This is not unique to Brazil, since many countries have to cope with uneven distribution of health professionals, especially physicians, and this has become a serious and persistent issue, which is resistant to all sorts of strategies[1,2].

The number of health professionals per inhabitant reflects the availability of professionals in selected categories, according to their geographic location. When there are shortages of physicians or unequal distribution in some regions, there is an increase in people who do not receive care and a resulting negative impact on basic health indicators[3].

The growth rate of the number of physicians in Brazil is about twice as high as the population growth rate. The ratio of physicians per 1,000 inhabitants went from 1.15 in 1980 to 2.11 in 2015. Medical personnel reached 364,757 professionals in 2010, an increase of 24.95% compared to 2000, opposed to a population growth of 12.48% in the same period. This is mainly related to the opening of new medical schools and the resulting increase in the number of seats in undergraduate courses of medicine[4].

The More Doctors Program (MDP) was created in 2013 and established by means of the Act 12.871. It was conceived of as part of a series of measures to fight inequalities in access to primary health care.

The MDP was structured around three strands of action: (1) investments in improvement of health care network infrastructure, with a focus on primary care; (2) expansion and reform of medical education, which contributed to an increase in the number of undergraduate courses in medicine and established new standards for professional training, favoring education-work integration and care practice in primary care on the basis of teaching, research and extension actions, in addition to increasing programs of medical residency across the country; and (3) emergency provision of physicians to vulnerable areas in need and with difficulties in getting professionals to settle in[5,6].

However, this increase in the number of physicians does not ensure homogeneous improvement of health indicators, since many regions, especially the most vulnerable, still lack professionals. In 2014, despite a national ratio of 2.09 physicians per 1,000 inhabitants, inequalities were found in the geographical distribution of these professionals: the North and Northeast regions (1.09 and 1.3 physician per 1,000 inhabitants, respectively) are below the national ratio; on the other

hand, the Southeast region has the highest number of physicians per 1,000 inhabitants (2.75), which is higher than the South (2.18) and the Mid-West (2.20) regions[4].

In view of the issue of settling physicians in remote areas that are difficult to access, this theoretical essay has the purpose of discussing health management strategies that can attract and retain medical professionals in the country's most vulnerable areas. This essay is based on a contemporary approach to gender equity that is able to use the growing number of women in the medicine labor market as an opportunity to improve health services management.

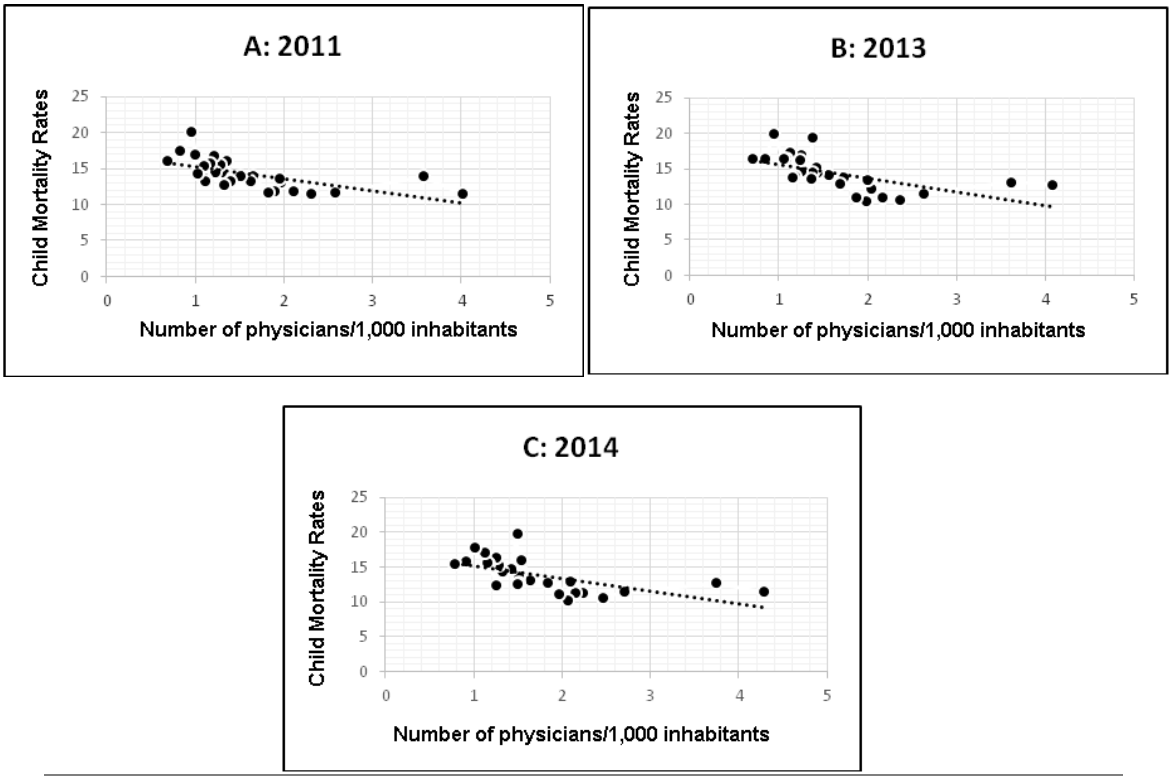
The methodological path that was taken associated the contemporary evolution of Brazilian medical demographics with its impact on health indicators, by means of the analysis of secondary data related to health indicators that were publicly available. We described the integration of women into the Brazilian labor market and their impact on family decision-making. And finally, we developed a proposal for retaining medical professionals, especially women, in remote and vulnerable areas, on the basis of strategies focused on gender equity in the labor market.

Geographical distribution of medical professionals and basic Health indicators

Life expectancy at birth and child mortality are considered to be indirect measurements of effectiveness within health care systems[3]. Child mortality is an indicator that is used worldwide to assess the health status of populations and to project the death risk of those who are born alive throughout their first year of life. It represents the number of deaths of children under one year old per 1,000 children born alive, within the population living in a given geographical location, in a given year[7]. This health indicator contributes to supporting processes for planning, management and evaluation of health policies and actions aimed at prenatal and delivery care, as well as child health protection.

The regions with the greatest shortages of medical professionals are those with high child mortality rates[2], which reflects the standards of accessibility and availability of resources for maternal health care and the child population[7] (Figure 1).

Figure 1. Correlation between child mortality rates and the number of physicians/1,000 inhabitants per Brazilian state in the years 2011 (A), 2013 (B), and 2014 (C).

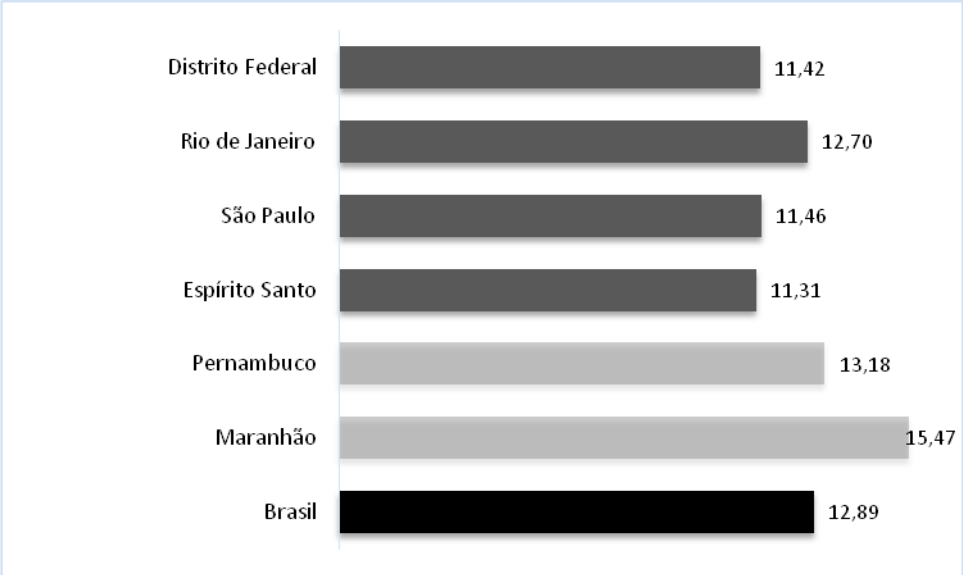


	2011	*2013*	*2014*
Spearman's coefficient (rs)=	– 0.7836*	– 0.8168*	– 0.7596*

*P<0.0001. Source: Scheffer. et al., Demografia Médica no Brasil 2011, 2013 and 2015; TabNet/DataSus.

The Brazilian states with the highest number of physicians per 1,000 inhabitants are the Federal District, Rio de Janeiro, São Paulo and Espírito Santo. As for the lowest numbers of physicians, they were found in Maranhão and Pernambuco, with 0.79 and 1.64 physicians per 1,000 inhabitants in 2014, respectively, which resulted in child mortality rates above the national average (Figure 2).

Figure 2. Child mortality rates in Brazilian States with the highest and lowest numbers of physicians per 1,000 inhabitants in 2014.



Source: TabNet/DataSus.

Although many physicians, especially recent graduates, choose to begin their market integration in the Family Health Strategy (FHS), not all of them intend to carve out their careers in this field or settle in remote areas with special needs. Most physicians hold positions as decision-makers and have a certain degree of independence with regard to their work, and few rely only on the salary paid by the FHS[8], so they are free to redirect their professional choices according to the socioeconomic setting of their profession.

However, graduate students from residency programs of family and community medicine tend to work in health care with FHS teams, which strengthens primary care and tends to improve the population's health indicators[9].

On the other hand, even though high salaries may attract physicians to relocate to remote areas, their settlement depends on basic conditions of economic and sociocultural development, basic material working conditions, and training in the field of work[2,10].

Attracting and settling professionals in poor and remote areas

One strategy for attracting and settling professionals in remote areas with special needs is to focus on efforts to meet needs related to the female gender, since decisions about settling families in other locations depends, to a great extent, on women's opinions.

Generally speaking, most decisions made by families depend on female members. It is possible to infer this on the basis of sociodemographic and financial data analysis, and factors related to the consumption of goods around the world:

> Women are one of the three emerging forces that are shaping the 21st century, along with global warming (weather) and the Internet (Web). We call them the 3 Ws: Weather – the need for environmental sustainability is widely accepted and is changing the way we think about the planet and our relationship with it; Women – the great contribution women can make to economic growth and future leadership; Web – the extraordinary transformation of the way we live, work and communicate by means of new technology[11] (Position 318 of 2783).

Women contribute with 40% of the gross domestic product (GDP) in developed countries, where they are responsible for 83% of purchases, including 91% of new

houses, 94% of furniture and decor, 60% of new cars, 80% of health insurance plans, and 89% of new bank accounts[11].

Although women's rights have only been secured since 1988 in Brazil, with the enactment of the new Federal Constitution, women are currently aware of their potential and have shown their value as citizens, mothers, and workers, influencing the whole social and economic development of the country[12].

The phenomenon of feminization of Medicine

One interesting fact is the increase in the number of women in the medical profession, especially among younger professionals. Among physicians who are 29 years old or younger, women already make up the majority, at 56.2% against 43.8% of men. With regard to new medical licenses, men were the majority until 2010. In 2011, 52.6% of new licenses from regional councils of medicine were granted to women and 47.4% to men. The feminization of this profession has been constantly increasing, totaling 54.8% of licenses to women in 2014, against 45.2% to men[4].

Women's participation in the Brazilian labor market follows a global trend and has been increasing significantly and steadily since the 1970s. However, as in most countries, there is gender inequality within organizations[11]. We can mention wage discrimination, occupational segregation and difficulty in progressing up the career ladder[13,14].

Women's participation in the labor market worldwide remains smaller than men's, whereas more women carry out unpaid work or have more informal jobs than men. Moreover, women's wages are lower than men's and this gap is even wider among professionals who have completed higher education[14].

In medicine, as well as in other professions, women tend to get lower wages than men, despite the same number of employment contracts and similar working hours[15].

In developed countries like the United Kingdom, 70% of women with degrees in science, engineering or technology are not working in these fields. Also, women hardly

ever hold leadership or management positions, in both public and private organizations[11].

In developed countries, men spend 66% of their time performing paid work and 34% are in unpaid activities, whereas in developing countries this ratio is 74% to 26%. As for women, in both developed and developing countries, this ratio is almost reversed: they spend 34% of their time in paid activities and 66% in unpaid activities, including household chores. Activities related to the care of children are more time-consuming, and the younger the children, the higher the number of hours spent[16].

Although greater participation of parents in care of children is desirable, the division of household chores continues to follow the traditional pattern, which is still deeply rooted. In this scheme, women are responsible for most duties related to hygiene, feeding, health care, education follow-up, and even playing games with their children[16].

Data show that more than half of Brazilian women are qualified for professional work, but they still face difficulties in entering the labor market due to their desire to start families[12].

These gender inequalities make part-time jobs more feminine, and it is a solution that women find in order to balance family and work responsibilities[14].

Women whose children go to daycare or kindergarten have higher incomes and more work hours, which helps their continued presence in the labor market and gender-related productivity[16]. Data also show that when good child education starts early, it can improve the social and economic development of countries[17]. Therefore, public policies that ensure children's integration into daycare or kindergarten at an early age promote virtuous cycles of productivity and social development.

In addition, women are more prone to invest a majority of their earnings in their children's education, so better work opportunities aimed at women contribute to increases in schooling, with resulting increases in the development of the economy of countries and decreases in poverty.[14]

Among professionals with higher education who work in family health teams, there is a predominance of women. Among specialists in family and community

medicine, the 20th-ranked specialty with the largest number of professionals, women are the majority, with a share of 56.5% against 43.5% for men[4,18]. These professionals are essential to strengthening primary care in municipalities and the resulting improvements in health indicators.

The turnover of physicians in primary care services hampers their relationships with communities, and has a direct impact on the work of teams and on health indicators[19].

There is a correlation between training and turnover in family health programs; the more professionals are trained, the lower the turnover will be[10].

The first residencies in general and community medicine started in 1976. Driven by the FHS in 2002, this specialty changed its name to family and community medicine and the number of residency programs increased. Even with limited availability of courses compared to other medical specialties, family and community programs have difficulty filling all vacancies. One of the reasons for so many vacancies is the lack of the specific training required to work in the specialty, especially in the FHS[20].

It is common for these physicians to encounter challenges to remaining in family medicine such as problems related to the basic composition of teams; lack of professionals with the profile suggested by the program; different types of work contracts; poor training in primary care; heterogeneous physical structures of family health units, some of which are inadequate or in poor condition; crowded services; difficulty balancing professional life with personal and family interests; impairment of the flow of people and information between different levels of the system; unreliable information provided by the Primary Care Information System (SIAB); different management styles, with either integrating or conflicting relationships; contradictory expectations and conflicts between family health teams and local authorities; and conflicts in the relationship between FHS and the population, when teams are not able to meet demands[8,19].

In view of the importance of specialization in family and community medicine in strengthening primary care within the Unified Health System (SUS) and women's

preference for this specialty, the development of public and organizational policies aimed at settling female medical professionals in poor and remote areas with special needs becomes strategic.

Policies for a gender approach as a management opportunity for the settlement of physicians

The expression "gender relations," as it is used in the social sciences, points to the cultural order as a shaper of women and men. Therefore, what we call "men" and "women" is a result, not just biological sexuality, but also of social relations based on different structures of power[21].

The topic of gender is addressed in the context of dilemmas faced by contemporary theories of justice, with a political and economic dimension that, on the one hand, separates productive paid work and reproductive and domestic unpaid work, and on the other hand, separates, within paid work, male-dominated better paid and professionalized occupations, and less specialized and badly paid occupations performed mostly by women[22].

It is important to deinstitutionalize cultural valuation standards that prevent equal social participation for women and men, and to replace them with standards that promote it. Policies for gender recognition and equity at work emerge, and this makes women full partners in social life, capable of interacting with others as counterparts[23].

The premise of this study is that the use of management strategies based on an equitable gender approach can increase the settlement of medical professionals in vulnerable areas, whether they are men or women, and improve basic health indicators.

Motherhood usually presents the first noticeable dilemma in women's careers, especially when they have reached the top of their careers, which is between their 30s and 40s[11]. Although it is unusual for female physicians to abandon their careers in order to take care of their children, they are expected to find working conditions that

are more suitable to their new life situation, which means places that provide resources for the academic, cultural and social development of their families.

Professionals who had the opportunity to study for many years often try to give the same opportunity to their children, so it is not possible to retain physicians in remote areas if they are not provided with good options for the education of their children.

Younger women have been planning their work schedules so as to have more flexibility and be able to find a balance between work and family. Therefore, lack of flexibility in work schedules in FHS units leads female physicians to seek other opportunities as independent professionals so they can have more autonomy regarding time spent with their families.

Traditional gender approaches have not proven to be effective, although they have had the praiseworthy objective of integrating and retain women in the labor market. The legal systems that ensure equal opportunity, equal treatment and equal pay are not sufficient and end up depicting women as victims, men as oppressors, and organizations as "crime scenes"[11,24].

Gender equity approaches are more contemporary and focused on gender recognition and equity within organizations, and such approaches consider the existence of bio-psycho-social differences between men and women and the need to take those differences into account. However, in these approaches, women should not be treated as a minority, since they account for half of the population, and most have college degrees and make most purchasing decisions[11].

Understanding and valuing gender differences makes it possible to manage them and ensure the permanence and work productivity of both men and women. There are differences in communication style, biological rhythms, hormones, brain functioning, and lifestyle preferences. For instance, women's leadership style can be very different from men's, and when they are similar, it tends to be considered rude when women are holding leadership positions, whereas men's style is just seen as assertive[11].

In short, what adds value to the work of both women and men is their differences, which enhance the human assets of organizations human when they are acknowledged and not suppressed.

A gender equity approach to the settlement of physicians in vulnerable areas with special needs

Government and organizational strategies aimed at attracting and settling female physicians provide great benefits to men in teams and increase productivity and work-related satisfaction for all workers, in addition to retaining talented and productive women.

From this point of view, actions to improve attraction and settlement of medical professionals in poor and remote areas require the development of public and organizational policies in order to understand and appreciate the interpersonal needs of female professionals.

Most women do not split their lives into personal and professional spheres. On the contrary, they usually merge them and try to understand each colleague's subjectivity[25]. Providing spaces and times for more informal interaction within teams during working hours attracts and retains female professionals, improving the organizational environment as a whole.

A sound organizational environment favors a high rate of talent retention, high productivity, low turnover, better adaptation to change, strong commitment, better performance in training, and infrequent psychosomatic health issues[26].

Men tend to be more aggressive and competitive, and they clearly express their will and need to progress in their careers. However, women dislike typically male aggressiveness and competitiveness, so they step back and do not show all their potential and competence. Managers who are sensitive and identify the needs and unexpressed potential of their teams are important for the identification of hidden talents and the development of individual skills.

Women tend to be responsible with regard to their duties, but they also have difficulty performing them properly when they feel their families are at risk, especially their children. Flexible working hours that allow women to balance their professional responsibilities and their role as mothers and wives, along with programs focused on integration into the labor market for their partners and guaranteeing educational support and follow-up for their children, are essential to their settlement and productivity[25].

Although access to good education, work, culture and leisure are rights ensured by the constitution, there are great regional disparities in Brazil that call into question the extent to which these rights are granted, in terms of both quantity and quality.

Despite these inequalities, the truth is that the community of physicians in Brazil is composed of a social elite, with wages far above the national average, in both the public and private systems.

High pay allows physicians access to the best services and infrastructure available locally. Therefore, as it has been pointed out by other authors[6,27], the financial improvements proposed by the MDP are insufficient, since they encourage temporary stays in the medium and long term in regions with few options for good quality of life, in addition to being a high-cost policy.

Access to medical education in Brazil is, and might remain for a long time, more elitist[28], and the medical profession remains ideologically focused on high personal incomes associated with high living standards[27]. Therefore, regions that do not ensure appropriate (and sometimes outstanding) work and study conditions to these professionals and their families will not be able to retain them for long periods.

Work organization is a source of pleasure and suffering for workers[29,30]. Programs designed to acknowledge the quality and importance of the work delivered and actions that strengthen the bonds between physicians and communities tend to improve professionals' identification with their work and the health services they work for[19,31], favoring them staying on the job and in the municipality.

Work is a source of personal accomplishment, in addition to earning a living. Work challenges lead to the search for constant learning and development of new skills, which boosts factors related to self-esteem.

Investments in worker training and qualification are essential to keep them motivated. With regard to primary care, a partnership between services and government to share the costs related to specialized training of health professionals is essential, and return is guaranteed, since professionals who work in public health services tend to remain in the service, even when they leave an institution or a municipality[25,32].

Residency posts in family and community medicine, as well as other medical specialties, are mainly located in southeast Brazil[33]. Although the MDP encourages the opening of new vacancies in recent courses in medicine, efforts by the government and local organizations are still necessary for consolidation of this expansion, limiting access by professionals who work in the FHS, especially in remote areas of that are difficult to get to. Municipalities must be involved with policies aimed at encouraging professionals who are willing to devote their time and resources to residency and specialization courses in family health, by providing financial support for their relocation and stay, when necessary, with possible decreases or flexibilization of working hours as compensation for time spent studying, which is a detriment to their availability to their families.

Acknowledgment by managers and workers of the specific health needs of women and attention directed to the morbidities that most affect women improve satisfaction at work and reduce absenteeism and worker turnover[34].

Inadequate working conditions related to excessive workloads and low wages do not favor the settlement of medical professionals[27], especially in areas with social indicators that are below the Brazilian average and where the possibilities of investing in their careers are limited.

Table 1 provides a summary of some of the strategies that can be carried out by municipal governments and health services managers in order to increase the

settlement of medical professionals in remote areas with special needs, by using the premises of a gender equity approach as an opportunity (Chart 1)

Table 1. Summary of government and organizational strategies for the settlement of physicians in remote areas with special needs, based on the contemporary gender equity approach.

Government Strategies	Organizational Strategies
Part-time job contracts that allow workers to balance family needs and professional activity.	Preservation of an organizational environment that is favorable to the female gender.
Municipal programs that enhance the absorption of non-medical manpower, favoring the employability of physicians' spouses.	Development of internal policies for family appreciation, with flexible working hours for women who have children of preschool or school age.
Availability of vacancies in daycare or good public nursery schools.	Development of health programs for workers, with a focus on the female gender.
Incentive measures for the integration of professionals who already work in family health centers in residency courses or in specialization in family health, sharing the costs with municipalities, either providing financial support or giving more flexibility in work schedules.	Creation and implementation of continued education plans aimed at the development of women-related skills.
Availability of good public elementary and high schools, or partnerships with surrounding municipalities that could welcome physicians' children.	Training aimed at the development of the managerial skills of female physicians, so as to enable them to hold leadership positions in health services.
Municipal development policies for culture, sports and leisure.	Programs aimed at mapping and developing talents.

Source: By the author..

Final considerations

The settlement of physicians in poor and remote areas with special needs can be more effective with the application of strategies aimed at gender equity in the medical profession.

This study suggests that efforts be made to meet the needs of women so as to retain medical professionals.

Women who are in the labor market become more productive and loyal to organizations that have a strategic gender approach. Workplaces that are more attractive to women also tend to favor male retention, affecting health services, quality of care, and population health indicators.

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References

1. Campos FE, Machado MH, Girardi SN. A fixação de profissionais de saúde em regiões de necessidades. Divulg Saúde Debate. 2009; 44: 13-24.

2. Carvalho MS, Sousa MF. Como o Brasil tem enfrentado o tema provimento de médicos? Interface (Botucatu). 2013; 17(47): 913-26.

3. Soárez PC, Padovan JL, Ciconelli RM. Indicadores de saúde no Brasil: um processo em construção. RAS. 2005; 7(27):57-64.

4. Scheffer M, Demografia médica no Brasil 2015. São Paulo: Conselho Federal de Medicina; 2015.

5. Pinto HA, Sales MJT, Oliveira FP, Brizolara R, Figueiredo AM, Santos JT. O Programa Mais Médicos e o fortalecimento da Atenção Básica. Divulg Saúde Debate. 2014; 51: 105-120.

6. Oliveira FP, Vanni T, Pinto HA, dos Santos JTR, Figueiredo AM, Araújo SQ, et al. Mais Médicos: um programa brasileiro em uma perspectiva internacional. Interface (Botucatu). 2015; 19(54):623-34.

7. REDE Interagencial de Informação para a Saúde. Organização Pan-Americana da Saúde. Indicadores básicos para a saúde no Brasil: conceitos e aplicações. 2a ed. Brasília: OPAS; 2008.

8. Ribeiro EM, Pires D, Blank VLG. A teorização sobre processo de trabalho em saúde como instrumental para análise do trabalho no Programa Saúde da Família. Cad Saúde Pública. 2004; 20(2):438-46.

9. Matos FV, Cerqueira MBR, Silva AWM, Veloso JCV, Morais KVA, Caldeira AP. Egressos da residência de medicina de família e comunidade em Minas Gerais. Rev Bras Educ Med. 2014; 38(2):198-204.

10. Campos CVDA, Malik AM. Satisfação no trabalho e rotatividade dos médicos do Programa de Saúde da Família. Rev Adm Pública. 2008; 42(2):347-68.

11. Maitland A, Wittenberg-Cox A. A era da mulher. Rio de Janeiro: Elsevier Brasil; 2011 (recurso digital).

12. Santos GE, Nestor NF. A influência da mulher como líder no mercado de trabalho. Rev Ciênci Gerenc. 2013; 17(25): 207-25.

13. Cavazotte FSCN, Oliveira LB, Miranda LC. Desigualdade de gênero no trabalho: reflexos nas atitudes das mulheres e em sua intenção de deixar a empresa. Rev Adm. 2010; 45(1):70-83.

14. Elborgh-Woytek K, Newiak M, Kochhar K, Fabrizio S, Kpodar K, Wingender P, et al. Women, work, and the economy: macroeconomic gains from gender equity. Washington: International Monetary Fund; 2013.

15. Bruschini C, Lombardi MR. A bipolaridade do trabalho feminino no Brasil contemporâneo. Cad Pesqui. 2000; 110:67-104.

16. Cordeiro MC. Mulher, mãe e trabalhadora: breve balanço de recentes políticas de conciliação entre trabalho e vida familiar no Brasil. Rev SER Soc. 2008; 10(23):71-99.

17. Warner ME, Prentice S. Regional economic development and child care: toward social rigths. J Urban Aff. 2013; 35(2):195-217.

18. Mendonça MHM, Martins MIC, Giovanella L, Escorel S. Desafios para gestão do trabalho a partir de experiências exitosas de expansão da Estratégia de Saúde da Família. Cienc Saúde Colet. 2010; 15(5):2355-65.

19. Medeiros CRG, Junqueira AGW, Schwinger G, Carreno I, Jungles LAP, Saldanha OMFL. A rotatividade de enfermeiros e médicos: um impasse na implementação da Estratégia de Saúde da Família. Cienc Saúde Colet. 2010; 15(Supl 1):1521-31.

20. Mello GA, Mattos ATR, Souto BGA, Fontanella BJB, Demarzo MMP. Médico de família: ser ou não ser? Dilemas envolvidos na escolha desta carreira. Rev Bras Educ Med. 2009; 33(3):464-71.

21. Moraes MLQ. Usos e limites da categoria gênero. Cad Pagu. 1998; 11:99-105.

22. Lima AMD, Rosa LCS. Equidade de gênero e welfare state pós-industrial: a contribuição de Nancy Fraser. Temporalis. 2014; 2(28):57-77.

23. Fraser N. Reconhecimento sem ética? Lua Nova. 2007; 70:101-38.

24. Almeida PP. 'Essa empresa não é lugar de mulher parideira': considerações feministas sobre as relações de gênero nas organizações. [dissertação]. Recife (PE): Universidade Federal de Pernambuco; 2012.

25. Andrade JO, Carvalho-Neto A, organizadores. Mulheres profissionais e suas carreiras sem censura: estudos sob diferentes abordagens. São Paulo: Atlas; 2015.

26. Bispo CAF. Um novo modelo de pesquisa de clima organizacional. Produção. 2006; 16(2):258-73.

27. Scheffer, M. Programa Mais Médicos: em busca de respostas satisfatórias. Interface (Botucatu). 2015; 19:637-640.

28. Ristoff D. O novo perfil do campus brasileiro: uma análise do perfil socioeconômico do estudante de graduação. Avaliação (Campinas). 2014; 19(3):723-47.

29. Dejours C. A loucura do trabalho: estudo de psicopatologia do trabalho. São Paulo: Cortez-Oboré; 1992.

30. Dejours C. Trabalho vivo: sexualidade e trabalho. Brasília: Paralelo 15; 2012.

31. Dejours C. Entre o desespero e a esperança: como reencantar o trabalho? Rev Cult. 2009; 12(139):49-53.

32. Gil CRR. Formação de recursos humanos em saúde da família: paradoxos e perspectivas. Cad Saúde Pública. 2005; 21(2):490-98.

33. Chaves HL, Borges LB, Guimarães DC, Cavalcanti LPG. Vagas para residência médica no Brasil: onde estão e o que é avaliado. Rev Bras Educ Med. 2013; 37(4):557-65.

34. Oliveira S. A qualidade da qualidade: uma perspectiva em saúde do trabalhador. Cad Saúde Pública. 1997; 13(4): 625-34.

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