Práticas e Cuidado: Revista de Saúde Coletiva
ISSN: 2675-7591

RELATO DE EXPERIÊNCIA

# PHONOAUDIOLOGICAL PERFORMANCE IN A PUBLIC NETWORK HOSPITAL: EXPERIENCE REPORT

## ATUAÇÃO FONOAUDIOLÓGICA EM HOSPITAL DA REDE PÚBLICA: RELATO DE EXPERIÊNCIA

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**Manuscript received on**: January 24, 2021
**Approved on**: June 3, 2021
**Posted on**: Jun 4, 2021

**Abstract**
**Aim:** expose the procedures applied and hospital conditions in a residency program for a Speech-Language Pathologist. **Methods**: this is a descriptive, exploratory research with a qualitative approach, an experience report type, carried out in a public state hospital, located in the city of Salvador / Bahia, from March to December 2019. **Results**: the resident works in practically all hospital units, providing care to patients with different illnesses, subjected to an exhaustive workload (60 hours per week), as well as difficulties common to the public health network (lack of inputs / materials, precarious facilities, defective equipment, delay exams or procedures). Despite this, the residency program is capable of providing great learning and maturation (personal and professional), the exchange of experiences with other members of the health team and the strengthening of autonomy and independence. **Conclusion**: the performance of the speech therapist residing in the hospital, especially in the public sector, has fundamental relevance, as it provides the hospital with professionals with recent training and, therefore, endowed with a current look at the scenario that is presented, minimizes the overload of the sectors, by allowing more patients to be treated in the same time interval. Finally, the residency program contributes to the training of bachelors in Speech Therapy, who can return to public service (hospital or not) with a greater theoretical-practical domain, benefiting those individuals who need assistance.

**Key Words:** Speech therapy; Health Unic System; Residence.

**Resumo**
**Objetivo:** expor os procedimentos aplicados e condições hospitalares em um programa de residência por profissional de Fonoaudiologia. **Métodos:** trata-se de uma pesquisa descritiva, exploratória, com abordagem qualitativa, do tipo relato de experiência, realizada em um hospital estadual da rede pública, situado no município de Salvador/Bahia, no período de março a dezembro de 2019. **Resultados:** o residente atua em praticamente todas as unidades do hospital, prestando atendimento a pacientes com diferentes enfermidades, submetido a uma carga horária exaustiva (60 horas semanais), bem como a dificuldades comuns à rede pública de saúde (falta de insumos/materiais, instalações precárias, equipamentos defeituosos, demora na realização de exames ou procedimentos). Apesar disso, o programa de residência é capaz de proporcionar grande aprendizado e amadurecimento (pessoal e profissional), a troca de experiências com demais membros da

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equipe de saúde e o fortalecimento da autonomia e independência. **Conclusão:** a atuação do fonoaudiólogo residente no âmbito hospitalar, especialmente na rede pública, tem fundamental relevância, na medida em que proporciona ao hospital contemplado profissionais com formação recente e, portanto, dotados de um olhar atual sobre o cenário que se apresenta, bem como minimiza a sobrecarga dos setores, ao possibilitar que mais pacientes sejam atendidos em um mesmo intervalo de tempo. Por fim, o programa de residência contribui na formação dos bacharéis em Fonoaudiologia, os quais poderão retornar ao serviço público (hospitalar ou não) com maior domínio teórico-prático, beneficiando àqueles indivíduos que necessitarem de atendimento.

**Palavras-chave:** Fonoaudiologia; Sistema Único de Saúde; Residência**.**

## INTRODUCTION

Speech therapy is increasingly present in health units, especially in the hospital environment. The contribution of this science has expanded in different segments, such as dysphagia, language, voice, orofacial motricity and audiology, from newborns to the elderly and patients in palliative care[1]. In general, the Speech-Language Pathology teams are composed mostly of residents, funded by the Ministry of Health (MS), who spend more time in hospitals compared to hired speech-language pathologists. Residents, in addition to field assignments, also carry out assessments in the disciplines provided for in the program, in addition to case discussions and clinical case presentations. And, finally, they need to present at least one work at a scientific event, write and defend the completion of the residency work (TCR) and submit it to a scientific journal.

According to the Ministry of Education, multiprofessional and professional health residencies were created through the enactment of Law No. 11.129 of 2005, being guided by the principles and guidelines of the Unified Health System (SUS), based on local needs and realities and regional[2].

According to the Health Department of the State of Bahia (Sesab), multidisciplinary health residencies are geared towards in-service education, under exclusive dedication, with a workload of 60 (sixty) hours per week, which is divided into 80 % practical and 20% theoretical-practical, with a minimum duration of 24 (twenty four) months[3].

In the hospital context, the speech therapist works to a lesser extent in the areas of language, voice and orofacial motricity, but participates more frequently and decisively in the area of dysphagia, which is a change in swallowing[1]. It is not a disease, but a symptom that indicates impairment in swallowing caused by several factors, namely: trauma in the head and neck region, stroke, dementia, neuromuscular diseases and prolonged orotracheal intubation. The treatment of swallowing disorders should involve a multidisciplinary team, composed at least by doctors, nurses, nutritionists and speech therapists. In the team, the speech therapist intervenes in swallowing and communication disorders, being responsible for the diagnosis and intervention of dysphagia[4]. In addition, it rehabilitates the mobility and strength of the orofacial muscles, language and voice skills, speech rehabilitation and, if this is not possible, the adoption of alternative communication strategies. In addition to dealing with clinical changes in these segments and giving a voice to patients, placing them in a privileged place for dialogue, speech therapy contributes to reducing the length of hospital stay and, consequently, saving material and financial resources[5].

The speech therapy work in the public service has remarkable characteristics, such as lower financial support and limited amount of materials/inputs. However, even in this scenario, the presence of Speech Therapy in the hospital environment is decisive for the early recovery and de-hospitalization of patients[6].

Given the above, this work aims to expose the procedures applied and hospital conditions in a residency program for a Speech-Language Pathologist.

## REPORT

- Context of intervention and target audience

This is a descriptive, exploratory research, with a qualitative approach, of the experience report type, carried out in a state hospital in the public network, located in the city of Salvador/Bahia, from March to December 2019. The report was based in the observation and experiences of a resident speech therapist during the work

internship in a public hospital, with a focus on the care of adult and elderly patients. In addition, the analysis of hospital conditions and their dynamics, as well as discussions during classes on topics related to the residency, contributed to the construction of the report.

During the internship-work journey at the public hospital, the resident was responsible for a specific unit, dealing with the existing demand, from assessments to care during hospitalization (therapeutic follow-up). After a month (on average), the resident was transferred to another unit.

- Description of actions

The beginning of the residency took place in the public network, which absorbs most residents, and for a longer time. The first pass took place from March to December 2019 and the second from July 2020 to February 2021.

The Speech-Language Pathology sector of this hospital had about twenty speech-language pathologists in its team, divided between the work schedules. Among this contingent, there were at least six permanent residents of the hospital itself, being three responsible for the adult public and the other three for the child public (neonatology and pediatrics), who were in the institution every day, except for Wednesdays (day of class). The other residents (two to three, depending on the period), linked to the University of the State of Bahia (UNEB), were on shifts from Monday to Thursday, and on Fridays they had classes at the university. The internship-work journey began at 7 am and ended at 7 pm.

The first passage marked the beginning of speech therapy activities in the hospital environment, one of the most responsible scenarios, considering the intervention in patients with different health conditions, from less to greater severity, including those in palliative care. Each month the resident was assigned to work in a certain unit. In case of absence of patients on the day or depending on demand, there was a displacement to other units in order to provide assistance to other professionals. Residents were accompanied by preceptors, who are hospital speech therapists with at least a graduate degree, designated by the sector coordination to perform this function. The preceptors acted in

observation/assistance in the care provided to residents, with subsequent advice from a distance, in order to guarantee greater autonomy to them regarding the management of their patients and their respective care.

At the beginning of the shift, work materials and the list of patients being followed were organized, and the discussion of cases with the preceptorship took place at the unit. In certain units, there were medical visits, at different times (generally in the morning shift), with the presence of all professionals from the current team, including, in addition to speech therapy, the presence of physiotherapy, nutrition and psychology. During the visits, the team discussed all hospitalized patients, becoming aware of the current status of each patient in all aspects (clinical, nutritional, among others), as well as defining the necessary procedures (prescription or suspension of drugs, tests, transfers and high, for example). As for the speech therapy approach, they inquired about the progress of the cases in relation to the introduction of food or the progression of the diet, a crucial aspect for the rehabilitation and hospital discharge of patients. In addition, new speech-language evaluations were usually requested during the visits, whether from newly arrived patients or even from those who presented a significant improvement in their clinical condition. Most of the requests for evaluation were aimed at patients using enteral diet (via nasoenteral tube) and, less frequently, those patients on parenteral diet, intubated for a long period (48 hours or more) or undergoing tracheostomy. These last two patient profiles were highly demanded by the Speech-Language Pathology sector, considering that they often present dysphagia, as well as greater risks of bronchoaspiration, due to the functional alterations that these procedures usually cause[7,8].

After the visit, the consultations were carried out; if necessary, the same patient was seen more than once. Afterwards, the findings or definitions of conduct were discussed with other professionals involved (physician, nurses, nutritionist and physiotherapist), most of whom were also residents. The evolutions were written and the records of the assistance were made via a computerized system for control, as well as aiming to guide the other speech therapists for the next shift.

The hospital where the residency took place has a general practitioner profile, receiving patients with numerous illnesses, in acute or chronic conditions. Despite this, it also has an emergency room, general surgery, neurosurgery and obstetrics wards, receiving patients from newborns to the elderly.

Depending on the unit, there were more demands in a given area than in others. For example, in the Neurological ICU, in the exclusive stroke ICU, in the neurosurgery ward and in the neurological ward, most patients needed not only the management of dysphagia (if any), but language approaches (due to different conditions of aphasia and /or dysarthria), as well as in orofacial motricity (to act on chewing difficulties, mobility and reduced phonoarticulatory organ strength, paresis or facial paralysis)[9]. In cases of patients with prolonged intubation, as well as tracheostomy patients, the priority approach included the treatment of dysphagia and vocal rehabilitation. Especially in these patients, performing vocal exercises (glottic closure, vocal fold adduction, semi-occluded vocal tract exercises) and myofunctional exercises (tongue mobility and strength, pharyngeal constriction, hyolaryngeal elevation) were essential, as they contributed to the treatment of dysphonia and, in particular, provided greater protection to the lower airway, by rehabilitating the swallowing process, minimizing the risk of bronchoaspiration[7,10].

One of the main actions with the patients was to manage the condition (if they were clinically well, with difficulties in eating, with good acceptance of the diet). Patients with dysphagia for liquids or solids and/or with other demands mentioned above underwent speech therapy. In collaborative patients (that is, with preserved comprehension), active exercises were performed, which the patient was able to perform. However, with non-collaborative patients, passive exercises were performed (if possible) and, mainly, the management of the patient's conditions and the guidance of family members/caregivers about the necessary care during the offer of food or liquids, allowing a safe intake[11.] It is also important not only to gather information from companions, but to guide them whenever necessary regarding the patient's posture, care in offering the diet, training them to safely offer meals, providing greater safety and well-being to the patient during your hospital stay.

With regard to elderly patients, it is necessary to pay special attention to bed mobilization, especially before offering any food. This public usually has several comorbidities (hypertension, diabetes, chronic pain, dementia, among others), in addition to sarcopenia and loss of muscle strength, which makes it more difficult to move and move structures (including orofacials), offering greater risks to food[12,13].

- Action against the coronavirus pandemic

On December 31, 2019, the World Health Organization (WHO) was alerted to several cases of pneumonia in Wuhan City, Hubei Province, People's Republic of China. It was a new strain (type) of coronavirus (Covid-19) that had not been previously identified in humans[14]. On Ash Wednesday (25/02/2020), the first case of the disease was confirmed in Brazil. It was also the first in South America[15]; a 61-year-old man, resident of the capital of São Paulo, who had traveled to Italy[16]. In Bahia, the first imported case of the new coronavirus was registered on 03/06/2021 (Friday). This is a 34-year-old woman, resident in the city of Feira de Santana, who returned from Italy on February 25, having traveled to Milan and Rome, where the contamination occurred[17].

The pandemic corresponded to an unimaginable incident, leading to changes in habits, behaviors and routines. Measures such as lockdown, social isolation, use of masks and hand hygiene emerged as necessary in the face of the disease's advance, aiming to reduce the rate of contamination and deaths. Confinement inside homes, home office work and virtual interactions became part of the daily life of many countries, including Brazil.

Within hospitals, it meant facing the disease head on, through the provision of care to the sick. The fear of being contaminated and, therefore, of contaminating relatives and friends, the fear of death, the suffering for the loss of patients and loved ones, are some of the phenomena that emerged or were enhanced as a result of the pandemic. Professionals overloaded by the increase in demand, more anxious and stressed, with greater propensity to conduct and biosafety errors, putting

themselves and those close to them at risk. Over the weeks and months, professionals fell ill; some were driven away, others did not resist the disease. A scenario of chaos never before experienced in Brazil.

In between this scenario, fear was also part of the other patients and caregivers, as they perceived the increase in cases and deaths, whether in the wards, isolation units and ICUs. From the beginning, the residents were also responsible for the care of positive patients, as well as trying to reassure other patients and family members in the units where they worked. Training in dress and undressing took place, with the aim of avoiding the contamination of the employee himself and the cross-contamination of other people. The cleaning of work materials, such as stethoscopes, pens, stamps, face shields, goggles, among others, became a routine before and after each service.

Analyzing the speech therapy performance in this audience, there are some particularities to be considered. Coronavirus cases can present from asymptomatic forms to severe pneumonia. Among the possible symptoms, one of the most frequent and worrisome is dyspnea[18]. Even in a stable condition, the dyspneic patient may lack coordination during meals, which increases the risk of choking and bronchoaspiration. Another concern is the rehabilitation of patients infected by the coronavirus who, due to the unfavorable evolution of the clinical condition, underwent orotracheal intubation (OTI) and tracheostomy (TQT). The longer the period in which the patient has used these devices, the greater the risks to safe food. Both OTI and TQT desensitize the oral tract and upper airway, as well as impairing suprahyoid muscle mobilization, hyolaryngeal excursion, laryngeal contraction, vocal fold adduction, and the effectiveness of the cough reflex. Thus, the perception of secretions and food particles in these tracts is reduced, favoring the occurrence or potentialization of dysphagic conditions[18,19,20].

In this sense, most of these patients need speech therapy, with exercises that favor the work of breathing, adequate pauses during swallowing, phonation exercises (both for the issue of speech and to favor glottic closure - an important mechanism in protection of the lower airways) and the adoption of compensatory

measures for safe eating (indication of food consistencies, postural adjustment, food management in the oral cavity, food volume offered, among others)[18,19,20].

## Results achieved and discussion

Working in a hospital is something amazing. It allows us the possibility of seeing a facet of reality up close, from joys to sorrows, the finitude of life, the smallness of humanity[21]. Reflections like these, deeper, existential, strengthen our psychic structure in the face of adversity, as well as favor our maturity and inclination to commit to the well-being of patients and the preservation of life.

In more practical lines, the possibility of discussing cases with the preceptorship, other colleagues in the sector, as well as other professionals, in a multidisciplinary interface, leads to the expansion of knowledge, whether in our area, as well as in other specialties, which leads to to a more comprehensive and complete professional performance.

With the advancement of residency, residents acquire greater autonomy and independence in the care and management of the unit for which they are responsible, which is extremely positive, in shaping professional training, ensuring the ability to act individually. This factor ends up being positive also because it avoids overloading the Speech Therapy sector at times of greater demand, with greater division of patients being monitored among the professionals involved.

Access to inputs and work materials is easier compared to many private institutions, which speeds up care and even allows for a much wider range of approaches and techniques. It is an advantage for the therapist as well as the patients.

Another relevant aspect comprises the discussions of cases and scientific events on the hospital premises, with a certain frequency. Thus, the ability to study and acquire more knowledge is always alive, which improves our professional practice.

- Challenges

As for the challenges, there are those intrinsic to the residency and others related to the hospital.

With regard to residence, there is a strenuous workload, with little time available for studies, rest and even leisure. Thinking about these issues is of paramount importance, considering that residents need physical and psychological well-being to be able to offer their best to patients. Every caregiver, in any environment or level, also needs care, physical and mental health, inner peace, to provide their services in the best way, and to avoid becoming just another patient in the future, depriving the multidisciplinary team and burdening public health because of something that could and should be avoided by the managers of residency programs, regardless of area or training[22].

Entering capitalism, residents are also seen as cheap labor, especially given the concept of surplus value, in which the professional works more hours in relation to the salary received; being more direct, for example, you work 8 hours a day, but you are only paid for the first 6 hours. This is one of the evils arising from this most oppressive and perverse production system that exists, in which profit reigns; after all, more patients seen mean more cash on hand[23].

Despite the greater ease of access to materials in the sectors, such as personal protective equipment (PPE), tongue depressors, gauze, aspiration probe, among others, we often come across the lack of them, which prevents us from performing certain procedures, to attend to certain patients, leading the team to prioritize certain cases over others in these circumstances, in order to guarantee the protection of the professional and, consequently, of the patients, avoiding cross

contaminations. Also with regard to PPE, protective covers usually have a quality below what is necessary to ensure adequate protection; they tear easily and do not have the impermeability expected when wet. It is also difficult to find disposable gloves for people allergic to latex, which compromises the health of some professionals[24].

Another frequent problem is the longer waiting time to perform exams and procedures, for various reasons: operating room unavailable, lack of doctor/anesthetist, lack of basic material for the procedure, defective elevators and equipment to perform exams, related problems to regulation, among others. All of this increases the length of stay of patients, occupying beds and generating more costs for a longer period, exposing them to greater risks of hospital infection (direct relationship with the length of stay)[24].

Culturally in our country, between servers (from different backgrounds) and users, there is a certain prejudice against civil servants, interpreting it as doing anything and anyway. In the health sphere, sometimes, the patient receives superficial care, without proper reception and care, as if to comply with the schedule. All patients deserve to be assisted in the most adequate way, taking into account their needs as much as possible, especially in the public network, where people with fewer resources are found, lacking in countless aspects, including love, dignity and respect.

## CONCLUSION

The residency in health is a unique experience, which allows the view from within the institutions, experiencing the daily joys and difficulties, from rehabilitation to the loss of patients.

The resident's stay for 1 month in each hospital unit has pros and cons. The faster rotation allows you to meet a greater number of professionals, allowing for greater exchange of information and networking. It also allows for the assimilation of information about different patient profiles, as well as their peculiarities and needs, in a shorter period of time. As disadvantages, a short rotation period can

interfere with the connection with patients and professionals of the unit, which may not be as solid, as well as being quickly dismantled. As the therapeutic alliance (TA) requires, among other factors, the development of the bond (trust and attachment) between the pair[25], it needs more time to settle down.

The period of residence was crossed by the coronavirus pandemic, an extremely adverse and unexpected situation. As a result, there was an increase in the number of consultations and hospitalizations, extra care with the safety of residents and other employees, especially to minimize the risk of cross-contamination, work overload and also an increase in the occurrence of deaths. In addition, many employees became ill, being removed from their jobs, further increasing the demand for work, not to mention the death of employees due to Covid-19. The fear of active professionals of becoming infected and the pain they brought to the hospital due to their personal losses were part of frequent issues in the hospital routine[22].

As explained throughout the text, professional performance with quality depends on countless professionals. However, the role of managers and governors is decisive, both in strengthening the SUS, and in providing the means and conditions necessary to carry out health actions and services with fluidity, agility and quality.

This precise and effective functioning of health units and, in particular, hospitals, will be decisive for the recovery of sick people, reflecting in a population with a longer, more productive and even happier life expectancy, allowing for improvement in social indicators and greater progress in our society.

This work hopes to contribute, as an additional source, to the reflection and decision-making by health managers about the reality in public hospitals, through actions and public policies that provide improvements in working conditions and, subsequently, in the provision of hospital services. And, finally, that this work can also contribute to researchers in the area regarding future studies, including cross-sectional ones, related, for example, to the conditions of public hospitals, the quality of services provided, the demands of patients and their families and the working conditions and quality of life of employees.

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