DOI: https://doi.org/10.36489/saudecoletiva.2021v11i65p6180-6191

Quality of life of professionals in a company providing general and administrative services

Calidad de vida de los profesionales en una empresa que presta servicios generales y administrativos

Qualidade de vida de profissionais de uma empresa prestadora de serviços gerais e administrativos

ABSTRACT
Objective: To assess the quality of life of employees of a company providing general and administrative services. Method: A descriptive, cross-sectional study with a quantitative approach was carried out, in which 66 outsourced professionals were interviewed using their own socio-demographic questionnaire, the SF-36 health-related quality of life instrument and anthropometric assessment. Results: Regarding health-related quality of life, the results found showed high average values (above 70) for most of the SF-36 domains analyzed. The results indicate that the highest scores were obtained in the dimensions Social Aspects, Physical and Emotional Aspects and the lowest scores were observed in the dimensions Vitality and Pain. Conclusion: It reinforces the importance of nurses to recognize professionals at risk of illness in the work environment and intervene through health education and monitoring strategies with a view to guaranteeing the worker's quality of life.
DESCRIPTORS: Quality of life; Occupational Health; Risk Factors; Cardiovascular Diseases; Nursing Care.

RESUMEN
Objetivo: Evaluar la calidad de vida de los empleados de una empresa que brinda servicios generales y administrativos. Método: Se realizó un estudio descriptivo, transversal con enfoque cuantitativo, en el que se entrevistaron a 66 profesionales subcontratados mediante cuestionario sociodemográfico propio, instrumento de calidad de vida relacionada con la salud SF-36 y evaluación antropométrica. Resultados: En cuanto a la calidad de vida relacionada con la salud, los resultados encontrados mostraron valores promedio altos (superiores a 70) para la mayoría de los dominios del SF-36 analizados. Los resultados indican que las puntuaciones más altas se obtuvieron en las dimensiones Aspectos sociales, Aspectos físicos y emocionales y las puntuaciones más bajas se observaron en las dimensiones Vitalidad y Dolor. Conclusión: Refuerza la importancia de las enfermeras para reconocer a los profesionales en riesgo de enfermedad en el ambiente laboral e intervenir a través de estrategias de educación y seguimiento en salud con miras a garantizar la calidad de vida del trabajador.
DESCRIPTORES: Calidade de vida; Salud Laboral; Factores de Riesgo; Enfermedades Cardiovasculares; Atención en enfermería.

RESUMO
Objetivo: Avaliar a qualidade de vida de funcionários de uma empresa prestadora de serviços gerais e administrativos. Método: Foi realizado um estudo descritivo, transversal com abordagem quantitativa, no qual 66 profissionais terceirizados foram entrevistados utilizando-se um questionário sócio demográfico próprio, o instrumento de qualidade de vida relacionada à saúde SF-36 e avaliação antropométrica. Resultados: Em relação à qualidade de vida relacionada à saúde, os resultados encontrados apresentaram valores médios elevados (acima de 70) para a maioria dos domínios analisados do SF-36. Os resultados indicam que os maiores escores foram obtidos nas dimensões Aspectos Sociais, Aspectos Físicos e Emocionais e os menores escores foram observados nas dimensões Vitalidade e Dor. Conclusão: Reforça-se a importância do enfermeiro reconhecer profissionais em risco ao adoecimento no ambiente de trabalho e intervir através de estratégias de educação em saúde e acompanhamento com vistas à garantia da qualidade de vida do trabalhador.
DESCRITORES: Qualidade de Vida; Saúde do Trabalhador; Fatores de Risco; Doenças Cardiovasculares; Cuidados de Enfermagem.

RECEIVED ON: 01/27/2021 **APPROVED ON:** 02/17/2021

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INTRODUCTION

In Brazil, cardiovascular diseases lead the number of deaths, being responsible for a high mortality rate, an event justified by the higher prevalence of cardiovascular risk factors. [1,2] Such cardiovascular risk factors are expressed in lifestyle habits, such as smoking, physical inactivity, diet, obesity and overweight and innate or inherited characteristics, such as diabetes mellitus, metabolic syndrome, dyslipidemia and systemic arterial hypertension. [3]

In the work environment, these risk factors can directly affect the patient's quality of life, negatively interfering with their daily life activities and can negatively impact the worker's health. [4]

Socioeconomic and occupational issues in the professional environment can also be related to quality of life and increased risk of developing cardiovascular diseases, in addition to being influenced by the pace of work and the structure and organization of the environment in which the professional is inserted. [5]

Quality of Life (QOL), according to the World Health Organization (WHO), does not have an exact definition. For this reason, the World Health Organization Quality of Life (WHOQOL) defined Quality of Life as "the individual's perception of his position in life in the context of the culture and value systems in which he lives and in relation to his goals, expectations, standards and concerns".[6]

According to the WHO, health is not the center of QOL. It is considered abstract, subjective and multidimensional because it involves various aspects of human life, such as social relationships, health, family, work, environment, among others. It is a dynamic process that can be influenced by cultural, religious, ethical and social values. [7]

In the professional environment, the concept of Quality Work Life (QWL) is considered, which is an understanding of living conditions in the work environment, including aspects of well-being, health guarantee, physical, mental, social security and training for performing tasks safely and with good use of personal energy. [8]

The hospital, for being an unhealthy environment, exposes the worker to innumerable risks, such as physical, chemical, physiological, psychic, mechanical and biological. Thus, it becomes an occupational environment that leaves the professional vulnerable to the acquisition of diseases, among them, those of the cardiovascular system. [9]

The consequences that the working conditions and the required workload have on the physical health of the worker are increasingly clear. Approximately 29% of the active population works in shifts, where the effects of intolerance at work assume a high importance in the field of occupational health. [10]

Quantitative work overload, duration, lack of autonomy, the presence of physical, chemical and biological risks, insufficient resources, responsibility for people, work relationships and social support in the workplace, remuneration, security in the employment relationship, the prospects for promotion, the family situation, the home-work conflict, the social and personal situation are considered risk factors for illness in these professionals. [10]

Within this context, continuous exposure to workloads generates wear on the worker, which can lead to illness. Thus, it is necessary for the worker to understand the peculiarities of the profession, and to appropriate strategies that can reduce professional exhaustion, seeking to preserve their health. [11]

In this sense, the present study aimed to assess the quality of life of employees of a company that provides general and administrative services.

METHODS

This is a cross-sectional, descriptive study with a quantitative approach. The research was carried out at the Cardiology Outpatient Clinic of the Cardiology Emergency Room of Pernambuco Profes-

sor Luiz Tavares, PROCAPE/UPE, Recife/PE, a reference in Cardiology that covers services to Recife and the North and Northeast regions of the country, from August to November 2017.

The sample consisted of 66 outsourced professionals from the company providing specialized services to PROCAPE distributed in general services (plumber, painter, electrician, cleaning assistant) and administrative services (secretary, receptionist). Employees of both sexes, aged 18 or over and who agreed to participate by signing the Free and Informed Consent Form, were included. Participants who had cognitive impairment that resulted in impaired verbal communication and who used antidepressants were excluded.

The data collection instruments consisted of a questionnaire with socio-demographic and economic data (gender, age, race, marital status, monthly family income in minimum wages in effect in the year 2017 - R$ 937,00), education, origin and clinical (lifestyle, personal and family history, pre-existing diseases).

To assess the quality of life of the professionals of the outsourced company, the Health-Related Quality of Life Instrument - SF36 (Appendix A) was used. It is a multidimensional questionnaire translated and validated in Brazil, which considers the perception of individuals regarding their own health status. It consists of 36 items subdivided into eight domains: Functional Capacity, Physical Aspects, Pain, General Health, Vitality, Social Aspects, Emotional Aspects and Mental Health.[12] The data are analyzed from the transformation of the responses of each domain into a score on a scale ranging from 0 (zero) to 100 (one hundred), with the highest scores indicating the best health status and the lowest scores corresponding to the worst general health status.[13]

The variables were analyzed descriptively and were processed and analyzed using the IBM SPSS software in version 20. 0. The t-Student test was used and p <0,05 was adopted.

This research followed the disciplinary rules of Resolution No. 510 of April 7th, 2016, of the National Health Council of the Ministry of Health (14), having been approved by the ethics and research committee of the Hospital Universitário Oswaldo Cruz/Pronto Socorro Cardiológico de Pernambuco complex (CAE: 68383817000005192) and Consubstantiated Opinion from the Ethics and Research Committee (Opinion Number: 2.142.908).

RESULTS

A total of 66 outsourced professionals (cleaning assistants, general services, secretaries, attendants, supervisors) participated in the study. The sample was composed predominantly of male participants (57,6%), with an average age of 38 years (± 1,189), of mixed race (47,0%), coming from the Urban Zone (97,0%), with a steady partner (54,5%). Most had more than 9 years of study (84,8%), with a monthly family income greater than 2 minimum wages (78,8%).

Regarding the length of service provided to the institution, 87,9% of the participants had more than 1 year of work, 71,2% perform the function of general services and 66,7% have on-call work.

In relation to clinical aspects, the most frequent risk factors for cardiovascular diseases were the use of alcoholic beverages socially (54,5%), physical inactivity (59,1%) and arterial hypertension (16,7%).

Regarding the assessment of health-related quality of life, table 2 shows the scores for the eight domains of the SF-36 Quality of Life Questionnaire expressed as mean and standard deviation and their respective confidence intervals. Question 2 does not belong to any domain, however, it analyzes the individual's perception of his/her health compared to a year ago. Part of the study participants (36,4%) replied that it is much better or a little better. The others were divided between those who considered their health a little worse (12,1%) and those who evaluated that it is approximately the same when compared to a year ago (51,5%).

For each of the eight dimensions of the SF-36, the mean and standard deviation values were calculated. The values for all dimensions could vary between 0 and 100, and the higher the score, the better the condition related to that dimension of quality of life. Mean scores were observed, in general, above 70 for most domains. Considering that the score in each domain can vary from zero to 100, the results show high average values in the vast majority of the domains analyzed.

The results indicate that the highest scores were obtained in the dimensions Social Aspects (93,56%), Physical Aspects (89,85%) and Emotional Aspects (88,67%). Regarding the lowest scores, they were observed in the dimensions Vitality (58,73%) and Pain (71,03%).

Table 1 - Evaluation of health-related quality of life by SF-36. Recife, Pernambuco, Brazil. 2018.

DOMAIN	MEAN	STANDARD DEVIATION	MINIMUM	MAXIMUM
General Health Status	77,83	±17,5	30	100
Functional Capacity	88,11	±16,30	30	100
Physical Aspects	89,85	±21,95	10	100
Emotional Aspects	88,67	±22,65	10	100
Social Aspects	93,56	±15,69	25	100
Pain	71,03	±21,73	32	100
Vitality	58,73	±15,52	6	100
Mental Health	79,55	±17,29	32	100

Note: sd: Standard deviation

Table 2 shows the results of the SF-36 Quality of Life assessment based on some socio-demographic and clinical variables. Statistically significant data show p <0,05.

Regarding socio-demographic variables, ADLIM professionals without a partner had a worse evaluation in the Emotional Aspects domain (p= 0,008), as well as in the Social Aspects domain (p= 0,012). Regarding working time, professionals with more than 1 year of service had a worse evaluation in the General Health State domain (p= 0,021). Regarding the clinical variables, the non-use of alcoholic beverages (p= 0,001) had a worse evaluation in the Pain domain.

Regarding the mental health domain, smokers (p= 0,027) and diabetics (p= 0,005) professionals had a worse evaluation in the mental health domain. Even in the case of diabetics, they also had a worse evaluation in the domains General health status (p= 0,005), functional aspects (p= 0,002) and emotional aspects (p= <0,001).

Regarding the Functional Capacity domain, professionals with altered body mass index (BMI) had a worse assessment (p = 0,018).

DISCUSSION

Regarding the evaluation of quality of life by SF-36, in the domain related to so-

Table 2 - Health-Related Quality of Life Assessment by SF-36 as a function of socio-demographic and clinical variables (n = 66). Recife, PE, Brazil. 2018.

	HEALTH-RELATED QUALITY OF LIFE (M ± SD)															
SOCIO-DEMO-GRAPHIC VARIABLE	GHS	P*	FC	P*	PA	P*	EA	P*	PAIN	P*	SA	P*	V	P*	MH	P*
Marital Status																
With companion	79,7± 17,4	,342	89,3± 15,9	,517	94,4± 13,5	,055	95,3± 11,7	,008	75,5± 22,9	,148	97,29± 7,6	,012	59,6± 17,3	,616	80,9± 14,0	,476
Without companion	75,5± 17,7		86,6± 16,8		84,0± 28,4		80,6± 29,3		66,8± 19,7		88,3± 20,7		57,6± 13,1		77,8± 20,6	
Working time																
Up to 1 year	91,1± 5,4	,021	87,5± 20,3	,912	90,6± 26,5	,900	87,4± 24,8		84,2± 21,9	,876	90,6± 26,5	,577	66,2± 11,2	,145	87,5± 16,0	,167
More than 1 year	76,0± 17,8		88,1± 15,88		89,5± 21,6		88,8± 22,5		69,2± 21,2		93,9± 13,9		57,6± 15,8		78,4± 17,3	
Health-Related Quality of Life (m ± sd)																
Clinical variables	EGS	p*	CF	p*	AF	p*	AE	p*	Dor	p*	AS	p*	V	p*	SM	p*
Uses of alcoholic beverages	77,7± 18,7	,978	89,3± 17,2	,581	95,3± 17,3	,058	94,4± 15,3	,059	80,7± 21,4	,001	95,8± 10,5	,286	61,8± 14,5	,139	81,3± 16,1	,448
Doesn't use alcoholic beverages	77,8± 16,7		87,0± 15,6		85,0± 24,6		83,8± 26,5		62,9± 18,7		91,6± 18,8		56,1± 15,9		78,0± 18,3	
Non-s-mokers	78,8± 16,8	,281	87,8± 16,1	,729	91,2± 19,8	,115	90,3± 19,9	,098	71,5± 21,9	,577	93,8± 13,9	,073	60,0± 14,3	,227	81,2± 16,7	,027
Smokers	70,6± 22,1		90,0± 18,7		78,1± 33,9		76,2± 36,1		67,3± 21,3		90,6± 26,5		49,5± 21,3		67,0± 16,8	
Without Diabetes	78,5± 16,6	,005	87,9± 16,6	,467	90,6± 20,7	,002	89,8± 20,5	<,001	71,3± 21,7	,382	93,4± 15,7	683	59,0± 15,4	,227	80,2± 16,6	,005
Without Diabetes	30,0**		100,0**		25,0**		10,0**		52,0*		100,0**		40,0**		30,0**	
Normal BMI	84,1± 18,4	,062	95,5± 8,3	,018	90,7±1 9,0	,801	86,4± 23,8	,620	74,7± 20,0	,376	94,7± 12,0	,702	60,5± 19,4	,542	82,3± 17,5	,412
Altered BMI	75,2± 16,7		85,1± 17,8		89,2± 23,3		89,5± 22,3		69,5± 22,4		93,0± 17,0		56,9± 13,8		78,4± 17,2	

Notes: m (sd): mean (standard-deviation); * Student-t test ** There is no standard deviation, as there is only one diabetic participant.
GHS: General Health Status; FC: Functional Capacity; PA: Physical Aspects; EA: Emotional Aspects; SA: Social Aspects; V: Vitality; MH: Mental Health.

cial aspects, which reflect the participants' relationship skills, the result of this evaluation revealed a high score in this domain.

A study that evaluated the quality of life and musculoskeletal symptoms in hospital hygiene and cleaning workers goes against the results of this research, as they had a worse score in this domain. [15] Regarding the scores, lower values were observed in the Vitality and Pain dimensions. The result is in line with those found in the study of the Brazilian Registry of Pacemakers, Resynchronizers and Defibrillators [16] which showed that the domain had values above the average. It is known that it can influence the functional capacity of the individual, as it can have an impact with negative impairment in the performance of daily and/or professional activities. It is observed that the more the individual feels pain, possibly, the more compromised their quality of life is, which can have a negative impact on daily and/or professional activities. [16,17]

Regarding the assessment of quality of life according to the sociodemographic variables of the study participants, with regard to marital status, the professionals evaluated without partners, had a worse assessment in the emotional (p= 0,008) and social (p= 0,012) domains. The result differs from that found in a study on the influence of arterial hypertension on quality of life [18], which showed that participants who had a spouse had better health-related quality of life averages in the functional capacity, physical capacity, physical aspects domains and emotional aspects (p <0,05) when compared to subjects who did not have them.

In relation to working time, participants who have been providing services for more than 1 year in the company, presented a worse assessment in the General Health State domain (p= 0,021). Work is an activity that can occupy a large portion of the time of each individual and their social life and does not always enable professional fulfillment, on the contrary, it can cause problems from dissatisfaction to exhaustion, interfering in the general health status of the worker. [18]

Regarding the QoL assessment due to the clinical variables of the study participants, regarding the use of alcoholic beverages in a social way by the professionals, the non-use of it showed a worse assessment in the Pain domain (p = 0,001). However, different findings were evidenced in individuals who presented an excessive consumption of alcohol in relation to those who do not consume or consume it moderately, obtaining a worse quality of life in the functional capacity dimension. [19].

In relation to the Functional Capacity domain, the participants who had an altered BMI, presented a worse assessment (p = 0,018).

Regarding the Mental Health domain, smoking professionals had a worse assessment (p= 0,027), corroborating the findings found in the study that investigated the impact of risk factors for chronic non-communicable diseases on the QOL of individuals, in which smoking presented as the risk factor with the greatest impact on QOL with the worst scores in the domains of physical aspects, general health status, social aspects and mental health. [20]

In contrast, a study showed that when assessing quality of life in relation to the severity of tobacco dependence of non-smokers, ex-smokers, light smokers (consumption of less than 15 cigarettes per day), moderate (consumption of 15-24 cigarettes per day) and severe (consumption equal to or greater than 25 cigarettes/day), impairment of moderate and severe smokers was observed in all dimensions of the SF-36, when compared to non-smokers. [21]

In relation to diabetic professionals, they had worse scores in the domains General health status (p = 0,005), functional aspects (p = 0,002), emotional aspects (p <0,001) and mental health (p = 0,005). Similar to these findings, the study that evaluated the quality of life of 40 type 2 diabetic patients and the prevalence of sensory deficit in the lower limbs reveals that diabetics tend to have changes in physical health or some emotional problem that negatively interfere with their work or in another regular daily activity like depression or complications from diabetes. [22]

In relation to the Functional Capacity domain, the participants who had an altered BMI, presented a worse assessment (p = 0,018). Similar findings were found in the study that assessed the quality of life and level of physical activity of health professionals in intensive care units, showing that individuals considered active had higher scores in the functional capacity domains when compared to inactive individuals with high BMI. [23]

With regard to the health-related QOL assessed by the SF-36, the result can be justified by the fact that the participants, despite having risk factors for the development of cardiovascular disease, do not yet have the disease installed, and, therefore, it is expected that good quality of life will be maintained between one year and the next.

CONCLUSION

The workers of the company providing specialized services have comorbidities, in addition to cardiovascular risk factors, which, if not intervened early, can lead to cardiovascular complications. In this context, prevention is evidenced as the best therapy for the non-appearance of cardiac outcomes.

The SF-36 Health-Related Quality of Life instrument was used to effectively assess the quality of life of outsourced pro-

fessionals. The issues surrounding the quality of life made it possible to reflect on the real need of the outsourced professional in relation to their health condition, which can directly assist the health professionals involved in the rehabilitation planning, thus providing subsidies for the implementation of assistance focused on the real needs of these workers. ■

REFERENCES

1. Sociedade Brasileira de Cardiologia. Doenças cardiovasculares mata mais de 30 mil pessoas só em Janeiro de 2017. Federação Médica Brasileira. Brasil. [Internet] 2017. [Acesso em 25 jan 2020]. Disponível em: http://portalfmb.org.br/2017/02/08/doencas-cardiovasculares-mata-mais-de-30-mil-pessoas-so-em-janeiro-de-2017/.

2. Guimarães RM, Andrade SSCA, Machado EL, Bahia CA, Oliveira MM, Jacques FVL. Diferenças regionais na transição da mortalidade por doenças cardiovasculares no Brasil, 1980 a 2012. Rev Panam Salud Publica. 2015; 37(2): 83–9.

3. Arend MC, Pereira JO, Markoski, MM. O Sistema CRISPR/Cas9 e a Possibilidade de Edição Genômica para a Cardiologia. Arq. Bras. Cardiologia. 2017; 108(1): 81-3. DOI: DOI: 10.5935/abc.20160200.

4. Sadir MA, Bignotto MM, Lipp MEN. Stress e qualidade de vida: influência de algumas variáveis pessoais: influência de algumas variáveis pessoais. Paidéia. 2010; 20(45): 73-81. DOI: http://dx.doi.org/10.1590/s0103-863x2010000100010.

5. Martins CCF, Santos VEP, Pereira MS, Santos NP. Relacionamento interpessoal da equipe de enfermagem x estresse: limitações para a prática. Cogitare Enferm. 2014; 19(2): 309-15. DOI: http://dx.doi.org/10.5380/ce.v19i2.36985.

6. Francisco MS, Azevedo DSB, Campos MTS, Rodrigues RP. Determinantes e condicionantes da vulnerabilidade da qualidade de vida da equipe de enfermagem na assistência em saúde mental e psiquiátrica. Rev. Cientifica Persp Online: bio& saúde. 2015; 18(5): 45-46. DOI: https://doi.org/10.25242/88685182015773.

7. Gouveia AMA, Fagundes CR, Macêdo SS, Junior AJC, Casa NLL, Cruz RS. Análise da Qualidade de Vida no trabalho em caminhoneiros de uma indústria petrolífera. Rev Eletr Saúde e Ciên. 2012; 2(2): 30-51.

8. Hipolito MCV, Masson VA, Monteiro MI, Gutierrez GL. Quality of working life: assessment of intervention studies. Ver Bras Enferm. 2017; 70(1): 178-86. DOI: http://dx.doi.org/ 10.1590/0034-7167-2015-0069.

9. Silva CDL, Pinto WM. Riscos ocupacionais no ambiente hospitalar: fatores que favorecem a sua ocorrência na equipe de enfermagem. Saúde Coletiva em Debate. 2012; 2(1): 95-105.

10. Oliveira V, Pereira T. Ansiedade, depressão e burnout em enfermeiros - Impacto do trabalho por turnos. Revista de Enfermagem Referência. 2012; SérieIII(7); 43-54. DOI: http://dx.doi.org/10.12707/RIII1175

11. Carvalho DP, Rocha LP, Barlem JGT, Dias JS, Schallenberger CD. Cargas de trabalho e a saúde do trabalhador de enfermagem: revisão integrativa: influência de algumas variáveis pessoais. Cogitare Enferm. 2017; 22(1): 01-11. DOI: http://dx.doi.org/10.5380/ce.v22i1.46569.

12. Cabral DL. Comparação dos Instrumentos SF-36 e perfil de saúde de Nottingham para avaliação da Qualidade de Vida de indivíduos pós Acidente Vascular Encefálico. Dissertação (Mestrado em Fisioterapia). Universidade Federal de Pernambuco, Pernambuco, 616.81 CDD (22 ed). CCS2011-032. 2011.

13. Laguardia J, Campos MR, Travassos C, Najar AL, Anjos LA, Vasconcellos MM. Dados normativos brasileiros do questionário Short Form-36 versão 2. Rev bras epidemiol. 2013; 16(4): 889-97 889. DOI: https://doi.org/10.1590/S1415-790X2013000400009.

14. Ministério da Saúde (BR). Conselho Nacional de Saúde. Resolução n° 466, de 12 de dezembro de 2012. Aprova normas regulamentadoras de pesquisas envolvendo seres humanos. Brasília; 2012.

15. Martarello NA, Benatti MCC. Qualidade de vida e sintomas osteomusculares em trabalhadores de higiene e limpeza hospitalar. Ver Esc Enferm USP. 2009; 43(2). DOI: http://dx.doi.org/10.1590/S0080-62342009000200023.

16. Pachón-mateos JC, Pereira WL, Junior-Batista WD, Pachón-mateos JC, Pachón-mateo EI, Vargas RNA, et al. RBM-Registro Brasileiro de Marcapassos, Ressincronizadores e Desfibriladores. Relampa. 2013; 26(1): 39-49.

17. Gomes TB, Gomes LS, Antônio IHF, Barroso TL, Cavalcante AMRZ, Stival MM, et al. Avaliação da qualidade de vida pós implante de marca-passo cardíaco artificial. Rev. Eletr. Enf. 2011; 13(4): 735-42.

18. Carvalho MVC, Siqueira LB, Sousa ALL, Jardim PCBVJ. A Influência da Hipertensão Arterial na Qualidade de Vida. Universidade Federal de Goiás, Goiania, GO. Liga de Hipertensão – Brasil. Arq. Bras. Cardiol. 2013; 100(2). DOI: http://dx.doi.org/10.5935/abc.20130030

19. Trigo TR, Teng CT, Hallak JEC. Síndrome de burnout ou estafa profissional e os transtornos psiquiátricos. Rev Psiq Clín. 2007;34(5):223-33. DOI: https://doi.org/10.1590/S0101-60832007000500004.

20. Campos MO, Neto JFR, Silveira MF, Neves DMR, Vilhena JM, Oliveira JF, Magalhães JC, Drumond D. Impacto dos fatores de risco para doenças crônicas não transmissíveis na qualidade de vida. Ciência & Saúde Coletiva. 2013; 18(3): 873-882. DOI: http://dx.doi.org/10.1590/S1413-81232013000300033.

21. Lima MBP, Ramos D, Freire APCF, Uzeloto JS, Silva BLM, Ramos EMC. Qualidade de vida de tabagistas e sua correlação com a carga tabagística. Fisioter Pesqui. 2017; 24(3): 273-9. DOI: http://dx.doi.org/10.1590/1809-2950/16711324032017.

22. Silva HGN, Lopes RMAL, Feitosa MCP, Souza KF, Oliveira RA. Avaliação da qualidade de vida de pacientes diabéticos tipo 2 e a prevalência de déficit sensitivo em membros inferiores. R. bras. Qual. Vida. 2017; 9(2): 165-77. DOI: 10.3895/rbqv.v9n2.6033.

23. Neto ACFA, Araújo RC, Pitangui ACR, Menezes LC, França EETF, Costa ECC, Andrade FMD, Junior MAVC. Qualidade de vida e nível de atividade física de profissionais de saúde de unidades de terapia intensiva. Ver Bras Ativ Fis Saúde. 2013; 18(6): 711-719. DOI: https://doi.org/10.12820/rbafs.v.18n6p711.