

# Dimensions of interprofessional work and of collaborative practices developed at a primary care unit by a Family Health team

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This article aims at identifying the dimensions of interprofessional work and of collaborative practices developed by a family health team at a primary care unit. This qualitative research was conducted through participant observation of the work developed by health professionals. The study evidenced advances in the incorporation of collaborative practices in primary healthcare and in the creation of spaces that favor dialogs and the establishment of a consensus that result in comprehensive care and patient safety, despite conflicts and tensions inherent to the health work process.

**Keywords:** Teamwork. Interprofessional work. Qualitative research.

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## Introduction

Due to the growing complexity of health issues and fragmentation of healthcare, collaborative interprofessional practices are increasingly required to transform healthcare into a more effective, comprehensive and safe practice. In this practice, professionals try to perform a collaborative work with collective actions focused on common tasks<sup>1,2</sup>. This practice can result in a more adequate care to people, families and the community needs<sup>3</sup> in primary healthcare<sup>3</sup>.

Interprofessionality can be defined as "the development of a consistent practice among professionals from different disciplines." It involves "reflecting and performing" a job that "can address the community needs"<sup>3</sup> (p. 9). Reflection upon practice by questioning the reality can favor the articulation and integration of health actions and a better response to organization problems faced by health services. In this perspective, there is an attempt to replace the two main barriers to a person-centered practice: competition for collaboration and partnership among health professionals, and "power imbalance due to commitment to equality and collective responsibility"<sup>4</sup> (p. 92).

According to Peduzzi<sup>5</sup>, health professional areas have peculiar work processes mediated by the encounter between users and health professionals and by the use of technical interventions. Teamwork, in turn, consists of a collective work modality developed in daily meetings and dialogs among peers in search for the necessary articulations to integrate its actions into the care process.

This perspective is part of what has been tried to be strengthened in our public health policies. These policies are aimed at reorienting education in different levels so that the new professionals can better address health needs following the principles and guidelines of the Brazilian National Health System (SUS). In this process, the required knowledge, skills and attitudes in health work need to be effectively identified and assured<sup>6</sup>.

Worldwide health systems have been affected by the increased complexity of health problems. These problems result from the increased social and populational diversity and the growth of social groups living in situations of vulnerability (elderly, homeless, people with chronic health conditions). Therefore, the need to reorient health work towards an interprofessional and collaborative care is increasingly necessary<sup>4</sup>.

In the case of Brazil, according to Fausto et al.<sup>7</sup>, primary healthcare gained ground with the adoption of the Family Health Strategy (ESF), in the late 1990s. ESF was a proposal to reorganize the health system. According to Pereira and Lima<sup>8</sup>, reorganizing the work process under ESF's perspective started requiring several professionals (with different knowledge and practice) able to embrace different health dimensions. Different workers result in challenges: care fragmentation, and isolated and independent professional healthcare work. These challenges have required new arrangements in the work processes of these teams, such as the institution of an interprofessional and collaborative practice.

"Collaboration is a central problem in any collective work," according to D'Amour et al.<sup>9</sup>. It is based on the "premise that professionals want to work together" to achieve better results through a collective action.

In order to analyze the collaborative processes of an institution, this author and her contributors<sup>9</sup> suggest studying the "collaboration structure"<sup>2</sup>. This structure is arranged into four dimensions: two related to interpersonal relationships and two to the organizational environment (that influences the collective action), respectively: 1) shared vision and objectives; 2) internalization; 3) formalization; and 4) governance.

In this study, conducted under ESF's scope, this analysis model was used to try to investigate the complex dynamics of a health team's work. Its objectives were: to identify the analysis categories related to the interprofessional work and collaborative practices dimensions developed in a Primary Care Unit (UBS).

ESF's care model is based on health teams comprised of doctors, nurses, nursing technicians and community health agents responsible for the healthcare of approximately four thousand people<sup>10</sup>. This organization can help acknowledge health needs and even the development of an interprofessional

practice, since it requires consistency among its players, regardless of their education areas or knowledge<sup>11-13</sup>.

In a perspective in which complex health problems faced by ESF teams require a collaborative practice, it is necessary to define some useful concepts. These concepts are: share as a collaborative commitment; partnership in which two or more agents join forces in a collaborative way; interdependence, i.e., mutual dependence and power shared among members, based on knowledge and experience, not in roles or titles<sup>2</sup>.

The study's guiding questions were: Is ESF's health team's work organized according to the perspective of a collaborative practice? Does the health team work according to the interprofessional perspective, favoring the articulation and integration of health actions?

## Methodology

This is a qualitative study of the social work reality of an ESF in primary healthcare. According to Minayo<sup>14</sup>, studies of this kind can identify the wealth of meanings and the possibility of enumerating facts as a quality of individuals and groups, i.e., the reality shown by the diversity of life in society and in the work environment.

The study's scenario was the daily routine of a family health team of a UBS in the Brazilian city of Belo Horizonte, state of Minas Gerais. At the time, the city's population was of 237,441 inhabitants who lived in an area with medium risk of social vulnerability, with 6 family health teams. Based on this study's objectives, the unit's manager assigned a team.

The fieldwork was conducted by participant observation of the health team's work for four months (January through April 2016) through a comprehensive experience in the unit and by continuously recording it on a field journal. The observations were guided by the research questions (work organization and healthcare practices of a family health team) and by the indicators of the collaborative interprofessional dimensions suggested by D'Amour<sup>2</sup>. D'Amour's dimensions are: team's values and objectives, patient-centered orientations, mutual interactions, trust, formalization tools, exchange of information, clear focus/direction, leadership, innovation support, connectivity among those involved.

Participant observation<sup>15-17</sup> is characterized by interaction between the researcher and their interlocutors in the context. Therefore, co-existence and exchange of experiences captured by the way people look, talk, feel, experience and experiment are expected<sup>18</sup>.

Participant observation of the daily routine of this team's work dynamics involved a group of healthcare activities. In these activities, individual scheduled appointments and urgent calls were predominant and overtook a significant part of these professionals' daily routine. Based on the observations made, the content was correlated, to the extent possible, with the dimensions and their respective indicators in order to gather groups of elements necessary to the analysis and constitution of the adopted categories.

The impressions on the professionals' daily routine were recorded in a field journal, particularly those describing teamwork; activity (routine or extraordinary) performed by each participant; technology used by the team; interprofessional conflict, support and shared construction situations; collaborative practices among professionals from the same or different areas; and user participation in healthcare spaces.

The team's work routine included internal meetings in the UBS; home visits and assistance involving more than one health professional; observation and assistance of suspected cases of dengue, zika and chikungunya due to epidemics; besides participation in the Local Health Council's meeting agenda and in meetings with Family Health Support Center (NASF) professionals (pharmacologist, physiotherapist, nutritionist, psychologist, physical educator and pediatrician), as well as with the health team's support pediatrician.

Participant observation moments were agreed upon by the team members taking into consideration the health unit's work schedule. All family health team members participated in this study: doctor, nurse, nursing technicians and community health agents.

Field journal records were analyzed based on the content thematic analysis suggested by Bardin<sup>19</sup>. Her analysis corresponds to a: "[...] group of techniques to analyze communications aimed at obtaining, through systematic and objective procedures to describe the messages' content, indicators (quantitative or not) that enable to infer knowledge related to conditions of production/reception (inferred variables) of these messages" (p. 48).

The thematic content analysis was developed in three phases: pre-analysis, material exploration and treatment of results. The first contact with the report was through free-floating reading, considering the research objective. This is the pre-analysis phase, which is followed by material exploration through a deeper reading of the document. The analysis was guided as to acknowledge interprofessional and collaborative practice in teamwork, aiming at the production of "meaning nuclei"<sup>20</sup> in this thematic field.

The classification of the elements that comprise a group by differentiation and, subsequently, by regrouping them with previously determined criteria is what Bardin<sup>19</sup> calls "categorization." Categories are rubrics that gather a group of elements. In this study, they were adopted as thematic categories: 1) meetings and interactions in the team; 2) partnerships; 3) collaborative practices and interprofessional work; 4) conflict resolution; 5) power in interprofessional teamwork; 6) new configurations of the work process; 7) patient-centered care; 8) consistency between the team and managerial levels; and 9) interdependence.

The result analysis was based on the occurrence and description of phenomena related to interprofessionality and collaborative practices, particularly due to collaborative care experiences of interprofessional nature in primary healthcare.

Regarding this study's ethical considerations, it was approved by the Research Ethics Committees of the School of Medicine of Botucatu, Unesp, under opinion number 1.332.539 and by the Municipal Health Department of Belo Horizonte under opinion number 1.347.033.

## Results and discussion

In the family health team where the study was conducted, healthcare is organized according to the teamwork's logic, under the terms recommended by Peduzzi<sup>13,21</sup>. The weekly work schedule of the professionals who participated in this study included systematic and regular meetings with the entire team. The objective of these meetings were to establish agreements or referrals and socialize case services provided by professionals in daily admission and home visits conducted by community health agents. Disagreements in the approach and follow-up of cases were also debated in this space of discussion. Depending on the issue complexity, they were escalated to another decision level: the UBS's team meeting. During the meetings, it was observed that the team is good at recognizing the characteristics of the territory of operation and the health issues of the catchment population, particularly the social reality's complexity.

The collaborative processes related to the interaction (in its "shared vision and objectives" dimension) dealt with the aspects regarding patient-centered objectives and orientations; the establishment of professional partnerships, particularly in team meetings; the new configurations of the work process, such as the alternation between conduction and analysis of the UBS' acute cases; the horizontal professional positioning, with share of information in the event of divergence, focused on the patients' demand. These collaborative processes were grouped into three categories: meetings and interactions in the team; partnerships; and collaborative practices and interprofessional work. They are detailed below.

The elements found in the first category (meetings and interaction in the team) favor interprofessional work and collaborative practice in the primary care unit, as was also observed in another study<sup>20</sup>. In this first category, the potential of the care protocols as tools of interaction was observed, as well as their ability to mobilize discussions, particularly related to epidemics of dengue,

zika and chikungunya. They provide information on the occurrence of cases and deaths by these diseases, and on the general health situation of the population. Integration and establishment of a bond among the team members were observed in different moments. In the studied UBS, besides the scheduled meetings, exchange of information and knowledge was common in other institutional spaces, such as in informal conversations during coffee breaks.

The second category, "partnerships," was observed in different team meetings. During these meetings, agreements among professionals were established when organizing the schedules with visits, in order to ensure the users' rights. In one of these meetings, the team determined that, due to the doctors' strike, prenatal appointments needed to be rescheduled. It was established that the community health agents would inform pregnant women of the new appointments.

Regarding the third category, collaborative practices and interprofessional work, the effort to establish a new care configuration for the health service in a short period was consistent between the manager and the UBS team. UBS's ability to articulate with the upper managerial level was also evidenced. Therefore, this initiative improved the quality of the assistance provided to suspected cases of dengue, zika and chikungunya. Follow-up of these cases was guaranteed by the health team, as well as interaction with the zoonoses control service. The zoonoses control service guided home visits and helped determine strategies of action according to the notified patient's address. The organization of this outpatient clinic also showed that, with a clear direction and support from health teams, primary healthcare can meet its role in care. This role is evidenced by the complexity of the health-disease process, particularly when it is organized based on an interprofessional perspective and potentializes collaborative practice<sup>4</sup>.

According to Molyneux<sup>22</sup>, personal qualities, communication among team members and opportunity to develop creative work methods can be positive indicators of collaborative work practices in a health team. The encouragement and opportunity provided by the management team to the health team, enabling them to develop creative work methods that are appropriate to their work environment, favor the development of professional commitment. Consequently, partnerships established with patients and their families have a greater potential<sup>22</sup>.

Another dimension of the collaborative processes is "internalization." It combines different aspects related to interaction, trust and mutual co-existence. In this study, two categories were identified in this dimension: 4) conflict resolution; and 5) power in teamwork.

The fact that ESF was constituted more than ten years ago was a decisive factor to the establishment of bonds among professionals. It was also a facilitating element of open communication, as well as trust and mutual respect<sup>23-25</sup>, which are essential aspects to conflict resolution (fourth category).

The fourth category was also observed in the case of a child that was admitted in the Emergency Care Unit (UPA) with a history of tonsillitis. Even after having taken the second dose of the prescribed antibiotic, the child was still quite struck down, so the mother returned to the UBS. The nurse assisted the mother and the child. The child had a fever and streaks of pus in the throat. The mother informed the child was not eating well and was vomiting. The nurse decided to share the case with the doctor in her team (with whom she had previously worked in other cases). The doctor, who was on her way out, said she had already assisted too many cases, so she requested that this case be discussed with the other doctor. The nurse disagreed that the doctor had already assisted too many cases, since all cases were actually assisted by herself. The other doctor informed that, since she had taken only two cases, she would not mind discussing this one with the nurse. Both of them remained in the clinic. In the conversation with the mother about the symptoms, the doctor examined the child's throat without using a spatula and did not see streaks of pus. The nurse required that the doctor conduct an oropharyngeal examination using a spatula, which was done, attesting an infection. Subsequently, the doctor examined the hemogram the child took in UPA and the prescription the mother had brought along. She concluded it was necessary to change the prescribed antibiotic, informing the mother on how to proceed.

"Conflicts" are inherent in teamwork and important to acknowledge strategies to overcome them<sup>26</sup>. Individual strategies of conflict resolution included: open and direct communication<sup>27</sup>, willingness to find solutions, respect and humility. According to Brown et al.<sup>26</sup>, interprofessional

teamwork in primary healthcare is not only complex but also diverse, showing the importance of identifying sources of conflicts and means to overcome them.

The fifth category, power in interprofessional teamwork as an object to be shared among team members, is related to accumulated knowledge and experiences, as sustained by D'Amour et al.<sup>2</sup>. According to the authors, power is not related to hierarchy among professionals, or roles or positions. Since ESF meetings are conducted every week and new cases are discussed with the team in order to make a decision related to the necessary interventions, there is a work dynamic where positions are horizontal. This dynamic enables all team members to take turns in conducting and analyzing cases, as well as in suggesting referrals.

"Formalization" is the third dimension that is present in collaborative processes<sup>2</sup>. It is related to tools and protocols that support the way the work process is organized. In this study, two categories were identified in the "formalization" dimension: 6) new configurations of the work process; and 7) patient-centered practices.

Assistance of acute cases of all ages conducted by the UBS followed a work schedule with weekly alternation of the family health teams. When this study was conducted, given the great demand of suspected cases of dengue, there was a new configuration of the work process (sixth category). The studied team consisted of a nurse, a nursing technician and a doctor. In the required interprofessional action, they maintained their specific knowledge and professional autonomy. Patients were referred to the nurse, who identified their complaints and followed the risk classification protocol, taking into consideration the main complaint. Doubts were discussed with the doctor. The necessary referrals were established by consensus. The entire process was supported by the medical record, which helped in the assistance of the cases, considering the patient's health history.

Due to new epidemics of dengue, zika and chikungunya, a new care arrangement was established for ESFs related to acute cases. In this new configuration, a specific outpatient clinic was created for suspected cases of dengue, zika and chikungunya in the UBS meeting room. In the shift schedule related to suspected cases of these diseases, the team was comprised of one nurse, one doctor, two nursing technicians and one lab technician. This outpatient clinic was equipped with the necessary technology to satisfactorily assist the cases, including with support to diagnosis. A notification form (with home address) was filled out to record the case. The medical record was accessed to identify interoccurrence/comorbidities and consult blood test results, which were sent to the lab and analyzed in the UBS. The decision on the outpatient clinic's structure was made by the committee that discussed the assistance to acute cases and by the UBS manager.

Literature has evidenced a patient-centered practice (seventh category) is essential to qualify care. According to Kitson et al.<sup>28</sup>, three main themes describe patient-centered practice, represented by the health, medicine and nursing policy discourses. These themes are: participation and involvement of patients, relationship between patients and health professionals, and context in which care is provided. According to Clayton et al.<sup>29</sup>, they involve the care provision required and desired by patients. According to Sidani and Fox<sup>30</sup>, empirical data shows there are differences in the care provided by the team and that expected by patients. Generally speaking, when teams work in an integrated way, trying to reach a consensus regarding the best therapies, it is possible to reduce this difference in expectations. According to patients, teams should take their needs into consideration. According to professionals, on the other hand, although they consider relevant taking these needs into consideration, they tend to follow current protocols and references. This process helps meet the demands but keeps professionals away from meeting the reported needs. In the studied case, just like in any team, despite conflicts of roles and understandings, the team tried to reach a consensus sometimes. In Brazil, some studies show stress and conflicts within the team are poorly managed. This poor management implies in the rupture of bonds, creation of new conflicting situations and damage to the professional development of its members<sup>31</sup>.

In one of the weekly meetings, the team discussed a case brought by the nurse: a suspected case of sexual abuse of a family member to a child. All team members were familiar with the situation. Since the case also involved use of drugs by the child's parents, the nurse was in doubt as to formalizing the case or not by filling out the notification form related to sexual abuse. The community health agents

and the doctor understood the right conduct would be to first talk to the social worker so that the case would be reported to the child protective council in order to protect the child. After discussing the case, with the contribution of all team members, the team considered the social reality was appropriate and reached a consensus as to refer the case to the UBS' social worker.

In another ESF meeting, the nurse and the doctor discussed the case of a young pregnant woman who was leaking fluid. The patient used to live in another city, but moved to the ESF coverage area less than a month before that. They considered the case was serious. Therefore, the community health agent needed to visit the patient in her house to make sure she was assisted in the maternity hospital referred by the unit.

Besides ESF meetings, other meetings were also conducted with NASF team once a month. These meetings aimed at discussing the cases identified by ESF that required the attention of the center's support professionals. However, referrals to NASF, which are decided in the team meetings without participation of the patients, can cause estrangement. In one ESF meeting, the community health agent brought back a referral made to NASF's physiotherapy. In this case, the mother did not think it was necessary, because, in her opinion, the child did not have a problem. This unawareness showed the team that, although they were all aware of the child's health situation and had reached a consensus as to the appropriate support, the mother was not sufficiently involved or informed.

The governance dimension is related to centrality, leadership, innovation support and connectivity implied in the action. It is organizational and gathers the eighth and ninth categories (consistency between teams and managerial levels, and interdependence, respectively).

Consistency between teams and managerial levels is defined by D'Amour et al.<sup>2</sup> as the interaction between managers and health professionals. This interaction is an important part of the work in health. The quality of this articulation can intensify collaboration and help achieve a comprehensive practice. In the case of the studied team's work, the establishment of a weekly schedule for meetings corresponded to a managerial decision that contributed to the articulation of the team and the exchange of information. Contributing, therefore, to the definition of a continuous communication process. Additionally, the existence of a specific space to conduct meetings in the health unit resulted in the institutionalization, from the managerial point of view, of the negotiation spaces as organizers of the studied team's work.

According to Abbad et al.<sup>32</sup>, the health work's daily routine has tensions, conflicts and disagreements related to how cases are conducted or whom are responsible for them, decision making or choice of procedures and therapies. These issues need to be overcome in order to achieve a collaborative work. The way these tensions or conflicts are perceived and mediated can contribute to increasing or decreasing the team's consistency.

The ninth category, interdependence, was observed in the family health team. The team's relationship with specialists, such as the pediatrician, was interdependent. The case of a child assisted by the family doctor illustrates this need for sharing. The child arrived at the UBS at around ten o'clock, totally sleepy, with altered blood glucose levels, which required the administration of intravenous dextrose solution. Subsequently, an ambulance was required to transfer the child to UPA. The family doctor and the pediatrician tried to find out, from the mother and grandmother, if the child had taken any medication as an attempt to mimic adults. Another possibility was the use of drugs by the mother, since she was still breastfeeding the child. There was no confirmation of the suspicions from the mother and grandmother who accompanied the child. The pediatrician explained that, in cases like this, in which there is a hypothesis of intoxication by medication or drug, the hospital that referred the patient should be contacted. The hospital is an important channel, since it has a technology (software) that, by describing the patient's symptoms, can identify if it is indeed intoxication and which actions should be taken in that specific healthcare level. Both professionals decided that the case required further clarification, since the alternation between sleepiness and awakening states presented by the child was compatible to intoxication. Conducted in Brazil, this study dealt with factors related to communication from an interprofessional perspective. It called attention to the importance of sharing information and of interaction as an interlocution that should actively involve professionals, patients and their family in order to achieve the desired understanding<sup>33</sup>.

This collaborative practice implies recognizing interdependence among professionals, considered a common wish to address patient needs and a way of emerging the synergy among contributors that were previously considered individualized<sup>2</sup>.

## Final remarks

The elements associated to collaborative practices and interprofessional action in health involve aspects that need to be addressed from a qualitative perspective in order to be well-understood. Concepts present in the team's work routine bring nuances that require immersion of the researcher, given its complexity. In this sense, the study had some limitations that are expected from participant observation. They were: recognition of phenomena experienced in the researcher's presence and difficulty to observe practices and rare events that occur in the work routine. Qualitative approaches help incorporate methodological tools that are more appropriate to the approximation with phenomena experienced in professional practices in dynamic environments. This is the case of health teams in primary healthcare, which are guided by the family health strategy. These approaches also help in the approximation with non-measurable interpersonal relationships among professionals, and between patients and professionals.

This study evidenced advances in the incorporation of collaborative practices in primary healthcare and in the creation of spaces that are more favorable to dialogs and to reaching a consensus. These advances result in comprehensive care and patient safety, despite the conflicts and tensions of the health work process.

Considering the obtained results, complementary studies should be conducted to correlate the incorporation of collaborative practices to patient safety, according to the family health's perspective.

### Authors' contributions

The fieldwork was conducted by the first author. All authors contributed to the preparation of the manuscript, actively participated in the discussion of the article's results and in the critical review and approval of its final version.

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