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Constructing professional identity in Interprofessional Health Education as perceived by graduates*

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This is an exploratory, descriptive-analytical study, qualitative and longitudinal in nature. It presents the perception of graduates about the construction of professional identity from the perspective of Interprofessional Education, with data collected in interviews with graduates of the program from six health professions. The results were organized into guiding nuclei and processed using content analysis. The results are presented as regards the nucleus Interprofessional Education and the construction of professional identity. The participants reported their educational experience with this innovative, interprofessional and interdisciplinary curriculum, giving emphasis to the opportunity for collaborative and interprofessional practices as important to developing, constructing and reinforcing professional identity in each area of education by recognizing the specificities of other areas. The graduates also highlighted the definition of their own professional field and their role in such teams, as well as the expansion of their professional outlook.

Keywords: Professional identity. Graduates. Interprofessional education. Collaborative practice.

Introduction

Interprofessional Health Education (IHE) is conceptualized as a proposal in which two or more professions learn together about joint work and about the specificities of each profession to improve the quality of care. It has been the object of studies in the United States, Europe, Canada and also in Brazil[1-3].

In a review that considered the international context, Barr[2] explains that IHE was created by the initiative of a group of specialists, summoned by the World Health Organization (WHO), who were increasingly concerned about health professions, especially those in the medical area. In 1988, the World Federation for Medical Education (WFME) recognized the importance of IHE and recommended that nations should provide training for physicians in close association with the other health professions[2].

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The report issued by the group of specialists inspired IHE initiatives all around the world, based on the belief that the implementation of IHE principles could improve job satisfaction, increase the public's appreciation of the health team and enhance effectiveness in the meeting of health demands.

According to the perspective of IHE, health professionals must be trained to mobilize knowledge, get involved in critical reasoning, and have an ethical conduct in order to participate, in a competent way, in healthcare systems centered on patients and the population, respecting the knowledge and practices of different professions[2].

Barr[2] mentions that there are some important conditions for the success of IHE: openness and mutual support at the workplace characterizing relationships among people; democratization in universities so that interprofessional learning happens; minimization of some professions' sovereignty over others in practice scenarios; and mitigation of the academic competitiveness that still persists in universities.

In a recent study about the development of IHE, Reeves[3,4] argues that there is a series of fundamental empirical and theoretical gaps about IHE and Collaborative Interprofessional Practice (CIP) that need to be filled so that studies about these two fields can advance.

Although he recognizes that advances have been made in the field of IHE and collaborative practice, Reeves[3] believes that new investigations are needed, based on five essential points: 1) observational studies on how interactive processes experienced by students during IHE activities have been occurring; 2) longitudinal research on IHE activities aiming to investigate the effectiveness of this proposal, considering behavior, collaborative practice and care provided for patients; 3) studies about costs and benefits of IHE and CIP activities, with economic analyses that approach these aspects; 4) multi-institutional studies that provide more convincing evidence; and 5) social sciences studies that investigate the nature and results of IHE and CIP.

Barr et al.[5] present some Guidelines provided by the Centre for the Advancement of Interprofessional Education (CAIPE). Originally, the guidelines are targeted at organizations in the United Kingdom that are responsible for the development, functioning, evaluation, regulation and supervision of IHE in the initial and permanent education of professionals to implement consistent policies, practices and procedures that can guarantee efficient, effective and economical IHE interventions.

Curran et al.[6] carried out a study about IHE in undergraduate programs whose curricula were grounded on IHE and identified significant differences in students' behavior. However, the study, conducted in a longitudinal way, showed that when IHE is experienced only at the beginning of the undergraduate program, it has no important effect in the long run.

On the other hand, the document released by the WHO[1] shows that professional training in the perspective of IHE, promoted since the undergraduate program and specially in permanent education, is grounded not only on changes in educational practices, but also on changes in the culture of professions and healthcare.

The development of IHE in Brazil has been supported by Inductive Policies for Health Education, like PET-Saúde (Program of Education through Work for the Area of Health) and Pró-Ensino na Saúde (National Program for Teacher Development in the Area of Health), and also by the National

Curriculum Guidelines for health programs. They are important tools to guide professional education and recognize the need to adopt IHE as a strategy to overcome the fragmentation of health work in Brazil[2].

Allied with these policies, IHE gains strength when it shows it is aligned with the principles of Brazil's National Healthcare System (SUS).

> The training of professionals to be more capable of developing collaborative work is essential to advance towards comprehensive care, equity in health actions and resolution of problems, mainly because it views the services' users and their needs as the center of health actions and policies[2] (p. 23).

Peduzzi[7] states that, in Brazil, there have been few opportunities for undergraduate or graduate studies in IHE. Only one public university has implemented an integrated curriculum based on this approach and a few courses have promoted isolated interprofessional practices.

Teaching and learning experiences in the perspective of IHE indicate that this kind of education favors changes in the professionals' profile and form health professionals who are critical, reflective, proactive, prepared to work in teams and in the world of labor[8, 9].

In 2006, Universidade Federal de São Paulo – Baixada Santista campus (UNIFESP-BS) proposed a curriculum design in which the disciplines' contents are organized in common and specific axes, in the perspective of IHE and in the interface among curricular units - an innovative pedagogical proposal for the Brazilian standards. The Pedagogical Project proposed to UNIFESP-BS has the following principles: education of health professionals who are capable of working in an interprofessional team and provide comprehensive care for the patient; excellence in technical-scientific and human education in a specific area of the health professional's action; and scientific education, for research is understood as the propeller of teaching and learning[2, 10].

This model of curriculum, directed at the development of teamwork competencies, demands an interdisciplinary action and breaks with the traditional structure centered on disciplines and on the specific formation of each professional profile. Thus, the undergraduate programs implemented at UNIFESP-BS (physical education, physiotherapy, nutrition, psychology, social work and occupational therapy) have a curriculum design structured in education axes and interdisciplinary modules[10].

The Pedagogical Project suggests the utilization of active teaching and learning methodologies, significant and collaborative learning as strategies to the development of knowledge, skills and attitudes in different practice scenarios. The classes have a mixture of students from the six undergraduate programs and promote an inversion in the logic of learning: the point-of-departure are students' experiences in real scenarios of action, followed by reflections on these practices supported by teachers' mediation and by the theoretical framework[10].

Professional identity has been discussed in the scope of studies that focus on interprofessional education, collaborative practice and interprofessionality, and also based on national and international documents about health policies and reforms, on the National Curriculum Guidelines[11] and on the Framework for Health Education[1]. However, the discussion about development of professional identity happens by means of the importance attributed to teamwork, collaborative practice and to the definition of roles and responsibilities with no predominance of one professional category over the others.

Matuda et al.[12] indicate the need of a new reorganization in the health practices, which implies changes to overcome the biomedical model that is in force in Brazil, and emphasize the contributions of other professionals to promote a better production of care for the healthcare system's users.

The study carried out by Matuda et al.[13] aimed to "capture the perception of professionals who work in primary care about shared work and interprofessional collaboration" (p. 2511). It showed that there are tensions between the traditional professional logic and the logic of collaboration, and between a model centered on specialized procedures and a collaborative model that focuses on the needs of the healthcare services' users.

A study about modalities of teams in multiprofessional work[14] has shown that teamwork in the Family Health Strategy "emerges as a possibility for a more communicative and cooperative practice, in which professionals recognize the other's work and share objectives, configuring a network of conversations" (p. 327).

With the aim of exploring changes induced by professional health education reorientation policies, Costa and Borges[15] present characteristics of the professional health education process and argue that some of the challenges that must be faced are "education centered on the specific skills of professional categories and the intense division of health work"[15] (p. 754). In addition, they argue that historical, social, economic and cultural determinants have demanded transformations in the health professionals' profile in order to implement practices and solve problems in an efficient way. However, they mention tensions, especially to break with professional identities "defined and legitimated by society, adding, to the professions, a differentiated status and social relevance"[15] (p. 754).

Casanova et al.[16] carried out a study to analyze the perception of professionals enrolled in Programs of Multiprofessional Health Residency about teamwork education. The results indicated, among other aspects, that "teamwork education does not impair professional identity; in fact, it strengthens professional identity"[16] (p. 232).

Câmara et al.[17] discuss social and political processes that pervade the development of IHE in Brazil and present a set of experiences spread across the extension and diversity of the national territory. They demonstrate the need to systematize the variety of experiences developed in different regions of Brazil and argue that it is necessary to disseminate productions as a "contribution to a critical reflection on these scenarios of implementation of IHE, combining forces to overcome difficulties and to demand the continuity of long-lasting and solid inductive policies"[17] (p. 11).

Aguilar-da-Silva et al.[18] evaluated IHE in higher education considering the aspects of collaboration and teamwork. According to the authors, it is necessary to develop cognitive, affective and psychomotor resources so that students educated in the interprofessional perspective understand the need to provide comprehensive care for patients, respecting the autonomy and domain of each profession.

With a curriculum structured in the IHE perspective, UNIFESP-BS has been the privileged locus for research. Souto et al.[19] conducted a study with psychology graduates and, among the results, there is evidence that IHE contributed to the construction and strengthening of the psychologists' professional identity.

Silva and Pinto[20], in a literature review about the identity construction of Collective Health actors in Brazil, argue that the understanding of professional identity is directly related to the

professional's insertion in the world of labor and in his relationship with the other. It "is a product of successive socializations, permanently reconstructed to the individual himself over time"[20] (p. 550). In addition, they show that "the construction of professional identity is strongly related to the choice of one area and to the education process in undergraduate programs"[20] (p. 554).

It is important to mention that conducting evaluations with graduates has not been a common practice in higher education institutions and "studies that monitor graduates are rare"[21] (p. 207).

Graduates are important elements of university, as they provide subsidies to evaluate the education they received and their insertion in the world of labor, and can contribute to the identification of potentialities and weaknesses, especially in innovative and integrated curricula structured in the IHE perspective.

This study aims to analyze graduates' perception of Professional Identity construction in the perspective of Interprofessional Health Education.

Methodological path

This is an exploratory-descriptive study developed longitudinally in two complementary moments, with the adoption of a quantitative and qualitative approach.

Of the 1005 students that graduated from the programs of physical education, physiotherapy, nutrition, psychology, social work and occupational therapy of UNIFESP-BS in the period from 2009 to 2015, 358 graduates (35.6%) who met the inclusion criterion (professional experience of at least two years) participated in the first moment of data collection[(e)], which consisted of the administration of the Readiness for Interprofessional Learning Scale – RIPLS[22], translated version, transculturally adapted and validated in Brazil[23].

The Readiness for Interprofessional Learning Measurement Questionnaire, with 26 statements in a Likert Scale[23], was prepared and uploaded to an electronic platform. It evaluated attitudes and readiness for three factors: Teamwork and collaboration; professional identity; and patient-centered care. The completion of this instrument enabled us to know the universe of the population in a quantitative perspective.

To further investigate these data, the second moment consisted of individual and face-to-face interviews that were performed to provide a better understanding of aspects that emerged from the initial analysis.

To form the sample of interviews, a database was organized with the respondents of the instrument in *Likert Scale* who had agreed, by means of a consent document, to participate also in this stage of the study. They were contacted by electronic mail or by telephone to schedule the interviews.

The Project was approved by Opinions no. 47.206/2012 and no. 1.388.191/2016.

The sample for the interview was progressively composed by a graduate drawn from each program/year until the qualitative criterion of a research sample was obtained: data saturation.

Saturation sampling is a conceptual tool of unequivocal practical applicability that can, based on successive analyses conducted in parallel with data collection, guide its finalization. The sample's

[(e)] Collection of quantitative data performed from 2012 to 2016.

saturation point depends on the objectives established for the study, on how deep the researchers want to explore the theme and on the homogeneity of the studied population [24].

Minayo et al.[25] state that qualitative research deals with the universe of meanings, motives, aspirations, beliefs, values and attitudes. This set of human phenomena is understood as part of social reality, as the human being is distinguished not only because he acts, but because he thinks about what he does and he interprets his actions within and based on the experienced reality, and also by sharing with his peers.

The interview script was developed from statements that approached the following themes: opportunity of collaborative and interprofessional practice; understanding of each profession's specificities; perception of the delimitations of one's own professional field; amplification of the professional view and understanding of the nature of the patients' problem; perception of professional autonomy, roles and responsibilities in teamwork.

According to Minayo et al.[25], the interview is an excellent instrument to collect information, as it is possible, by means of speech, to have access to subjective data from reality, such as ideas, beliefs or ways of acting.

Four nuclei, aligned with the factors of the instrument in *Likert Scale*, guided the analysis of the interviews: IHE and the development of competencies for teamwork and collaborative practice; IHE and the construction of Professional Identity; IHE and training for patient-centered care; and Evaluation of the education received in the IHE perspective. In this text, we will present the results of the nucleus IHE and the construction of Professional Identity.

To preserve the participants' identity, the graduates' discourses are indicated by letter "G" followed by a sequential number G1, G2 and so on).

Data collected through interviews were transcribed in full and treated by means of the Content Analysis technique, according to Minayo's theoretical framework. Content analysis allows to discover what lies behind manifested contents, going beyond the appearances of what is being communicated. Thematic analysis was used, in which the theme is central judgment, which can be represented by means of a word, a sentence, or a summary[25].

The steps established for thematic analysis consisted of the identification of units of context with their respective units of register. The unit of register is the smallest part of the content and can include, for example, the word, the theme, the character and/or the item. According to Franco[26], the unit of context is the broadest part of content, that is, the context of the message that will be analyzed.

The categories were identified after exhaustive readings of the units of context and their respective units of register. A long exercise, of immersion in the theme and intellectual reasoning, is highly challenging to the identification of categories and subcategories.

The categories of analysis were defined following the recommendations of Franco[26]: "categorization is an operation of classification of the elements that constitute a set by differentiation, followed by a regrouping performed through analogies, based on defined criteria" (p. 63).

Results and Discussion

Based on the data that stood out in the statistical analysis, and aiming to amplify the understanding about the study's object, semi-structured interviews were conducted with 35 graduates: 7 from Physical Education, 6 from Physiotherapy, 7 from Nutrition, 4 from Psychology, 4 from Social Work and 7 from Occupational Therapy.

In the analysis of the guiding nucleus IHE and the construction of Professional Identity, 91 units of context (UC) were found, in which 222 units of register (UR) were identified. In the confluence of these UR, the category Strengthening of professional identity emerged, with its sub-categories: 1) Knowledge of the specificities of the other areas; 2) Delimitation of one's own professional field; 3) Delimitation of roles in the team; and 4) Amplification of the professional view.

The subcategories of analysis and what the graduates say

The strengthening of professional identity occurs when there is knowledge of the specificities of the other areas, with attitudes of respect, ethics and search for knowledge.

The recognition of the "interdependence and complementariness of the actions of various professionals to improve the quality of care"[14] (p. 328) indicates that breaking with the fragmentation of knowledge, actions and interactions among professionals in a health team is the way to understand that the specificities of each area cannot be seen in isolation. They complement one another, each one acting in the same space but in a collaborative way, contributing to the quality of healthcare, "avoiding omissions or duplication of care" and, consequently, bringing benefits to the users of the healthcare system[12, 27].

We must strive to consolidate a model of care in which teamwork is considered a "modality of collective work that is constituted by means of a reciprocal relationship between technical actions performed by distinct professionals and the interaction of these actors", with the aim of providing comprehensive care for patients[14] (p. 328).

According to Câmara et al.[17], "teamwork in Brazil still has a long path ahead of it to be consolidated as an efficient practice to overcome the traditional process of fragmented work" (p. 5). The biomedical model imposed on students from the area of health, whose learning process is centered on procedures, medical specialties and the hospital, does not favor teamwork and the recognition of interdisciplinarity as a way of providing care beyond the aspects of the disease[12].

However, when people who were educated in the perspective of IHE and collaborative practice recognize the specificities and contributions from other areas of health to the provision of effective comprehensive care for patients, it is possible to infer that investing in this type of education will benefit the population assisted by the SUS and also the professional himself, who can achieve better results[12, 19].

Recognizing the limitations of their field of activity, being respectful and identifying, in the other, possibilities of new learnings, are fundamental aspects in and for teamwork that strengthen professional identity in the interdisciplinary environment[19].

The reports of graduates from UNIFESP-BS programs indicate this.

> "(...) when I'm near someone whose knowledge is greater than mine, this stimulates me to study, to strive, to get close to this person and learn more." (G2)

> "(...) getting to know other professions, a little of each profession and the interest in searching for knowledge (...) I try to benefit from this knowledge and absorb it! I try to seize the moment to learn with him, the person, the professional." (G9)

> "(...) The more we're able to say and act in a safer way about our positions, the more we can produce things together with the others, with the teams, so... if I know that I can say something and the team will welcome what I say, that I can have a certain conduct and the team will be with me... then I think we're able to act better and better." (G24)

The strengthening of professional identity starts with the delimitation of one's own professional field by means of the recognition of roles and autonomy. Silva and Pinto[20] argue that "professional identity is legitimated by the experience of graduating in a certain area" (p. 555).

In this aspect, Souto et al.[19], in a study developed with undergraduate Psychology students, also indicate that "at the end of the undergraduate program, the student leaves university with the conception that his professional identity was strengthened by the undergraduate program" (p. 40)

Delimiting one's field of activity does not mean demarcating a territory in an authoritarian and competitive way; on the contrary, it means recognizing one's limits and the exact moment of requesting collaboration, as well as sharing actions with other professionals, recognizing and strengthening one's identity over time, with one's work experiences incorporating one's role[12, 20, 27].

Due to reasons that have been historically consolidated, health professionals' education and action for collaborative practice, comprehensiveness of care, and recognition of borderline and interdependence spaces among professions still are complex and challenging aspects.

Overcoming the biomedical model that has always prevailed and, in some moments, still prevails at healthcare units means recognizing that the complexity of diseases involves much more than one single type of knowledge. It means leaving one's own interests aside to give to the other a space of action in order to provide better care for users of the healthcare system[12, 28].

Recognizing one's professional value, the importance of his knowledge and the place of his field of activity within a health team, "maintaining the specificities of one's own area", does not mean giving up his action and the knowledge he has built[27] (p. 979). It is fundamental that the professional recognizes himself in a team to understand his limits and potentialities.

> "You learn that... either you'll be a proactive person that is always ahead, leading the group... or you'll learn, in a certain way, to follow someone who does that..." (G3)

> "(...) I try to delimit it like this... I have to have a limit, but at the same time I don't have to have a limited view!" (G4)

> "(...) what makes us search and see in another way is precisely the practice with other programs since the beginning of our undergraduate studies, and the perception of our own limitations and the complementariness of our actions..." (G10)

> "I felt that, during my education, the fact that I studied with people from other programs helped me a lot to understand the psychology involved in dealing with other professions. It helped me in my professional relationship with other professions." (G26)

The delimitation of roles in the team, with the perception of borders between professions, meant the creation of spaces of trust, the possibility of getting close to and accepting contributions from other professionals, and the strengthening of interpersonal relations. According to the graduates, these factors indicate the strengthening of their professional identity, and they recognize that their activity does not have rigid limits; rather, it is pervaded by partnership and collaboration, in joint actions. This is related to the perception and recognition of the moment when a professional should lead the assistance in order to meet the patient's specific demands and when he perceives the need to be complemented by another professional, so that they can amplify their views and understand situations better, meeting the demands with more effectiveness.

Recognizing one's own place and the other's place in a health team implies the development of skills and competencies, in an exercise of dialogs, reflections and multiple learnings, which unfold in the undergraduate program to be experienced in practice scenarios.

The recognition that one's field of activity has common borders is related to understanding the delimitation of roles in the team, something that is challenging and necessary, as, according to Aguilar-da-Silva et al.[18], "professionals are not competent in 100% of the approaches" (p. 176).

Concerning this aspect, Flores et al.[9] argue that the participation of health service professionals in the teaching and learning process of students, mediated by the tutor, contributes to the formation of competencies to the health practices.

In the graduates' reports, it is possible to identify the recognition of limits for their action and the importance of the other as a member of a health team for the comprehensive care of the patient.

> "(...) in the end you understand the importance of the other in a team (...) it involves the space of trust that you gradually create in the team, and this depends on how each professional positions himself." (G1)

> "(...) I think that... we really need to defeat limitation, the program's specificity, and understand that I could approach the issue of listening to the patient, being close to him, but I could only reach a certain point and then I'd feel the need to interact with the other professional." (G7)

> "(...) we can't work with everything, we can't handle everything! ... Each one could give a better contribution with another view... a view from our area... our specificity!" (G11)

The amplification of the professional look emerges as a subcategory to delimit the strengthening of professional identity.

Interprofessional education amplifies the professional's view beyond specific and fragmented education, enabling the recognition of the values and skills of other professions in the provision of comprehensive care for patients[16].

Teaching-service integration puts students in direct contact with professionals from the health services, favoring the amplified view of the other professionals' field of activity and recognizing the importance of each professional in the team[9].

Amplifying the view beyond the borders of one's own education, "recognizing that the skill of sharing knowledge is an essential trait for the performance of complex activities in teams", and seizing opportunities to learn with the other and about the other, will bring important benefits for healthcare[12] (p. 181).

> "(...) for us to see the patient as a whole,... learning with the other students from the other programs was fundamental." (G6)

> "(...) the other professions of UNIFESP-BS look at physical practice in different ways! This helps us have this amplified view of health... of wellbeing! You start looking at the subject and at the practice, not only because of the issue of performance, but in different angles!" (G10)

> "(...) I think we learn something everyday. The other learns with me and I learn with the other... we learn to have different views about the same case, about the same person, we talk together and think of an strategy and an action plan to that patient based on knowledge from different areas." (G30)

Final remarks

To the graduates, the reflection on interprofessional education and practice contributed to evaluate the experienced path and teamwork as the potentializer of professional identity construction; in addition, it enabled them to rethink their current practice, establishing new perspectives for future education.

To undergraduate programs, the results bring different benefits, as they allow to identify potentialities and weaknesses in initial education, which can contribute to promote curriculum restructuring and to delve into issues related to education in the perspective of IHE and collaborative practice.

Based on the inductive policies for health education in Brazil and on the world's recognition of the effectiveness of IHE, demonstrated by many investigations, the need to educate health professionals prepared for teamwork, collaborative practice and comprehensive care has become increasingly evident. Such education fosters reflections and transformations in the professionals' own practice, as reflection enables them to exercise thought, action and professional development.

Thus, the professional starts to be seen as an actor who builds his knowledge based on experiences, by means of the understanding and (re)organization of knowledge obtained by the interlocution between theory and practice.

The interdisciplinary and interprofessional Pedagogical Project of UNIFESP-BS was implemented ten years ago. The data presented here shows that it educates professionals who are sensitive to health issues and to the recognition and importance of partnerships and the complementariness among professions. These professionals can put themselves in the other's place and perceive other needs, have an amplified view of health, and provide a more humanized healthcare centered on the patient. The professional educated in the perspective of teamwork and comprehensive care is a professional who, beyond the construction of knowledge and the specific skills of each professional area, has advanced in the development of collaborative attitudes and competencies and has become a differentiated health professional.

As an innovative curriculum to the Brazilian standards, we highlight the richness, the contributions and possibilities of change in the national health scenario. The data drive us towards new challenges and advances in the review and reformulation of curricula, with the aim of enhancing education in the perspective of Interprofessional Health Education and Collaborative Interprofessional Practice.

Collaborators

Rosana Aparecida Salvador Rossit participated in the conception of the research project, in data analysis, interpretation and discussion, and in the writing of the article. Maria Aparecida de Oliveira Freitas participated in the discussion of the results, in formatting and review. Sylvia Helena Souza da Silva Batista participated in the conception of the research project and in the analysis and discussion of the results. Nildo Alves Batista participated in the conception and supervision of the research project, in the analysis and interpretation of the results and in the writing of the article. All the authors approved the final version of the text.

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