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Interprofessional education and collaborative practice in Primary Health Care*

Educação interprofissional e prática colaborativa na Atenção Primária à Saúde

Educación interprofesional y la práctica colaborativa en la Atención Primaria de Salud

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ABSTRACT

Objective: To understand the perceptions of professors, health care providers and students about the articulation of interprofessional education with health practices in Primary Health Care. **Method:** To understand and interpret qualitative data collection, carried out between 2012 and 2013, through semi-structured interviews with 18 professors and four sessions of homogeneous focus groups with students, professors and health care providers of Primary Health Care. **Results:** A triangulation of the results led to the construction of two categories: user-centered collaborative practice and barriers to interprofessional education. The first perspective indicates the need to change the model of care and training of health professionals, while the second reveals difficulties perceived by stakeholders regarding the implementation of interprofessional education. **Conclusion:** The interprofessional education is incipient in the Brazil and the results of this analysis point out to possibilities of change toward collaborative practice, but require higher investments primarily in developing teaching-health services relationship.

DESCRIPTORS

Interprofessional Relations; Work; Higher Education; Health Communication; Primary Health Care.

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INTRODUCTION

The Brazilian Unified Health System (SUS) provides for a comprehensive approach joining health promotion, prevention, and recovery actions encompassed by the identification of social determinants and conditions of the population health[1], intersubjective practices and care service network coordination. The increasing complexity of health needs of users/population, and the changes driven by the aging process and increasing chronic diseases in the demographic landscape, demand for a new professional profile characterized by interprofessional collaboration[2–3]. In the SUS context, the Primary Health Care (PHC) is the space/locus performing the coordination role of the Health Care Network (HCN). This level of care is organized around the Family Health Strategy (ESF), in which teamwork is one of its main operational guidelines[4].

This study is based on the assumption that changes in the health care model and in professional training are processed in reciprocal interactions[5–6]. Such interdependence should be considered in the search for the reorganization of the work process in health services, focusing on user needs[3,7–9].

In Brazil policy-inducing proposals were developed since the 1970s to promote integration between professional training and health services practices, as well as team-based organization of services. In 2001, the National Curriculum Guidelines for Undergraduate Courses in Health (DCN) was implemented, following SUS principles and guidelines established by Law No. 8080/90. The DCN represents a legal framework for the coordination between health services and education and advocates for teamwork training from the standpoint of the need of comprehensiveness and quality of communication between the team and users, families and community[5].

Although SUS and the DCN put teamwork as their focus, the predominant model of education and development of health care workers still remains uniprofessional[5,7,10]. It is characterized by the focus on thematic disciplines and results in fragmented care, knowledge and practices as well as professional tribalism, reinforcing biomedical hegemony with professional isolation[3,5].

The focus of this study is interprofessional education (IPE) in health care. In IPE, professions cooperatively learn about collective work and the specificity of each professional field[7], oriented towards collaborative work in an interprofessional team to ensure health care quality[10].

On the Brazilian context IPE implementation is still incipient with unknown results. This study was conducted to understand the perceptions of professors, workers, and students about the coordination of IPE and health practices in the PHC settings. Its purpose is to contribute to the strengthening of the interprofessional practice and education in the SUS.

METHOD

A qualitative research with comprehensive and interpretative approach was used. Data collection was carried out from January 2012 to September 2013. Forty-four individuals, including 24 professors, 15 workers, and five students were included in the research, distributed in the following professional fields: 20 in Nursing, 11 in Medicine, three in Psychology, three in Pharmacy, three in Dentistry, one in Speech-Language Therapy, one in Occupational Therapy, one in Physiotherapy, and one in Social Work.

Eighteen semi-structured individual interviews were conducted with well-known professors from eight Brazilian public universities with relevant expertise in teaching and research in SUS primary health contexts. Four homogeneous focus group (FG) sessions were held: one group composed by professors, a second one by students and the last two by staff members of the health services that participate in a special program of the Ministry of Health called Programa de Educacao pelo Trabalho na Saude (PET-Saude)[11], in PHC services in the City of São Paulo. Workers participating in the study worked in two Primary Health Care Centers, selected by two criteria: by their performance in PET-Saude and; to be evaluated by the researchers as centers with good teaching practices.

All the interviews and the focus groups were conducted after the participants signed a consent form and performed by the primary researcher, with an observer collaborating in the FG. The reports were recorded, transcribed by an outsourced service, and re-checked by the primary researcher. Contacts with participants were conducted by the researcher, who used e-mails and phone conversations to schedule meetings in advance. The average duration was 45 minutes for interviews and two hours for the FG sessions.

The interview scripts addressed IPE perceptions, life experiences, initiatives of IPE practices in Brazil, and implementation challenges. The results of the interviews served as an input for the FG guide. The main topics were: IPE coordination with practice in the PHC setting; influence of IPE on PHC practices and; description and purpose of integrated activities among professional fields. All the reports were identified by reference to the group to which they belong – professors, workers, or students–, and a random identification number and their professional category was assigned to each of them.

Data analysis used a thematic content analysis technique[12] through a critical hermeneutics approach[13], under a theoretical framework comprising the following concepts: health care work process, communicative action, instrumental action, IPE, user-centered collaborative practice, and PHC. It was performed a triangulation of the results of the interviews and FG[14].

The study was approved by the Research Ethics Committee of the university in which the study was conducted (CAAE 0096.0.196.196-11) and the Research Ethics Committee of the São Paulo Department of Health Services (CAAE 130.0.0.196.162-11), following the ethical regulations of the resolution No. 196/96 (later: Resolution No. 466/12 of the National Health Council).

RESULTS

This section will be organized in three parts: the outcomes of the analysis of the interviews with professors; the analysis of the FG with health workers, students and

teachers participating PET-Saude; and the triangulation of the former results.

Perspectives of the professors surveyed

The analysis of the narrative of the interviewed professors led to the development of a category that represented their perceptions on the subject of study: "IPE shifts the emphasis from training and practices towards comprehensive care". This category was created as a synthesis from four subcategories: "training oriented towards care for the complexity of health needs", "training for interprofessional teamwork in health care networks", "interprofessional communication for care", and "barriers for implementing IPE".

The subcategory "training oriented towards care for the complexity of health needs" indicated that professors believe that IPE promotes the approach of students and workers to the health care needs of users from the perspective of comprehensiveness. They value the interaction with users, the interchange between professional fields, and expertise coordination. They also bring into focus how that would allow addressing the complexity of health needs, as opposed to the isolated and specialized training and practice.

Professors suggested the development of a comprehensive therapeutic plan, rather than breaking down the 'user into pieces'. Care coordination enables a professional to understand the actions of other professionals and add new knowledge to their respective practice. Because of the need of moving forward on shared practices, the interviewees stress the importance of learning to work together during the undergraduate program by developing therapeutic plans.

> *(...) we would have to work together towards that goal, the students in training already working together, (...) to build the therapeutic plan together, (...) one beginning to understand the way the other person thinks, the knowledge that comes that comes from that field. (...) how to add value to another professional's knowledge? I think that due to the shared practice we start to learn to work together (professor No. 10 – psychologist).*

> *When I am taking care of him (a decompensated diabetic patient), (...) there is an alteration, the doctor is acting on it (...). The nutritionist helped me to think and guide the patient (...). For me, that would be an interprofessional action, in the sense of care coordination (professor No. 14 – nurse).*

The subcategory "training for interprofessional teamwork in health care networks" was indicated by respondents as a way to strengthen the changes in the model of care, with emphasis on working in a collaborative team, which is coordinated with the other health services in the network. Coordinating different fields requires interaction between professionals who contribute to the care with their expertise, in spaces for the discussion of the clinical case study. However, professors also argued that the predominance of the biomedical care model based on individual and isolated office visits, without coordinated and interprofessional interventions, hamper improvement possibilities towards IPE.

> *The main strategy is getting a practice context in which the model is centered on interprofessionalism, on interdisciplinarity. In which care and attention arrangements are reference teams at various levels, with matrix support to the person who enters and leaves the team (professor No. 5 – physician).*

Some reports indicated that interprofessional collaboration is related to inter-organizational collaboration, i.e., networking. They reported that IPE promotes learning for teamwork as well as the necessary attitudes for this type of work, such as listening and appreciation of another person's knowledge.

> *Therefore, what the students did was to coordinate a process of meetings among such organizations, and from there the interprofessional cooperation also has to do with inter-organizational collaboration, with the collaboration with their work (...), with the importance of networking (...), the need for organizations to collaborate with each other (...). Working with professionals from other fields, learning to work in teams, to listen to each other, to appreciate the knowledge that the other professional has and his/her ability. And, based on that, working in teams, knowing that one's action can have a greater impact on the other person's action as well (professor No. 15 – physician).*

The subcategory "interprofessional communication for care" refers to the argumentative interaction and intersubjectivity for the purpose of understanding between employees and users, seen as advocates for their own care. Information sharing and interaction hinge on communicative reciprocity, with a process of dialogue, with active participation of the subjects involved, in the interest of understanding.

> *To understand "care", it is necessary to understand the relationships among many professionals, including the pharmacist in the laboratory, the nurse (...), how information flows (professor No. 8 – physician).*

Respondents indicate possible IPE ramifications, such as preparation for collaboration at work and mobilization for interactions that would not occur in uniprofessional spaces. They also mentioned aspects that facilitate working from the perspective of integrality, considering the complexity of health needs by placing the user as the advocate for their own care so they can actively participate in the decision-making process for therapeutic interventions.

> *(...) I think it is possible to obtain (...) two things. First, {the student} operates with a broader concept of "health" (...). Second, operating with a broader concept of "health", dealing with a collective result, by various professions, and having user as advocates for it, too (...) (professor No. 3 – physician).*

The analysis of the professors' reports also enabled the identification of "barriers for implementing IPE", determining the fragility of the institutional support in Brazilian public universities, its fragmented structure, the incompatibility of the curriculum framework for the courses, and the insufficient teaching-service coordination.

> *(...) we understand that it must happen within the work. Therefore, this shared training must also be a counterpart from the university to the mentor, but it has to be shared with the health service manager as well, for him to understand that it is not enough to place the student there and stand there (...), as with the mentor and the people who are part of the team (professor No. 13 – speech-language therapist).*

Perspectives of the focus group participants: workers, students, and professors

The analysis categories built according to results of the FG were: "user-centered collaborative practice", "interprofessional communication", and "IPE barriers".

The FG results with professors, workers, and students indicate the IPE perception as a "user-centered collaborative practice" by stating that the coordination between the professionals in the team can trigger co-responsibility for the needs of users as well as sharing between team and users about care goals and outcomes.

User participation in the care plan was brought into focus in a few reports that reckoned the importance of the users and their families' integration in the decision-making process for individual therapeutic plans.

> *We always try to involve the patient in the care process. If that is not possible due to a specific limitation, we then turn to the family. But we share the plan (...) and it is common for us to convene a family meeting, it is very common. We convene meetings with our families, along with professionals and do [it] (...) (Nurse No. 2 – Unit B).*

In this study, students revealed themselves as the social agents that are most aware of the importance of user involvement in the care process. However, they acknowledge that the user still does not participate in decisions about the therapeutic plans, which are predominantly prescriptive, even though there is a possibility of social participation in the Managing Board of the Health Care Centers.

> *In my experience, the user does not actively participate in what happens. It is a team meeting that decides what will be the therapeutic behavior, and the team concurs in that process. (...) Not once are the users called or given empowerment so they can decide what will happen in that situation (Master's student and new graduate nurse).*

> *I think that despite everyday life situations that happen, there is the Managing Board nowadays. And I think people who represent the community really get involved (...), they participate a lot (...) (medical student).*

Student reports show that users participation in the therapeutic plan contributes to the improvement of health practices, as it can contributes with information that enables therapeutic adjustments to their health needs, thus sharing the responsibility for care outcomes with health care workers.

> *From my point of view, treatments require user participation. Because if you prescribe for example, a treatment plan, and the patient does not accept it, he/she had no part in it (...) and, therefore, will refuse it, you see? (Nursing student No. 2).*

An element identified by students that can interfere and hinder user participation in the care plan is the information asymmetry between users and professionals. Students mentioned that such asymmetry interferes with the communication between professionals and users. However, a student stressed that, despite the dominant behavior of care prescriptions that leaves decisions to professionals to the detriment of the user's opinion, there may be space for negotiation between parties for decision-making.

In the focus group conducted with professors, the emphasis on user-centered collaborative practice conflicted with the prevailing health care model, as indicated by the professor in the next report. The professor described that the practice approach still have a biomedical focus and there is a constant clash with the organization logic for the PHC services, based on the ESF. Such situation illustrates the tension between the emphasis on practices with regard to the intervention subject, which can be understood exclusively as the disease versus the health needs of individuals and their families.

> *(...) we have a very strong contradiction in Primary Care about what is the object of Primary Care today. It is said to be the family, (...) by the Family Health Strategy. However, the entire system is organized in services, according to a procedural structure and according to the disease. Not according to the family and not according to the individual. That is the case with diseases, pathologies, patients with tuberculosis, hypertensive individuals, diabetic individuals (professor No. 5 – occupational therapist).*

'Interprofessional communication' was stressed in the focus groups conducted with students and workers as a central element for work in integrated teams. They acknowledged that communication as knowledge exchange may occur through the discussion of cases and shared office visits. They also mention that communication enables action complementarities, a necessary condition for user care and interprofessional training.

> *I think we also share the problems that we find (...). Because when we share the case, we talk and discuss those cases that are more difficult, (...) which brings us a great comfort. And we develop a different look, there are other things we determine and start to investigate in a more decisive manner (Nurse No. 1 – Unit B).*

The FG analysis also showed the perception of professors, workers, and students on "barriers to implement IPE". They identify as a main barrier the incompatibility of the curriculum framework for the courses, followed by the difficulties in the teaching-health service coordination, the departmentalized university structure, and the need for organizational support to implement IPE strategies.

The results of the interviews and of the focus groups were triangulated in order to better understand the coordination of the IPE with the PHC practices. Such triangulation enabled the development of two empirical categories: the first states that IPE is directly related to a new proposal for the health care practice and attention, "'IPE as part of the collaborative practice that focus on the user", and the second indicates tension in the training context, which hinders or even prevents the improvement of IPE in Brazilian public universities, or "IPE barriers".

DISCUSSION

This study was conducted in the PHC framework, which, in Brazil, is organized according to the ESF model, based on teamwork, therefore a privileged space for interprofessional practice and training in health. The triangulation of results enabled the development of two categories that showed the perception of professors, workers, and students on IPE and its coordination with the PHC practices: IPE as part of **user-centered collaborative practice** and **IPE barriers**. The first showed that the IPE requires, and simultaneously promotes changes in the model of care and in the way training of health professionals is done, from the standpoint of comprehensiveness, teamwork, interprofessional communication, and user-centered collaborative practice. The second revealed the difficulties perceived by different social agents concerning IPE implementation on the national PHC scene.

All the study participants, including professors, workers, and students, mentioned the emphasis on the health needs of users. However, it is underlined that students remarked user participation in the therapeutic care plan, with shared decision-making as a central aspect of their interprofessional training, which is in accordance with characteristics indicated by literature on user-centered collaborative practice.

International literature presents different definitions of user-centered collaborative practice, but in this study we decided to approach it as a process of partnership or coproduction between professionals and users for the planning, development, and evaluation of care, suited to their health needs regarding preferences, values, family status, social status, and lifestyle[15].

The increasing complexity of health needs requires trained professionals to work collaboratively in teams committed to health care. Interprofessional collaborative practice refers to the coordination between teams from different Health Care Network services, a trend in the organization of health care, with new clinical practices that may promote action integration and the establishment of care networks between primary, secondary, and tertiary care[16]. It is a feature of integrated teams, whose attributes are: mutual respect and trust, recognition of the professional differing roles, knowledge, skills and expertise, interdependence, and knowledge and action complementarities[16].

IPE can contribute to training in favor of collaborative teamwork as well as in inter-teams and network services, but to do so changes are needed concerning communication, socialization of professional roles, and of the health work process itself. Interprofessional learning requires the development of an interdependent and interactive relationship, with partnership between teams, health care professionals, and users for shared decision-making about health needs[2].

The aforementioned collaborative practice characteristics may be related to the four PHC attributes: contact, longitudinality, comprehensiveness, and coordination. Contact refers to accessibility and use of health services. Longitudinality implies the responsibility for care by the health team over time, with the establishment of interpersonal ties. Integrality depends on the recognition of the broad spectrum of user needs. Health care coordination or integration refers to the continuity of care practices by referral, counter-referral, and monitoring of medical records[17]. In that case, it is noteworthy that in the ESF, user referral is within the team, and not with an isolated professional. These teams are responsible for the integral and longitudinal monitoring of the user, aspect that reinforces the movement of interprofessional collaborative practice.

Another type of participation mentioned by the students in the reports was the social participation of users. This participation is included in one of the operational guidelines in SUS, in accordance with the provisions of the Organic Law for Health, No. 8080/90. The regulation of the participation of the population through two collective bodies, Health Boards (Local, Municipal, State, and National) and the Health Conferences is determined by the Supplementary Law No. 8142/90. The definition of social participation mentioned is related to social control, with the intention to promote the monitoring by the society of the actions of the State concerning formulation and evaluation of public policies[1].

The interprofessional collaborative perspective refers to the concepts of practice field and professional core developed by Campos[18]. The practice field consists of the common area of practices of health care professionals that develop an "expanded clinic proposal", whilst the professional core is related to the specific actions of each profession involved in health care. Both dimensions are essential for the implementation of collaborative practices, since they allow the development of common practices, with emphasis on health needs, coordinated with the specific contributions of professional knowledge in different areas.

The "expanded clinic proposal" can be understood as a collaborative practice because it is related to the care given in each individual user case, with information exchange, link between professionals and users, collective development of therapeutic projects, sharing of uncertainties, and co-responsibility between users and professionals in the care process, through interprofessional collaborative teamwork and communicative action[19].

A model and a typology of professional collaboration in health care was developed in Canada, based on four dimensions and their respective indicators[16]. The first refers to shared objectives and vision by consensus, with emphasis on the promotion of user-centered practice. The second

is the internalization for mutual recognition and respect. The third is the governance function related to the role of the manager in encouraging collaboration and the inclusion of local leadership necessary for interprofessional integration and coordination among health services. The fourth dimension, called formalization, is related to shared responsibilities and negotiation between the involved parties. According to these collaboration typology and indicators aforesaid, there may be three collaboration levels. Active collaboration, that takes place when professionals focus on the user; collaboration in development, when the emphasis of the practices is on professional and organizational interests; and the latent collaboration, outlined by the predominance of individual interests[16].

It is possible to say that interprofessional collaboration is considered a necessary element for health care quality[10]. For that reason, American and Canadian international groups developed a set of competences for the collaborative interprofessional practice that may help compensate for limitations in health training towards IPE.

The Canadian Interprofessional Health Collaborative (CIHC)[20] established six domains of core competencies for the interprofessional collaborative practice: interprofessional communication; patient-, client-, family-, and community-centered care; clarification of professional roles; team working dynamics; interprofessional conflict resolution; and collaborative leadership.

In 2011, the American Interprofessional Education Collaborative Expert Panel (IPEC)[9] released the core competencies for the interprofessional collaborative practice, with emphasis on safety and high quality for patient-centered care and access. The competences developed by the IPEC are: values/ethics for interprofessional practice, professional roles and responsibilities, interprofessional communication, and teamwork.

Findings of the present study on the Patient-, family-, and community-centered care and interprofessional communication that are also underlined by the Canadian and American groups, reveal the significant changes in the health work process that are expected and desirable. Such micro-social sphere of the work routine practice can be understood from two main dimensions: instrumental action and intersubjective interactions that are referred within the Habermasian approach[21].

The collaborative and interactive nature of the work process in health materializes during clinical care between health workers and users, and is mediated by the intersubjectivy that enables its characterization as immaterial labor[22].

The dialogical encounter between workers and users in view of Habermas' communicative action[21] can be understood as a space guided by the pursuit of mutual understanding, built by democratic interaction in which a common understanding is sought and presupposes the intersubjective sharing of common ethical outlooks, standards, and beliefs. In this sense, the user is perceived as an authentic subject that has an identity and participates as an agent of his/her social transformation for their individual and collective history about their health[23].

Training practices based on effective communication results in patient safety by reducing clinical errors. The communicative integration promoted by IPE helps to reduce students' negative attitudes towards other professional fields by promoting respect for other professionals, recognition of the work and professional role of others, and elimination of negative stereotypes[10].

Communication between workers and users is an element that can ensure the success of care practices or lead them to their failure, depending on the logic guiding it, i.e., if it is focus on the understanding between the subjects involved, on the communicative action, or exclusively on the technical or instrumental success. Although the instrumental action is predominantly used for work because the technical dimension informs the production of health care, it can be used inappropriately to convince or manipulate the other involved person. This practice accentuates asymmetrical relationships between professionals and users[21], as remarked by the students who participated in this study.

A comprehensive approach to care, advocated by the study participants is supported by the proposal for comprehensiveness of care. From this standpoint, IPE and health care should not be restricted to the technical tasks of the instrumental action which encourage individualization, considering that the success of health interventions requires dialogue[23] and shared decision-making.

Instrumental action prevails in the scenario of training and health practices because it is present in the fragmented knowledge characteristic of siloed uniprofessionalism. It creates professional isolation, a fractured approach to the subject of knowledge and health care, with emphasis on the disease, and hinders the coordinated resolution of problems, given the complexity of the intervention subjects. In contrast, collaborative interprofessional action requires teamwork, coordinated around the care for users' health needs, with the participation of different professionals and collaboration between them. Such professionals commit themselves to assimilate the complexity of the situations presented by the user, inserted in his/her life context, rather than from the standpoint of a "part of the user" on which they must intervene, as the interviewees remarked.

Despite the consensus of study participants, in which IPE may help the collaborative practice that focus on the user, comprehensiveness of care, teamwork development, and interprofessional communication, these participants in the study – professors, workers, and students also indicate barriers that interfere with the sought changes. These barriers include: incompatibility of the curriculum framework for the courses, difficulties in the teaching-service coordination, departmentalized structure of universities, and the need for institutional support to implement IPE initiatives.

These obstacles are mentioned by all the study participants, but were especially stressed by professors who face the teaching work process challenges of the Brazilian public universities.

The teaching-service integration can be defined as the collective work agreed-upon between students, professors, and workers in the practice field, aiming the quality of care,

of users´ needs, training quality, and users and workers satisfaction. This integration may have as ramifications an enhanced focus on education, service, health sector management, social control, and respect for users[24].

The results of a workshop developed with the goal of strengthening of the teaching-service integration indicate the need for institutions of higher education to understand that the services also produce knowledge and that the partnership with universities improves such production, therefore adding to the curriculum change implementation processes[24].

Fragmentation between teaching planning and execution was mentioned by workers that participated in the FG, deserving special attention given the possibility of improvement in health training due to the inclusion of the health care workers in the development of practical teaching proposals.

Lack of coordination between teaching and health services has the potential to trigger conflicts associated with division of labor between professor and practitioners. Professors will be responsible for teaching coordination, i.e., the most intellectual part of the training, while the field workers (practitioner) is required to execute the operational work. This latter role is socially perceived to bring less prestige[25].

An expanded teaching-service coordination including research activities, can be considered an educational resource that contributes to the ongoing in-service training and education of practitioners[26] as well as to the sustainability of technical health care innovations, considering the support of the professionals that feel themselves as participants of the change processes.

Another IPE challenge is related to the universities fragmented structure, reflected on the traditional model of siloed teaching, focused on knowledge specialization by disciplinary fields. Interdisciplinarity in the context of university education constitutes a response to science and knowledge fragmentation[6].

The fragmented and departmentalized structure of universities reinforces the emphasis on the specialization of technical and professional knowledge, affecting coordination between the undergraduate courses. In this context, the interviewed professors remarked the product-driven logic of universities, expressed as quantity indicators, as a barrier for the implementation of changes in the curriculum framework towards IPE. This quantitative logic e.g. number of published articles) leads to the overrating of graduate activities to the detriment of undergraduate activities. According to the consulted professors, the fragmented university structure between fields from different courses, with specific faculty, departmental production indexes, and control of the course load of individual faculty members, interfere with the teaching coordination process between courses.

The movement for change in training in favor of IPE is counter-hegemonic, when considering the current production-driven logic of that, according to a study[27], may be a result of the shift from the concept of the university as a social oriented institution to the university as a service provider organization. The university as a social oriented institution should reflect the structure and operating mode of the society. It may develop a social practice based on knowledge intellectual autonomy, independent of State and Religion, enabling the manifestation of contradictions with regard to the course of society and its function in the context of the social struggle. The author adds that as a service provider organization, the University is now included in the sector of nonexclusive services of the State. This means that education ceases to be a right and the University can be considered a private service. Thus, the social practice of the university organization sets as its goal to compete with other universities that follow norms and standards not related to intellectual knowledge.

Brazilian universities are focused on technical and professional training, having a multidisciplinary nature. Therefore, starting in 2008, a process of university reform began, with the implementation of the cycle framework prevailing in Europe, under the influence of the Treaty of Bologna[28].

In the context of the university reform, 18 Brazilian universities and 16 Interdisciplinary Bachelor Degrees in Health (BIS) feature education models by cycles. The BIS is based on the inter- and transdisciplinarity and on the emancipatory pedagogy[28], whose successful experiences are at the Federal University of Bahia, the Federal University of Southern Bahia, and the Federal University of Recôncavo da Bahia.

Participants also mentioned curriculum incompatibility and rigidity as challenges that affect the implementation of interprofessional activities and hinder PET-Health actions. A recent systematic review supports that aspect[29], as well as other studies that determine organizational support as an element that can facilitate IPE implementation in universities, as it is related to global considerations and aims that lead to training reorientation facing the need for change and the social responsibility of the University[30].

CONCLUSION

The study shows that in the view of professors, health workers, and students IPE requires and, at the same time promotes changes in the models of practice and in the training of health professionals. These changes are based on a collaborative practice that focus on the users, on their health needs, and the health needs of the population, and not anymore on services and professionals interests.

Collaboration, working together and performing actions whose logic involves the search for answers to the needs of users, refers to the sphere of social interactions and communication between professionals and users. This implies the communicative practice and, therefore, the argumentative intersubjective practice based on the sharing of normative outlooks, even in the context of asymmetries inherent to the social contradictions. It is noteworthy, the recognition of the double movement set forth by the collaborative practice with focus on the user that IPE in the PHC: the strengthening of the dialogue between profes-

sionals and, especially the ties between professionals, users, and the population.

Such movements for change refer to IPE and the professional development within the care practices in PHC, supported by teaching-service integration, understood as collective work developed between professors, practitioners, and students so as to provide an expanded responsiveness of services and quality of health care.

RESUMO

Objetivo: Compreender as percepções de docentes, trabalhadores e estudantes sobre a articulação da educação interprofissional com as práticas na Atenção Primária à Saúde. **Método:** Qualitativo compreensivo e interpretativo, cuja coleta de dados foi realizada de 2012 a 2013, por meio de 18 entrevistas semiestruturadas com docentes e quatro sessões de grupos focais homogêneos com estudantes, docentes e trabalhadores da Atenção Primária. **Resultados:** A triangulação dos resultados possibilitou a construção de duas categorias: prática colaborativa centrada no usuário e barreiras para educação interprofissional. A primeira indicou a necessidade de mudança do modelo de atenção e de formação dos profissionais de saúde, e a segunda apontou dificuldades percebidas pelos diferentes atores sociais no que se refere à implementação da educação interprofissional. **Conclusão:** A educação interprofissional é incipiente no Brasil e sinaliza possibilidades de mudança em direção à prática colaborativa, mas requer maiores investimentos na articulação ensino-serviço.

DESCRITORES

Relações Interprofissionais; Trabalho; Educação Superior; Comunicação em Saúde; Atenção Primária à Saúde.

RESUMEN

Objetivo: Comprender las percepciones de los profesores, trabajadores y estudiantes sobre la articulación de la educación interprofesional con las prácticas en la Atención Primaria de Salud. **Método:** Cualitativo, comprensivo e interpretativo cuya recolección de datos se realizó de 2012 hasta 2013, a través de 18 entrevistas semi-estructuradas con profesores y cuatro sesiones de grupos focales homogéneos, con estudiantes, profesores y trabajadores de Atención Primaria. **Resultados:** La triangulación de los resultados llevó a la construcción de dos categorías: práctica (s) colaborativa centrada en el usuario y barreras para la educación interprofesional. La primera indicó la necesidad de cambiar el modelo de atención y formación de los profesionales de la salud y la segunda revela las dificultades percibidas por los distintos actores sociales en relación con la implementación de la educación interprofesional (EIP). **Conclusión:** La educación interprofesional es incipiente en Brasil y apunta las posibilidades de cambio hacia la práctica colaborativa, pero requiere mayores inversiones en la articulación enseñanza-servicios.

DESCRIPTORES

Relaciones Interprofesionales; Trabajo; Educación Superior; Comunicación en Salud; Atención Primaria de Salud.

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