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Interprofessional practice and health care: a study in a Multi-professional Health residence

Prática interprofissional e cuidado em saúde: um estudo em uma Residência Multiprofissional em Saúde

Práctica Interprofesional y atención en Salud: un estudio en una Residencia multiprofesional en salud

Ana Beatriz Barros Ferreira da Silva[1], Talita Miranda Pitanga Barbosa Cardoso[2], Juliana Alves Leite Leal[3], Mariana de Oliveira Araújo[4], Magno Conceição da Merces[5], Marcio Costa de Souza[6]

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Resumo

Objetivo: analisar as práticas de cuidado na perspectiva interprofissional em uma residência multiprofissional em saúde. Método: Pesquisa qualitativa de natureza exploratória realizada em um Programa de Residência Multiprofissional em Saúde de uma universidade pública do estado da Bahia, Brasil. As ferramentas para a produção dos dados foram a entrevista semi estruturada e o diário de campo. A amostra foi definida por meio da saturação dos dados composta por 13 residentes entrevistados distribuídos em cinco campos de atuação da residência (Saúde da Família, Saúde Mental, Nutrição Clínica, Oncologia e Terapia Intensiva). Os dados das entrevistas foram interpretados por meio de análise de conteúdo, onde emergiu uma categoria: Prática Interprofissional na Residência: experiências ou políticas? Resultados: As atividades práticas de caráter interprofissional ocorrem de acordo com o ponto de atenção para o cuidado, e essas vivências dependem dos trabalhadores desses locais, o que demonstra que não há uma política institucional. Na atenção básica, permite ao residente ter uma visão ampliada da saúde e, assim, sobressai à subjetividade, o que permite associar a formação ainda pautada no modelo biomédico. Considerações finais: As práticas interprofissionais acontecem principalmente com residentes de saúde da família e que o processo de formação do residente possibilita o desenvolvimento de uma perspectiva subjetiva sobre o cuidado, diferente dos demais módulos.

Palavras-chave: Formação Profissional; Cuidado Centrado no Paciente; Educação Interprofissional.

Abstract

Aim: to analyze care practices from an interprofessional perspective in a Multi-professional Health Residency. Method: Qualitative exploratory research carried out in a Multi-professional Residency Program in Health at a public university in the state of Bahia, Brazil. The tools for data production were the semi-structured interview and the field diary. The sample was defined through data saturation, consisting of 13 interviewed residents distributed across five fields of activity at the residence. (Family Health, Mental Health, Clinical Nutrition, Oncology, and Intensive Care). The interview data were interpreted through content analysis, where a category emerged: Interprofessional Practice in Residency: experiences or policies?. Results: Practical activities of an interprofessional nature occur according to the point of attention for care, and these experiences depend on the workers in these places, Which demonstrates that there is no institutional policy. In primary care, it allows the resident to have an expanded view of health, and thus, subjectivity stands out, which allows associating the training still based on the biomedical model. Final considerations: Interprofessional practices happen mainly with family health residents and that the resident's training process enables the development of a subjective perspective on care, which differs from the other modules.

Keywords: Professional Training; Patient Centered-Care; Interprofessional Education.

Resumen

Objetivo: analizar las prácticas de cuidado desde una perspectiva interprofesional en una Residencia Multiprofesional en Salud. Método: Investigación exploratoria cualitativa realizada en un Programa de Residencia Multiprofesional en Salud en una universidad pública del estado de Bahía, Brasil. Las herramientas para la producción de datos fueron la entrevista semiestructurada y el diario de campo. La muestra se definió mediante saturación de datos, formada por 13 residentes entrevistados distribuidos en cinco campos de actividad de la residencia (Salud Familiar, Salud Mental, Nutrición Clínica, Oncología y Cuidados Intensivos). Los datos de la entrevista fueron interpretados a través del análisis de contenido, donde surgió una categoría: Práctica Interprofesional en Residencia: ¿experiencias o políticas?. Resultados: Las actividades prácticas de carácter interprofesional ocurren según el punto de atención para el cuidado, y estas experiencias dependen de los trabajadores de estos lugares, lo que demuestra que no existe una política institucional. En atención primaria permite a los residentes tener una visión más amplia de la salud y, así, destaca la subjetividad, que permite asociar una formación aún basada en el modelo biomédico. Consideraciones finales: Las prácticas interprofesionales se desarrollan principalmente con residentes de salud de la familia y el proceso de formación de residentes posibilita el desarrollo de una perspectiva subjetiva del cuidado, diferente a los demás módulos.

Palabras clave: Formación profesional; atención centrada en el paciente; Educación interprofesional.

Afiliação dos autores:

[1]Mestre em Saúde Coletiva pela Universidade do Estado da Bahia, Salvador, Bahia Brasil. E-mail: anabeatrizbarros22@gmail.com. ORCID: https://orcid.org/0000-0002-3001-6156.
2 Mestre em Saúde Coletiva pela Universidade do Estado da Bahia, Salvador, Bahia, Brasil. E-mail: talipitanga2@gmail.com. ORCID: https://orcid.org/0000-0001-9794-251X.
3 Docente do Mestrado Profissional em Saúde Coletiva da Universidade Estadual de Feira de Santana, Brasil. E-mail: julianaleal@uefs.br. ORCID: https://orcid.org/0000-0003-4744-4832.
4 Docente do Mestrado Profissional em Saúde Coletiva da Universidade Estadual de Feira de Santana, Brasil. E-mail: moaraujo@uefs.br. ORCID: https://orcid.org/0000-0001-6001-6299.
5 Docente do Mestrado Profissional em Saúde Coletiva da Universidade do Estado da Bahia. Salvador, Brasil. E-mail: mmmerces@uneb.br. ORCID: https://orcid.org/0000-0003-3493-8606.
6 Docente do Mestrado Profissional em Saúde Coletiva da Universidade Estadual de Feira de Santana e da Universidade do Estado da Bahia, Feira de Santana, Brasil. E-mail: mcsouzafisio@gmail.com. ORCID: https://orcid.org/0000-0002-4922-6786.

Email de correspondência: anabeatrizbarros22@gmail.com

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Background

Multi-professional Health Residencies (MHS) were created in response to a need for change in healthcare education and practice. These programs aim to align with the principles and guidelines of the Brazilian Unified Health System (UHS), moving away from the traditional, fragmented, and biologically-oriented healthcare model towards a more interprofessional, integrated approach to care[1]. Health professionals seek these programs not only for post-graduate education but also for the experiential learning opportunities they offer. According to Dallegrave and Ceccim[2], residents seek expression, multiplicity of teaching and learning, in addition to enriching themselves through experience with professionals and workers from the service itself, with families, the community and the territory. These are exchanges provided by encounters and daily learning of living work in action [3].

In this scenario of working in an environment with multiple actors and with such complex needs brought by users, Interprofessional Education (IPE) and Interprofessional Practice (IPP) stand out. Such practices, along with ongoing health education, enable the development of important attitudes and competencies beyond the technical and biological aspects of patient careJust like Permanent Health Education (PHE), IPP foresees that work is also a training environment, which attitudinal skills are developed, in addition to the skills and techniques related to the health condition presented by the user, in other words, different from multiprofessionality that promotes only a juxtaposition of actions aimed at user care, interprofessionality seeks to overcome this fragmentation of care and promote collaborative interaction between professionals[4,5].

For residents to experience interprofessional practice, it is necessary to implement both administrative and educational strategies, characterized by support from health services (which are training institutions) and teaching staff. They must also rely on the individual behavior/involvement of each professional, so that the resident is able to gain knowledge about the field of activity of each profession, the enhancement of group action, exchange and the development of collaborative skills for effective work in team[6].

This practice and experience are fundamental for expanding the professional perspective on care. By considering the holistic perspective of care, including the subjective and social aspects of health, we can move beyond strictly biomedical diagnoses and treatment plans. This approach requires us to acknowledge the contexts and emotions behind illness and care needs, with the user's active participation[7]. This understanding allows us to access other dimensions of care, considering the social and affective context of the patient's life. According to Franco and Hubner[8], this is a challenge in healthcare, requiring healthcare professionals to move beyond established protocols and consider values, social relationships, and emotions in caring for others.

Forming professionals who are willing and able to provide comprehensive care to individuals and their families remains a challenge. Many educational institutions still focus on traditional biomedical and curative practices, making MHR one of the key strategies for change in healthcare education. These programs play an important role in preparing health professionals to work interprofessional and effectively in teams, within the context of the UHS, with a focus on community and team-based care[9]. Within this context, this study aimed to analyze care practices from an interprofessional perspective in a Multi-professional Health Residency.

Methodology

This is an exploratory, qualitative study that focuses on the meanings, motives, beliefs, values, and attitudes attributed by individuals, as well as the deeper space of relationships and subjectivities[10,11].

The study was carried out in a Multiprofessional Health Residency program at a public University in the state of Bahia, in the 13th residency class of that same institution, in the year 2022. The program is organized into five areas of activity (Family Health, Mental Health, Intensive Care, Oncology and Clinical Nutrition) and candidates for vacancies, during selection, must choose one of these training fields in order to participate in the election. For selection, 39 places were available per class/year, and the training process lasts 02 years.

The number of participants in the research was defined based on the saturation of responses defined by Fontanella, Ricas and Turato[12], that is, when nothing new emerged during the interviews, respecting the participation of all thematic areas with distinct professional categories, which totaled 13 participants. The inclusion criterion was to be a resident and in the second year of the course during the research, and as an exclusion criterion, to have already completed another training process at the residency level, at another institution or at this institution.

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The invitation to participate in the research was made through personal contact or WhatsApp application. For those who agreed to participate, an Informed Consent Form (ICF) was provided. For data production, the techniques chosen were: the semi-structured interview and the field diary. Participant observation was not adopted as a data production instrument, as the aim was to produce data based on the residents' understanding of the experience, and connect it with the experience of researchers who had already experienced this practice

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as a resident, as a preceptor, as a tutor or as a teacher of this type of training process.

In the interview, the script included three dimensions (Interprofessional Practice, Teamwork and Professional Collaboration), guided by the triggering questions. Regarding these dimensions, the interview sought to reveal the residents' experiences with a look at initiatives in daily practice from the perspective of interprofessionality; in addition to seeking action from residents in the field that was actually represented by teamwork; and the way communication and/or collaboration in health care was presented in practice. To preserve the confidentiality of participants, the text material of each interview was coded by the name "Resident" plus a sequential number from 1 to 13. The average interview length was 50 minutes, and interviews were conducted through the Microsoft Teams platform.

The interviews were transcribed in Microsoft Word™ and subjected to a Content Analysis as proposed by Laurence Bardin[13], with adaptation by Minayo[10]. The analysis included the following stages: pre-analysis, and material exploration (floating and exhaustive reading), which allowed researchers to connect with the implicit and explicit content in the analyzed material. Subsequently, data were classified by creating meaning cores and hence building one category, which was called: Interprofessional Practice in Residency: experiences or policies?

To interpret the submitted material, a spreadsheet called an interpretative trail was created to carry out the horizontal and vertical synthesis of the data produced. Immanently, what was described in the field diary was inserted into that spreadsheet to obtain the final analysis, and from this, we sought to relate empirical data with what has already been scientifically published

The Research Ethics Committee of the State University of Bahia approved this article, under opinion n° 5,185,595 (CAAE 53419821.40000.0057), following the ethical precepts of Resolution 466/2012 of the Brazilian Health Council.

Results and Discussion

After interpreting the data, it was possible to establish a category, which was called "Interprofessional Practice in Residency: experiences or policies?", and constructed through the following sense cores: living in interprofessionality and the field of activity and different interprofessional experiences.

Interprofessional Practice in Residency: experiences or policies?

The way in which care was constituted in acting and doing in health had as its striking characteristic the fragmentation, whether it be of the body, health conditions and factors that can lead to this reality. This is largely due to a focused approach to illness and/or a specific problem presented by an individual. In addition, training processes in the health field have directed uniprofessional actions separated by each core knowledge, without moments/spaces for the sharing of knowledge[14].

Within this context, discussion on interprofessional care emerges as a strategy to break down the barriers imposed on a potential shared clinical practice in the daily work of health services, in which there is a premise of greater sharing of knowledge when work is performed as a team. This could enable health workers to have a broader view of the lives of those seeking the service, as well as the real needs of the person and their family who are going through a process of illness or some health-related demand[2].

However, MHR, as they are training space that necessarily involves different professions, should provide tools that bring together the different professional categories involved for user-centered health care focused on comprehensive care for the person and their family. However, what we observe are isolated practices, directed toward procedures and with little reflection on actions and even fewer experiences that stimulate interprofessional collaboration[14].

The residents' accounts of their experiences with interprofessional practice reveal the different forms that they can take, according to the reality of the service and the professionals involved. Regarding interprofessional practice in the residency, we can observe what interviewees 3, 5, and 13 experienced,

> *I think the development of a therapeutic project was an interprofessional experience for me. We also had the practice [...], as we were part of a family health team, we shared many patients, right? So, we discussed many cases, which are somewhat less complex than a therapeutic project, but we had those moments. There were times when we consulted with other professionals. I invited some colleagues and other professionals sometimes, when there was a need to have other professionals with me, and also, other professionals invited me to be in attendance with them* (Resident 3). *[...] We agreed to always schedule a day so that we could discuss the cases we experienced, if we had some difficulties, so, [...] I had this moment with them, with my colleagues [...], depending on the service, we would bring together the teams, those that are mini references, and then we would schedule a moment for us to discuss these cases* (Resident 5).

These residents bring to the discussion different realities of their residency experience when the topic is interprofessional practice, which is established because of the singularities and multiplicities of the services and fields that were part of their journeys in discovering, (trans) forming, and (re) discovering care and work in health.

For most of them, the residency is their first

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professional experience, which presents itself full of challenges and apprehension for the unknown. After all, at the university, they rarely share the learning process with those individuals and future professionals who will be in the world of work. The residency, as a first professional experience, is a new world to be unraveled by the resident professional[15].

One of these challenges is learning to work as a team, with colleagues and other professions/professionals who are part of the healthcare team. A fundamental highlight/criticism of this process is the lack of knowledge about the scope of actions of others, as well as their responsibilities within care provision. Moreover, the professionals themselves often do not know their competencies/actions. In practice, this leads to distancing, fragmentation of care, and weakening of interpersonal relationships, which are essential features for the successful execution of integrated teamwork and interprofessional education and practice[16].

IIn one researcher's experience, the residency was her first opportunity in the world of work, and at the same time, one of the great opportunities to learn to work as a team, as well as a challenge for others with other roles (tutors, preceptors and teachers). The mistaken knowledge or lack of knowledge about the actions of others puts us in a place of judgment, and consequently, can lead us to distance ourselves.

Within the experience researched, discussed, and reflected upon here, we first observe the discoveries about the interprofessional practice from a Family Health resident. They address the construction of a Singular Therapeutic Project (STP) and shared consultations and interconsultations, which are common practices within the reality of the Family Health Strategy (FHS). The FHS features a minimum team comprising a nurse, physician, and dentist, as well as a Multi-professional team with varied configurations, according to the discretion of the manager in each municipality. This team may include a psychologist, physiotherapist, nutritionist, and physical education teacher, among others.

The STP is a strategy/tool for shared care, grounded in interventions from various dimensions and professional categories, produced through dialogue, in harmony with the demands and needs of the users and their families. This broadened perspective that considers individuals, their uniqueness, and complexity, concerning social determinants of health, makes the case increasingly challenging to manage. However, it also represents an opportunity to achieve comprehensive care[17].

A guideline that can be highlighted in the National Primary Care Policy (PNAB) is the longitudinally of care, which presupposes the continuity of the clinical relationship within a network of services and people. This involves establishing bonds and monitoring the effects of health interventions, with care being a co-construction with and for individuals. This guideline also demonstrates the importance of the STP for person-centered care, focusing on the family and its relationship with the environment[18].

It is worth noting that Primary Care, formally considered the coordinator of care and organizer of the Health Care Network, which invites us to look at the user within their life context and their relationship with the territory, family, environment, work, etc[18]. Therefore, when we receive a person in a family health unit, we are led to an understanding of their needs that goes beyond the limits of biological determinism.

Experiencing the formative process in this environment makes us recognize that, alone (each within our box), we will not be able to provide the attention and care that the individual needs. Thus, these interprofessional practice experiences with interconsultation, shared consultation, and STP demonstrate our understanding of the limits of our scope of action and that we consider the perspective of a professional colleague from another category to be necessary and important for the same user[19].

However, the needs of users encourage us to dive into the unknown. In this case, diving shows us new possibilities for teamwork, and then residency presents us with multiple dimensions of care, based on the various perspectives we have on Family Health. Thus, we are introduced to interconsultation, shared care, and finally, the Singular Therapeutic Project (STP), so that we can experience the possibility of networked care and ensure comprehensiveness - matrix support[20].

In the words of interviewee 5, narrated earlier (page 4), we also identify another strategy: case discussion. Whether in Family Health, Mental Health or within the hospital environment, this should be a behavior adopted by the team and the service. However, reality shows us that this was often an action sought by the resident in the face of daily life difficulties and the absence of spaces that provided this case discussion, such as team meetings[21].

A fruitful space/strategy to reach this case discussion that favors Interprofessionality would be Permanent Health Education (PHE), due to its connection with learning and working, that is, learning in service and driven by it[1], with discussions, approaches, and exchanges of opinions from different professional categories to enable the construction of care with the user for a more comprehensive practice[22].

In the hospital context, we gather the reports brought by Residents 7 and 13,

> *We have a Multi-professional visit daily, where we discuss all the patients, the doctor leads, but there is always space for other professionals to give their opinion [...], everyone was heard, everyone was respected, the visits that occurred daily, everyone would bring their chairs to the ICU hallway and had their moment to speak, even*

> *if I had not changed the patient's treatment* (Resident 7). *But usually, it is inside the wards, in the first field, there is a multi-meeting every day, in the second field, it is on Wednesdays, but this shift change does not happen properly, it happens in a hospital corridor and the patients can hear it. In the institution that has the multi-meeting, The shift is spent on each patient, there is a demand from the social service and we share it, and it was routine for that institution to have it every day at 7 am. They also have an index where some patients are selected and discussed, usually the doctors do not participate* (Resident 13).

In this scenario, we have the Multi-professional meeting/visit/shift change, in some cases, not institutionalized, in others, having a specific professional as the holder of space and other categories participating in a complementary and not integrated way. This evidences paths to the fragmentation of care from two different perspectives. In the first reality, there is no protected space for multi-professional meetings and case sharing; Therefore, it is considered that the institutional policy does not include interprofessional actions, which must include the activities carried out;which can be seen that it is not established as a work routine, therefore, the promotion of these powerful meetings for the organization and comprehensiveness of care end up not being guaranteed; it happens because the team recognizes the importance and seeks ways to do it. Therefore, there is a protected space, but we observe the overlap of one knowledge over others.

ThThis reality can impact the quality of care provided. However, the complexity of the hospital service and its organization influenced by the defense of professional spaces, face many difficulties related to the integration between professionals, to adhere to interprofessional and collaborative practice, beyond teamwork. However, dialogue and communication are above all, identified as essential behavioral attitudes for the development of collaboration[23].

Its operationalization can be related to the shared consultation of Primary Health Care (PHC), considered a facilitating strategy for interdisciplinary teams in the health area. This tool can promote teamwork and action based on the expanded concept of health.. Thus, it allows the discussion of each case individually, as well as a more comprehensive and holistic view of the patient, avoiding the fragmentation of work and health care, which is one of the objectives of interprofessional education and practice and allows the professional to add new knowledge to their professional practice[24].

> *[...] in the ICU, there is this characteristic of having a multi-professional visit every day. And these visits are very enriching, right?! And we discuss, it's time to talk about some patients that we consider important [...], they collaborate with their specialty, according to their specialty, with the treatment plan that is being taken with the patient, with the therapeutic plan, with the diagnosis that you found, the alterations that you found. It is really an exchange, right? A dialogue. Each professional points out their issues* (Resident 4).

Another issue is the perception of residents about Multi-professional visits as a moment of collaboration between professionals of different categories and specialties. One of the outcomes of Interprofessional Education (IPE) and Interprofessional Practice (IPP) is the possibility of acting in an integrated way, as preparation for collaboration, which is not allowed in spaces of uniprofessional practice[25].

In line with this discussion, it is important to highlight a new way of caring with a proposal for teamwork, in which they are no longer characterized by the presence of different professional categories that act in isolation and become a collective capable of providing comprehensive care to users. In this sense, Faria *et al.* [19] state that for the effective functioning of teamwork, it is not enough to have only the willingness and guidance of its members, but the establishment of a democratic environment and mechanisms within the institution that guarantee and strengthen spaces of collaboration, integration between the team, and Interprofessionality in caring for others.

In this sense, a study carried out by Silva *et al.*[25] showed that it is essential that there is interaction between the team to develop collaborative skills for shared action and that the user and their needs are at the center of the process. Thus, the construction of the STP occurs through a collective construction that promotes Interprofessional Education and Practice.

Discussion of cases appears as an IPE and IPP strategy in the three services reported above. It allows different professionals to offer their view on that person, their health needs, and other demands, enabling a convergence of different knowledge in proposing activities that consider the user integrally. Still, one should highlight again the Matrix Support, that in addition to care, these practices enable students to undergo critical and reflective training oriented towards comprehensive health care [26].

Such an analysis invites us to reflect on the training program the resident is inserted in; whether their interprofessional practices are really part of their daily routine in services or if they would only be seeking the implementation of a policy that is still in process of construction and, therefore, facing difficulties for its operationalization, which opens up the idea of a gap in the institutional pedagogical project on this way of doing health.

Final Considerations

This study presented the experiences of interprofessional practice reported by residents and showed that experiences in the hospital environment are limited to visits and shift changes, and are influenced

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by the profile of professionals working in the service. In primary healthcare (PHC), experiences were affected by the pandemic and adjustments in the work process of health units.

Reflecting on these practices, the residents recognize the importance of sharing knowledge, discussing cases, sharing interventions, and integrating the team for the care of users/patients and the evolution of the presented clinical condition, as these tools can effectively improve health care in the production of horizontal and vertical networks.

This highlights the need and importance of more research on the subject, especially in residency programs, to strengthen the discussion about the formative processes in the field of health and, consequently, so that future professionals can contribute to health care with a look at the needs of patients in a resolute and comprehensive way.

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