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Interdisciplinarity and interprofessionality in teamwork: perceptions of multiprofessional residents in Hospital Care

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ABSTRACT. Multiprofessional Health Residency Programs were created to further align health training with the needs of the population and, through an emphasis on teamwork, have been contributing to the consolidation of the Brazilian Unified Health System. The present study sought to understand the perceptions of a group of multiprofessional residents in Hospital Care about interdisciplinarity and interprofessionality within the scope of teamwork. This is a qualitative study that had the participation of 29 multiprofessional residents in the 'Hospital Care' area of concentration, all female (six psychologists, six social workers, six nurses, six physiotherapists and five nutritionists). Data were collected by means of a semi-structured interview script. The *corpus* was subjected to thematic content analysis. Most of the participants: (1) reported that their first contact with the notion of interdisciplinarity occurred when they were in college, which led to them assimilating it as a synonym for joint action, and (2) claimed to have no knowledge of the notion of interprofessionality, but valued the horizontalization of relations between health professionals. Additionally, important conditions concerning both interdisciplinarity and interprofessionality were not emphasized by the participants. Further studies on the subject are needed, due to its importance for public health.

Keywords: non-medical residency; health team; interdisciplinary practices; interprofessional training; tertiary health care.

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Introduction

Multiprofessional Health Residency Programs [*Programas de Residência Multiprofissional em Saúde*] (PRMSs) were instituted in Brazil through Law n. 11.129 (Lei n. 11.129, 2005) and are considered a *lato sensu* graduate program oriented to in-service teaching and aimed at health professionals in general, with the exception of physicians. Created with the basic purpose of further aligning health training with the needs of the population, PRMSs are structured into correlated areas of concentration concerning the strategic organization of the Brazilian public health (*Comissão Nacional de Residência Multiprofissional em Saúde* [National Commission for Multiprofessional Health Residency] (*Resolução n.* 2, 2012) and, through an emphasis on teamwork, have contributed to the overcoming of certain obstacles that still exist regarding the consolidation of the Brazilian Unified Health System [*Sistema Único de Saúde*] (SUS).

The specialized literature is consensual when highlighting that, due to the complexity of the health-disease-care process and the multidimensional nature of the human being, the practices of health professionals must be contextualized to one's social reality and guided by a holistic view capable of enabling the extrapolation of fragmented knowledge as a result of its separation into isolated disciplines (Guedes & Ferreira Junior, 2010; Borges, Sampaio, & Gurgel, 2012; Peduzzi, Norman, Germani, Silva, & Souza, 2013). Consequently, interdisciplinarity poses itself as a requirement in the health field (Vilela & Mendes, 2003; Mahdizadeh, Heydari, & Moonaghi, 2015). However, the notion of interdisciplinarity does not accept a univocal definition, in addition to presenting a series of related terminologies (Nancarrow et al., 2013; Silva, 2013).

Based on the analysis of several formulations on the theme, Scherer and Pires (2011) proposed a comprehensive definition, according to which interdisciplinarity essentially concerns the integration of both knowing and doing in order to build an intimate relationship between knowledge and practice. Thus,

the operationalization of interdisciplinarity in the health field, in accordance with said authors, would demand, on the one hand, an ethical and political stance aimed at solving problems experienced in the daily routine of health services and, on the other hand, valuing negotiation as a support to decision making.

On these assumptions, interprofessional collaboration – or interprofessionality – has been gaining visibility in recent years in the Brazilian public health (Peduzzi et al., 2013; Rocha, Barreto, & Moreira, 2016; Baquião et al., 2019). In terms of the conception underlying this movement, however, it is necessary to distinguish the suffixes 'disciplinary' and 'professional', since the former alludes to the theoretical plan, and the latter, to the concrete plan. Therefore, in the health field, interdisciplinarity could be understood as a knowledge integration process, whereas interprofessionality would be characterized as a teamwork strategy developed by different professionals from the exchange of knowledge and the sharing of practices, always in order to build a user-centered care (D'amour & Oandasan, 2005; Farias, Ribeiro, Anjos, & Brito, 2018).

Despite the existence of certain specificities between the notions of interdisciplinarity and interprofessionality, it is possible to propose that both can offer contributions to the health field, especially in the context of developing a new training model. As mentioned, PRMSs are an important initiative in this direction. However, there is little research in Brazil addressing the theme with multiprofessional residents, namely in the 'Hospital Care' area of concentration, with the study conducted by Araújo, Vasconcelos, Pessoa and Forte (2017) being an exception. In light of the foregoing, the present study sought to understand the perceptions of a group of multiprofessional residents in Hospital Care about interdisciplinarity and interprofessionality within the scope of teamwork

Material and methods

The present study derives from a broader cross-sectional research, of a descriptive-exploratory and qualitative nature, in which 29 multidisciplinary residents in the 'Hospital Care' area of concentration participated, all female (six psychologists, six social workers, six nurses, six physiotherapists and five nutritionists). It is worth mentioning that the participants, intentionally, had training in each of the professional categories included in two PRMSs, taken at different public institutions. Most of them declared to be white, single, recently graduated (up to two years) and from public universities. All had a minimum experience of three months as a resident and, among the representatives of each professional category, at least one was a first-year resident, and one was a second-year resident.

The criterion used to define the number of participants was the time scope, and data collection took place between December 2016 and July 2017. The institutions were chosen on the basis of how easy contact and access were for the researchers. The PRMSs, in their turn, were chosen based on the presence of the same professional categories in both, as well as on the existence of coincident characteristics as to curricular organization.

Data collection was carried out using a semi-structured interview script, an instrument considered of great relevance for the development of qualitative research in the health field (McGrath, Palmgren, & Liljedahl, 2019). The script consisted of identification items and ten questions. The first five questions, basically, addressed the theoretical and practical activities developed in the PRMSs, explored the participants' perception of teamwork and aimed at identifying the moment when, for them, they had the first contact with the notions of interdisciplinarity and interprofessionality. The focus of the four subsequent questions was to identify, based on the participants' statements, whether and how the PRMSs enabled the exercise of interdisciplinarity and interprofessionality. Finally, the last question sought to make room for the addition of information and suggestions for future research.

The participants were approached individually, in person and in a private place. With their prior permission, the interviews were audio recorded, then transcribed literally and fully. The analysis *corpus*, made up of the transcripts, was subjected to thematic content analysis, in accordance with the methodological procedures established by Bardin (2016), namely: (1) fluctuating reading of data taking notes on emerging impressions; (2) aggregating data into preliminary categories, and (3) defining categories and drawing inferences.

It should be noted that the first researcher undertook the first two methodological procedures and made it possible to refine the preliminary categories through analysis by two other researchers. The third methodological procedure involved the direct participation of all researchers. The results, so, went through

an external-validation process in line with that recommended by Faria-Schutzer, Surita, Alves, Vieira and Turato (2015) for qualitative research. It is worth noting as well that the present study was approved by a Research Ethics Committee (protocol No. 2.001.539) and conducted in accordance with the current legislation. Therefore, the participants were duly informed about the study objectives and signed the Free and Informed Consent Form, which ensured the commitment to the confidentiality of their identity.

Results and discussion

Based on the objectives of the present study, the results referring to two categories will be reported here. The first covers the participants' perceptions of interdisciplinarity. It is interesting to mention that the majority reported that the first contact they had with this notion happened while in college. And a significant portion of the participants described that this occurred only through their participation in internships or extension projects and led to them assimilating interdisciplinarity and joint action as synonyms. Report 1 stands out as the best example in this sense. As for report 2, the perception that interdisciplinarity would be linked to integration of practices is not grasped as easily. Thus, few participants claimed to have had their first contact with the notion of interdisciplinarity only after joining a PRMS, as one can see in report 3.

> Report 1: I heard about this concept [interdisciplinarity] for the first time when I joined a program by the Ministry of Health called PET-Saúde [...] and we had a lot of discussions about what being interdisciplinary meant. And this program, it aimed precisely at that, you know? We didn't have the practice proposal for our field, it was not a specific practice, it was about proposing a joint action, and this program had students from all health fields, including Medicine (Participant 23, psychologist).

> Report 2: I can't say that it [interdisciplinarity] is an intervention, but a... a combination of disciplines [...] they interact with each other, each contributing with their share of knowledge to a certain common goal (Participant 10, psychologist).

> Report 3: It was actually here in the Residency [the first contact with the notion of interdisciplinarity], you know? In college, we don't have much contact, you know? One or two disciplines talk about [...] the importance of having teamwork in the hospital [...] this is very vague, it was in actual practice [that] this concept became clearer, more, like... introduced in the Residency (Participant 6, nutritionist).

These findings, to some extent, can be considered positive, as they signal that the health training provided by undergraduate courses in Brazil in recent years has undergone changes that have helped overcome the historically predominant uniprofessional practice model, which corroborates Montanari's (2018) observations. In this way, the notion of interdisciplinarity is now apparently being discussed with students more regularly, though, above all, in elective components in the undergraduate curriculum. However, the fact that the participants, predominantly, did not mention the importance of knowledge integration for interdisciplinarity contrasts with the definition by Scherer and Pires (2011), already mentioned.

It is necessary to underline, as Peduzzi et al. (2013) and Rossit, Batista and Batista (2014) point out, that health training in Brazil, at least in part, has evolved thanks to curricular reforms recently undertaken with the purpose of strengthening teamwork and bringing different professional categories closer to each other. The creation of the Education through Work for Health Program [*Programa de Educação pelo Trabalho-Saúde*] (PET-Saúde), mentioned in report 1, reflects this movement and constitutes, in the undergraduate scenario, an important initiative of interprofessional training in Brazil (Farias-Santos & Noro, 2017; França, Magnago, Santos, Belisário, & Silva, 2018). And the same could be said, in the postgraduate scenario, about PRMSs.

On the other hand, the fact that, for some participants, the notion of interdisciplinarity was discussed vaguely during their undergraduate courses, then understood by them with greater clarity after they became residents – according to report 3 –, reinforces the importance of PRMSs in consolidating the new health training model. After all, as stressed by Scherer and Pires (2011), each one of the types of knowledge involved in the interaction proposed by interdisciplinarity tends to enrich each other through dialogue, which promotes cooperation between the practices resulting from them, and such cooperation is essential for the work in the health field.

Additionally, it should be noted that, besides changes in terms of health training, the exercise of interdisciplinarity also depends on a reorganization of health services in the sense of valuing them as spaces

where knowledge can be produced jointly and, as a consequence, more integrated practices can be built (Araújo, Miranda, & Brasil, 2014). Thus, health services should not be reduced to a place where technical skills, specific to certain professional categories, are applied, as they do not take into account the social reality of users. This condition, however, was addressed, directly or indirectly, by few participants in the present study, as illustrated by report 4.

> Report 4: Technical practice has a greater difficulty seeing interdisciplinarity [...] it has a great difficulty working, for example, with Social Work, with Psychology, because working with Nutrition, working with Nursing [...] you are seeing only technical things there, you are not seeing the individual as a whole, you are not seeing families, you are not seeing the reality surrounding the individual outside the hospital (Participant 20, social worker).

In this line of thought, which, it should be emphasized, was not explored by most participants, reports 5 and 6 signal their recognition of how important it is to view users holistically, which would result, basically, from a process of complementing specialized knowledge possessed by different health professionals. This type of relationship is typical of interdisciplinarity, for, according to Matos, Pires and Campos (2009), the valuation, in teamwork, of multiple influences in the constitution of an individual underlies this notion in order to prevent the latter from being compartmentalized and, above all, reduced to their organic dimension, which could occur under the aegis of the biomedical paradigm.

> Report 5: I think that teamwork lies in the different perceptions that each field may have of that user. So, in this way, you can see the user as more than a hegemonic model, which today is the biomedical [...] The ideal would be the professional being able to see in that user all dimensions of their life, the whole, the social dimension, the economic dimension, the political dimension is also very important. It's... about being able to identify in them what social needs they have, which goes [sic] far beyond curing the disease (Participant 8, social worker).

> Report 6: In my point of view, it [teamwork] is about looking at all of the patient's faces. They were admitted for a clinical thing and it's obvious that this is the first thing that will be looked at in the patient. Clinical data, laboratory data, [...] medication is [sic] the first thing to consider when the patient is in the hospital. They didn't come to rehabilitate [sic], they are not being referred to secondary care. But, when the patient reaches their clinical, hemodynamic stability, it's important to see their other faces, because they're not the disease only, they're a person (Participant 26, physiotherapist).

The second category included in the present study encompasses the participants' perceptions of interprofessionality. The fact that most of them reported not knowing this notion is noteworthy. Nevertheless, many, when commenting on practices in their respective PRMSs, outlined an equivalence between interprofessionality and the work they have been doing, with a greater or lesser degree of integration, with the other health professionals, when gathered in the same physical space. Therefore, interprofessionality, for them, would be very similar to interdisciplinarity. Reports 7 and 8 are illustrative in this sense. Thus, it is possible to observe that the participants, in general, presented a somewhat generic understanding of the notion of interprofessionality, especially for not having emphasized the role of exchanging knowledge and sharing practices for its realization, which opposes to what D'amour and Oandasan (2005) defend.

> Report 7: I think it [interprofessionality] is what we do here [in the PRMS], right? We collaborate with each other. Sometimes the physiotherapist needs energy substrate, and I give him the substrate. We need the diagnosis, and the physician gives us the diagnosis. I think that's it (Participant 29, nutritionist).

> Report 8: For example, I'm with my patient, doing my job, then I detect a need for another professional to intervene, so I request their collaboration (Participant 19, nurse).

It should be noted that interprofessionality depends on mutual respect and on recognizing the role of each professional category (D'Amour, Goulet, Labadie, San Martín-Rodriguez, & Pineault, 2008), and it must result in a joint definition of care plans, with the active participation of users (Batista, 2012). However, these conditions were also not emphasized by the participants. Moreover, few of them directly connected interprofessionality to the concrete public health plan, so report 9 stands out. Therefore, it is possible to perceive, among the participants, a lack of clarity as to the eminently interprofessional nature of the SUS that is underlined by Peduzzi (2016).

> Report 9: It [interprofessionality] is about you working together by dialoguing, and trying to see the common points for the user, and I'm talking about practice itself, about several professionals being able to dialogue with each other at work (Participant 8, social worker).

However, a significant number of participants highlighted that teamwork in the health field cannot do without horizontalization when it comes to the relationships established between health professionals, as it would be a condition for the provision of a comprehensive assistance. Reports 10 and 11 summarize this point of view, which, by the way, can be considered correlative to an essential guideline for case management in the logic of interprofessionality, according to Arruda and Moreira (2017). After all, said horizontalization allows opening a communication channel between different types of knowledge.

> Report 10: I think that teamwork is a work that has more than one professional involved, from different fields, who can communicate well, take actions together, it's not about one professional dictating what will be done, but managing to promote a conversation in their team (Participant 24, nutritionist).

> Report 11: Teamwork is about everyone having the chance to expose their field, expose their knowledge, but it's also about working together, having a conversation that benefits the patient. It's not about you just going there, writing what you do in the patient's records and not having this conversation. [...] Each one has a specificity from their field but, if everyone talked, found something good for the patient... (Participant 1, psychologist).

This finding can be considered indicative of perceptions compatible with the assumption that interprofessionality translates into practices when health professionals prove to be capable of learning with each other, from each other and about each other to benefit the assistance they provide to users (World Health Organization [WHO], 2010). For this reason, interprofessionality is exercised in situations in which collaboration between different professional categories predominates in the face of competition and fragmentation (Miranda Neto, Leonello, & Oliveira, 2015) and, thus, allows overcoming structural hierarchies still rooted in the Brazilian public health. By the way, specific criticisms of these hierarchies were made by some participants, as report 12 shows.

> Report 12: [...] our greatest difficulty has to do with Medicine, because they are really distant (Participant 7, social worker).

The valuation of horizontalization among health professionals was also observed in Hospital Care multiprofessional residents who participated in a research conducted by Araújo et al. (2017). Furthermore, they emphasized that PRMSs have emerged as important spaces for collective learning, though also highlighting the existence of challenges regarding the undertaking of collaborative practices, particularly for understanding that they are often responsible for presenting a whole new work process to the health services in which they act.

In this sense, both the present study and the one developed by said authors – perhaps the only ones in Brazil that specifically explore interdisciplinarity and interprofessionality from the perspective of multiprofessional residents in Hospital Care – underline the centrality of the role to be played by PRMSs in consolidating a practice model that can help subvert the medico-centric view that still persists in the health field. And it seems reasonable to propose that such view is more evident in hospitals, giving cause for a technical assistance at the expense of humanized care, thus contradicting one of the coordinates of the SUS.

In short, for the participants, an important change in favor of interdisciplinarity with regard to health training seems to be underway. They added that such change was operationalized during their undergraduate courses mainly by means of internships or extension projects, whereas, in postgraduate programs, this happened as a consequence of PRMSs. Therefore, the participants recognized that, in the health field, the teaching-service articulation is capable of promoting the integration of practices and, eventually, of knowledge. Some of them further warned that this process must be contextualized to the social reality of users.

When expressing their perceptions about interprofessionality, the participants highlighted that said integration involves valuing horizontal interactions within the scope of teamwork. However, they did not explicitly mention exchange of knowledge, sharing of practices and a joint definition of care plans as conditions for the exercise of interprofessionality, which suggests a more limited understanding of the notion in question, particularly with regard to its specificities in relation to the notion of interdisciplinarity.

Conclusion

Though related to a specific group of multiprofessional residents in Hospital Care from two different institutions, the results reported here shed light on certain weaknesses and potentials of PRMSs regarding the improvement of health training and practice models. And this process should focus on users,

considering that, since the advent of the SUS, they are entitled to a qualified and resolutive assistance. However, this subject is obviously not exhausted and deserves to take a more prominent place in the current public-health research agenda, requiring further studies.

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