DOI: 10.1590/1807-57622017.0687

articles

Analysis of professional practices as a multiprofessional residency education tool

Luana Pinho de Mesquita Lago[a]
Silvia Matumoto[b]
Simone Santana da Silva[c]
Soraya Fernandes Mestriner[d]
Silvana Martins Mishima[e]

The complexity of the population's health needs increasingly demands collaborative work qualification in the Brazilian National Health System (SUS). This article aims at reflecting on the possibilities, limits and challenges of using the Institutional Analysis of professional practices as an interprofessional education tool in a multiprofessional health residency program. This was a participatory intervention research based on the Institutional Analysis' theoretical and methodological framework that provided subjectivities through self-analysis, acknowledgement of non-knowledge and of the education needs, collective listening, and analysis of possibilities of roles and of knowledge sharing. It was also possible to highlight contradictions in the work context and aspects of interprofessional relationships that can impose limits on collaborative practices.

Keywords: Interprofessional education. Health residency. Institutional Analysis. Collective Health.

[a, c] Pós-graduanda do Programa de Pós-Graduação Enfermagem em Saúde Pública (Doutorado), Departamento de Enfermagem Materno-Infantil e Saúde Pública, Escola de Enfermagem de Ribeirão Preto, Universidade de São Paulo. Avenida Bandeirantes, 3900, Campus Universitário, Bairro Monte Alegre. Ribeirão Preto, SP, Brasil. 14040-902. luanamesquita@usp.br; simone_ssilva1@usp.br

[b, e] Departamento de Enfermagem Materno-Infantil e Saúde Pública, Escola de Enfermagem de Ribeirão Preto, Universidade de São Paulo. Ribeirão Preto, SP, Brasil. smatumoto@eerp.usp.br; smishima@eerp.usp.br

[d] Departamento de Estomatologia, Saúde Coletiva e Odontologia Legal, Faculdade de Odontologia de Ribeirão Preto, Universidade de São Paulo. Ribeirão Preto, SP, Brasil. somestri@forp.usp.br

(cc) BY

Introduction

This article is based on interprofessional education studies, in the Multiprofessional Health Residency (RMS) modality, and on the possibility of using Institutional Analysis of Professional Practices (AIPP) as a tool to redirect interprofessional education. The baseline for the reflections suggested here is grounded on Institutional Analysis concepts, particularly by René Lourau and Gilles Monceau[1,2].

A brief context of the need to transform practices in Brazilian National Health System (SUS) is presented, focusing on primary healthcare, on the movement from which RMS emerges and on the interprofessional education challenge, on AIPP as an interprofessional education tool and on its convergence with permanent health education axes. It is worth clarifying that we intend to question and extrapolate multiprofessional teamwork aimed at the interprofessionality perspective in order to qualify healthcare. To begin with, we take into consideration that hegemonic professional practices delineate, day after day, a scenario of weaknesses in SUS's quality of service. The need for transforming these practices originated discussions of elements related to political and health education projects. These discussions aim at supporting and fostering changes that value participation of different agents in an articulate way, by experimenting innovative practices[3]. In this sense, National Policy for Permanent Health Education adopts comprehensive care as a structuring axis to foster qualification of workers as a strategy to face the challenges of a disease-centered hegemonic model. This perspective encourages changes in education, undergraduate and postgraduate studies, and in the daily routine of health services, unleashing processes where workers give new meanings to work based on local health needs[3].

In line with this movement of change, in order to qualify professional education and promote public policies aimed at including young people in the job market, the federal government instituted, through Law no. 11129[4], a *lato sensu* postgraduate Residency course in the professional health area. This modality is focused on in-service education of professional health categories[5], except Medicine, namely: Biomedicine, Biological Sciences, Physical Education, Nursing, Pharmacology, Physiotherapy, Speech-Language Pathology and Audiology, Veterinary Medicine, Nutrition, Dentistry, Psychology, Social Work and Occupational Therapy, without necessarily expecting integration among different areas.

An important fact to be highlighted is that, in Brazil, Residency was initially consolidated as a Medicine specialization. It occurred preferentially in hospitals, according to the Flexnerian Model's logic[6]. This reality reinforces the hegemonic health practice by specialties focused on a healing, private and individual liberal practice. Additionally, integration of other professionals in residency occurs through a partnership between the Ministry of Health and the Ministry of Education. This approach enabled the creation of National Multiprofessional Health Residency Committee (CNRMS) in June 2005[4]. Also in 2005, the Multiprofessional Health Residency modality was instituted through Directive no. 2117[7]. It is important to highlight that the multiprofessional profile started in the 1970s in the Community Health Residency Program of the Public Health Unit of São José do Murialdo, Rio Grande do Sul, Brazil, which is a residency model integrated into the health system[8,9].

An incentive to maintaining RMSs was the care model reorientation towards a primary healthcare perspective based on Family Health Program (PSF) and, subsequently, Family Health Strategy (ESF). This model resulted in more job offers to professionals of Family Health teams, who would subsenquently also work in Family Health Support Centers (NASF), according to the National Primary Care Policy[10].

Another relevant aspect to this discussion is understanding the idea of residency programs as intervention tools to qualify SUS at the local level. This is possible by teaching health professionals about aspects that involve planning, management and clinic in primary healthcare. In this sense, focus is given to the multiprofessional teamwork aimed at a comprehensive healthcare[9,11] that, despite not being totally achieved, aims at building and offering a toolkit to provide each professional with the necessary tools to create their own intervention method.

Throughout the years, RMSs were permeated by discourses based on the medical residency model. Due to their multiprofessional characteristic, they are considered an important "invention"

when searching for qualification, expansion and cooperation among different knowledge that respond to health challenges[12,13]. This education model, which integrates different professions into services, destabilizes the medical practice hegemony and questions health education paradigms by suggesting interprofessional teamwork[12]. Additionally, it can provide a political education, one where competencies and skills related to negotiation, mediation, tolerance, conflict experience and power relationships are developed in health services[13,14].

Literature indicates that this multiprofessional education modality can be an intercessor space for permanent health education. It suggests a combination of different agents, residents, teachers, users and service professionals, and the development of relationships and interactions[15]. Nevertheless, it is relevant to evidence that, in primary healthcare, multiprofessional teamwork is often characterized by the wait for the change subject. When faced with SUS weaknesses, professionals are truly actionless and frustrated[9,16]. Based on what we have seen so far, we argue that, in order to change this reality, i.e. to transform residency into a strong area where the education-service articulation is strengthened, with an interprofessional education that integrates different areas, it is necessary to foster the essential role of these agents towards a participative management where everybody is co-responsible for care[9,11,13,16].

We understand that the difference between interprofessional education, initially disseminated in the United Kingdom[17], and multiprofessional education[18] is marked by interaction among those involved. In the former, students from two or more professions learn in an interactive and engaged way with the group members about their professions. In the latter, they learn about the other professions and with them in a parallel but fragmented way, with no interactive learning[19].

Based on what was explained so far, it is possible to understand the importance of contextualizing the historical, political, social and economic moments, among others, when delineating SUS qualification strategies. Therefore, based on the changes to the epidemiological profile and the complexity of the Brazilian population's health needs, it is important that the care model suggested by SUS be focused on acknowledging these needs and making shared decisions among all those involved. In order to do that, there is a gradual demand for collaborative and participatory work education in supporting an interprofessional health system[20].

Institutional analysis in the institutional socio-clinic perspective

This article is based on the theoretical and methodological framework of Institutional Analysis[1], particularly Institutional Socio-clinic, which is related to the in-depth Lourau's framework conducted by Gilles Monceau[21] in the 2000s. Institutional Analysis emerged in France in the 1960s based on Lourau's thesis and has three basic concepts: the instituted forces, the instituting forces and the institutionalization process[1].

This framework is based on the institutions' contradictions, with their peculiar rules, and on the social relationships involved. Contradictions result from the dialectical movement between instituted forces (immobility and permanence) and instituting forces (transformation, mobility and creation). In a relationship of dispute, both the instituted forces and the instituting forces result in a third moment, the institutionalization process[1]. In this moment, the instituting forces are incorporated into the institution, becoming the instituted force, in a dynamic movement that is typical of institutions[22]. The Institutional Analysis' sense is questioning these institutions, analyzing them.

Regarding the institutions analyzed in this study, they are able to objectify people against their own roles, since they establish standards. Their dynamism and power to hide when faced with the explicit are acknowledged. It is "present and absent, it sends false messages in a clear language due to its ideology and true coded messages due to its organization type"[1] (p. 157).

The intervention strategies suggested by Lourau's socioanalysis[1] follow principles, such as the analysis of orders, demands and implications, and the use of analyzers and of the research journal as an intervention tool[1]. After reanalyzing the socioanalytic practices, Monceau[21] suggested a theoretical and methodological framework with eight steps in longer interventions and using different tools, which he called Institutional Socio-clinic. The socio-clinic intervention is thus comprised of: analysis

of orders and demands; participation of subjects in the tool; analyzers' work; analysis of upcoming transformations as the work progresses; application of restitution modalities; work of primary and secondary implications; intent to produce knowledge; and attention to institutional interferences and contexts[21]. Therefore, when we refer to the analyzers' work, our intention is to highlight it is a key concept during the collective analysis process, since it helps identify hidden contradictory aspects of institutions.

Among the reflective tools that can be used, we will emphasize the AIPP[2,23], which has been successfully transforming professional practices in countries like France. In order to do that, we will start from the understanding that Institutional Analysis is based on the analysis of social practices and, in this article, of professional practices.

This article's objective is to reflect on the possibilities, limits and challenges of using institutional analysis of professional practices as an interprofessional education tool in a multiprofessional health residency program.

Methodology

This article is part of an ongoing qualitative intervention research based on the Institutional Analysis' theoretical and methodological framework[1]. We will focus on AIPP's use as an interprofessional education tool in a multiprofessional residency program context in order to highlight the residents' health practice and its contradictions.

Operationally, AIPP is characterized by a process where professional collectivity conducted by a facilitator aims at elucidating issues of its practice distancing itself from it, providing different views of the same situation[23]. Therefore, professionals analyze aspects of their practice taking into consideration the context into where they are inserted.

The residency program in question is connected to a public university of a city in the state of São Paulo, which has residents from different health professions: Pharmacology; Physiotherapy, Speech-Language Pathology and Audiology, Nutrition, Dentistry, Psychology and Occupational Therapy. The participants were 32 residents of two classes (R1 and R2), among which 26 were women and six, men, aged between 22 and thirty, mostly graduated by public institutions where residency was their first professional experience.

AIPP was conducted in monthly meetings, with an established space in the curricular matrix for studies related to the common theoretical content of all professionals. Reflection groups were held as conversation circles, recorded and subsequently transcribed, with the presence of a moderator/researcher, in eight meetings previously scheduled with participants. The researcher used the field journal to register observations, impressions on the meeting and the dynamics of information and knowledge exchange among residents. Based on these records, narratives were written in order to trigger analysis in the following meeting. In these meetings, the group had the opportunity to reflect upon their practice as learning health professionals, particularly under the primary healthcare scope, and even more so, to share knowledge that subsidizes collaborative or non-collaborative practices in SUS.

In order to complement the education context presented here, the program's documents were analyzed, particularly the Political-Pedagogical Project and the program's proposal enrolled in a 2011 notice, which were obtained upon request to the program's coordination. The data were subsequently analyzed based on the Institutional Socio-clinic concepts[21].

As part of the collective data production, it is essential to restitute data throughout the research, which is one of the Institutional Socio-clinic elements that helps the AIPP process by creating a collective analysis space[24] of the residents in their interprofessional relationship, not in their individuality. In Institutional Analysis, restitution is a meeting to collectively analyze data and temporary results[21,25], when participants can contribute with their points of view on the analyses made by the researcher, either validating them or not.

In this study's context, we chose to write narratives based on the researcher/first author's records as a restitution modality in every meeting. Therefore, meetings began by reading the previous meeting's

narrative in order to recollect and discuss its aspects. This was the moment when the researcher/first author and the residents who participated in the study conducted the collective data analysis. The issues that called the group's attention the most were valued, discussed and analyzed. A limit to be taken into consideration is that restitution was conducted by reading the situation (by the researcher), but this can be worked out as it is collectively discussed. Rossi and Passos[26] explain that, in these moments, institutional analysis is both intervention and continuous education, enabling a collective production of the research's results, and the acknowledgement and reflection upon important points of practice.

Restitution strategies such as writing narratives by the researcher include participants in the production of data and provide a moment when research, intervention and education come together. In this kind of research, this partnership between the researcher and professionals aims at achieving an objective that is typical of professional practice analysis tools, i.e. continuous and permanent education, and production of new knowledge related to practice[27].

AIPP was conducted as a conversation circle. This research tool enables participants to become closer, express their opinions and be heard, as well as reveal fears and anxieties. We understand that, way beyond their circular conformation or cost-effectiveness for those who work in groups, discussions are empowered by the possibility of producing knowledge. This occurs through exchanges among participants, which reverberate in the transformation of practices based on the transformation of subjects[28].

Another relevant aspect in this research is paying attention to institutional interferences[21]. Based on these interferences, it is possible to understand how institutions work in us and how they can interfere in the other person's practice. Therefore, based on this analysis, we will produce knowledge and, consequently, the research's results. With this perspective of thought, it is important to consider that health professionals have unique knowledge, which they are often reluctant in sharing. This behavior is explained by the fear of losing their power and control, since power lies precisely in these relationships[29], not in an individual. Admitting one's non-knowledge, doubt and curiosity means exposing their weaknesses to the group or health team, and evidences what is instituted. AIPP recommends these relationships be reconsidered as they dialog about the health work complexity and recognize each other in the differences between all knowledge groups to rebuild practices under the collaborative perspective.

The research project was approved by the Research Ethics Committee under CAAE protocol 66290417.0.0000.5393. All the research participants signed a consent document.

Results

In order to understand the contradictions that arose during the AIPP process and from its context, it was necessary to explore the program's documents in order to search for aspects related to its institutionalization process. Upon the program's creation, when the Institutional Analysis was founded, we evidenced contradictory aspects. On the one hand, there is the search for education qualification aimed at a comprehensive care, expanding opportunities to professionals who could work in teams in an interdisciplinary way. On the other hand, there is the instituted proposition of allocation of professionals who could be part of NASF, still incipient in the city. This movement represents a dispute of forces present in this program's institutionalization process.

It is repeated in other health education scenarios in the country, where residency supplies a demand for assistance in detriment of education[13]. This fact contributes to moving residency away or closer to its initial prophecy[1]: user care based on interdisciplinary education and comprehensive care, which is a clear objective in the documents upon its foundation.

When faced with the challenge into where residents are immerged – managing relationships of their in-service education that qualify their work in SUS –, AIPP provided a powerful meeting to transform practices. In this case, residents from different classes (R2 and R2) started self-analyzing their education by reflecting on how common education spaces work (related to content that is

common to all health professionals), their objective, content, methodology, workload and the need for inviting other members of the program to this discussion.

In this perspective, the group was able to revisit their different education moments – some in the beginning of the course (R1), others in the end (R2) – and suggest new ways to manage its space by including part of the program's coordination in the discussions. This approach evidenced this process' contradictions. On the one hand, it strengthened the communication network among these agents. On the other hand, it revealed many institutional interferences and conflicts within the group (between R1 and R2, among different professions) and between the group and the other agents involved – a confrontation among different subjectivities that is typical of the in-service education process.

In the scope of this participatory research that uses AIPP, we considered the production of subjectivities and, in their confrontation, the acknowledgement and inclusion of differences, and thus the proposal of participants undertaking a different approach, as protagonists[24]. Participants can also internalize their context and problems, being able to self-analyze. As residents understand their role and standing in this process, they also search for solutions for their problems, e.g. by expanding the communication channels among each other and with other agents of the program (teachers, tutors and preceptors). Therefore, we consider this process is dynamic and mutable, and the residents' meetings are powerful self-analysis moments that can move instituting forces and/or act towards maintaining the instituted forces.

Dilemmas and challenges of using AIPP in interprofessional education

The possibility of a collaborative education in multiprofessional residency is interfered by different institutions – interests that constitute dilemmas and challenges to an effective practice. In Institutional Analysis, interference means the entire network that acts towards maintaining the instituted forces in order to reproduce the system's rules, i.e. aspects that work together towards exploration and conservation[30]. Therefore, using AIPP showed interferences in in-service education that hinder collaborative practices. These are some of the interferences: mass production requirement, particularly by a specialized individual care; centrality on medical professionals; short time for reflection in spaces of practice; and failure to meet among different professionals.

The Institutional Analysis invests towards the acknowledgement of these interferences by agents, placing them in a different and powerful position of interaction and knowledge sharing. Therefore, in interaction, there was an opportunity of reflection about the shared work possibilities, meeting moments and learning themes with common education. Nevertheless, it is salutary to consider these aspects are also delineated by political issues. These political issues, in turn, are directly connected to the State, which is responsible for the multiprofessional residency's legal design. This is why multiprofessional residency is often vulnerable to meet the State's structural and productive interests, which can be expressed as interferences. Therefore, in Institutional Analysis, the State where we are inserted into is also being analyzed, being part of the analysis field[31].

Despite being difficult to determine its role, the State must not be customized. In an intervention research context, it is also necessary to analyze some of its force manifestations, such as the institution of a permanent education policy and the proposition of multiprofessional residency as in-service education. When the State shows its strength by enacting Law no. 11129[4], it responds to a demand for maintenance of the health system and qualification of workers. In contrast, in this dispute of forces, the State puts the primary healthcare prerogative as this system's organizer at risk when it "updates" the National Primary Care Policy's guidelines[10].

Therefore, when using AIPP, it is necessary to take into consideration we are also interfered by the State and we have professional implications with our surrounding institutions, i.e. relationships we

establish with the institutions that interfere in us, such as care, education, health[32]. Residents have professional implications with the State, with the university they are affiliated to, with the health services where they work. All these different professional implications must be analyzed. This collective analysis can evidence what the transformation limits of their practices are[32].

These limits are hidden, because the State often abnegates itself and goes against its own initial prophecy. Thereupon, we can reflect, for example, that the residency's initial prophecy is aimed at professional education, health system qualification and comprehensive care. Therefore, self-negotiation ends up producing work superspecialization and care fragmentation, which are effects of the dissolution of its initial prophecy[31].

Based on what was shown so far, it is possible to understand the importance of using AIPP in the interprofessional education process. Even being constituted of different knowledge and professional practices, interprofessional education can interactively achieve collaboration and contribution by reaching its objective, i.e. offering a quality health service based on comprehensive care.

This movement reveals aspects of the residents' education, work and society context. The challenge lies in stirring up the construction of a collective project[33], where it is possible to acknowledge residents' potentials and limits, and glimpse possibilities to negotiate strategies with teachers, tutors, preceptors and team, which favor their protagonism as a learning health professional.

Final remarks

Using reflective tools, such as AIPP, to build knowledge and transform practices in in-service education can evidence critical nodes that need to be faced by all agents involved: residents, preceptors, tutors, teachers, managers and users. In order to do so, the organizations' complexity and institutions' interferences that operate in the health and education areas must be taken into consideration, since this tool enables to reflect upon its practice, and its education and work context.

Therefore, we also consider that using AIPP as an analysis tool contributes to qualifying care of the population assisted by learning professionals in the relevant health services. Additionally, focusing on the job, on reflection and on practice provides subsidies to increasingly more interactive job offers that value communication and knowledge sharing among different professionals of the health teams. A limiting factor is that, in this case, this tool was used only with residents. However, its potentialities converge towards the permanent health education's purposes and indicate a possibility of being used in groups that include participation of health services' workers.

During the research, data restitution through written narratives read with the group was evidenced as an analysis-enabling tool and an important element to follow up changes that occurred as the reflective work progressed, from the perspective of knowledge through transformation. Despite the researcher's unique view, writing and meeting have great potential as a process to identify non-knowledge, needs and professional implications.

The reflections presented here are not definite. They aim at expanding the possibilities to critically reanalyze and face issues raised in the health and education areas. We also believe other complementary reflections are possible after the conclusion of this research. Analyzing the work routine can help build a collaborative interprofessional practice in the health system and is the path towards facing resistance to change and to transformation of health practices. We highlight this analysis has a greater potential in the collective context, not due to its specific group characteristic, but mostly due to its effort in providing a new meaning to its own reality in a time when public and collective things are devalued.

Authors' contributions

Luana Pinho de Mesquita Lago, Silvia Matumoto, Simone Santana da Silva, Soraya Fernandes Mestriner and Silvana Martins Mishima actively participated in the discussion of the work's results and in the review and approval of its final version.

Acknowledgments

We would like to thank residents for their collective production and other members of the program for the possibility of conducting this research. We would also like to thank Coordination for the Improvement of Higher Education Personnel (CAPES) for fostering this research through a Social Demand scholarship.

References

1. Lourau R. A análise institucional. Ferreira M, Tradutor. 3a ed. Petrópolis: Vozes; 2014.

2. Monceau G. Técnicas socioclínicas para a análise institucional das práticas sociais. Psicol Rev. 2015; 21(1):197-217.

3. Feuerwerker LCM. Micropolítica e saúde: produção do cuidado, gestão e formação. Porto Alegre: Rede Unida; 2014.

4. Brasil. Presidência da República. Lei n° 11.129, de 30 de Junho de 2005. Institui o Programa Nacional de Inclusão de Jovens – Projovem; cria o Conselho Nacional da Juventude (CNJ) e a Secretaria Nacional da Juventude; altera as Leis nº 10.683, de 28 de Maio de 2003, e 10.429, de 24 de Abril de 2002; e dá outras providências. Diário Oficial da União. 30 Jun 2005.

5. Brasil. Ministério da Saúde. Conselho Nacional de Saúde. Resolução CNS nº 287, de 8 de Outubro de 1998. Brasília: Ministério da Saúde; 1998.

6. Da Ros MA, Pierantoni CR, Haddad AE, Ribeiro C, Severo DO, Souza TT. Residência multiprofissional em Saúde da Família: uma conquista do Movimento Sanitário. Cad RH Saude. 2006; 3(1):109-17.

7. Brasil. Portaria Interministerial MS/MEC nº 2.117. Institui no âmbito dos Ministérios da Saúde e da Educação, a Residência Multiprofissional em Saúde e dá outras providências. Diário Oficial da União. 4 Nov 2005. sec. 1, p. 112.

8. Sól NAA. A medicina geral comunitária no Brasil: uma análise institucional sócio histórica de sua trajetória enfocando programas específicos [tese]. Campinas: Universidade Estadual de Campinas; 2011.

9. Rossoni E. Residência na atenção básica à saúde em tempos líquidos. Physis. 2015; 25(3):1011-31.

10. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Portaria nº 2.436, de 21 de Setembro de 2017. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes para a organização da Atenção Básica, no âmbito do Sistema Único de Saúde (SUS). Brasília, DF: Ministério da Saúde; 2017.

11. Batalha E. Residência não é fábrica de recursos humanos [Entrevista de Paula Cerqueira]. RADIS. 2013; 133:32-3.

12. Dallegrave D, Kruse MHL. No olho do furacão, na ilha da fantasia: a invenção da residência multiprofissional em saúde. Interface (Botucatu). 2009; 13(28):213-26.

13. Batalha E. Mergulho na vivência e na (dura) realidade. RADIS. 2013; 133:30-1.

14. Lobato CP, Melchior R, Baduy RS. A dimensão política na formação dos profissionais de saúde. Physis. 2012; 22(4):1273-91.

15. Silva JAM, Peduzzi M, Orchard C, Leonello VM. Interprofessional education and collaborative practice in Primary Health Care. Rev Esc Enferm USP. 2015; 49 (Esp 2):16-24. doi: 10.1590/S0080-623420150000800003.

16. Cardoso CG, Hennington EA. Trabalho em equipe e reuniões multiprofissionais de saúde: uma construção à espera pelos sujeitos da mudança. Trab Educ Saude. 2011; 9(1):85-112.

17. Barr H, Ford J, Gray R, Helme M, Hutchings M, Low H, et al. Interprofessional education Guidelines [Internet]. London: Centre for advancement of interprofessional education; 2017 [citado 2 Out 2017]. Disponível em: https://www.caipe.org/resources/publications/caipe-publications/caipe-2017-interprofessional-education-guidelines-barr-h-ford-j-gray-r-helme-m-hutchings-m-low-h-machin-reeves-s.

18. World Health Organization. Learning together to work together for health [Internet]. Genebra: WHO; 2013 [citado 5 Jan 2017]. Disponível em: http://apps.who.int/iris/bitstream/10665/37411/1/WHO_TRS_769.pdf.

19. Barr H, Koppel I, Reeves S, Hammick M, Freeth D. Effective interprofessional education: arguments, assumption & evidence [Internet]. Oxford (UK): Blackwell; 2005 [citado 25 Mar 2017]. Disponível em: http://onlinelibrary.wiley.com/doi/10.1002/9780470776445.fmatter/pdf.

20. Peduzzi M. O SUS é interprofissional. Interface (Botucatu). 2016; 20(56):199-201.

21. Monceau G. A socioclínica institucional para pesquisas em educação e em saúde. In: L’abbate S, Mourão LC, Pezzato LM, organizadores. Análise institucional e saúde coletiva no Brasil. São Paulo: Hucitec; 2013. p. 91-103.

22. Monceau G. Transformar as práticas para conhecê-las: pesquisa ação e profissionalização docente. Educ Pesqui. 2005; 31(3):467-82.

23. Monceau G. L’institutionnalisation de la réflexivité: succès du praticien réflexif et obstacles à l’analyse de l’implication [Internet]. In: Colloque International Réflexivité en Contextes de Diversité: un carrefour des sciences humaines?; 2010; Limoges, France. Limoges: Dynadiv, Université de Limoges; 2010 [citado 14 Mar 2017]. Disponível em: https://hal-univ-paris8.archives-ouvertes.fr/hal-01080588.

24. Escóssia L. O coletivo como plano de criação na Saúde Pública. Interface (Botucatu). 2009; 13(1):689-94.

25. Lourau R. René Lourau na UERJ: análise institucional e práticas de pesquisa. Rio de Janeiro: UERJ; 1993.

26. Rossi A, Passos E. Análise institucional: revisão conceitual e nuances da pesquisa-intervenção no Brasil. Rev Epos. 2014; 5(1):156-81.

27. Breugnot P, Fablet D. Analyser les pratiques de professionnels de la protection de l’enfance, entre recherche et intervention. In: Monceau G, director. Enquêter ou intervenir? Effets de la recherche socio-clinique. Nimes: Champ Social Éditions; 2017. p. 120-8.

28. Sampaio J, Santos GC, Agostini M, Salvador AS. Limits and potentialities of the circles of conversation: analysis of an experience with young people in the backcountry of Pernambuco, Brazil. Interface (Botucatu). 2014; 18(2):1299-312.

29. Lemos FCS, Cardoso HR Jr, Alvarez MC. Instituições, confinamento e relações de poder: questões metodológicas no pensamento de Michel Foucault. Psicol Soc. 2014; 26 (Esp):100-6.

30. Baremblitt G. Compêndio de análise institucional e outras correntes: teoria e prática. 5a ed. Belo Horizonte: Instituto Felix Guattari; 2002.

31. Lourau R. O Estado na análise institucional. In: Altoé S, organizador. René Lourau. Analista institucional em tempo integral. São Paulo: Hucitec; 2004. p. 140-53.

32. Monceau G. Implicação, sobreimplicação e implicação profissional. Fractal. 2008; 20(1):19-26.

33. Sá MC. Subjetividade e projetos coletivos: mal-estar e governabilidade nas organizações de saúde. Cienc Saude Colet. 2001; 6(1):151-64.

Translated by Caroline Alberoni

Submitted on 10/15/17. Approved on 06/13/18.