

Portraits of interprofessional collaborative practice in the primary health care teams



Retratos da prática interprofissional colaborativa nas equipes da atenção primária à saúde

Retratos de la práctica interprofesional colaborativa en los equipos de la atención primaria a la salud

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ABSTRACT

Objective: To analyze the Interprofessional Collaborative Practice in Health from the perspective of professionals of the Primary Health Care teams.

Methodology: Participatory, qualitative, exploratory-descriptive study, performed in Basic Health Units of a municipality in the northwest of the Paraná, with 88 professionals of the Primary Health Care teams. The data collection took place from February to April 2017, through the “Photovoice” data collection and analysis technique.

Results: Two categories of analysis emerged: A picture of the process of constructing concepts of the Collaborative Interprofessional Health Practice; A picture of the configurations of the Collaborative Interprofessional Health Practice in the work process among the Primary Health Care teams.

Final considerations: It was pointed out that Collaborative Interprofessional Practice is a new term and little explored in the Primary Health Care scenario, but the reflections about the photos allowed the assimilation, the thematic approximation and the collective construction of knowledge validated by the practice.

Keywords: Interprofessional relations. Cooperative behavior. Health personnel. Primary health care. Qualitative research.

RESUMO

Objetivo: Analisar a Prática Interprofissional Colaborativa em Saúde na perspectiva de profissionais das equipes em atuação na Atenção Primária à Saúde.

Metodologia: Estudo participativo, qualitativo, exploratório-descritivo, realizado em Unidades Básicas de Saúde de um município do noroeste do Paraná, com 88 profissionais de equipes da Atenção Primária à Saúde. A coleta de dados aconteceu de fevereiro a abril de 2017, por meio da técnica de coleta e análise de dados “Photovoice”.

Resultados: Emergiram duas categorias de análise: Um retrato do processo de construção de conceitos da Prática Interprofissional Colaborativa em Saúde; Um retrato das configurações da Prática Interprofissional Colaborativa em Saúde no processo de trabalho entre as equipes da Atenção Primária à Saúde.

Considerações finais: Apontou-se que a Prática Interprofissional Colaborativa é um termo novo e pouco explorado na Atenção Primária à Saúde, mas as reflexões das fotos permitiram assimilação, aproximação temática e construção coletiva de saberes balizados pela prática.

Palavras-chave: Relações interprofissionais. Comportamento cooperativo. Pessoal de saúde. Atenção primária à saúde. Pesquisa qualitativa.

RESUMEN

Objetivo: Analizar la Práctica Interprofesional Colaborativa en Salud en perspectiva de profesionales en equipos de actuación en Atención Primaria de la Salud.

Metodología: Estudio participativo, cualitativo, exploratorio-descriptivo, realizado en Unidades Básicas de Salud de un municipio del noroeste de Paraná, con 88 profesionales de equipos de Atención Primaria de la Salud. Se recolectaron los datos entre febrero y abril de 2017, por medio de la técnica de recolección y análisis de datos “Photovoice”.

Resultados: Emergieron dos categorías de análisis: Un retrato del proceso de construcción de conceptos de la Práctica Interprofesional Colaborativa en Salud; y Un retrato de la Práctica Interprofesional Colaborativa en Salud en el proceso de trabajo entre los equipos de la Atención Primaria de la Salud.

Consideraciones finales: Se señaló que la Práctica Interprofesional Colaborativa es un término nuevo y poco explorado en el escenario de la Atención Primaria de la Salud, pero las reflexiones de fotos permitió asimilar, aproximarse a la temática y realizar una construcción colectiva de saberes asociados a la práctica.

Palabras clave: Relaciones interprofesionales. Conducta cooperativa. Personal de salud. Atención primaria de salud. Investigación cualitativa.

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■ INTRODUCTION

An effective organization of the work process in Primary Health Care (PHC) has been identified as essential so the various professionals can make progress in ensuring universal access and comprehensiveness of healthcare, with improvements in user care and team work. Thus, the PHC demands professionals with a knowledge core expanded beyond the technical knowledge and prone to cooperative work⁽¹⁾.

This perspective of interdisciplinary and team work is one of the foundations of the PHC, which has the Family Health Strategy (FHS) as a priority for its organization. In this scenario, the so-called Family Health Support Centers (FHSC) support the FHS teams, with the purpose of developing comprehensiveness and helping in the development of interdisciplinarity⁽²⁾.

The effective work of the FHSC demands quality of relations and collaboration between professional categories⁽³⁾. In order to improve the interaction between professionals in the FHS and FHSC teams and reach the goals of the PHC, the Interprofessional Collaborative Practice in Health (ICPH) is an acknowledged path to the necessary involvement of health teams⁽⁴⁾.

The ICPH is presented as a polysemic construct, though it can be broadly defined as a partnership between a team of health professionals of different fields of knowledge and a client, in a collaborative, participatory and coordinated approach of shared decision-making involving health and social issues. Such practice provides a more comprehensive, qualified, expanded and effective healthcare to users of health services⁽⁵⁻⁶⁾. It is claimed that, by establishing the ICPH, healthcare is implemented without fragmentation and in sync with different professional categories⁽⁷⁾.

Although the ICPH is globally successful, especially in developed countries, it remains under construction in the Brazilian scenario, established in the professional formation and in the work process of health teams through permanent education⁽⁸⁾. Thus, the on-screen research seeks to unveil interprofessional collaboration in the context of FHS and FHSC, for little is known about the subject in such environment⁽⁹⁾, justifying the relevance of this study for the production of knowledge.

In that direction, this study was aimed at answering the following questions: Which are the conceptions of FHS and FHSC teams' professionals about the ICPH? By what means the ICPH is established in the work process of FHS and FHSC? By clarifying such questions, this study will contribute to strengthening the team work in PHC, encouraging the incorporation of this concept in daily practice.

Thus, the goal of the study was to analyze the Interprofessional Collaborative Practice in Health from the perspective of professionals in teams working in the Primary Health Care.

■ METHODOLOGY

This was a participative, qualitative and exploratory-level research, with descriptive-interpretive character, the data being the partial results of a master's degree dissertation*. It was carried out in Basic Health Units (BHU) of a municipality located in the northwest region of the State of Paraná - Brazil. The location of the study is relevant for being an important Regional Health reference in the state. The municipality has nine FHSC teams, organized to support 74 existing FHS teams, covering 65% of the local population, an average of 262.000 inhabitants of the municipality.

Thus, the participants of the study were professionals from the FHS and FHSC teams. The inclusion criteria for the FHSC professionals were the following: being registered in the National Register of Health Establishments (NRHE), exercising their FHSC group functions in the period of data collection, thus excluding professionals who were away on vacation or working in the individual care in the BHU. So, 48 out of 53 eligible FHSC professionals were included in the study. It is worth noting that the five FHSC professionals who did not participate in the study were on vacation or attending courses at the time of data collection.

As for the FHS professionals, those who were included belonged to a team indicated by its respective FHSC team, due to actions and practices developed and agreed among themselves, who were registered in the NRHE of the municipality researched and who were in full exercise of their profession, that is, exercising their functions in the FHS during the period of data collection. Professionals who were away on vacation or did not belong to the FHS team indicated by the FHSC teams were excluded from the study. So, 40 out of 59 active professionals from the FHS teams participated in the study. The FHS professionals who did not participate were on vacation, attending courses or doing external service at the moment of data collection.

The data collection took place from February to April of 2017, through the "Photovoice" data collection and analysis technique, preceded by a questionnaire for the characterization of the participants. It should be highlighted that *Photovoice* can be translated into Portuguese as "foto e voz" [photo and voice], and it is a participatory and qualitative technique in which participants identify their experiences that are related to a certain subject through photographs,

* Previato GF. Domains and competencies of the Interprofessional Collaborative Practice in Health in the work process of Primary Health Care teams [dissertation]. Maringá (PR): State University of Maringá; 2017. Ongoing research.

and discuss it in groups using their voices⁽¹⁰⁾, which allows the characterization of practices and experiences, as the focus of this study.

Four steps of the *Photovoice*⁽¹¹⁾ were followed: problem conceptualization, referring to the stage of research planning in the present study, when the object was defined focusing on the knowledge and experience of the ICPH by professionals in the FHS and FHSC teams; definition of the goals and purposes regarding the use of the technique, when the purpose of the technique was outlined so it could be anchored in the purposes of the study; selection and recruitment of the participants, in which the professionals of the FHS and FHSC who met the inclusion criteria of this study were chosen and invited through a previous meeting and delivering of a printed self-explanatory invitation; conduction of the *Photovoice* through an orientation process about the participation of those involved in capturing photographic images and subsequent group discussions, supported by the unveiling of the photographs previously provided by each participant and collectively chosen as representative of the group.

As for the conduction of the *Photovoice*, it should be highlighted that there was a choice of forming 9 groups of professionals, each contemplating a FHSC team and its respective indicated FHS. Two meetings were held for each group, one to explain the collection technique and another to actually execute the *Photovoice* technique.

A total of 45 pictures were initially presented by the 88 professionals from the nine groups, and one picture was chosen by each group for analysis and reflection, totaling nine pictures for the study. In order to preserve image rights, the photographs were not included in the present study, they are only mentioned (picture 1 to 9) along with the meanings pointed out by the participants, and they were related to the discussion group of the pictures in a chronological order (*photovoice* 1 to 9).

The discussion regarding the chosen images was carried out through descriptive and reflective triggering questions prepared by the researcher, which were: 1) By reflecting about the picture, how can an Interprofessional Collaborative Practice in Health be characterized? 2) By reflecting about this image, does the Interprofessional Collaborative Practice in Health occur during the work process between FHSC and FHS teams? How does it happen?

The group meetings occurred in the meeting rooms of the BHU of each FHS team and its referent FHSC, ensuring private environments. The discussions about the conduction of the *Photovoice* had an average duration of 30 minutes in each group, with all speeches and reflections recorded and transcribed in their entirety, totaling

225 minutes of recorded material. In order to analyze the findings, methodological steps related to *Photovoice* were followed, consisting of previous analysis of photographic records; review, comparison and theorizing, facilitated by the formation of categories for analysis⁽¹¹⁾.

The findings were discussed in the light of Freire's Dialogical Theory⁽¹²⁾, specifically centered on authentic dialogue and praxis, and this choice was due to the belief that unveiling concepts and collective practices, such as ICPH in PHC, depend on the dialogue for their characterization, which can serve as an opportunity for learning and elucidation of team work.

Every participant of the research received the Free and Informed Consent Term (FICT), and after agreeing to participate in the research, they signed two copies of the document, one for the participant and another for the researcher. The anonymity of the answers was granted, as well as every other ethical norm.

The research was submitted to the appreciation of the Human Research Ethics Committee of the State University of Maringá (COPEP-UEM) and received a favorable opinion (nº 1.903.172/ 2017).

■ RESULTS AND DISCUSSION

Characterization of the participants

From the 88 professionals who participated in the research, the majority were female. There were 79 women (89,8%) with an average age of 37,5 years old. A similar profile was identified among the professionals of the health teams of another analysis⁽⁶⁾.

40 professionals from the FHS teams (45,5%) participated in the study, totaling 26 Community Health Agents (CHA): nine nurses, three nurse technicians, two medical doctors and one oral health technician. The number of participants from the FHSC teams was 48 professionals (54,5%): five social workers, four pharmacists, four physiotherapists, seven speech therapists, nine nutritionists, seven physical education professionals, nine psychologists and three occupational therapists.

As for the qualification time, most of the professionals completed their technical or academic qualification more than 10 years before the study, totaling 35 participants (60,3%). It is worth reminding that this question was not applied to the CHA professionals. A qualification time superior to 10 years suggests a small approximation to the interprofessional education during school and supposedly makes harder the acknowledgement and applicability of ICPH. Although the Unified Health System treats team work

as a priority, the prevailing model of education and development of the workers is uni-professional. However, there has been changes to this model⁽¹³⁾, especially due to the incorporation of multiprofessional health practices, which eventually makes the discussion of ICPH unavoidable.

The amount of work experience of the professionals on the FHSC and FHS teams varied from less than a year (5,9%), to 1 to 2 years (22,6%), 5 to 10 years (25%), and more than 10 years (20,2%) in the team. The work experience of the professionals was diversified and denotes a need for professional collaboration, because their experiences are distinct, and therefore, relevant to the collective learning and action, with an exchange of knowledge mediated by practice and reflection⁽¹²⁾.

The images of the interprofessional collaborative practice in health from the perspective of primary health care professionals

The analysis process of the photographs in a collaborative and dialogical manner, mediated by trigger questions, allowed the people involved to individually analyze and review their pictures, looking for particular interpretations. Subsequently, through a comparison between the pictures and the collective verbalization of such interpretations, they were capable to choose the pictures that were more representative of the ICPH from a collective perspective.

Through this movement of individual and group reflections generated by the chosen photographs, two main subjects emerged in the theorization stage of the *Photovoice*: 1) An image of the process of constructing concepts of the Interprofessional Collaborative Practice in Health; 2) An image of the configurations of the Interprofessional Collaborative Practice in Health in the work process among the Family Health Support Center teams.

An image of the process of constructing concepts in the Interprofessional Collaborative Practice in Health

There was not a clear and constant concept of the ICPH among the participants. Therefore, the elucidation of this concept came through a reflection, permeated by the dialogue about two photographs elected by consensus: two pictures portrayed health promotion events for the general public that counted on the co-organization of two teams (pictures 1 and 2); three pictures portrayed the meeting among the teams (pictures 3, 4 and 5); one picture portrayed a domestic visit shared among professionals from

the FHSC and the FHS and the user (picture 6); and three pictures were representative: a hand touching a piano (picture 7), a building under construction (picture 8), and a meeting room without professionals working (picture 9).

It should be highlighted that the participants who chose pictures 1 and 2 claimed previous unfamiliarity with the ICPH term, but the *photovoice* technique - by favoring the collective reflection about the pictures in the face of a triggering question - allowed the unveiling of concepts and of the subject importance. In *photovoice* 5, one of the professionals claimed that he decided to learn more about the term after taking the picture, so he did a brief research on the construct.

It is understood that the discussions about the ICPH carried out by the participants reveal how important the unveiling is to the new dialogical process. This inference demonstrates an epistemological curiosity, which drives the subject towards discovery of what is unknown, something that, in a contradictory manner, exists in practice but is ignored by the critical consciousness⁽¹²⁾, as it was observed in the professionals' reflection on the images responsible for triggering the recognition of the ICPH in their daily practices.

The following excerpts of discussions serve as evidence for this finding:

"We are not used to analyzing the pictures we take after doing team work between the FHSC and the FHS like that. This is an opportunity for us to see that the pictures have an important role in our reflection about our work process, for although the theoretical concept about this practice is not widely known, we noticed that the interprofessional collaboration exists". (PHOTOVOICE 1).

"I did a research on this collaborative practice, and realized that it is similar to what the FHSC calls Amplified Clinic. I guess that if we were interprofessionally collaborative, we would reach what the UHS advocates in all of its instances, we'd be able to fulfill the functions of the FHS and the FHSC in a more effective manner, so it's worth knowing more about it, the pictures showed us that we already do a lot, we only need to improve." (PHOTOVOICE 5)

It is important to point out that the unfamiliarity with the ICPH and the will of the professionals to learn something new drove them to deepening the thematic. The codification and decodification using photographs of a health team practice that improves the work processes of the PHC were important moments for the unveiling its limits: the silence caused by the unfamiliarity with ICPH.

Ignoring its existence was what drove them to overcome through knowledge and towards doing more⁽¹²⁾.

The group discussions moved towards a collective definition of the ICPH, so they could recognize in themselves and in others work practices permeated by collaboration. In this process, learning by professionals allowed an authentic room for dialogue, capable of knowledge emancipation^(12,14), and making it possible to acknowledge the existence of collective learning.

The spaces of discussion about the ICPH promoted by the reflections on the selected photographs materialized the certainty that people should not be fixed to a guaranteed space and only adjust to it, corroborating the dialogic theory and providing evidence for the fact that, by denying temporality, the professionals denied themselves, but by searching for a change, the adventure into the new is continuous^(12,15), and it establishes the acknowledgement of what exists and what needs to be expanded.

Thus, we emphasize the importance of spaces where people become aware of how much they know and of how far they should go in the search for new knowledge, in a continuous and constant process of making and re-making their own knowledge.

It was possible to see that the participants understood there are no absolutely ignorant people, nor absolutely wise people, but individuals who seek to learn more in collaboration⁽¹²⁾. Therefore, the relevance of an opening to new constructs, such as the ICPH, is emphasized through the encounter of dialogues among diverse professionals in the teams. The following group discussion reinforces this:

"We had never heard of this term, this way, so complete, it even sounds complicate, but when we stop to analyze and think about the pictures, we realize that we already know it through day-to-day practice. It is important that we have knowledge about something new that helps us improve our team work on Primary Health Care, because knowledge is something that must be sought on a daily basis, for it is not something finite and it only makes us grow." (PHOTOVOICE 2)

About the conceptualization, the ICPH was characterized by participants as: "permanent exchange of knowledge and experience among professionals"; "a practice of collaboration and cooperation"; "learning and interacting between different professionals – interprofessional"; "a practice of improvement of user care".

Besides that, most of the groups thought of ICPH as a daily process of "exchanging knowledge and experience among professionals in the teams", with reports on the im-

portance of permanent education for its accomplishment, therefore facilitating the knowledge about the roles of others in practice.

In this regard, the following clippings of the group discussions provide evidence for such findings:

"ICPH is when a professional's knowledge adds to the knowledge of another, when there's an exchange, because each person has a specific knowledge, but we cannot work merely as parts which unite, but as parts that intertwine, these exchanges among teams have to be continuous, and this picture reminded us of that, because we have this exchange in meetings, especially when users are involved" (PHOTOVOICE 3)

"ICPH is when we exchange knowledge, experience, when we create intertwined bonds, it is a continuous exchange, we see that some professionals constantly do only what they see fit to their own fields, but we believe collaboration goes beyond the individual, we are all getting to know each other's roles and doing things together, and this picture portrays professionals collaborating to this event for the community, which was a success." (PHOTOVOICE 4)

"It is several types of professionals exchanging experiences, it is a continuous integration. The fact that this happens, that there is an integration, these exchanges, a collaboration, makes us know what the other professionals do, and have our work informed by that area as well, and to exemplify this practice, we will take a picture now of this moment, with us from FHSC, FHS, including our doctor and you from the university, who are facilitating this reflection." (PHOTOVOICE 5)

"It is not always that all professionals manage to be together, so we teach and we learn with each other in practice, day-to-day, as in a home visit, which is what this picture shows, that's why this interprofessional collaborative practice is an exchange..." (PHOTOVOICE 6).

"It's not a sum of the parts, it is not each professional alone doing something and then in the end we put it all together. Instead, it is an idea of continuous exchange; it is, through my specific knowledge, generating on other professionals and on the team some insights that they wouldn't have. When I offer that to someone else, when we exchange knowledge and create dialogue among the teams, I understand collaboration occurs on the work process of the teams, as well as a form of permanent education, mostly about care, so we must be the opposite of this empty room,

we must always stay together and interact with each other" (PHOTOVOICE 8).

From the perspective of the participants, it was possible to interpret the ICPH as an opportunity for exchanging knowledge and experiences. This conception reaffirms there is no superiority or inferiority between professionals and teams, but it considers the differences in the roles over time⁽¹²⁾, just as the characterization of the work in health supported by the ICPH.

In this context, and according to the researched professionals, the ICPH can be understood as an appreciation of different types of knowledge leading to a problematization of the reality and integrated health practices, consolidating an alternative to what is considered usual and capable of stimulating change^(12,15), as well as new processes of work focused on health improvement⁽⁵⁾. These repercussions coordinate the interprofessional collaboration, although they were identified by the professionals as difficult due to the scarcity of moments in team aimed to this purpose.

The respect for different types of knowledge and the recognition of its relevance for everyday actions allow what the ICPH calls clarification of roles and functions of the various professional categories of the health teams, something crucial for the collaboration to occur. In this sense, it is said that mutual respect, trust, acknowledgment of the professional roles in different fields, interdependence, exchange of knowledge and actions⁽¹⁶⁾, acknowledging that everyone has something to offer and to share⁽¹²⁾ and approaching all aspects of population health⁽⁶⁾ are essential for a collaborative practice.

The role of the dialogue, in the process of constructing ICPH concepts in this study, was to establish an innovating moment, without reducing it to an act of merely transferring ideas from a subject to another, nor to a mere exchange of ideas to be consumed by the people involved, but an act of creation, an exchange of knowledge that could emancipate them⁽¹²⁾ from the prevailing fragmentation in biomedicine, making them more critical towards the existence and the possibilities of interprofessional collaboration.

The term "collaborative practice", from the ICPH denomination, was understood by the participants as an opportunity of "collaboration", "cooperation" and "coordination" of the diverse professionals in team work. The following clipping of the group discussions confirms that:

"This practice is integration, collaboration, cooperation, shared coordination, it is when something exceeds the individual competence of a specific professional and the

other one is there to collaborate, and they both get to know what the other professional does, and have their work informed by that area as well, and this is facilitated by events like the one portrayed in this picture." (PHOTOVOICE 1)

In fact, the collaboration between different professionals in a team is necessary to the success of the ICPH⁽¹⁷⁾, as has been shown in the present study. Besides that, coordination and cooperation constitute the base for collaboration, although they are not synonyms for collective practice, since the ICPH overcomes cooperation through the involvement of a collaborative health force, prepared to practice, ready to face complex or emergency problems and solve them together⁽⁵⁾. This cooperation, collaboration and coordination perspective had been present in the conceptualization of the ICPH done by the participants, as it has been presented above.

It is important to outline that collaboration, as a characteristic of the dialogical action, must be permeated by authentic and responsible communication in the sense of collaboration⁽¹²⁾, i.e., to take on the labor work done collectively. This conception of collaboration permeated the discussion about the ICPH among the participants of this study.

They have also reflected on the concept of "interprofessionality", identifying this practice as horizontal and as having cross-working relationships⁽⁷⁾. They stated that this perspective is different from what happens on the PHC, which is multiprofessional due to the presence of several professional categories on the same scenario, which, however, do not always do the interprofessional work, as can be seen in the following excerpts:

"[...] being interprofessional is when we have the professionals interacting among themselves, in a two-way street, with openness among everyone on the team, because it is necessary to be interprofessional, for the individual we care of is complex, and we always have to be interconnected, so that effective action happens" (PHOTOVOICE 5)

"It is a very different practice than the concept of multiprofessionalism we adopt currently in the PHC teams, which is when we only have the professionals from different areas, but they do more things individually than on a team. It stops being only multiprofessional when things start happening inside the teams themselves, with support among them, as this picture represents, we are musical notes that together constitute a melody. (PHOTOVOICE 7)

"Interprofessional is different than multiprofessional, with each one doing their work separately, several professionals

only working inside their own areas, which happens a lot. Interprofessionality is the relationship between the practices, it is intertwined work among the professionals, it is like the picture of this building, each one working to build a better health system.” (PHOTOVOICE 8)

The interprofessionality, which improves the perceptions, the understanding and the efficacy of work team relations⁽¹⁸⁾ needs a change of paradigm regarding values, codes of conduct and work processes for its reach to be effective. It does not develop spontaneously, it needs support in the day-to-day services, such as the interaction between managers and professionals⁽²⁾ and, therefore, it is essential that moments of dialogue about its collective construction process are instituted, since the understanding of what is to be “interprofessional” is fundamental to overcome the multiprofessional work⁽⁵⁾.

Therefore, the opinions and reflections expressed can be considered dialogical spaces, and, as such, a profitable terrain for the consolidation of interprofessionality and permanent education, since through learning with each other and with daily practice, learning and teaching happen mediated by the real working world⁽¹²⁾.

The concept of ICPH was also unveiled as a possibility of improvement in popular healthcare, evidenced by the frequent mention of the term “user” related to the concepts of “health improvement”, “quality”, “effectiveness”, “resolutiveness”, “comprehensiveness”, “care”, “assistance”, and “health promotion”, exemplified as follows:

“As much we, professionals of the PHC, have specific knowledge in each area, we do not know everything, and we provide care to users with diverse demands, who require that we see them as a whole being, so, each one collaborates with what their area allows, building and learning something new with the other professional, and for us the ICPH is seeing the user on the forefront.” (PHOTOVOICE 1)

“The ICPH is the co-work between different professionals who must focus on improving the quality of life for the user, and that’s what this picture portrays, as a moment of providing improvements in health, socialization and leisure for the population.” (PHOTOVOICE 2)

“We conclude that the ICPH has as its goal the comprehensiveness, for the benefit of a single thing, which is the effectiveness of the patient care... Everyone is involved in a single mission to improve the health of our users.” (PHOTOVOICE 5)

“The ICPH is the integration among all the professionals in the team, portraying the importance of having so many different professions working together, with complementary solutions for the patient, contributing with different perspectives for this individual, based on a common good, which is a work process capable of producing improvements and effectiveness in user care, just as the home visit to an user shown in the picture.” (PHOTOVOICE 6)

Having the user as the main goal of the interprofessional collaborative work process, as has been pointed out, is essential for an effective, safe and quality care, in face of the necessity of dealing with the complex demands of healthcare and the individuality of each human being. Therefore, and corroborating the perspectives of the participants in the present study, the ICPH is fundamental for reaching comprehensiveness in care^(7,19).

It is relevant to elucidate that a professional approach based on the ICPH has been identified as successful in many scenarios, especially in those with a bigger complexity of care⁽⁵⁾, in order to promote health and ensure equity in care⁽²⁰⁾. As practical examples, in the prevention and management of mental and chronic diseases, the ICPH contributes to the user’s health state and quality of life by centering on the person⁽¹⁷⁾, just as the participants of this study inferred.

Thus, centering on users demands authentic dialogue⁽¹²⁾, so that the real healthcare needs are the main focus of care. Through this interaction, a new practice of care is established with interprofessional and intrinsic agreement and collaboration, demonstrating a work process that refutes the fragmentation of care.

An image of the configurations of the Interprofessional Collaborative Practice in Health in the work process among the Family Health Support Center teams

Through the shaping of concepts and reflection about the importance of the ICPH, the professionals pointed out, through the chosen photographs, the actions and behaviors which shaped this practice in their process of team work in the PHC.

The dialogue was the most mentioned way through which the ICPH happens, from the perspective of the deponents. According to them, the dialogue permeates specific and concrete actions in FHSC and FHS, such as home visits, meetings, group activities for the population and matrix-based strategies:

"This picture represents the interprofessional practice, because this is how we work, the FHS and the FHSC plan the actions together, and there's a process of permanent exchange, of matrix-based strategies, and they develop this gradually in the process of team work. In the PHC activities each professional collaborates in some way, the physical educator, the physiotherapist, the nurse, the doctor in some cases, and the CHA are always involved." (PHOTOVOICE 1)

"A collaborative work process between the FHSC and the FHS is about thinking together, doing together, and it also involves joint activities and actions between professionals of different fields in health, and that's what happens when we meet, when we are capable of dialogue, and this picture of our meeting is a good representative of a work process that can be collaborative, despite our difficulties in doing so." (PHOTOVOICE 3)

"One of the means to have an interprofessional collaborative practice is to have communication and dialogue, so we can plan and execute actions, discuss cases and all of that, having the well-being of the population in mind, and that's why we emphasized the picture of our meeting, because that's where everything begins, where we are able to establish a dialogue, so we can be collaborative." (PHOTOVOICE 4)

"This interprofessional collaboration makes itself present among the FHSC and FHS teams, especially in shared visits, in groups, in meetings, when they exist, through matrix-based strategies and also through direct contact with two or more professionals, so we can have the resoluteness of that patient and work situation." (PHOTOVOICE 9)

It is important to infer that the dialogue is made in a horizontal relation, in which trust from one pole to another is an obvious consequence⁽¹⁵⁾. In fact, the ICPH is built in the exercise of communication and dialogue among professionals and between them and the users, families and communities, favoring the participation of all the people involved in decision-making about healthcare⁽¹⁹⁾. Thus, the emphasis given by participants on the daily existence of dialogue allows us to grasp how much it is assertive to the ICPH, because this is one of many ways to search for a critical and reflective awareness of reality. It allows for a democratic construction of work through the participation of all protagonists⁽¹⁵⁾ and configures itself as one of the means to reach the ICPH.

The punctual actions listed by the participants as concrete scenarios of dialogue are those already affirmed as

relevant to the ICPH, namely, case discussions, planning, matrix-based strategies, and action articulation⁽⁶⁾. Also, the groups and meetings shared in the FHS are similarly necessary strategies for the ICPH to happen and, as previously stated, they use communication, which is an important part of interprofessional collaboration⁽¹⁷⁾.

The settings of the ICPH portrayed by the professionals and discussed by their peers evidence the praxis in the sense of action-reflection-action⁽¹²⁾. They discussed the concrete actions performed by them, reflected about them and, at least, they were able to come up with new perspectives about the ICPH which, in a contradictory manner, were not understood as something external to the groups, but as something that was happening in a veiled manner and could be improved if they were critically conscious of it.

In that sense, individuals are praxis beings, acting beings. They can know and alter the reality through their work, in a process of reflection-theorizing about the experienced reality⁽¹²⁾, with contributions to the construction of knowledge in response to the needs of team work.

■ FINAL CONSIDERATIONS

It was possible to analyze the ICPH from the perspective of professionals in teams working in the PHC. It was, thus, evident that the professionals see the ICPH as a new and barely explored term in the context of the PHC, though the reflections about the pictures allowed for a thematic approach and collective construction of knowledge based on the practice. The unveiling of the photographs allowed the identification of collaborative practices in the daily work routines between the FHS and the FHSC, showing that this practice occurs in the work process of the teams, although at first they did not define it by using this term.

Therefore, the ICPH was unveiled as a permanent exchange practice of knowledge and practices between professionals, of collaboration, cooperation and interprofessionalism focused on the improvement of the healthcare, highlighting the use of *photovoice* to support the collective perspective elaboration.

It should be emphasized, therefore, that this study is aimed at contributing to health professionals in their reflections about the ICPH in the PHC, with emphasis on the nursing team, which is currently one of the main work forces in healthcare. Therefore, we praise the role of this study for professional nurses, who present themselves as the FHS team coordinators and as essential members for an interprofessional practice in team work, seeking to arouse the necessity of dealing with subjective issues of care, dialog-

ical relations and the process of teaching and learning in service, and with the collaboration and interprofessionality in healthcare, fostering a more effective and quality practice in health by nurses and all other professionals.

The limitations of the study lie in the strict loco-regional space in which it was performed, as well as in the conscious selection of its participants, indicating the necessity of expanding it to other regions and teams, allowing a better understanding of the ICPH perspectives in the PHC.

In view of the aforementioned results, it is suggested that the ICPH should be spread in health environments, so that it can be recognized and implemented in the work process of teams, since the proposal is consistent with the recommendations of the current national health system.

Finally, it is recommended that moments of reflection permeated by participative techniques, such as the *photo-voice*, are made available for the collaboration with the process of recognition and criticality of the local realities, and also for expanding knowledge and practices. In this sense, the technique can be understood as a potent strategy for permanent education in health.

■ REFERENCES

- Galavote HS, Zandonade E, Garcia ACP, Freitas PSS, Seidl H, Contarato PC, et al. The nurse's work in primary health care. *Esc Anna Nery*. 2016 [cited 2017 Apr 20];20(1):90-8. Available from: http://www.scielo.br/pdf/ean/v20n1/en_1414-8145-ean-20-01-0090.pdf.
- Araújo EMD, Galimberti PA. [Interprofessional collaboration in the family health strategy]. *Psicol Soc*. 2013[cited 2017 Apr 20];25(2):461-8. Available from: <http://www.scielo.br/pdf/psoc/v25n2/23.pdf>. Portuguese.
- Gonçalves RMA, Lancman S, Szelwar LI, Cordone NG, Barros JO. [Work study in Family Health Support Centers (NASF), São Paulo, Brazil]. *Rev Bras Saúde Ocup*. 2015[cited 2017 Apr 20];40(131):59-74 Available from: <http://dx.doi.org/10.1590/0303-7657000078013>. Portuguese.
- Supper I, Catala O, Lustman M, Chemla C, Bourgueil Y, Letrilliart I. Interprofessional collaboration in primary health care: a review of facilitators and barriers perceived by involved actors. *J Public Health*. 2015[cited 2017 Apr 20];37(4):716-27. Available from: <https://doi.org/10.1093/pubmed/fdu102>.
- World Health Organization (CH). Framework for action on interprofessional education and collaborative practice. Geneva: WHO; 2010[cited 2017 Apr 20]. Available from: http://www.who.int/hrh/resources/framework_action/en/.
- Matuda CG, Pinto NRS, Martins CL, Frazão P. [Interprofessional collaboration in the Family Health Strategy: implications for the provision of care and work management]. *CiêncSaúde Coletiva*. 2015;20(8):2511-21. doi: <http://dx.doi.org/10.1590/1413-81232015208.11652014>.
- van Dongen JJJ, Lenzen AS, Bokhoven MAV, Daniel R, van der Weijden T, Beurskens A. Interprofessional collaboration regarding patients care plans in primary care: a focus group study into influential factors. *BMC Family Practice*. 2016[cited 2017 Apr 20];17:58. Available from: <http://bmcfampract.biomedcentral.com/articles/10.1186/s12875-016-0456-5>.
- Costa MV. The interprofessional education in Brazilian context: some reflections. *Interface (Botucatu)*. 2016 [cited 2017 Apr 20];20(56):197-8. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1414-32832016000100197&lng=pt&lng=en.
- Rathbone AP, Mansoor SM, Krass I, Hamrosi K, Aslani P. Qualitative study to conceptualise a model of interprofessional collaboration between pharmacists and general practitioners to support patients' adherence to medication. *BMJ Open*. 2016[cited 2017 Apr 20];6(3):e010488. Available from: <http://bmjopen.bmj.com/content/bmjopen/6/3/e010488.full.pdf>.
- Gill R, Black A, Dumont T, Fleming N. Photovoice: a strategy to better understand the reproductive and sexual health needs of young mothers. *J Pediatr Adolesc Gynecol*. 2016[cited 2017 Apr 2];29(5):467-75. doi: <http://dx.doi.org/10.1016/j.jpag.2016.03.001>.
- Wang CC. Photovoice: a participatory action research strategy applied to women's health. *J Women's Health*. 1999[cited 2017 Apr 2];8(2):185-92. Available from: http://www.public.iastate.edu/~bestler/arts_based_articles/1999_Libbert_Photovoice.pdf.
- Freire P. *Pedagogia do oprimido*. 21. ed. Rio de Janeiro: Paz e Terra; 2011.
- Silva JAA, Peduzzi M, Orchard C, Leonelo VM. Interprofessional education and collaborative practice in Primary Health Care. *Rev Esc Enferm USP*. 2015;49(spe2):16-24. doi: <http://dx.doi.org/10.1590/S0080-623420150000800003>.
- Labegalini CMG, Previato GF, Sgrignoli GMD, Carreira L, Estevam JA, Baldissera VDA. Leisure in virtual social network: a possibility of an authentic dialogue. *Esc Anna Nery*. 2017;21(2):e20170037. doi: <http://dx.doi.org/10.5935/1414-8145.20170037>.
- Rule P, Bakhtin and Freire: dialogue, dialectic and boundary learning. *Educ Philosophy Theory*. 2013[cited 2017 May 31];45(11):924-42. Available from: <http://www.tandfonline.com/doi/abs/10.1111/j.1469-5812.2009.00606.x>.
- Orchard CA, King GA, Khalili H, Bezzina MB. Assessment of Interprofessional Team Collaboration Scale (AITCS): development and testing of the instrument. *J Contin Educ Health Prof*. 2012;32(1):58-67. doi: <http://dx.doi.org/10.1002/chp.21123>.
- Gocan S, Laplante MA, Woodend K. Interprofessional collaboration in Ontario's family health teams: a review of the literature. *J Res Interprof Pract Educ*. 2014[cited 2017 Apr 2];3(3):1-19. Available from: <http://www.jripe.org/index.php/journal/article/view/131/84>.
- Fleischmann N, Tetzlaff B, Werle J, Geister C, Scherer M, Weyerer S, et al. Interprofessional collaboration in nursing homes (interprof): a grounded theory study of general practitioner experiences and strategies to perform nursing home visits. *BMC Family Practice*. 2016[cited 2017 Apr 2];17(1):123. Available from: <https://bmcfampract.biomedcentral.com/articles/10.1186/s12875-016-0522-z>.
- Agreli HF, Peduzzi M, Silva MC. Patient centred care in interprofessional collaborative practice. *Interface (Botucatu)*. 2016;20(59):905-16. doi: <http://dx.doi.org/10.1590/1807-57622015.0511>.
- Gunaldo TP, Brisolará KF, Davis AH, Moore R. Aligning interprofessional education collaborative sub-competencies to a progression of learning. *J Interprof Care*. 2017;31(3):394-6. doi: <http://dx.doi.org/10.1080/13561820.2017.1285273>.

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