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Interprofessional education and provision of care:

analysis of an experience

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This article This article aims to present and analyze an interprofessional education experience that started in 2008 involving third-year students of the undergraduate courses of Physical Education, Nutrition, Psychology, Physiotherapy and Occupational Therapy of a public university. During the semester, teams of different students supervised by two teachers each, also from different professional areas, provided weekly care service and developed care projects aimed at specific people/groups chosen by the service team. The methodology included the production of narratives of significant situations experienced by the teachers in their education activities. Based on these narratives, the issues presented in this education proposal were detected. The discussion of these issues showed potential common interventions and the challenges faced by teacher supervision in maintaining the students' experience and enabling the creation of a clinic that values the users' perspective.

Keywords: Healthcare. Supervision. Interdisciplinary team. Professional education. Teaching.

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Introduction

> Could you please check if the boys can come to Mr. Duarte's place now? The glucose test's result was normal, and we promised him that, if he managed to control his glycemia, we would take him for a walk. We need strong students, because we have to carry him on his wheelchair down four floors, and he is quite heavy. (teacher's narrative)

Soon after that, we were in eight people, including teachers and students, around Mr. Duarte, trying to find the best way to take him out of the house. It was the first time in months he would go out since his second leg was amputated due to diabetes complications. It was hard. Mr. Duarte was obese and lived in the fourth floor of a building with no elevators. However, we were all quite excited. We went down the stairs to join other dwellers, students, teachers and professionals from different services of the region for a walk against violence.

Mr. Duarte's follow-up by undergraduate third-year students of the module "Integrated clinic: provision of care" began in his hospitalization, eight months before this episode. Students and teachers who followed his case in the hospital noticed he was discharged without referral to rehab. They found out he lived in a region of the city that received students and teachers from this module in primary care services. Therefore, believing on the importance of building care networks by articulating teams and services, the hospital's group called for SUS' group, and they paid a home visit to Mr. Duarte. He was really happy to see those who followed him again and was introduced to the new trio of students and pair of teachers who would continue the monitoring process.

This user's and his wife's history was reviewed by the reference family health team. At first, the following were diagnosed: hard-to-control diabetes, significant dependence to perform daily activities due to his double amputation and retinopathy, and the need for bandage in order to reduce edema and sensitivity of the newly amputated leg's stump. The health team complained the patient did not follow recommendations. Indeed, it seemed to be really hard for the family to change his eating habits, introduce some physical activity and correctly use insulin. The team insisted instructions were given and, despite the health community agent, nurses and doctor's visits, his case would not change.

The group of students had different feelings and opinions regarding the team's behavior. At first, indignation: "How could they dare say there was nothing left to do for Mr. Duarte? He is such a friendly and loving man, willing to live, cheerful, despite his situation!" However, when they observed he kept his eating habits and incorrectly intake of medication, and the numerous difficulties to perform the technical actions learned, students were discouraged. "What can we suggest? It seems he only wants to talk. He tells stories of his past, shows the songs he likes, wants to know who we are... But what can we do as professionals here?"

Between the criticism to the team and the helplessness in fighting symptoms, it was necessary to recreate horizons for a possible care. The first step was to look beyond the symptoms. Listening and observing further showed us other needs and desires: leaving the house, having a company, feeling productive, increasing independence, as well as taking care of the stump, improving accessibility around the house, studying other medication possibilities and listening to his wife, his most important caregiver.

Each one of these needs/desires motivated actions by the students, such as playing the guitar and singing, watching movies, listening to the radio, solving riddles, providing the personal phone number to talk during the week, taking pictures, helping in the shower, changing the furniture's position, making weights with plastic bottles filled with sand for exercising, contacting the rehab service to check the possibility of a second prosthesis, etc. These strategies had their ups and downs, in a dynamic of hope and disappointment, anger and consolation, invention and reinvention of hypotheses and actions.

It was visible that the actions performed by the students every week were contributing to Mr. Duarte's care. However, his blood sugar levels were still high. He only managed to keep them stable in the end of the semester, after being encouraged to participate in the walk. It was possible to control his diabetes as long as this would mobilize his wish. We followed this user for five years with both teachers, and a new team of students every semester.

The objective of this module, which integrates the Health Work curricular axis, common in health courses from Universidade Federal de São Paulo, Campus Baixada Santista[1], was to observe the limitations of the prescribed and isolated actions of each professional area, and the possibilities of those that are jointly reinvented, not necessarily being specific of any profession.

In the predominant education practices, health professionals learn a group of theories related to the needs they need to respond to and with which techniques. However, Mendes Gonçalves[2] alerts there is no "natural" need. The very existence of health work is not natural, but rather historically and socially determined.

The trend, particularly when services are provided by a professional category or specialty, is to separate and interpret the demand according to the professional area's frame of references[3]. However, exposure to a user's daily routine tends to show the available knowledge and techniques' limitations: How can we increase accessibility of an obese wheelchair user who lives in a four-story building with no elevator? How can we control his diabetes without resorting to a restrictive diet? Insufficiency of our resources seems to be more evident when confronted with the user's life out of clinics or infirmaries.

The composition of interprofessional teams is usually considered a solution[4]. However, the objects of each health profession do not coincide; therefore, juxtaposition of all of them does not seem to build a supposedly lost unit[3]. How can we integrate actions and, more than that, question the way we identify and learn the care needs?

The extensive critical production in the health area has highlighted the limitations of the predominant education focused on the biological dimension of illness, specialization, and fragmentation of knowledge and disciplinary areas, which result in decontextualized practices distant from the population's health needs. These criticisms have substantiated change movements in health education with proposals that aim to expand dialog among different professional areas, diversify scenarios of practice and question understandings and interventions restricted to the biological body or to the risk of users becoming sick[1,4-7].

The care topic (considering the users' different ways of existing, knowledge, desires and possibilities) has been covered by several authors[8-13] as important to reorganize health work practices and processes. Exposing students to experiences in different territories and practice scenarios is, above all, placing care in a central role in education, and it has guided the interprofessional education's activities of the Health Work axis[1].

Interprofessional education experience in health work

The Health Work axis activities are present in the first three undergraduate years and are based on educating professionals with resources to provide care taking into consideration the complexities and singularities involved when one becomes sick, as well as the ethical, political and relational dimensions present in health work[1].

The axis' main pedagogical strategy is exposing students to contact with people and their different ways of living, being responsible for carrying out interventions in order to practice the health work's different dimensions. Modules are conducted semiannually and cover transversal issues: the concept of health, public policies, organization of services, teamwork, care, hearing, ethics, responsibility, among others[1].

The "Integrated clinic: provision of care" module is offered since 2008 in the third year of the undergraduate Physical Education, Nutrition, Physiotherapy, Psychology and Occupational Therapy courses. Its workload is comprised of four weekly hours, amounting to a total of eighty hours. It is a theoretical and practical module that involves 120 students and 18 teachers from different professional and disciplinary areas every semester.

In the first day, students choose the field they would like to be inserted into based on the module's initial presentation. Mixed classes are formed with approximately 12 students distributed into nine different services in the city of Santos, including primary care, mental health, one hospital and a cultural space. Each team is supervised by two teachers from different areas that go to the field with

students every week. In contact with the services' professionals, teachers select cases or groups that can receive a pair or trio of students (mini-teams) to conduct a care project during the semester. During each field, students meet with users (mostly at home) and write a journal describing the activities they performed, the impressions and feelings of each meeting. These journals contribute to the supervisions, which are generally conducted in the services.

It is worth highlighting some aspects of this module. One of them is the belief in learning by experience[1]. Cases are not selected to measure so that students can practice technologies they have already learned. The most frequent scenario is that, when faced with difficult situations, they realize their "toolbox" lacks tools that are appropriate to the case. The initial feeling of impossibility of intervention is rather common. However, the objective is to overcome it with the creation of inventive possibilities.

Another aspect is the belief in the singularity of care. The module is preceded by others from the axis, where social, economic and subjective health dimensions are explored. Territories with vulnerable people are visited, familiarizing with their context of life and the conditions they are immerged into, in order to better approach each situation's peculiarities. It involves training for the clinical work and reconfiguring theory and practice according to a particular history and the patient's possible interests. The clinical art is vital in places where reality is more difficult. We have been calling this clinic comprised of professionals from different areas "common clinic." These professionals take risks when working among other professionals. This work is operated in the interstices of the areas' boundaries through actions not reclaimed specific prerogatives and those invented in each situation[1,14].

A third aspect is the teachers and students' visit to users in their houses or places where they live. In order to do so, universities need to provide transportation, and it needs to be constantly defended, particularly in times of resource cuts. However, this practice also moves (in the figurative sense) students and teachers from their safety area. This is due to the fact that our rules have greater value in the academic environment or in the services' physical space. Other conditions are unforeseen, impeding the anticipated control of the mission. It is necessary to learn how to negotiate our knowledge, review the routine schedule and handle failures.

A fourth aspect is related to the supervision of student teams conducted by two teachers from different areas. Considering there are five health courses, teachers also supervise students from other courses. Therefore, if the teachers are from the Occupational Therapy and Nutrition areas, for example, they are also responsible for students from Physical Education, Physiotherapy and Psychology.

Regarding this diversity of references, similarity to reality seems to favor interprofessional ties. Maybe due to the fact that problems frequently found overcome our intervention ability, we tend to be more welcoming to interprofessional work and open to the creation of unconventional strategies. The defense of our professional "territories" loses its focus when faced with the feeling of helplessness one can have when in pain or presented to the other's difficulties. However, nothing guarantees this occurs – that the concrete situation of a life makes us see it according to its complexity, that the combination of professionals results in a feeling of mutual support and openness to new experiences. It is possible to resist it all, and maybe this is the first expected reaction, as often seen.

This article aims at presenting issues we have been facing in this proposal of care-centered education. In order to do so, the methodology used was the creation of narratives of significant situations experienced by the teachers, who are the authors of this article and integrate the module. The narratives were collectively analyzed. For this publication, the following issues, grouped in topics, were prioritized: some supervision challenges, different perspectives and attention to discomforts.

Some supervision challenges

Teachers who follow students in the module address the case in different ways, filter and choose aspects, interpret them according to their reference, based on their professional and personal history[1]. When supervising students from other professions, teachers also tend to offer them their point of view. Being aware of this fact, teachers can make an effort to handle the case according to the views brought by students and by the other supervising teacher, benefiting from this exercise. However, this

behavior requires an exercise of knowledge suspension in order to listen to others. This is hard, since the position of teaching is legitimated by a supposed difference of knowledge and experience, and the teacher should also adopt a learner attitude, including towards those who supposedly know less.

The supervision aims at helping students to move away from the action, encouraging spaces of thought and enabling the transformation of interaction into experience, so that their marks be incorporated as knowledge. Therefore, teachers should provide a teaching and learning framework where students can think and act, act and think[15]. Regarding the module in question, it involves supporting a team of students from several courses that need to constitute a group and suggest interventions. Teachers coordinate the group. However, this coordination should constantly decide the level of interference and how long to wait, enabling students to organize and disorganize, and change themselves. It is a close enough follow-up to favor the group's action and, if necessary, to act, but distant enough not to inhibit or occupy the students' place.

How to provoke thought where these common places, catchphrases, simplifications meet? How to encourage speaking not placing anyone as the holder of the truth? How to deal with our corporatism, concerned with the profession's prerogatives? How to sustain the experience?

The narrative below shows some tensions experienced by teachers in the activities of an arts and culture non-governmental organization in a region of high social vulnerability. A team of students tries to create bonds with a group of women and suggest artistic and bodily practices aimed at healthcare.

Students are divided into pairs, being a reference to each woman in the way of establishing closer relationships to spot unique demands. They need to plan and coordinate the group.

> Students suggested an activity to the group of women – a box with different questions: What is your greatest quality? What would you like to learn? Who is a hero to you? Each woman needs to choose a different question and answer it. We considered it would be more interesting to spend more time in each question, creating a conversation environment. Students did not accept our suggestion, so it remained as it initially was.
> In the following meeting, the proposal was to work on the women's histories and maybe record a short video. Meanwhile, one of the pairs suggested working with sentences that could increase the women's self-esteem. We asked them the following questions: Who said you have a low self-esteem? What is self-esteem and what is the reason behind this idea? However, the group of students quickly accepted the proposal, without even thinking about it, as if they wanted to get rid of the task. During the week, after reading a magazine article on violence in high-vulnerability regions, one of the students suggested working with this issue: How does violence affect women in this area? We intervened once again: Whose issue is this, the students' or the women's? Why are your changing what was agreed upon?
> We asked them to reflect on the team's behavior. There was no answer. The team seemed to organize itself around resisting the thought. We would like to talk more and have a hearing space. Our hypothesis was that the students' insecurity and anxiety were maybe generating a defense against any questioning. We did not know how to approach students again without constraining their initiatives. The supervision time, which occurs before or after meeting the women, is not enough when compared to what needs to be worked on. (teacher's narrative)

Teachers are conflicted between enabling students to experience their actions or imposing certain ways of acting, which would leave everyone more comfortable. However, if they choose not to predetermine the process, they may have to deal with extremely quick answers, which seems to only mitigate the anxiety of not knowing what to do. On the other hand, the education experience seems to gain another perspective when students are able to make decisions based on their observation and analysis, provided that they can also assess their effects. It is the teachers' role to intervene in order to impede whatever can cause damage to patients. However, it is also their responsibility to support this "birth" of other professionals, with their unique perspectives and resources.

The way teachers relate with students, the flexibility they show when negotiating points of view, their openness in developing works together, but also their ability in suggesting issues that were

not previously considered evoke the students' relationship with the care projects' users. It would be contradictory to expect from students a different ethics than the one practiced with them in the education work. According to Figueiredo[16], balancing moments of reserved presence (as a way of enabling someone to be) and implied presence (where someone acts and intervenes) seems to favor not only the provision of care but also the development of one's own care skills by those who receive it.

Considering different perspectives

Marinete, 66, had a stroke 11 years ago. She was an active woman and worked as a housekeeper. At the time, she was separated. Her main caregiver is her daughter, who lives with her and works during the day. Therefore, Marinete is alone at home most of the day.

As a stroke sequela, she has right-side hemiplegia and cannot walk nor support her feet on the ground to change to a wheelchair or an armchair. She also has aphasia of verbal and written expressions, and communicates through gestures, sound intonations and facial expressions. With little schooling, she does not write. Since the stroke, she is bedridden and uses geriatric diapers.

The family health team that follows her every month thought that the university service could help recover her mobility. The module's students began monitoring her, trying to understand her needs and demands, and come up with a care plan.

Students are impressed with the fact that Marinete spends the entire time in bed and lives a poor daily routine, isolated in her house. Although her house does not have stairs and has wide rooms, she does not go to the bathroom neither eat her meals in the kitchen, because she does not have a wheelchair that can properly accommodate her. Therefore, she takes a shower in her bedroom, with her daughter's assistance. Since this is a difficult process, she does not take a shower every day. At predetermined times, relatives bring her meals, change her diapers and turn the TV on.

At first, students tried to identify possibilities of intervention based on the perspective of their specific knowledge. Psychology students assume it would essential to improve her communication. Physiotherapy and Physical Education students want to apply bodily mobilization, strength improvement and range of motion techniques. Nutrition students want to improve her eating habits. Occupation Therapy students glimpse adapting her house and intervening so that she can perform her daily routine activities with autonomy.

At first, the fact that her relatives did not adhere to several suggestions of the students is understood by them as disinterest or negligence. Only after trying to transfer Marinete from the bed to the wheelchair, for example, students are able to understand the difficulties experienced by her family. During the five years of follow-up, what impresses the most is that the interventions considered a priority by the students are not always, or almost never, the same as the family's.

Taking into consideration the perspective of the patient or their families depends on the health professional's willingness, which seems obvious, but not usual, as pointed out by Merhy et al.[12] and Cecilio et al.[13]. As health professionals, we tend to consider only our technical assessment as the most appropriate one. After all, it indicates an action we understand[17]. If we accept listening and considering the patient's point of view, we risk venturing into a less known territory, but that is where the patient lives. Providing students with the experience of shifting their perspectives has been an important resource in this education process.

Special attention to discomforts

Two students, one from Physical Education and the other from Nutrition, liked the idea of monitoring a lady who was recently submitted to a bariatric surgery. They already anticipated possible interventions related to their professional areas. However, the lady traveled, so the students were offered to monitor Gabriela, forty, who lived near the stilt houses, in a single-room house with only one bunk bed to accommodate six of her children in different age ranges.

The impact of the first visit on students was huge. They returned disheartened and paralyzed by the huge amount of problems involving this family: malnourished and anemic children, one teenager

that refused going to school, another with non-controlled type 1 diabetes mellitus, one son involved in drug abuse, another unemployed. Added to all this was Gabriela's difficult history of life: she lost her parents really young, lived on the streets, prostituted herself and had violent and troubled romantic relationships. Gabriela wanted help, particularly to care for her younger children, so that they would not follow the same path as the older ones. Where to begin? What could be done?

> We tried to understand the situation better, discussing with professionals from different institutions who cared for the family (health, social work, education and tutelary council). Based on these meetings, several actions were listed. However, both students were still disheartened and not able to see what they could do. When asked why nothing made sense to them even with so many possible actions, they answered they did not quite know. (teacher's narrative)

During the supervision, it was observed that this user's social issues, values and lifestyle, different from what they were familiar with, were mobilizing the students. Moral judgements also interfered on the availability for this family. It was necessary to work on these discomforts to open other possibilities to deal with this situation.

The analysis of the situations and resulting interventions are also characterized by the impact the situations and other people have on us. These aspects tend to be somehow problematized in the health work processes[11,14]. Opening space in supervision[15] to talk about discomforts, mobilizations, fears, judgements and feelings that result from experiences with the users' different ways of living is essential to the education of professionals who are also able to perceive themselves in the care relationships.

Persisting issues

The issues we, as teachers, identified when working with the students, which show their difficulties, were also, or still are, ours. The students' difficulty in accepting the teachers' contributions in supervision also reflects the teachers' difficulties in establishing significant and trustworthy bonds with students in order to enable this process.

It is also not hard to notice our difficulty in devaluing the users' speech when it differs from the technical knowledge. The asymmetric relationship with patients due to unequal knowledge/power indicates who would have a legitimate speech[11,18]. Who is responsible for the diagnosis and therapeutic authority if not the professional? This is why we discuss adhering to the treatment as an expectation one has that the user will accept the prescription, which is what scientific evidence indicates as the most appropriate course of action. If the patient does not accept it, this would be irrational, a break of agreement, a position that questions the scientific and professional knowledge. In these cases, the trend is considering the mission as accomplished, "I did what I could, but he/she did not do his/her part." Feeling hurt in our professional identity, we tend to give up on the patient, instead of trying to come up with other strategies or an alternative to reduce damages.

Another important point is related to the students' expectations of performing actions that can effectively solve problems. Maybe this is due to the idea that they are there to cure, in the sense of reestablishing a lost previous condition. Contact with the case's complexity can give rise to the feeling of helplessness for not being able to do something that solves the situation according to this definition of cure. Not being able to offer anything in this dimension, students sometimes think the experience is exclusively for their own learning benefit, as if the developed work was not helping patients at all. It takes some time to value a less vertical, more horizontal care clinic of follow-up, where what can be done is not something that would eliminate problems.

This acceptance of a less spectacular clinic decentralizes professionals and is syntonic with the perspective of constitution or acknowledgement of a care network for patients. Therefore, health professionals can help build this supporting group, of which services, technicians, friends, family, neighbors, etc. are part. We know how the intersectoral network needs to be actively called forth, but we rarely acknowledge the importance of the informal affective network, which sometimes supports

even the health system network. There are other points of care to be taken into account, such as university, education (undergraduate courses and residency), extension program and research activities. In this sense, the opposite of the immediate problem-solving intervention may be not the therapeutic nihilism, but a constellation of support actions, viable arrangements, share and stimuli to life.

This education experience has shown the existence of possibilities in health work, even where and when they seem inexistent, depending on our ability to listen and pay attention to users and particularly on our willingness to reinvent ourselves as professionals.

Authors' contributions

All authors participated actively in all the stages of the preparation of the manuscript.

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