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ARTICLE

Health team: negotiations and limits of autonomy, belonging and the acknowledgement of others

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Abstract *The scope of this paper was to establish the significance of teamwork within the complex interaction in a Neonatal Unit. The techniques used for data collection were document analysis, participant observation and interviews. Twenty-four professionals working in a public and highly complex Neonatal Unit in the city of Rio de Janeiro were interviewed. The data were analyzed using the thematic approach of the content analysis technique, based on the literature on humanization, health work processes, teamwork and ergology. The conclusion drawn is that even in the neonatal environment, the construction of teamwork is established when the care model is geared to the logic responding to the health needs of individuals, taking into consideration the babies and their families, encompassing negotiations, limits of autonomy and notions of belonging and the recognition of others.*
Key words *Humanization of care, Teamwork, Neonatal Unit*

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Introduction

Several authors address the topic of health care[1-12]. Other authors focus on understanding how this type of work characterizes or not as integrated teams[3,4,6-10,13]. The National Humanization Policy (NHP) emphasizes as transversal themes for the discussion of team building[13]: participative management, welcoming, autonomy, bond and co-responsibility[5,14-18].

It is essential to expand the discussion on the possibilities and difficulties to build integration of competences in the basis of healthcare teamwork. Santos-Filho[19] points as common problems in the healthcare environment: degeneration of bonds, lack of workers' rights, poor working conditions, organization and social work relations in compliance with traditional management. Associating such considerations to Schwartz's[20] ergological approach, it can be considered that a team is organized beyond the sum of individuals and accomplishment of rules. The author emphasizes that from the activity, it is possible to consider prevention, management and competence in organizational settings that work with hierarchy, authoritarianism, imposition and the maximum possible normalization.

Organizational related issues are linked to interpersonal aspects here defined by the symbolic component of power, autonomy and recognition and belonging processes that arise in the everyday experience of multi-professional teamwork. The multidisciplinarity of the health area is simultaneously a concrete and essential reality, and implicates challenges in the transition of a group/grouping composition for interaction, integration and common project[8] that would characterize "being a team, being in a team, feeling a team", objective-image of the interdisciplinary project. This consideration on the construction of a common project, which in this article will address a very early life cycle that triggers differentiated feelings, leads us to what Schwartz[20,21] denominates as measurable values, field of appropriation of norms, spaces, worker protocols, which produce competent performance. In other words, each situation places the worker in discussion with his own choices, with the product of his work in relation to other workers with whom he did not choose to work with; thus, leading him to face many unpredicted circumstances.

Working in the health area has some peculiarities that result from the work progress process (es) which implicates the establishment of direct relations between subjects involved in the health-disease process[6,22], which leads to the possible dialog between measurable and immeasurable values established due to the subjective conditions of the involved subjects[23]. We refer to measurable values, those related to the field of ethics and its choices, emotions, values – of the interpersonal universe. This universe supervenes and at the same time constitutes action in health, dialoging with the designated measurable values, which refer to formal aspects of work: norms, rules, schedules, standardized and previously agreed actions[23], producing unpredictability in the performance and outcomes.

In the present article, result of a broader research study[24], we studied teamwork in a neonatal unit (NU). Such setting is based on healthcare provision to newborn babies, considering the fact that baby and family live with the challenges of prematurity and birth support needs. These themes outline a space where the professional needs to activate several types of knowledge, feelings and cope with them, at the same time that they need to take care of the newborn baby and family.

We analyzed the meaning of team work concerning negotiations, limits of autonomy, and notions of belonging and recognition of other – values present in teamwork building according to the NHP.

Methods

A qualitative case study[25] was carried out in the NU of a public hospital, in the city of Rio de Janeiro (RJ, Brazil). The criteria for the unit choice were: recent multiprofessional team composition; rota among those who work in the Intensive Care Unit (ICU) and Intermediate care Unit (IU); interaction between permanent and temporary workers, newly arrived workers and those near retirement; and existence of professionals linked with other services. Neonatal care provided to low-, middle- and high-risk newborn babies, holds several complexity levels, including ICU, IU and rooming-in.

We interviewed 24 professionals who work with babies and/or families in the Neonatal Unit. The inclusion criterion was the length of service, considering professionals hired in the three last public exams (1994 and 2005 for permanent positions, and 2004 temporary positions). Such criteria comprised subjects with differentiated learning experiences and teamwork (re)building. The profile of the interviewed subjects is shown in Table 1.

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The field work (including observation and interviews) occurred between May and September of 2009. Field approach occurred through participant observation. This technique served two purposes: 1. to build a feeling of strangeness or a differentiated position due to the fact that the investigator had a history as a professional with the field team, then data was produced from a routine, which was observed in days, times and activities when the investigator was not necessarily involved; 2. the previous phase contributed to the choice of interviewees and the contact with them, through identification of their meeting and organization routines. The fact that the investigator acted in that environment contributed so that the presence of an investigator was not initially noticed in the field. Participant observation worked as a strategy so that the environment, which seemed very familiar as work place as a social worker, was target of strangeness, nuisances, doubts regarding belonging. It served as an approaching and exclusion strategy, training the research look by observing the familiar[25,26].

The semi-structured interviews occurred at reserved places in the hospital setting, according to subjects' availability and choice, following previous reading of the free and informed consent form. We respected anonymity, by nominating the subjects as "interviewee" plus the interview number.

Data were analyzed according to the adjusted thematic form of the content analysis technique[25], assuming the theoretical and empirical saturation model of Fontanella et al.[27]. Data were interpreted from Yves Schwartz's ergology approach. The author contributes with the discussion on concrete work for identification of the meanings of teamwork in everyday experiences[14,19,28]. The interpretation of data evaluated the symbolic aspects that permeate and constitute the optics of professionals on teamwork building. We created two thematic cores: 1. team belonging and team perception: temporal and spatial presence; 2. dialog, conflict and negotiation: team meeting. This study was approved by the Research Ethics Committee.

Table 1. Profile of professionals interviewed in years.

Category	Age	Training Time	Length of Service	Length of service in studied unit
Social worker	27	3	2,5	2
Social worker	25	3,5	3	2,5
Nursing assistant	29	10	9	3
Nursing assistant	57	29	27	27
Nursing assistant	50	32	31	27
Nursing assistant	30	8	8	3
Female Nurse	56	31	29	29
Female Nurse	49	25	25	25
Female Nurse	47	19	16	16
Female Nurse	39	14	14	3
Female Nurse	30	4	4	2
Female Nurse	29	5	5	2
Male Nurse	37	11	11	3
Speech therapist	31	6	4	4
Speech therapist	29	8	6	4
Doctor	58	33	29	27
Doctor	55	30	30	23
Doctor	47	21	19	3
Doctor	44	21	21	2
Doctor	37	15	15	13
Doctor	44	21	19	3
Psychologist	59	35	34	26
Psychologist	43	19	13	3
Occupational therapist	47	24	23	2

Results and discussion

Team belonging and team perception: temporal and spatial presence

According to the ergological approach, the simplest task involves the production of senses revealed by who performs it[6]. The interviewees consider as part of the NU team only professionals who they see, or those who remain longer in the NU.

It is essential to justify and recognize who is or not part of the team by "being seen", which means to frequently be in the same space where nurses and doctors habitually are. All work requires collectivity, a set of workers who may or may not form "collective work", which involves individual and collective decision-taking[3]. Louzada et al.[6] report that *the collective dimension of teamwork is not apparent*, and becomes more difficult to be identified when professionals do not know who the actors that form this community are.

Teamwork in the health field can rationalize assistance and integrate disciplines and professions with sights to primary healthcare[9]. But how can one act collectively if professionals who structure the NU space are not defined? Who are they? What are their functions? Where are they?

The neonatal intensive care team[29] has its basic structure formed by professionals with direct contact with the baby. The interviewed professionals use a similar logic, they consider the categories that spend more time in the NU as those who effectively comprise the team. This perspective leads to the construction of common values that are produced from action focused on the core-activity[8], which is baby care. The closest to the place where the baby is, the most positively the recognition of that professional occurs in the group, increasing the possibilities of building positive recognition relations which may lead to teamwork.

In answers on team composition, expressions such as "in there", "present" and "shows up more" allowed an analysis that explores time and space presence as work group delineation coefficients. What registers the identity of a possible team is the possibility of being in the space where babies are, which is the purpose of the neonatal care. The space reference does not disregard the attribution of value to those that effectively occupy and participate in the unit on a daily basis.

Expressions that indicate that problem solution depends on a spontaneous decision and/or on "good will", naturalizing "natural" and/or "personal" attributes to motivate a movement of change, demonstrate poor reflection about collective processes.

[...] *Sometimes, they are solved by themselves* [the problems] *and sometimes someone gets tired of seeing the problem dragging on and literally runs after to solve it.* (Interviewee 5)

We try to do it our way. We almost always get it. With good will, right? (Interviewee 6)

Personal will produces mobilization when the search for the other occurs, but personalist interpretation empties the negotiation skill, clash and conflict, traits that are part of collective actions, of generation of formal channels for problem solving and referral. *A priori*, material adjustments are easily solved when performing is defined as cooperation. In order for work to occur as teamwork, besides the good environment[20], a sense of collaboration among professionals is considered, with mutual help relations. In the development of work, the professional creates strategies to deal with situations that come up, in other words, "they use themselves", revealing a peculiar intelligence to all human work[20]. When the professional considers that he pertains to the work setting and a complication appears, he searches for possible strategies using scientific-technical knowledge to solve the question, and tries to detect in the peculiarity of the situation characteristics that help solve the problem, making efforts to relate with the other attempting a positive outcome[21].

In the present study, only medical and nursing professionals work directly in the NU; therefore, their space is more obvious. Professionals of other categories work in different services, having to divide the workload and perform the routine in the UN in harmony with other sectors. Accumulation of different placements requires changes of schedules, causing physical absences, mismatches; thus reducing routines and people meeting each other. These factors reduce meetings, permanence, interactions and, consequently, weaken cooperation, which is the basis for collective and teamwork[21].

The construction of professional authority and recognition may take place during meetings, where technical capital is accessed on behalf of benefits and acquisition of information about patrons, but in our study, the significance of professional recognition follows permanence in the space.

They tend to stay in their own departments. People do not pass by each other here. People have some kind of resistance dealing with those who are not their partners. (Interviewee 2)

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[...] *the nurse was like the housekeeper, a very big responsibility, and it seemed that if she did not do her work well, the house would fall apart.* (Interviewee 11)

Sometimes it is stressful for them to understand what our attributions are [...] *we depend on other actors.* (Interviewee 17)

The expressions about professional occupation and visibility in the work space activate qualifiers that compare professional activities with those of a housekeeper, contrasting with arguments that claim the recognition of the work process of other categories that perform activities that are not limited to physical presence. There is a resistance in valuing professional labor that does not perform directly with the baby, manipulating, examining. It suits to professionals, who structure their work processes beyond physical contact, to establish occupation strategies that allow recognition and expression of technical knowledge that expand the biomedical perspective.

The process of care leads to real collective which differs from prescribed collective, since the meeting between subjects is always singular. Thus, it is possible to reaffirm that *micro-re arrangements of collective occur in the staff* [30].

Division of the unit in sectors and professionals placed in other services impair contact between them. This is expressed by the lack of understanding about the function of the other, by the stressful relation between those who, within the short time spent together, make efforts to obtain recognition as professionals of the sector. Professionals who are part of the nursing team were submitted to a rotation agreement in the NU, which was composed by three subunits (ICU, IU or rooming-in). Each one in the group had a general placement in the unit and, depending on the day, was designated to work in one of the three subunits. The professional was submitted to constant change and to more significant unpredictability than other categories.

In work settings, the professional must be able to be permeated by the "dimension of meeting of meetings" [21]. However, they not always occur:

It is, very fragmented. Completely cut out. I do not see sewing. The baby is there, so there are completely different looks [...]. *The little baby is like an object, each one looks, gives their opinion.* [...] *This is the routine. It is something that* [seems to be] *upside down, something that everyone does, it's either in the handbook, or it is in a procedure, that what it is like. My look at them is like this, a look down.* (Interviewee 8)

The evaluations about fragmentation, non-integration or even about cohesion in the work routine are highlighted in reflections about poor team ability to direct the look toward meeting, both with the user and the co-worker. The dimension of meeting is based on leading toward the other which is not restricted to task instrumentality: check and write evolution in handbook, examine baby and perform a procedure. This *look down* makes the world to be positioned *upside down*, according to individual domain logic poorly focused on alterity.

Integration between teams[31] requires investment, which is related to the field of immeasurable values, dialog between competences and ability to understand autonomy as relation between professional knowledge. Autonomy in choosing the best practice, the most appropriate technique, the limits of one's actions in view of the user's necessities.

Dialog, conflict and negotiation: team meeting

The performed routine is adjusted and rebuilt on a daily basis. There is an effort in planning actions, establishing specific procedures, in advance and continuously. Such an effort is related to what Merhy[7] assigns as the "light-hard" dimension of healthcare work: standards, protocols, routines. This dimension of instrumentality and rational preparation would work by mediating processes and would lead to a previous consensus in work management relation.

The testimonies demonstrate that the dimension of work management, routine organization is not limited to leadership. However, its "micro-management" or daily processes management needs to dialog with greater processes, which are not always accessible to all, at times not socialized in collective building. And it is in the axis of light technologies[7] that negotiation processes, art of dialog, achievement for adhesion to technical processes and protocols are situated. In this axis we identify the greatest dilemmas of teamwork building.

Professionals mention the "enigmatic and unpredictable character" of healthcare work, describing that routines are not closed and occur according to what they find in the unit[22], mainly because routines are inter-related and depend on the problems and unforeseen circumstances of each day. The medical professional demonstrates greater autonomy to manage his work process. On a daily basis, with different work hours, it

is difficult to meet with staff members to define what will be done.

Meeting and communication are even more difficult between IU and ICU doctors, and these with neonatologists in charge of service in the rooming-in. The NU of the studied hospital has many settings[32], which result in three differentiated spaces for service: rooming-in, neonatal ICU and neonatal IU:

There is another group also responsible for the intermediate nursery, which is another unit, not the neonatal ICU, and another group also responsible for the rooming-in. (Interviewee 4)

The medical staff ends up being divided into three distinguished teams that communicate very poorly. The agreements created for organization of the work routine become fragile in view of the force of logic and apprenticeship of a professional *ethos* where individual decision prevails. The autonomy of these professionals, in some cases, reveals a fragmentation of actions, which are converted into obstacles in assisting the health needs of hospitalized babies. Too much value is attributed to the negotiation power that doctors have in the hospital organization as they are the only ones who can take pacients[33]. The current debate on professional training in the health area of the Public Brazilian Health System (SUS) points to the review of doctor hegemony and to interdisciplinary practices as a way of improving healthcare quality and entirety[30,34,35]. There is motivation towards the transformation of higher education aiming at equity and quality of assistance to recover the *essential dimension of care: interpersonal relationships*[32].

The problems that arise in day-to-day life make professionals recreate their working practice. Taking the baby as the focus of action, dialog is demonstrated as the best form of resolution of situations.

You have to listen and see what your responsibility is there … Finally, you have to listen and try to solve, promote dialog. (Interviewee 2)

It is ideal to talk about them, but it is not always possible, and I think that talking is the best way of deciding. (Interviewee 19)

Besides the ICU and IU, the multiprofessional NU team does not usually use other spaces for communication. Only some professionals, mainly those of the nursing team, interact in different moments in the lunchroom, which is used by doctors and nurses. However, even in this space, interaction occurs in a very limited group, since there is rotation to leave the NU. Thus, the moment they are acting in the unit is privileged for professional communication:

The space I see there is the space which I stay in, it is the space of my schedule and it is when the professionals are there, and in this space people exchange information. (Interviewee 14)

I think it occurs in the natural course of assistance, there isn't a moment. (Interviewee 23)

Communication between professionals from different categories generally occurs according to the situations that come up each day. Sá[36] presents hospitals as services in which the "ethics of communication" and "recognition of other" is already naturally fragile. Thus, the perception of the suffering of babies and their relatives creates distress in the professionals, allowing identification with them and mobilization around a common purpose. Cases that escape the protocols require meeting/dialog in the team.

At the same time that the multiprofessional characteristic of healthcare work can be influence for interdisciplinary construction, it can contribute to fragmented team actions that do not guarantee that assistance needs are fully met[30].

References to feeling alone in decision-making moments, to the need of consulting those from other categories, appear along with team qualification as small nucleuses of same-category professionals: social service, ICU doctors, IU doctors, nursing of certain night or daytime shifts. Although the existence of multiprofessional teams in hospital units is already a common reality, their presence does not necessarily bring interdisciplinary work. Vasconcelos[37] differentiates multiprofessionality from interdisciplinarity, indicating that, in the first, professional performance is isolated and without cooperation. In the second, professional (and power) relations are more horizontal, existing reciprocity between different disciplines, acknowledgement of a *common problematics*, with a greater degree of cooperation and value of knowledge. In our study, we observed a multiprofessional team which sometimes, from a *common problematics,* created interdisciplinary actions.

Miranda et al.[38] demonstrate that interaction among professionals depends on the recognition of different points of view and on their legitimacy, able to evidence the needs of professionals to know their discursive, technical, epistemological and value specificities.

The context of health assistance has been marked by the prevalence of the biomedical model and positivistic paradigm, which emphasize the domain of competences of each profession and increase the boundary between groups[30]. Biomedical knowledge does not allow knowing man

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in his totality, requiring a review in the practice of health professional training, taking entirety as one of the fundamental principles[39,40].

In the professional training process, the focus is on the specificities of each profession, without demonstrating that practice in the health area is permeated by several work processes that arise, complement and can be cooperative and codependent. Such scenario makes the possibility of building interdisciplinarity even more distant and may cause discomfort to action that unfolds in professional interfaces daily, as well as to conflicts derived from poor negotiation skill.

Cooperation is intertwined with collective work achievement, because this work is a result of the fusion between professional life and subjective courses of each subject[21]. Thus, Schwartz[21] demonstrates the work situation as something structured in what is programmed, but that leads to unpredictable happenings and to the choices made by each one.

Communication implicates the use of principles and values that are updated with the development of health practices, being this re-signification performed according to individual choice[6]. Cases that produce greater professional mobilization allow for meeting and dialog moments.

For Peduzzi[9], communication is the main factor for teamwork establishment, with the purpose of integrating practices and technical knowledge and interaction between different categories, each with their own purposes, knowledge and tools, to assist a particular subject[8,22].

Work as self-use [20], of one's abilities to perform activities, may be use "by oneself", and also "for others", if the work space is recognized as negotiation space. Isolated work impacts on the discontinuity of actions and creates weaknesses. The traditional organizational structure of health services reinforces professional isolation and reproduces the fragmentation of work processes[41], offering no motivation for exchange of opinions to occur among professionals of the same category, or among those of different categories.

Recognizing the importance of other professionals reinforces the notion of team belonging. On the other hand, the absence of legitimation of non-medical professionals fragmentizes and impairs collective action, where rejection of these professionals as partners may occur in the health production space[3]. It is important that professional performance occurs within the limits of respect to specificities and responsibilities of each other[3], which may vary according to the social, economic and political context.

Relational aspects, pointed out by the interviewees, are already recognized by the literature on teamwork: work together, recognition of other, professionals with common purposes, responsibility, commitment, dialog, solidarity, cooperation[7,8,10,21]. We add that in these relations there may be the exchange of symbolic goods which outlines the social bond[42].

The accomplishment of work in services requires a relative autonomy due to the unpredictability that involves meeting with the other[33]. Therefore, all health professionals reveal "reasonable autonomy" to perform a synthesis between the norms and the particular cases that occur on a daily basis.

Recognizing the importance of performance and technical autonomy of professionals from different categories becomes crucial, so that each one can assume their responsibility, making care more efficient, while understanding this autonomy not as independence, but as relationship in a dependence management network that guarantees our existence[43,44].

The understanding that there is a difference between "being with" and "working with" or "through teams"[43] can be one of the axes that derive from the perspectives presented by the interviewees. In informal meetings that happen in the work space it is possible to recognize signs of teamwork, with discussions that allow meeting and dialogs that favor not only work, but the easing of relations. Decisions can occur when the environment manages to associate work and pleasure. There is an idealization of "team" or "through team" work as something unachievable, very formal, but with rules that are certainly understood and operated by all.

Conclusion

Professional training does not prepare individuals to deal with the relational aspects that trigger meetings and teamwork. Awareness of the function defined by training may lead to specialization, which is also among the factors that make service fragmented when associated with professional sectorization, hospital architecture and subordination of professionals to hierarchy of specialties; thus compromising teamwork building, and consequently, the quality of the assistance provided.

The work space appears as a place of dispute and struggle for recognition, which leads us to the starting point: that norms alone do not produce

collective work, but feelings of commitment, solidarity, responsibility and experience which are values that are not assumed *a priori*, but that are revealed in interpersonal relationships.

Although it is necessary to re-formulate professional training, focusing on learning the integration between disciplines, this change alone does not guarantee the necessary conditions for integrated work. Health care is marked by unpredictability, due to the impossibility of defining with whom each professional will interact and who will be part of the team.

Teamwork does not come down to a set of professions, in other words, to multiprofessionality. The following are indicators for identification of an interdisciplinary team: recognition of other, dialogued meeting, cooperation, appreciation of the technical knowledge of other, more horizontal and less stressful relations, and cohesive work around a common object.

An important indicator for team delineation concerns time and space presence, where identification with the service is associated with the sense of group belonging.

Collective work requires individual commitment, considering the work environment as his environment, since this produces greater mobilization of individual technical and interactional skills for problem solving. In everyday life several teams are formed: one by identification, from the corporation itself; another one by duty; and one also by direct identity regarding permanence and belonging to the NU environment.

In neonatal care, besides high technological skill and specialization required, the profile of the target-population is put into action in this segment: newborn babies who depend exclusively on the translation of their needs, and their worried relatives, all *a priori* at an unknown place.

In this setting, negotiations, limits of autonomy, notions of belonging and recognition of other, essential for teamwork building, assume a positive aspect when the service approach is focused on logic guided by the health needs of the baby-subjects.

Collaborations

EM Silva conducted the field work and wrote the article, from the master's degree dissertation. MCN Moreira supervised the master's degree dissertation and was co-responsible for writing, reviewing and analysis of the manuscript.

References

1. Barros MEB, Mori ME, Bastos SS. O desafio da humanização dos/nos processos de trabalho em saúde: O dispositivo "Programa de Formação em Saúde e Trabalho/ PFST". In: Santos-Filho SB, Barros MEB, organizadores. *Trabalhador da Saúde: muito prazer! Protagonismo dos trabalhadores na gestão do trabalho em saúde*. Ijuí: Ed. Unijuí; 2007. p. 99-121.
2. Barros RB, Barros MEB. Da dor ao prazer no trabalho. In: Santos-Filho SB, Barros, MEB, organizadores. *Trabalhador da Saúde: muito prazer! Protagonismo dos trabalhadores na gestão do trabalho em saúde*. Ijuí: Ed. Unijuí; 2007. p. 61-71.
3. Bonaldi C, Gomes RS, Louzada APF, Pinheiro R. O trabalho em equipe como dispositivo de integralidade: experiências cotidianas em quatro localidades brasileiras. In: Pinheiro R, Mattos RA, Barros MEB, organizadores. *Trabalho em equipe sob o eixo da integralidade: valores, saberes e práticas*. Rio de Janeiro: IMS/UERJ, Cepesc, Abrasco; 2007. p. 53-72.
4. Bonet O. A Equipe de Saúde como um Sistema Cibernético. In: Pinheiro R, Mattos RA, organizadores. *Construção Social da demanda*: *direito à saúde, trabalho em equipe, participação e espaços públicos*. Rio de Janeiro: Cepesc, Abrasco; 2005. p. 117-128.
5. Lacaz FAC, Sato L. Humanização e qualidade do processo de trabalho em saúde. In: Deslandes SF, organizador. *Humanização dos cuidados em saúde*: *conceitos, dilemas e práticas*. Rio de Janeiro: Ed. Fiocruz; 2006. p. 109-139.
6. Louzada APF, Bonaldi C, Barros MEB. Integralidade e trabalho em equipe no campo da saúde: entre normas antecedentes e recentradas. In: Pinheiro R, Mattos RA, Barros MEB, organizadores. *Trabalho em equipe sob o eixo da integralidade*: *valores, saberes e práticas*. Rio de Janeiro: IMS, CEPESC, Abrasco; 2007. p. 37-52.
7. Merhy EE. Um dos grandes desafios para os gestores do SUS: apostar em novos modos de fabricar os modelos de atenção. In: Merhy EE, Magalhães Júnior HM, Rimoli J, Franco TB, Bueno WS, organizadores. *O trabalho em saúde*: *olhando e experienciando o SUS no cotidiano*. São Paulo: Ed. Hucitec; 2007. p. 15-35.
8. Peduzzi M. Equipe multiprofissional de saúde: conceito e tipologia. *Rev Saude Publica* 2001; 35(1):103-109.
9. Peduzzi M. Trabalho em equipe de saúde no horizonte normativo da integralidade, do cuidado e da democratização das relações de trabalho. In: Pinheiro R, Mattos RA, Barros MEB, organizadores. *Trabalho em Equipe sob o Eixo da Integralidade*. Rio de Janeiro: IMS, CEPESC, Abrasco; 2007. p. 161-177.
10. Pinho MCG. Trabalho em equipe de saúde: limites e possibilidades de atuação eficaz. *Ciências & Cognição* 2006; 8:68-87.
11. Rollo AA. É possível valorizar o trabalho na saúde num mundo "globalizado"? In: Santos-Filho SB, Barros MEB, organizadores. *Trabalhador da Saúde: muito prazer! Protagonismo dos trabalhadores na gestão do trabalho em saúde*. Ijuí: Ed. Unijuí; 2007. p. 19-59.
12. Vieira M, Chinelli F. Relação contemporânea entre trabalho, qualificação e reconhecimento: repercussões sobre os trabalhadores técnicos do SUS. *Cien Saude Colet* 2013; 18(6):1591-1600.

13. Brasil. Ministério da Saúde (MS). Secretaria-Executiva. Núcleo Técnico da Política Nacional de Humanização. *Humaniza SUS*: *Política Nacional de Humanização – a humanização como eixo norteador das práticas de atenção e gestão em todas as instâncias do SUS*. Brasília: MS; 2004.
14. Benevides R, Passos E. Humanização na saúde: um novo modismo? *Interface (Botucatu)* 2005; 9(17):389-394.
15. Deslandes SF. Análise do discurso oficial sobre a humanização da assistência hospital. *Cien Saude Colet* 2004; 9(1):7-14.
16. Deslandes SF, Mitre RMA. Processo comunicativo e humanização em saúde. *Interface (Botucatu)* 2009; 13 (Supl. l):641-649.
17. Nogueira-Martins MCF. Humanização na Saúde. *Revista Ser Médico* 2002; 5(18):27-29.
18. Souza WS, Moreira MCN. A temática da humanização na saúde: alguns apontamentos para debate. *Interface (Botucatu)* 2008; 12(25):327-338.
19. Santos-Filho SB. Um olhar sobre o trabalho em saúde nos marcos teórico-políticos da saúde do trabalhador e do humaniza SUS: o contexto do trabalho no cotidiano dos serviços de saúde. In: Santos-Filho SB, Barros MEB, organizadores. *Trabalhador da Saúde: muito prazer! Protagonismo dos trabalhadores na gestão do trabalho em saúde*. Ijuí: Ed. Unijuí; 2007. p. 73-96.
20. Schwartz Y. Trabalho e uso de si. *Pro-Posições* 2000; 5(32):34-50.
21. Schwartz Y. Uso de si e competência. Texto anexo ao capítulo 7. In: Schwartz Y, Durrive L, organizadores. *Trabalho e Ergologia*: *conversas sobre a atividade humana*. Niterói: Eduff; 2007.
22. Pinheiro R, Barros MEB, Mattos RA. Introdução. In: Pinheiro R, Mattos RA, Barros MEB, organizadores. *Trabalho em Equipe sob o Eixo da Integralidade*. Rio de Janeiro: IMS/UERJ, CEPESC, Abrasco; 2007. p. 9-17.
23. Schwartz Y. Entrevista: Yves Schwartz. *Trabalho, Educação e Saúde* 2006; 4(2):457-466.
24. Silva EM. *Construção do trabalho em equipe*: *um estudo no âmbito da atenção neonatal* [dissertação]. Rio de Janeiro: Fundação Oswaldo Cruz; 2010.
25. Minayo MCS. *O desafio do conhecimento*: *pesquisa qualitativa em saúde*. São Paulo: Hucitec; 2006.
26. Velho G. Observando o Familiar. In: Velho G. *Individualismo e Cultura: Notas para uma Antropologia da Sociedade Contemporânea*. 2ª ed. Rio de Janeiro: Jorge Zahar Editora; 1987. p. 121-132.
27. Fontanella BJB, Luchesi BM, Saidel MGB, Ricas J, Turato ER, Melo DG. Amostragem em pesquisas qualitativas: proposta de procedimentos para constatar saturação teórica. *Cad Saude Publica* 2011; 27(2):388-394.
28. Campos GWS. Apresentação. In: Santos-Filho SB, Barros MEB, organizadores. *Trabalhador da Saúde: muito prazer! Protagonismo dos trabalhadores na gestão do trabalho em saúde*. Ijuí: Ed. Unijuí; 2007. p. 11-15.
29. Filho FL. A equipe da UTI neonatal. In: Moreira MEL, Braga NA, Morsch DS, organizadores. *Quando a vida começa diferente*: *o bebê e sua família na UTI Neonatal*. Rio de Janeiro: Editora Fiocruz; 2003. p. 107-116.
30. Scherer MDA, Pires D, Schwartz Y. Trabalho coletivo: um desafio para a gestão em saúde. *Rev Saude Publica* 2009; 43(4):721-725.
31. Peduzzi M. Arranjos e dispositivos de cogestão: espaços coletivos, função coordenação equipe/serviço e apoio institucional. In: 2° Seminário Nacional de Humanização; 06 ago 2009; Brasília, Brasil.
32. Pereira SMP, Cardoso A. *Neonatologia além da UTIN. As Experiências das Famílias com a Prematuridade – Narrativas Clínicas*. Rio de Janeiro: Editora Revinter; 2012.
33. Ribeiro JM, Schraiber LB. A autonomia e o trabalho em medicina. *Cad Saude Publica* 1994; 10(2):190-199.
34. Brasil. Ministério da Saúde; Ministério da Educação. Portaria Interministerial n.º 2.101, de 3 de novembro de 2005. Institui o Programa Nacional de Reorientação da Formação Profissional em Saúde – Pró-Saúde – para os cursos de graduação em Medicina, Enfermagem e Odontologia. *Diário Oficial da União* 2005; 4 nov.
35. Brasil. Ministério da Saúde (MS). Ministério da Educação (MEC). *Pró-saúde: Programa Nacional de Reorientação da Formação Profissional em Saúde*. Brasília: Editora do Ministério da Saúde; 2007. (Série C. Projetos, Programas e Relatórios).
36. Sá MC. A fraternidade em questão: um olhar psicossociológico sobre o cuidado e a "humanização" das práticas de saúde. *Interface (Botucatu)* 2009; 13(Supl. 1):651-664.
37. Vasconcelos EM. Serviço Social e interdisciplinaridade: o exemplo da saúde mental. *Rev Serviço Social e Sociedade* 1997; 18(54):132-157.
38. Miranda L, Rivera FJU, Artmann E. Trabalho em equipe interdisciplinar de saúde como um espaço de reconhecimento: contribuições da teoria de Axel Honneth. *Physis* 2012; 22(2):1563-1568.
39. Heckert ALC, Neves CEAB. Modos de formar e modos de intervir: quando a formação se faz potência de produção do coletivo. In: Mattos RA, Barros MEB, Pinheiro R, organizadores. *Trabalho em equipe sob o eixo da integralidade*: *valores, saberes e práticas*. Rio de Janeiro: UERJ, Abrasco; 2007. Vol. 1. p. 145-160.
40. Machado MFAS, Monteiro EMLM, Queiroz DT, Vieira NFC, Barroso MGT. Integralidade, formação de saúde, educação em saúde e as propostas do SUS: uma revisão conceitual. *Cien Saude Colet* 2007; 12(2): 335-342.
41. Campos GWS. Equipes de referência e apoio especializado matricial: um ensaio sobre a reorganização do trabalho em saúde. *Cien Saude Colet* 1999; 4(2):393-403.
42. Martins PH. *Contra a Desumanização da Medicina*: *crítica sociológica das práticas médicas modernas*. Petrópolis: Vozes; 2003.
43. Moreira MCN. *Uma Cartografia dos Dispositivos Institucionais de Humanização da Atenção à Saúde Infanto-Juvenil em Ambientes Hospitalares: um enfoque a partir do processo de trabalho e do associativismo em saúde* [relatório de pesquisa CNPQ]. Rio de Janeiro: Fiocruz; 2009.
44. Soares JCRS, Camargo Júnior KR. A autonomia do paciente no processo terapêutico como valor para a saúde. *Interface (Botucatu)* 2007; 11(21):65-78.

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