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Connections and boundaries of interprofessionality:

form and formation

Ricardo Burg Ceccim[a]

The debate presents a discussion on interprofessionality: its trajectory and the need of this concept for the management of work and education in the area of health, especially when patient safety, education oriented to health systems, and coordination of the services network guided by integral care, efficacy, users' satisfaction and workers' comfort are present. It discusses the distinction among "multi", "inter" and "between" in relation to the terms profession and discipline. A focal review of the literature was carried out, in a search for the introduction of the term and its variation in education, practice, praxis and audit of educations and professional actions. It problematizes connections (challenges) and boundaries (limits), pointing to learning, thought and creation. The text is concluded by bringing the idea that form and form-giving supports the notion of fixation of forms (normative) or movement of forces (permanent health education).

***Keywords*:** Interprofessionality. Interprofessional practice. Interprofessional education. Health education. Formation.

[a] Programa de Pós-Graduação em Educação, Faculdade de Educação, Universidade Federal do Rio Grande do Sul. Avenida Paulo Gama, s/n°, prédio 12.201, 7° andar. Porto Alegre, RS, Brasil. 90046-900. burgceccim@gmail.com

Introduction

The word "interprofessionality" has been gaining some notoriety along with health policies, both in the public and in the private sectors, in Brazil and abroad, especially regarding interprofessional education. The reason for this popularity is that it has become relevant to include, in the management of work and education in the area of health, criteria and parameters to regulate professional activity performed in teams and to organize curricula aiming at teamwork education. However, the necessary debate should not involve only these criteria and parameters. The concept and its history are still little known to this day, and its use, in the world of labor or education, continues to be permeated by confusion, not to mention when it is simply considered synonymous with the words multiprofessionality, multidisciplinarity, and interdisciplinarity. I mention "words" and not "terms" or "concepts" because the latter, more frequently related to teamwork, do not receive a conceptual or terminological treatment either, when used by managers, teachers, workers, and health counsellors.

The words *profession* and *discipline* indicate a large difference, and the prefixes "inter" and "multi" indicate a distinction in the probabilities of integrated, diversified or fragmented action. If discipline is related to the domain of technical or scientific information, profession is related to a craft, to the formal exercise of an occupation. Discipline is related to the domain of knowledge, while profession is a license to perform an occupational activity, even though the disciplinarization of knowledge, science and work has resulted in the emergence of professions in positions of power and subordination. Thus, it is extremely necessary to reverse this in favor of integration, intersection and defragmentation potencies, in increasing levels, depending on the desire or on the necessity to work in teams. The debate about the opportunity, the need, or the simple possibility to be explored is necessary, and the contribution about ways of acting, regulating and assessing depends on the best appropriation of their designations.

The concept of interprofessionality was thought within a set of formulations and practices that involve the prefix "inter" as the antecedent of the root word "profession". The prefix "inter" indicates "inside two things" and can refer to the intersection or encounter of two professions and also to the operation through which we obtain a set formed by elements common to two or more professions. The "inter" zone, between two or more professions, is the zone of what they have in common or that point of indiscernibility to which the elements of the same field of knowledge converge, in which the practices of a professionalized action are born. We could, perhaps, call "interprofessional competencies" those practices related to knowledge that is "common to two", avoiding to suggest a separation or the enunciation of a third professional occupation different from the others each time "common" is recognized, as the territories of common also indicate new knowledge demands to professions in composition. One way would be the reestablishment of the evident professional boundaries - the preservation and defense of the profession's contours. This, however, is exactly what has been denounced as fragmentation of knowledge and practices. Another way would be the enunciation of interprofessional boundaries, that is, enabling what is "common to two". This is what has been claimed as teamwork, a fairly particular claim in the health sector, where we talk about the need of integration, cohesion and collaborative practice among workers.

As it happens, when we work in the same sector (health, in this case), we systematically come across the points of intersection and encounter related to this field - points that do not belong to a profession disciplinarized in a particular science. We even speak of "medicine and health", "nursing and health", "nutrition and health", for example, indicating a particular professional field and a broad field of knowledge where the particular field is included. A "science like profession" and a "science like sanitary health field". Even if we do not work in a team (in this case, even more), in order to achieve success with a care practice or a therapeutic practice, we need to resort to knowledge and actions that are not disciplinarized in our profession, but are configured in knowledge domains from other health professions. In addition, we need to resort to interdisciplinary knowledge from other scientific and popular fields[1,2]. Therefore, we talk about "interdisciplinary knowledge" and "interprofessional competencies"; it is inescapable.

Interdisciplinary knowledge encompasses knowledge originating from various sciences, popular knowledge and tacit knowledge. Interprofessional competencies encompass skills systematized in professions and actions organized in professional aptitudes. The more we work in teams, the more we can share knowledge with each other, amplifying our arsenal of competencies and response capacity. The more we work in isolation, the more we need to know, individually, about the others' knowledge and the highest the risk of errors or unsafe practice. One watchword among interprofessionality authors is "patient safety"[3,4].

The inescapable supervene: "inter" makes new words and expressions

Undoubtedly, some of the reasons why teamwork is so strongly emphasized in the interprofessional perspective are patient safety, integrality of healthcare, humanization of practices, and the promotion of workers' comfort and wellbeing[5]. Interprofessionality increases care safety, reducing risks, errors and damages; contributes to the satisfaction of health needs, introducing disease prevention and health promotion actions with precision and on the right time; and enhances users' satisfaction and comfort, which reflects on user embracement, integral care, and patients' adherence to the prescribed/oriented treatment or care plan[6]. Therefore, we must strongly defend teamwork, question teamwork, struggle for permanent health education, and claim for teaching-service-management-participation integration.

The terms, in this case, most related to interprofessionality involve: interprofessional education; interprofessional practice; interprofessional nature of "field" actions (as opposed to professions' "nucleus" interventions); and interprofessional praxis (the pragmatics of teaching, learning, doing and acting in an integrated or cooperative way). Integrated action in multiprofessional teams, professionals' concern about reconciling their actions as cohesive teams, and workers' synergic collaboration to achieve team results in healthcare are unequivocal dimensions of interprofessionality.

The dimensions of healthcare quality, adherence to treatment, and patient safety have led interprofessionality to be designated as "health work centered on the user/patient," but we have found no reference to workers' comfort and relief nor to work oriented towards integrated care networks. However, interprofessionality refers to work centered on the strengthening of health systems, on the reduction of suffering in the workplace, on a better supply and retention of workers, and on planning and assessment in the perspective of integral care, humanization and permanent health education. The formal admission (programmatic or ethical) of interprofessionality interferes in work modes. It demands (and favors) that work is performed in integrated teams, that partnerships recognize themselves as collaborative, and that two notions are placed in the scene of daily routine to compose work: intercomplementarity of knowledge and practices and apprentice communities (design, configure, model). The workers' willingness to build an apprentice community is articulated with team activities proposed by the workgroup and with the effective participatory process in their permanent education, which involves problematizing power relations and transforming moments of conflict and dispute in didactic-pedagogical strategies for confrontation of ideas and negotiation.

Subsidizing team practices, interprofessionality favors information and knowledge exchanges, cooperation with solidarity in the performed actions, co-responsible attention to health needs for the construction of therapeutic and health promotion projects, collective action in the territory, and a network of affective bonds, which intensify the feeling of belonging to a team. From the health systems' point of view, it is under interprofessionality that we visualize a higher supply and retention of workers[7]. The opportunities to plan and assess "clinic management" according to provision of access to the actions and services needed are strengthened when an interprofessional praxis is affirmed and included among the parameters of improvement in access and efficacy[8]. The management of integral and humanized assistance implies lines of care, efficacy, and affirmation of users' autonomy.

Nevertheless, there are connections and boundaries in everything that was mentioned above: interprofessional as an adjective; interprofessionality as a noun, for example. Interprofessionality as a theme for multiprofessionality and as a theme for interdisciplinarity, when we add multiplicity of professions and the intersection of knowledge among knowledge fields and domains. Interprofessionality as an assumed element of the work performed by different professionals, who

act, think and write in the same broad field (health sciences, for example). Interprofessionality as a protocol limit to what is possible in the blurring of boundaries among the regulated health professions, preventing the establishment of imponderable connections previously to the encounters "on the ground".

Ana Ecilda Lima Ellery summarized the proposals involving the adjective "interprofessional" and the noun "interprofessionality". To the researcher, the most frequently used terms were Interprofessional Education and Interprofessional Practice, but the term Interprofessionality now allows to explore the interprofessional nature of an intervention, either in the field of education or in the field of practice. It is not a choice; it is an emergence of the interventions themselves[9]. After the consideration that interprofessionality lies in the interventions, that the interprofessional education approach is possible, and that we can propose and regulate interprofessional practice, there would effectively be an Interprofessional Praxis, present in educational practices and in work practices, and also in the curricular organization of education and in the management and assessment of health systems and services. Furthermore, it is possible to audit educational and occupational practices.

Ellery proposes a "Conceptual Structure of Interprofessionality", presenting it in three dimensions: "the cognitive dimension (socialization and knowledge integration); the pragmatic dimension (practice that is shared or performed in collaboration); and the subjective dimension (which involves affections such as envy, jealousy, love, power and status dispute etc.)". The author assumes a daily routine deriving from "doing together" that would mobilize "reconciliatory and contradictory feelings". To the author, such affections can "facilitate or hinder collaboration, interaction, exchange and partnerships".

Juarez Furtado argues that the interdisciplinary development reached the operational ground a long time ago and that its challenge has become a recurrent theme among professionals and their teams, belonging to the discourse of work[10]. In addition, he argues that workers have been frequently reporting the irrationality present in the compartmentalization of practices by health professionals and in the excessively disciplined distribution of actions (the "irrationality" of the "rationalization" of knowledge and action, when excessive). He suggests that the development of interprofessionality should shift the discussion about disciplinary and pragmatic integration from the plane of disciplinary knowledge and professional actions to the plane of collective action in the organization of work and in the qualification of health services.

Involved in the formulation of concepts, design of tracers, and in the study of teamwork in all variations of this form of action in the area of health, Marina Peduzzi has been analyzing conceptions of workers, teachers and researchers since the mid-1990s. Moreover, she has been searching for empirical and historical evidences of the collective character of therapeutic and care activities in assistance units of the health sector[11-13]. The researcher has shown distinctions between a "grouping team" and an "integration team", as well as aspects of complementariness and interdependence, not only in the action of generalists, but also in the action of specialized workers. Throughout her intellectual production, she has shown that, in the core of the relationship between professional intervention and interaction among actors (workers of all levels and users), professionals build interdisciplinary consensuses that configure interprofessional care projects. It is possible to conclude, based on the reading of the author's works, that in "team integration", as part of the "development of work", workers' articulation occurs and their technical autonomy is amplified. Furthermore, it is possible to understand that the evaluative inequality in the technical difference of specialized works is what reduces the possibility of integration, but the reciprocity between intervention and interaction leads to collective work, promoting an interprofessional praxis, that is, a "local action" and a "situated education", both centered on the scene of care.

In a previous text, I suggested "in-between-disciplinarity" as a term opposed to the disciplinarization of knowledge and practices. It does not refer only to epistemic knowledge or to professions and the competencies of each profession. Instead, it refers to an "intellectual discomfort" in relation to positive science and to the regulation of professions, that is, a defense of boldness and the usufruct of intellectual autonomy to explore the usual boundaries of knowledge and professions. I revisited the theme in production together with Eliana Goldfarb Cyrino, in "*O sistema de saúde e as práticas educativas na formação dos estudantes da área*"[14] (The health system and educational practices

in students' education). Intellectual discomfort is the uneasiness in relation to rules and boundaries, the effective problematization of the meaning, need and function of rules and boundaries. The boldness of intellectual autonomy means welcoming the intelligence that derives from problematization: every boundary is a "border policy", the imposition of a reality. Boldness means assuming the value of the variation and creation of *becoming* in the sciences and professions; recognizing contradictions, paradoxes and conflicts, not through dialectics, but through the turn in power policies, uncoupling their gears. When thinking and doing depend on creating, we have acting: we do not have the guarantees of what is already known; we experiment with the potency of what is new or current. The prefix "inter" indicates "inside two things" while "in-between" does not have an inside and always refers to something in the middle, between things, interbeing, intermezzo. "In-between" contains the vibration of what ends, without revealing all its purposes, and the vibration of what is announced, in expectation and desire, without knowing what will come. "In-between" contains only the clues of desire and the game of those who inhabit the scene[2].

Not so old, not so new: the actual and the "new actuals" in interprofessionality

Let us begin with the aspect of Patient Safety, a matter addressed in 1999 with the instigating title "To err is human: building a safer health system"[15]. In the article, the serious problem of errors is explained. It should be understood - by professionals, managers and users - as a problem of the structure and administration of health systems and services. The matter is discussed by the World Health Organization, culminating in the creation of the World Alliance for Patient Safety in 2004. The Brazilian Ministry of Health published, on April 1, 2013, Directive no. 529, which instituted the National Patient Safety Program. Patient safety is a theme related to the importance of integrated work among managers, professional councils and teaching and research institutions, with a multiprofessional and interdisciplinary focus. The theme is connected with the perspective of interprofessional education, allied with the purposes of improvement in the quality of assistance, development of protocols, guides and manuals, and promotion of a patient safety culture.

Interprofessional Education is present mainly in the Learning and Teaching Support Network for Health Sciences and Practice, represented, today, by the Centre for the Advancement of Interprofessional Education (CAIPE), of the United Kingdom. It acquired a formal concept in 1997. The initial idea was to engage teachers in interprofessional education, aiming to mobilize universities towards shared learning for health and social care professions. Isolated experiences had been showing, since the 1960s, the importance of interprofessional education for the learning of approaches in mental healthcare, for disabled people or individuals with special needs, and for community care, palliative care and care for frail older people. The development of interprofessional education took into account the need to form primary care teams, the introduction of care in the community, investigations into child abuse, integral care in HIV/AIDS, and strategies to effect change and improve the quality of health services and actions. Studies evaluating outcomes before and after multiprofessional training or interprofessional education revealed improvements in the quality of care, related to changes in attitudes, concerns about the theoretical and practical foundations of the intervention, and competency-based outcomes[16].

The bases of interprofessional education involve the principles and values of pedagogy in adult education and interactive learning methods (active methodologies). The theories of anthropology, social psychology and sociology converge on studies and teaching to understand collaboration and the obstacles that hinder it. Postgraduate education and, mainly, permanent health education present the highest record of educational practices with some level of interprofessionality. Curricular change is reported, but moves at a lower speed. It is one of the current objectives, together with the search for evidences about its success in improving health and social care. Other contemporary goals are the construction of interactive learning in undergraduate interprofessional education, involvement of university teachers in work-based interprofessional education, development of a continuum of professional, multiprofessional and interprofessional education, and the listing of objectives for shared learning in workforce planning (management of health work and education).

The notion of Interprofessional Practice emerges together with the notions of "interdisciplinary education" and "interdisciplinary health teams". The formulation involved thinking about the successful development of "interdisciplinary health teams" in medical and surgical care in the United States in the Second World War. The new proposal promoted this understanding in the organization of community health systems targeted at the lower class or peripheral areas. The concept of "teamwork in the area of health" or "interdisciplinary teams of health professionals" resulted in a means of providing integral and continuous care for the population. As a successful experience, the notion of interprofessional practice should bring significant implications to the education and training of future health professionals. Both the government and philanthropic foundations should endeavor to effect changes in traditional disciplinary models. Despite repeated efforts, strong barriers remain, as reported in "Some historical notes on interdisciplinary and interprofessional education and practice in health care in the USA"[17].

Interprofessionality designated as such has its first affirmation with professors Danielle D'Amour and Ivy Oandasan[18]. On the one hand, the authors desire to draw a clear distinction in relation to the concept of interdisciplinarity, attributed to the field of knowledge; on the other hand, to permit the observation of professional practices as cohesive and integrated among professionals in response to users' needs. They present interprofessionality as a concept emerging from interprofessional education and interprofessional practices, aiming to reach a better understanding of a phenomenon that is practice, not only based on interdisciplinary knowledge, but cohesive among different professionals from the same organization or from different organizations and the factors influencing it. As there was no concept that focused clearly on this field, the proposal of the term interprofessionality was accompanied by a frame of reference that regards the processes and determinants that influence interprofessional education initiatives, as well the determinants and processes inherent in interprofessional collaboration[9].

Formal interprofessional education finds fewer barriers than formal interprofessional practice. Thus, interprofessionality aims to deliver greater consistence and conviction about success in the quality of care for users, exposing linkages between these two spheres of activity. The frame of reference[18] presents the determinants and processes of collaboration in three dimensions: micro (links among students, teachers and professionals), meso (organizational level or level of links between teaching and health institutions), and macro (political, socioeconomic and cultural systems). The authors argue that research must play a fundamental role in the development of interprofessionality in order to document these linkages and the results of initiatives as they are proposed and implemented, making it clear that its advance depends on political will.

The announcement of interprofessional education and interprofessional practice as strategies to help the health services improve patient care contains history, memory and is intensely documented in articles, especially in Canada, United States, United Kingdom and Australia. A research agenda emerges from the efforts to formalize education and the scope of interprofessional practices - an effort to institutionalize their inclusion in health systems and services, as all the results indicate improvement in the quality of care in terms of integrality, humanization and efficacy[19]. Even if work in integrated teams is promoted in circumstances that have demanded a high technical-scientific efficiency since the Second World War, in primary and community care or in the assistance provided for populations and complex care segments, like mental health, sexual abuse, disabled individuals, frail older patients or people living with HIV/AIDS, sometimes the interprofessionality that is present there does not achieve the status of management of work and permanent education in the area of health. Furthermore, sometimes it does not impose a curricular change in undergraduate programs, that is, in the basic education of health professionals.

Researchers from the Centre for Clinical Governance Research of the School of Medicine, New South Wales, Australia, state that, although health professionals approve interprofessional education and interprofessional action in the daily routine of the health services, the capacity to understand and comprehensively map such practices has remained elusive, presenting the structure of an Interprofessional Praxis Audit. According to the proposal, the impact on the organizational context and on the culture of work and education requires attention. The Interprofessional Praxis Audit

emerges as a tool to approach these two issues and comprises five components: context, culture, conduct, attitudes and information. Used within an action research methodology, the Audit allows a synchronized inspection in which the components' similarities and differences are simultaneously considered, and the knowledge developed is used to promote projects of change to improve users' treatment and follow-up[20].

Working and studying in an interprofessional manner is the minimum level of coherence on behalf of patient safety, qualification of care, efficacy of practices, and respect for multiprofessionality and interdisciplinarity. Consequently, interprofessionality should represent an obvious terminology for the management of health work and education; however, it is a current theme. It is not new but it is extremely current, causing doubt, uncertainty, questioning. As it is presentified as current, it should really stimulate the exercise of interrogation, showing its face of critical resistance (intellectual discomfort or dissidence in relation to disciplinary and professional hegemonies), bringing disruptions (instituting rupture) to light.

Introducing the terminology of interprofessionality, however, also serves the creation of a comfort zone for those who fear dissidence or disruption; after all, it might result in the unfeasibility of market reserve, in a weakened inspection of professional activity, in the suppression of private practices by a professional group. Instead of these fears, it offers a conceptual and pragmatic delimitation that can be apprehended and dimensioned and does not suppress disciplinarization as biopolitical power - does not even propose to face biopolitical power. The fact is that the theme is not new, nor are the problems to which it offers an alternative; what happened is it has become a current theme.

A Brazilian summarization to the debate

In "*Interprofissionalidade e experiências de aprendizagem: inovações no cenário brasileiro*" (Interprofessionality and learning experiences: innovations in the Brazilian scenario)[21], I presented a particular summarization of interprofessional work and education in Brazil without focusing on terminology; my aim was the recognition of challenges of multiprofessionality (healthcare team) and interdisciplinarity (amplified concept of health) where, although all the examples converged on collaborative practices and interprofessional learning, none of them used this conceptual seal to enunciate themselves. Although the reader should ideally search for the original text, I recompose, in a brief synthesis, the considerations of that moment.

Regarding practices, an inventory reveals the current initiatives in the Brazilian health system:

– User embracement: the central axis of care is shifted from the medical consultation to assistance provided by a multiprofessional team, where a reference professional is in charge of hearing the user, committing him/herself to the institutional orientation of the user's demand;

– Reference teams and specialized matrix support: longitudinal bond team and technical and pedagogical backup and support team. The multiprofessional team organizes work with a minimum number of referrals and maximum responsibility for the therapeutic procedure;

– Field and Nucleus of Knowledge and Practices: while the "nucleus" delimits an area of knowledge and professional practices, the "field" represents a space of indefinite limits in which each discipline and profession search for support in other disciplines and professions to perform their theoretical and practical tasks;

– Institutional Support: supports the implementation of changes in the work process, helping in the analysis of the institution, searching for new modes of operating and producing organizations, stimulating collective spaces and interactions among the social agents of the work;

– Clinical-Institutional Supervision: discussion of cases associating clinic, context of networks and intersectoriality, questioning adopted management notions and mobilizing innovations in practices;

– Individual Therapeutic Project: set of therapeutic and care conducts articulated in an interdisciplinary and collective discussion;

– Clinic Management: line of care and integrated care networks.

Concerning interprofessional education, important strategies have been experimented with in the struggles for *Sistema Único de Saúde* (SUS - Brazilian National Health System):

– Experiences and Internships in the Reality of SUS: process of theoretical-practical immersion in spaces of care, management and social control provided by SUS managers for organized groups of undergraduate students from various courses in the area of health;

– Permanent Health Education: local-regional and interinstitutional articulations of discussion and study about needs related to work development and qualification of the health system's response to the needs of teams, users, territory and networks;

– Regional Interprofessional Internship: academic practice integrated to the regular curriculum of undergraduate health courses, targeted at students' multiprofessional and interdisciplinary experience in rural cities or cities that are not capitals;

– Popular Health Education Experiences: academic practice integrated to university extension, targeted at experiences in social movements crossed by popular health education practices;

– Integrated Multiprofessional Health Residencies: in-service postgraduate education modality supervised by teachers and health professionals, targeted at the multiprofessional health team, aiming to articulate practical, theoretical-practical and theoretical experiences, integrating teaching and work;

– Knowledge Connection Tutorial Education Program: innovative university extension actions that amplify knowledge exchange between popular communities and universities, valuing students' protagonism;

– National Reorientation Program in Professional Health Education: teaching-service-territory integration aiming at the reorientation of professional education, from the biomedical and hospital model to a multiprofessional modeling with a integral approach to the health-disease process, emphasizing primary care;

– Education through Work Program for the Health Area: intersectoral actions directed at strengthening strategic areas for SUS, having education through work as their presupposition and teaching-service-territory integration as their conducting wire.

As a result of so many initiatives in the field of practices and in education, the scientific literature and institutional health productions have focused on interprofessionality, collaborative practices and interprofessional education. As an expression of this focus, I mention, here, the initiatives of *Revista Interface* and *Rede Unida*, which published public notices for articles, fostering changes in teaching and the diversification of educational proposals. Thus, they support professional development in the network of services and management of this sector, as well as the expansion of integration and interaction with the population, users and social control levels[22].

Form, formation and gray point between two or more terms

The educational action of the health professions occurs in the sphere of the possibilities opened by the health field. However, while in the configuration of professions this field is identified with specific skills and competencies, in the configuration of work we find a field that is much more undifferentiated, where the needs and demands that arrive must be embraced and solutions must be offered. This field presupposes a dimension of composition in which workers do not have only technical functions perfectly structured and independent, and juxtaposition is not sufficient for the achievement of integral and humanized care. It is a space of concatenation, of intensities to be traveled through. Dominating a notion of field, the education of professions must "educate" for composition, not for fragmentation. This is an essential place for permanent education in the area of health due to a connection with the rhythm of work and to the non-segregation between the space of education and the space of work. However, low familiarity with this potency hinders its appropriation in the daily routine of the practices.

On the one hand, the "educational action" generates professions; on the other hand, it must generate "apprentices", who must find their place in the context without a reprimanding relationship

among professions. Each professional "figure" (profession or specialty) must accommodate itself with the others and all of them must accommodate themselves together in order to form a cohesion. However, cohesion is not a prescription of work or of the work activity. The real activity only exists in act and encompasses the fulfilled activity and the real of the activity[23], that is, the multiple possibilities unfulfilled during the worker's action. Because of this, it is constituted during the way, due to living possibilities, in act[24]. It is not improvisation, however. Rather, it is an assembly, a formation, a work of composition among apprentices.

In *Teoria della Forma e della Figurazione: pensiero immaginale* [Theory of form and figuration: The imaginal thought], Paul Klee[25], talking about the artist's creative thought or the artist's formation, states that the march towards form prevails over the terminal end, the end of the route. "Orientation" determines the character of the "consummated" work. "Formation determines form and is, consequently, predominant, but never, nowhere, is form an acquired result, a finish, a close, an end, a conclusion; that is, it is necessary to consider it as genesis, as movement" (heterogenesis). The essence of formation is the action of happening, and "form as appearance is nothing more than a malignant apparition, a dangerous ghost". According to the artist, "good, therefore, is form as movement, as doing; good is form in action". Bad would be "form as closed inertia, as terminal detention". He says: "bad is the form with which one feels satisfied, like an accomplished duty". "Form is the end, death. Education is life". Education is movement, action. The artist says "do not think of 'form' but of 'formation': the 'form-giving' forces are more important than the 'final forms'" (p. 269). This is the ethical condition for permanent education in health and, I propose, for interprofessional education.

To Klee, there would be the "gray point" (*punto grigio*). The gray point is the intermediate point between terms; it is the point of summoning, of an appeal to form/formation. The gray point as an intermediate between chaos and cosmos. The intermediate point is "in-between", not "inter", but "inter" is the route, the experimentation time, the duration. Interprofessional education can be an education for chaos; chaos in the first place, from where the form-giving principle derives. The gray point is undifferentiated, that is why the "form-giving learning" belongs to it. Each form is a need before the undifferentiated, but forms do not cover the undifferentiated except as representation; therefore, the forces continue to be alive, sensitizing. Klee masters music and the visual arts, and explains: without silence, we do not understand sound, we do not make music. Representation or form weakens movement and depth, and that is why it is necessary to maintain formation – learning - alive.

Conclusion

Concluding this debate is difficult. Interprofessionality should be considered the gray point; interprofessional education should be viewed as education for learning; and interprofessional practice, the territory to the real of the activity. The recognition of interprofessionality, however, is the presence of order in chaos, antithetical balance. Therefore, interprofessional is not the new ideal place, the place of "definition" of common; it is a place of undifferentiation that summons learning, the thought of creation. It is necessary to expand teamwork (integration team), as it is absolutely fundamental to patient safety, integrated networks, humanization, integral care, and to relief in the workplace (as well as to an increase in professional retention: more comfort and pleasure in the workplace through self-restraint, friendship). In addition, it is necessary to provide interprofessional education in order to provide a habitus, the feeling of being at ease with darkness (nightfall) and dawn, learning to be an apprentice in the profession(s). Interprofessionality emerges in multiprofessional territories (without multiprofessionality there will not be the point in-between or inter professions), and also from interdisciplinary intersections (active acceptance of the plurality and multiplicity of knowledge); therefore, the classical summoning of permanent health education, multiprofessionality and interdisciplinarity, is a summoning for interprofessionality: learning community.

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