Interprofessionality and interdisciplinarity in health: reflections on resistance from concepts of Institutional Analysis

Interprofissionalidade e interdisciplinaridade em saúde: reflexões sobre resistências a partir de conceitos da Análise Institucional

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ABSTRACT This study aimed to report the experience of the students of the professional master's degree in health services management, regarding the use of concepts of Institutional Analysis, to analyze the resistances to interprofessional and interdisciplinary work in health, locating them as an analyzer of the process and of work relationships. The study was prepared from the experience and analysis of institutional journals, written by students, and analyzed based on the theoretical framework of Institutional Analysis. It was observed that resistance to interprofessional and interdisciplinary work, especially on the part of physicians, crosses health organizations, work relationships, and assistance to users. However, this resistance is also exercised by other professionals and users, which limits the interdisciplinarity and comprehensiveness of health care. But if, on the one hand, there is still a certain predominance of the biomedical model, on the other hand, resistance to this model is also observed in health organizations, needing to expand the spaces of collective analysis capable of enunciating the reductionism of this paradigm. It can be concluded that collectively analyzing these resistances allows health professionals to expand the conditions to leave their established places and perceive the instituting movements in the services in which they work.

KEYWORDS Health management. Professional practice. Patient care team. Interdisciplinary placement. Health human resource training.

RESUMO *O objetivo deste estudo foi relatar a experiência dos alunos do mestrado profissional em gestão de serviços de saúde acerca da utilização de conceitos da Análise Institucional, para analisar as resistências ao trabalho interprofissional e interdisciplinar na saúde, localizando-as como um analisador do processo e das relações de trabalho. O estudo foi elaborado a partir da vivência e da análise dos diários institucionais, escritos pelos alunos e analisados com base no referencial teórico da Análise Institucional. Observou-se que a resistência ao trabalho interprofissional e interdisciplinar, principalmente por parte dos médicos, atravessa as organizações de saúde, as relações de trabalho e a assistência aos usuários. Entretanto, essa resistência também é exercida por outros profissionais e pelos usuários, o que limita a interdisciplinaridade e a integralidade da assistência à saúde. Todavia, se, por um lado, ainda, há certa predominância do modelo biomédico, por outro, também se observam resistências a esse modelo nas organizações de saúde, necessitando ampliar os espaços de análise coletiva capazes de enunciar o reducionismo desse paradigma. Conclui-se que analisar coletivamente essas resistências possibilita aos profissionais da saúde ampliar as condições de sair de seus lugares instituídos e perceber os movimentos instituintes nos serviços em que atuam.*

PALAVRAS-CHAVE *Gestão em saúde. Prática profissional. Equipe de assistência ao paciente. Práticas interdisciplinares. Capacitação de recursos humanos em saúde.*

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Introduction

Interdisciplinarity has been the target of discussions in the realm of science and health practice development, due to intense fragmentation of knowledge and distancing between disciplines, as well as to corporatist interests permeating the process. This subject area has led to much debate, especially in the production of the academia related to care provided by health services[1].

The 19th century was marked by the restructuring of universities resulting from the emergence of disciplines, encouraged by the advancement of scientific research and the development of specializations. This movement was maintained and consolidated throughout the 20th century, and it was in this scenario of hegemony of the Cartesian model of science that the term interdisciplinarity emerged, as opposed to fragmented knowledge. In the health sector, interdisciplinarity proposes to integrate the different disciplines to better understand and face daily challenges. In addition, as a shared ethical-political position, interdisciplinary work requires from health professionals a permanent dialogue to define the skills needed to solve problems[2].

One of the strategies to be used to face the complex challenges of the health sector – among them, the establishment of interdisciplinarity – is interprofessional work, through the accomplishment of a collaborative practice. While interdisciplinarity is related to disciplines, sciences or areas of knowledge, interprofessionality concerns professional practice developed from teamwork, articulating different fields of practice and strengthening the focus on users and their needs in the dynamics of production of health services[3,4].

Thus, for health professionals to have a broader view of the health-disease process and to develop their ability to work as a team, enhancing the problem-solving trait of the care provided, it is necessary to have an interprofessional and interdisciplinary approach to health-related issues[4].

However, it is noted that, despite significant advances in the health sector, in its various aspects, professionals

> Are trained separately, in order to work together in the future, this being an inconsistency that has important implications for the quality of care provided within [the Unified Health System (SUS)]. There is resistance to the rupture of the current training model, which reverberates in the legitimation of the current health care model based on strong division of labor[5(198)].

A study carried out with family health team workers in the city of João Pessoa, in Paraíba, showed that, despite the fact that professionals indicated an interdisciplinary perspective in the work carried out, they did not carry it out from the perspective of interprofessionality[4].

The look towards a health situation, therefore, should not be limited to a single professional and requires involving an entire team to provide an interprofessional and interdisciplinary approach, so as to offer comprehensive care to users. This is one of the guidelines found in co-management and in the expanded clinic established by the National Humanization Policy (PNH) of the Ministry of Health[6].

The need to work in this context requiring the development of skills from different disciplinary fields to carry out interprofessional work led to creating in 2018 the Professional Master's Program in Health Service Management offered at a Public University in the state of Minas Gerais, with a syllabus proposal structured by the principle of interdisciplinarity. Thus, the aforementioned course aims to promote a theoretical-methodological learning that enables professionals to act in their daily work in a collaborative, critical, grounded and innovative way, integrating their practices with state of the art scientific research.

In the Professional Master's Program, research on practices in the health sector is drawn up by the initial interests of

professional-students. However, along this stricto sensu course in postgraduate studies, such interests are confronted with new tools, new concepts and new methodological references. Based on that, these professionals elaborate assumptions, reflections and interventions in their daily practices[7]. In that sense, in this postgraduate course, one of the disciplines offered adresses the theoretical-methodological framework for Institutional Analysis (IA), which is aimed at intervening into groups and organizations, providing resources to those who wish to do research on their professional practice.

The fact that students of a professional master's degree program can do research on their own practice creates a complexity to be discussed and analyzed, since it involves decision processes, power relations, their role as a researcher, among other factors that require being analyzed. Thus, in that discipline, students were asked to prepare an institutional diary, based on situations experienced in their workplace, having the concepts of Institutional Analysis as a basis for their analyses.

The institutional diary provides moments of reflection on the practice itself, through the writing of individual or collective experiences, assuming the researcher's non-neutrality in the investigations, which allows to reveal what is usually unsaid in the organization and contributes to the analysis of its implications[8,9].

The reflections, based on the records in the diaries, brought up several issues related to the process and the work relationships of these professionals. Among these issues, resistance to teamwork stands out, especially from physicians, which greatly affects interdisciplinarity in health services.

Resistance can be defined as a social force in opposition to another force called power, in a relationship that tends to favor the latter. The uses and meanings of this word have two main aspects: the first one is related to the struggle against oppression, being of a revolutionary nature; and the second one is traditionalist and tends to preserve what already exists[10]. It is from this perspective that resistances are questioned as being transversal to interdisciplinarity and interprofessionality in the practice of health professionals.

Therefore, these resistances can be considered an analyzer of professional practices in the health sector. This is because

> In general terms, the effect of the analyzer is always to reveal something that remained hidden, to desorganize what was somehow organized, to provide a difference sense to facts already known[11(82)].

The objective of this article is to report the experience of the students of the professional master's program in management of health services regarding the use of IA concepts, in order to analize the different forms of resistance to interprofessional and interdisciplinary work in health, finding them by means of an analyzer of the process and of the work relations.

Material and methods

This is an experience report based on the experience of its authors and on the analysis of institutional diaries carried out in that discipline, based on the dialogue of these authors with certain concepts of the theoretical framework of IA.

The experience report is a type of study that belongs to the social domain and seeks to describe a particular experience producing reflections on certain phenomena, through the authors' impressions and conjectures[12].

Regarding the IA theoretical refferences, this one was founded in France in the 1960s and 1970s to better understand a certain social and organizational reality, based on the speeches and practices of the subjects. Among their main theoreticians are Georges Lapassade and René Lourau, the latter being the one who ellaborated the dialectical concept of institution[13].

Institution was defined as a "universal norm [...], being it related to marriage or to education, to medicine, to salary work, to profit, to credit"[14(15)]. This concept decomposes itself into three moments: a) the instituted, in other words the way how the institution presents itself; b) the instituting, encompassing the denial of that form based on particular situations; and c) the institutionalization, what is yet to become , resulting from the dialectic relation between the two previous moments[14].

For institutional analysts, every institution comprises norms constructed, reproduced or denied by subjects in a permanent socio-historical process[15]. Therefore, the institution is not external to the subjects and, on the contrary, crosses all their practices. However, as subjects are not mere reservoirs, they react in different ways to this crossing, which is associated with the concept of implication.

Implication represents the libidinal, organizational and ideological relationships that individuals establish among themselves and with institutions[14]. It must be remarked that one is always implied with the institutions, and that is why it is important to analyze such implications, which allows to denaturalize and deindividuate daily activities[16].

In that sense, the authors of this article sought to analyze the implications found, based on the situations that came out spontaneously and contingencially in the professional practice reported in the institutional diaries. Thus, this is a study developed within the teaching context and aiming at a theoretical deepening of the professional practice situations, which did not require approval from the Committee of Ethics in Research Work. However, data capable of identifying the participants are not to be disclosed, assuring secrecy and annonimity of organizations and professionals involved in the work process[17].

Among the authors of this article, five of them had been enrolled in the aforementioned discipline, with four of them being nurses and, one of them, a physical therapist, and they all worked in public health and phylantropy services such as university hospitals and rehab daycare. One of them, however, worked at the district health management in a municipality in Minas Gerais. The discipline coordinator also worked as an author in this study.

The course was taught from October 8 to December 10, 2018, with a workload of 45 hours. The methodological strategies adopted were: a) dialogued expositions; b) lectures; c) video-conferences and other activities carried out in the remote modality; and d) preparation of the institutional diary. Thus, a discussion forum (asynchronous remote education activity) was created to enable the sharing of the prepared diaries, providing collective discussions and analyses. Based on this experience, the students were able to identify in their diaries that, despite working in different health services, resistance to interprofessional and interdisciplinary work, especially medical resistance, was a common theme in their analyses.

Initially, a critical reading of the institutional diaries was done, highlighting some excerpts that made it possible to analyze and exemplify resistance as something transversal to work relationships and to the assistance provided to users. In addition, to have a more in-depth discussion on resistance as an analyzer of interprofessionality and interdisciplinarity in health, another professor and a doctoral student from another university were invited to join the group, as they had already carried out studies on this concept in the area of mental health, a fact that strengthened collective and interdisciplinary production in this article.

The resitances to interprofessional and interdisciplinary work as analyzers of professional practices in health

In the health sector, although there is a diversity of professionals, there is hegemony of the biomedical model in the work process and in

the assistance to the user, granting a central role to physicians in the practices adopted. Thus, medical knowledge translates into power, occupying the top of the hierarchy of services and guiding the social division of health labor[18].

One can note that in several health services, due to this central role played by medical power, the other workers end up having their professional autonomy limited, and this can be observed in the description made by the physical therapist of users asking if her conduct was based on medical guidance, in spite of her clarifying that each health professional has skills of his own in interdisciplinary actions and interprofessional work. In general, users do not accept such clarification, making the professional dissatisfied given the lack of belief in their conduct and decisions, as shown in the excerpt from the diary 01:

> *I talk again with the mother of my patient with Chromosome 18 in Ring Syndrome. She refuses to reduce the amount of the girl's weekly* [therapy] *sessions. She will only do it if the pediatrician agrees. We called the pediatrician, the doctor was nice, but she didn't agree with me. She also thinks that the child should continue with four weekly physical therapy sessions even if she does not gain any weight. I stood very respectfully in front of the pediatrician and said that the physical therapist, not the doctor, would know this better. Begrudgingly, she accepted and asked me how many times I thought she should have their sessions. I said twice, one time fort speech therapy and one time for music therapy, as these two require less energy. At great cost, the doctor accepted. I asked her to speak to the child's mother, as it was the only way for her to accept it. I was somewhat upset, because a decision that should have been made by the physical therapy professional was only accepted when the medical professional gave her approval. I thought, this could be an analyzer within an institutional analysis. It is impressive how the Medicine institution crosses the integration with Physical therapy. I decided to talk to other colleagues from other sectors within the service about this.* (Institutional Diary 01).

This overlapping of the doctor's actions also occurs in the practices of obstetric nursing, since a culture centered on the medical professional still prevails in society, mainly when it comes to childbirth and birth care. Such actions still remain instituted even after the issuance of the Cofen Resolution No. 516/2016, which regulates the role and responsibility of nurses, obstetric nurses and midwives in assisting pregnant women, women in labor, postpartum women and newborns[19].

The excerpt from the institutional diary highlighted below shows not only an overlap between medical and nursing actions, but also a power struggle for occupying the central role in care. In addition, it shows that there is a relationship of domination within medicine itself, especially in the university hospital, where professors/preceptors often have authoritarian behaviors towards medical residents, also demarcating an institutional hierarchy.

> *I took care of the woman in labor together with the medical and nursing staff of the obstetric unit. She was in a lot of pain due to the uterine contractions of labor, she was screaming a lot and was not listening to the team's recommendations for pain relief. The medical team prescribed analgesia. Close to birth, fetal heart rates began to slow down, but for physiological reasons, given the fetal position in the birth canal. The medical resident and the medical student began to stimulate the parturient's perineum for delivery to come sooner. At that moment, as an obstetric nurse, I said that there was no need for that intervention, since the fetal cephalic pole was being compressed by the birth canal. Then they withdrew their hands. Fetal heartbeats were remaining between 100-110 bpm. However, the obstetrician asked the resident physician to pass a relief bladder catheter to 'facilitate delivery', and again they began to stimulate the perineum. After the procedure, the obstetrician recommended an episiotomy. I asked the medical resident not to do it, but she did. I felt like crying and left the room very sad. After delivery, the resident called me to talk and said that she found herself in a very difficult situation, as there was not much dialogue*

> *and conduct discussion with the medical preceptor who was on duty. She also said that she greatly respects the knowledge of each one, that everyone has something to teach, however, that, depending on the medical preceptor, everything becomes more difficult. I told her that it is not easy to deal with that, however, that it is necessary to discuss the conduct, because* [this] *involves a whole training process and that residents need to seek this path. In view of this, I can analyze how much the obstetric nurse professional feels oppressed in professional situations and relationships, especially with some medical preceptors of obstetrics. Therefore, we can consider the medical resistance to the performance of obstetric nursing* [an] *analyzer [...].* (Institutional Diary 02).

Health professions can be considered institutions, as they bring together legislation and regulatory standards of professional practice and the advocacy of their specificities. Of course, this is necessary to define the field of action of each one of them, but at the same time, it can trigger corporatist defenses and contribute to the formation of certain resistances to interprofessional work and interdisciplinarity. Thus, when considering interprofessionality and interdisciplinarity as an analyzer, this can reveal to health professionals that they must be careful not to fall into traps, such as corporatism, which can reinforce the boundaries between disciplines and professional practices.

Resistance to interprofessional work and interdisciplinarity, as an analyzer, can also reveal that this is also present among the users, since there is mainly an expectation regarding the request for exams and the prescription of medicines to be carried out by the doctor, as can be seen in the excerpt from the first diary. In this case, resistance to interprofessionality and interdisciplinarity should not be attributed exclusively to the physician, since the user's experience in a culture must be considered, and experience in which, historically, medicine has been consolidated as a central profession in the health sector. This socio-historical construction reinforces the view of medical superiority and makes users also show some resistance to the care and guidance of other health professionals.

The clinical method based on the biomedical model had its beginning in the 19th century and reached its hegemony in the 20th century, introducing new knowledge in the health sciences. In 'The birth of social medicine', Foucault[20] considers that this model goes beyond the boundaries of the health sector, leading to the phenomenon of medicalization of society.

It is remarked that

> the non participation of the patient in approaching his problem or in defining the therapeutical planning stresses the position of the medical doctor in a place of superior and authoritarian knowledge[21(218)].

This fact configured health assistance based on diagnosing illnesses, reducing it to the procedures resulting from this diagnosis, ignoring the integrality of health assistance.

From that perspective, medical resistance would be more aligned to the conservative trend of the concept of resistance[10]. Therefore, it is structured for the preservation of medical hegemony, opposite to the forces of transversality tensioned by the proposition of team work and interdisciplinarity instituted by the National Curriculum Guidelines of the 14 health professions, by the Unified Health System (SUS) guidelines and by the PNH[6,22].

However, most important is to perform this analysis 'through' the resistances and not 'of' them[10]. In the analysis performed this way, it is verified that, in spite of the strong resistance to the interprofessional and interdisciplinary work in health, this is not a trait only of the medical professionals, given that professionals from other areas in health and even users of services can strengthen such resistance.

In the movement of institutionalization of interprofessional and interdisciplinary practices in health, the dialectical concept of

institution allows considering that the biomedical model is still something instituted in society, since it crosses the other professions in the health sector all the time; as can be seen in this excerpt from the diary:

> *As an occupational health nurse, I have asked myself: what is really the role to be played by this professional that has been included in the practices of workers' health in the public health service? This professional, being his a new position in the hospital health scenario, is very much at dependant on the biomedical model, where all the actions we develop do not define a conduct, but serve only as an instrument for the doctor to evaluate and determine what is to be carried out. The activities that occupational nurses perform in their daily practices are numerous, but I have been questioning myself about this lack of openness and the difficulties you come across when wanting to be included as a protagonist in the actions related to workers' health. As an occupational health nurse, I took notes and created several practices and behaviors to be developed for the network, I feel involved and I question why we have to demonstrate our worth all the time and not be recognized in accordancde to our experience and academic and scientific training. I believe that the management process in relation to the multiprofessional team in the network needs to be reassessed and enable a more holistic view and the opening of new perspectives for the other 'non-medical' professions.* (Institutional Diary 03).

In the biomedical model, there is a tendency to use the term 'non-medical professionals', which implies a devaluation of other knowledge and limits the possibilities of interdisciplinarity by reinforcing a predetermined hierarchy of medical knowledge, which impairs interprofessional work and, consequently, comprehensive care to the user.

Thus, a first effect of resistance to interprofessionality and interdisciplinarity in health is a movement to support the hierarchy in work relations, which tends to submit the various knowledge to medical knowledge, so that other health professionals remain in the position of mere 'assistants'. However, these vertical relationships are also observed from an institutional hierarchy within medicine itself, between professors/preceptors and resident physicians, who are supposedly in an inferior position. A second effect produced by this resistance is the loss of the centrality of the user in health care, given that, both in the process of social legitimation of physicians and in the dispute for authority between different professionals, one often loses sight of the demands and needs of users. Furthermore, a third effect is that, due to physicians imposing their will and disregarding the knowledge and practices of other health professionals, users may be submitted to unnecessary procedures and may cause some kind of harm to their health.

However, resistance may be associated with other forces, including those in favor of interdisciplinarity. This was observed in a study that analyzed the sustainability of working in favor of an interdisciplinary approach, as there was resistance from most professionals, who challenged the prioritization of medical consultations, rather than collective interventions carried out in the area of mental health. In this case, the strength of the central role of medicine in care was confronted, with the participation of some doctors, when the multidisciplinary team, based on the analysis of its implications, produced instituting movements to build practices with the participation of professionals of various kinds, without establishing a hierarchy of knowledge, and enhancing interdisciplinary work[23].

From this perspective, professionals in the health sector must constantly analyze the implications of this in the different contexts in which they are working, including the analysis of institutions such as health and education when considering academic training; the social division of labor; public health policies, among others. This is a way of enabling a professional repositioning capable of providing strategies to

deal in an expanded way with the challenges of everyday life and, above all, with interpersonal relationships. Therefore, analyzing the implications allows to develop a critical and reflective look at professional practice and the search for a new know-how as an involved professional who analyzes his performance in a multiprofessional and interdisciplinary health team.

Thus, the emphasis on the need for a collective analysis, avoiding the mistakes of accountability or, even worse, of blaming individuals[24]. When the implication is analyzed collectively, health professionals gather more elements to reflect on ways to build interprofessional work and interdisciplinarity in a context in which the biomedical model is still predominant. This favors the emergence of analyzers that, at first glance, seem to be trivial and naturalized events, but which, in a given context, acquire meanings that reveal aspects that can no longer be ignored, allowing for a deeper analysis in progress.

Collectively analyzing the resistance to interprofessional and interdisciplinary work, especially medical resistance, allows health professionals to leave their established places and perceive the instituting movements that occur in the services in which they work. Certainly, this enables new perspectives and an ethical repositioning of professionals and managers, which can contribute to the integration of professional knowledge and practices, for the provision of comprehensive and humanized care.

From this perspective, an instituting example in the training of health professionals, which seeks to strengthen interprofessional work and interdisciplinarity, is the Education Program through Work for Health (PET-Saúde/Interprofessionalidade), which aims to promote teaching-learning integration and community service, focusing on the development of the SUS, based on the theoretical-methodological elements of Interprofessional Education (IPE)[6,25].

It must be said that this innovative strategy was not developed in the work venues analyzed in this study, and this even more restricts the possibilities of consolidating the interprofessional education and the interdisciplinary perspective for the health actions.

The multiprofissional residency can be considered another instituting factor in health training, considering that, in this context the

> Interprofissionality demonstrates to be a relevant strategy for professional education and assistance quality improvement, based on the shared planning of care, of the user as the center of care, of learning about other professions and the exchange of knowledge with others[26(9)].

It can be considered that the multiprofessional residency program is still being institutionalized in university hospitals, which implies the need to carry out specific studies and investigations that may identify benefits, strengths and weaknesses about this training strategy for interprofessional and, consequently, interdisciplinary work.

In the management of health services, we have other examples of instituting movements, such as co-management and expanded clinic. These are strategies that favor institutional democracy and the construction of interdisciplinary clinical protocols and guidelines, which can be observed in the elaboration of the singular therapeutic project adopted in the Family Health Strategy (ESF)[27]. Those are practices that are still seldom observed, especially in the hospital context, as well as in the workplaces analyzed in this study.

Although not all analyzed workplaces develop the instituting strategies exemplified in this study, it can be said, from the literature consulted, that such strategies strengthen the relevance of the collective movement of institutionalization of interprofessional and interdisciplinary work to face the problems clarified by the analyzers, in view of the process of transformation of professional health practices.

Final considerations

The students of the Professional Master's in Health Services Management reflected on the theme of resistance to interprofessional and interdisciplinary work through classroom discussions and reports in the institutional diary, which were analyzed based on the concepts of the theoretical-methodological framework of AI. This led to the collective elaboration of this article, which also relied on the expertise of professionals from another university.

It can be said that writing the institutional diary was a challenge to the students, but they recognized that this proved to be a powerful working tool with 'therapeutic benefits', as it provided resources for self-analysis, analysis of practices and professional implicatins, based on remarkable facts of everyday life, such as: suffering at work; power relations in the work environment; conducts and professional postures of team members, among others.

In this sense, this group analyzed professional health practices in a more critical way, and the students were also able to share their reflections with their co-workers, and this may result in a more integrative and interdisciplinary care, based on interprofessional work in their work venues. In addition, the skills acquired in this process can make them more prepared to face the constant challenges that arise in the daily life of health services.

The experiences and reflections showed that if, on the one hand, health practices and the work of professionals in the current scenario still bring marks of a certain predominance of the biomedical model, on the other hand, resistance to this model is also observed in health organizations, which highlights the need to expand the spaces of collective analysis capable of enunciating the reductionism of this paradigm.

To conclude, it is emphasized that the potential of interprofessional relationships in health work and the analysis of the implications of professionals in health services point to real possibilities for transforming the quality of health care. In other words, it is necessary to create innovative proposals capable of associating interpersonal relationships and interprofessional work in order to produce a collaborative model of comprehensive and interdisciplinary health care within the scope of the SUS.

Collaborators

Spagnol CA (0000-0003-1588-2109)* contributed to guiding and writing the article. Ribeiro RP (0000-0002-9863-0101)*, Araújo MGF (0000-0003-0922-656X)*, Andrade WV (0000-0003-1907-6286)*, Luzia RWS (0000-0002-8463-0784)*, Santos CR (0000-0003-0260-9939)* and Dóbies DV (0000-0001-5583-1109)* contributed to writing the article. L'Abbate S (0000-0003-2163-0901)* contributed to the final version and final revision. ■

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