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Interprofessional Education in Multiprofessional Residency in Primary Health Care: Phenomenological analysis

Educação Interprofissional na Residência Multiprofissional em Atenção Primária à Saúde: análise fenomenológica

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ABSTRACT Interprofessional Education (IPE) is a strategy that contributes to shared learning among professions, promotes collaborative practices, positively influencing health actions and results. This phenomenological qualitative research aimed to understand how IPE is perceived in the curriculum of a Multiprofessional Residency in Primary Health Care (PHC), from the perspective of residents. All the second-year residents took part in semi-structured interviews (n = 10). The textual material produced was interpreted by content analysis, using Visual Qualitative Data Analysis software. PHC training enabled shared learning and working between different professions, expressed through interaction, exchange of knowledge and recognition of roles at work. Among the shared practices were case discussions, team meetings, multi-professional consultations, prenatal care, home visits, territory recognition and collective health promotion/education actions. Communication was highlighted as a fundamental element for collaborative teamwork and conflict resolution. Experiences of shared learning within multi-professional teams dedicated to caring for individuals, families, and communities, along with their interactions, confirm the power of PHC for the development of IPE. However, it is necessary to advance in curricula that express the pedagogical intention for IPE and in research that brings the perception of preceptors-tutors-coordination of the Program.

KEYWORDS Interprofessional Education. Learning. Primary Health Care. Unified Health System. Qualitative research.

RESUMO *Educação Interprofissional (EIP) é uma estratégia que contribui para o aprendizado compartilhado entre profissões, promove práticas colaborativas, influenciando positivamente ações e resultados em saúde. Esta pesquisa qualitativa fenomenológica propôs-se a compreender como a EIP é percebida no currículo de uma Residência Multiprofissional em Atenção Primária à Saúde (APS), na perspectiva de residentes. Todos os residentes do segundo ano participaram de entrevistas semiestruturadas (n = 10). O material textual produzido foi interpretado pela análise de conteúdo, utilizando o software Visual Qualitative Data Analysis. A formação na APS possibilitou o aprender-trabalhar compartilhado entre diferentes profissões, expresso pela interação, troca de saberes e reconhecimento dos papéis no trabalho. Entre as práticas compartilhadas, destacaram-se a discussão de casos, reuniões de equipe, consultas multiprofissionais, pré-natal, visitas domiciliares, reconhecimento do território e ações coletivas de promoção/educação em saúde. A comunicação foi evidenciada como elemento fundamental para o trabalho colaborativo em equipe e resolução de conflitos. Experiências de aprendizagem compartilhadas com equipes multiprofissionais que atuam no cuidado de pessoas-famílias-comunidade, com interação, confirmam a potência da APS para o desenvolvimento da EIP. Entretanto, é preciso avançar em currículos que expressem a intencionalidade pedagógica para a EIP e em pesquisas que tragam a percepção de preceptores-tutores-coordenação do Programa.*

PALAVRAS-CHAVE *Educação Interprofissional. Aprendizagem. Atenção Primária à Saúde. Sistema Único de Saúde. Pesquisa qualitativa.*

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Introduction

Changes in the demographic and epidemiological profile of 21st century society have led to people's health needs becoming increasingly complex[1,2]. In this context, teamwork and interprofessional collaboration are presented as means to improve access to and quality of healthcare and to strengthen healthcare systems based on comprehensiveness and the central role of the user-family-community[1,3-5].

The different professions that make up the healthcare network require training focused on teamwork, which involves the development of collaborative skills[4,6-9]. Collaborative skills are skills developed by workers to improve their work by improving common skills and those specific to each occupational group[10].

Interprofessional Education (IPE) is an educational strategy to prepare professionals for effective teamwork. It takes place when students and professionals learn from, about and with each other, in interaction and with the intention of improving interprofessional collaboration and the quality of healthcare people receive[3,11]. IPE contributes to shared and interactive learning, promotes collaborative practice, and encourages interprofessional work, which has a positive impact on health measures and outcomes[3,12-16].

From the perspective of workforce training in Brazil, Multiprofessional Health Residencies (MHR) are educational/learning proposals in the Brazilian Unified Health System (Sistema Único de Saúde, SUS) that provide opportunities for learning/doing among different professions and characterize experiences with potential for IPE[17-19]. Studies show that RMS promote improvements in health care by putting the user at the center of this care and promoting the exchange of practices[18-20].

Aware that IPE should be part of the training of health professionals, from undergraduate level and progressively in postgraduate and continuing education, the aim of this study was to understand how IPE is perceived in the curriculum of a Multiprofessional Primary Health Care (PHC) residency from the perspective of residents.

Material and methods

This was a qualitative research using a phenomenological approach[21] that investigates human phenomena experienced in the social contexts in which they occur and from the perspective of the people who experience them – social phenomena. The phenomenon examined in this study was IPE in the formation of Multiprofessional Residency, focusing on the perceptions of resident professionals. The Consolidated Criteria for Reporting Qualitative Research (COREQ)[22] was used. The study complied with ethical principles according to Resolution CNS/MS No. 466/2012[23] and Resolution No. 510/2016[24] and was approved by the Research Ethics Committee of the Federal University of Rio Grande do Sul (Certificate of Ethical Approval – CAAE No. 53291021.2.0000.5347 and Opinion No. 5.131.280) and the City Hall of Porto Alegre (Certificate of Ethical Approval – CAAE No. 53291021.2.3001.5338 and Opinion No. 5.185.733). All participants have signed the Free and Informed Consent Form.

The study was developed in the city of Porto Alegre, Rio Grande do Sul, as part of the Multiprofessional Residency Program in PHC of the Municipal Health Department. The residency was launched in March 2020 to promote the training of professionals to work in PHC[25]. Each core area that makes up the residency – nursing, dentistry and pharmacy – provides for these professionals to work in each of the four health units (HU) that are learning settings[26]. Of the 12 positions offered for 2021, 11 were filled and there was one request for dismissal.

All 10 residents who were in their second year of training (R2) participated in the study. No R2 residents were excluded. The selection of the R2 group was justified by the aim of the study to analyze the residency curriculum from the perspective of residents who were in the final stage of their training.

The invitation to participate in the study was sent by email to the residents, with only one sender and one recipient to ensure confidentiality of the participants' identity. The email contacts were requested by the RMS coordinator.

Semi-structured individual interviews were conducted. The interview guide consisted of questions about the residents' profile (contextual data) and experiences of interaction between the different professional groups in terms of IPE during residency (*box 1*).

Box 1. Guiding questions for the interview

Guiding questions	Information
The context of residents Demographic profile Undergraduate and postgraduate training	Sex, age Undergraduate course Time from graduation Undergraduate training institution Student financing Student quotas Other postgraduate course completed
About the residency training experience	Choice of field (health unit) and optional internship Description of activities carried out in the residency (interaction) Multiprofessional-interprofessional performance (teamwork) User participation Description of class organization Knowledge about interprofessionality IPE in the residency curriculum

Source: Prepared by the author.

Interviews were conducted from April to September 2022 by a single researcher (Master's student, with experience in PHC work and qualitative research) in person in a healthcare setting in a quiet room, according to the availability of the participant. All biosafety and social distancing precautions required for the COVID-19 pandemic were observed. Interviews were audio-recorded and transcribed. The interviews lasted an average of 45 minutes (a total of seven hours of recording time). The transcribed text material of the interviews was given back to the participants so that they could reread/add to the ideas put forward.

The information obtained from the textual material of the interviews was analyzed using content analysis 27 from the perspective of the phenomenology of perception 21, which focuses on people's experiences at a particular time and place, including the meaning, structure and nature of a particular social phenomenon. To approach the empirical material, the steps of pre-analysis based on skimming and re-reading were followed. Subsequently, the material was explored through coding by identifying emergent themes that were transformed into categories (units of meaning)[27]. The initial analysis matrix was created by the researcher who conducted the interviews and later discussed with the second researcher to determine the final matrix. The Visual Qualitative Data Analysis (Atlas.ti) software was used to organize the research material and unitize it according to emergent themes and categories of analysis.

Each interview was coded with sequential numbers (E1 to E10) to ensure anonymity of the research participants.

Results

Ten second-year residents (R2) participated in this study. There were no refusals or withdrawals from participation in the study.

Nine residents were women between the ages of 24 and 37 who had completed their undergraduate studies between 2012 and 2020. Eight of the participants had graduated from a public university from general admission, and two had gained access through student quotas. Those who had completed their undergraduate studies at a private institution received student funding. Two residents stated that they had completed a further postgraduate course (*table 1*).

Table 1. Profile of residents (R2) participating in the research

Variables	n
Sex	
Female	9
Male	1
Age (years)	
24-26	4
30-32	5
35-37	1
Year of graduation	
2012-2013	2
2014-2015	2
2020	6
Higher Education Institution (HEI) of the undergraduate course	
Public	8
Private	2
Undergraduate financing	
Student Financing Fund (Fies)	1
University for All Program (Prouni)	1
Public HEI Training	8
Admission to undergraduate studies	
Student quotas	2
General admission	8
Completion of a previous postgraduate course	
Yes	2
No	8
Experience interacting with students from other undergraduate courses	
Yes	5
No	5
Total	**10**

Source: Prepared by the author.

The preliminary analysis and exploration of the textual material produced as part of the study resulted in themes and two categories (*box 2*).

Box 2. Categories of analysis

Emerging themes	Analysis categories	Definition
In-service training with a focus on interprofessionality	Strengths and challenges of in-service training: PHC as a dynamic space for interprofessional education and work	Presents, from the resident's perspective, the potential and challenges of in-service training for interprofessional work
Interprofessional education in the curriculum	Identification of IPE in the curriculum of the Multiprofessional Residency in Primary Health Care (*Remaps*) from the resident's perspective	Expresses the IPE moments in the residency curriculum

Source: Prepared by the author.

Strengths and challenges of in-service training: PHC as a dynamic space for interprofessional training and work

PHC, the first-year MHR practice setting, shaped the accounts of residents as they expressed their perceptions of the spaces of interaction between the different professions.

Although they recognized the space of specific activities of their professions at different times – "*I was very absorbed by the core of nursing*" (E1), "*I spent half of my residency mostly in clinical care*" (E7) – residents recognized that their in-service training allowed them to not be limited to their professional core.

By identifying activities that allowed for interaction between professions as powerful spaces for IPE, the residents demonstrated the need to build interprofessional articulations to recognize the roles played and, in doing so, acknowledge knowledge and actions through the work, with the user/territory as the center of care. Residents emphasized knowledge of the "*territory*" (E2), participation in multidisciplinary "*consultations*" (E1), "*home visits*" (E3, E4, E9), actions of the school health program (Programa Saúde na Escola – PSE (E3, E4), "*prenatal care*" (E1, E9, E10), "*vaccination campaigns*" (E1, E3, E5, E10), "*case discussions*" (E7) and "*groups*" (E7) with various professionals in the team (nurses, pharmacists, doctors, community health workers).

The joint home visits with different professionals deserve to be highlighted among the results of the study. They enabled learning that went beyond the professional field and shaped the lives of these residents.

> *I went with the social worker* [on the home visit]. *She said it was a very vulnerable family. I know what vulnerability is, but I didn't know that kind of vulnerability existed. [...]. I took a toothbrush with me, just for the bedridden patient. And she said, 'Maybe you can take one for everyone in the house, there are six people' [...]. There were three children, one bedridden person and two adults [...]. Then the little girl, whose teeth were already black, smiled at me. I gave instructions to the bedridden person, explained and gave everyone the toothbrushes [...]. The youngest must have been about three years old [...] I gave her the toothbrush and toothpaste. She said to me: 'What's that, auntie? I explained it to her and she was very happy [...] and started to eat the toothpaste. 'My God! What's happening? I felt like crying and running away from that place. The children's mother said to me: 'I'm glad you brought*

the toothbrushes, we didn't have any! Nobody had a toothbrush. So it was an experience, I don't even know if it was just a learning experience, but a life experience. (E10).

The opportunity for learning and collaboration with multidisciplinary teams in PHC brought the discussion of cases and sharing of knowledge through interaction, collaboration and shared learning with other professionals into the context of residency training.

[...] we were all in one room – doctor, nurse and pharmacist – and then you end up with this view of other professions. [...] my learning would not have been so enriching if we had not had this multidisciplinary approach. We have a very good exchange between the medical, nursing and dental professionals. We discuss the case. It's an exchange of experiences that you will not find in any book. (E4).

This variety of actions developed in PMC was permeated by the needs of users in these areas, with a focus on the context of the COVID-19 pandemic, as can be seen in the following report from a resident.

We provide care for several cases of COVID-19, carrying out rapid tests and have been following the entire start of the vaccination campaign. [...] I also had to deal with STIs [sexually transmitted infections] *that I didn't know about, such as reporting, rapid testing for HIV and other STIs, in addition to the biosafety issue. In addition to dentistry, which is my major.* (E2).

In view of the increase in people with COVID-19 symptoms, the Municipal Health Department suspended team meetings for a certain period of time by normative instruction 019/2020[28], which was reflected in the reports of the residents.

We don't have a meeting. [...] it was suspended due to the increase in respiratory symptoms in emergency rooms and health units. (E5).

In the residents' perception, the team meeting was the moment when they could "*talk*" (E3, E5), "*agree on decisions and drive them forward, [...] discuss problems*" (E9). The lack of this meeting impaired communication between the professionals and led to a disorganization of work processes.

[...] the team works well, but because of the lack of meetings, the lack of talking to each other, we only talk little by little, we can't define things that everyone will do and that everyone is aware of, [...] we get lost because of this lack of team communion, [...] we get lost because of the lack of meetings. As a result, the flow gets disorganized. (E3).

Team meetings resumed between late 2021 and early 2022, following the recommendations of the Organization Guide for the municipality's PHC units. PHC services with two or more family health teams can hold monthly two-hour team meetings, with the service being closed. The remaining meetings can be held by the health teams, with each team meeting for a maximum of two hours per week, maintaining the services and with the recommendation to split them into two one-hour meetings on alternate days of the week[29].

In this configuration, the team meeting was perceived by the residents to take place in a fragmented manner, with part of the healthcare team, so that communication, coordination of procedures and decision-making were conveyed quickly and objectively, without interrupting care, which weakened the power of the meetings.

The meetings were more informal and very quick. Not everyone could be present, because the Unit was closed. There were alternating moments with each team. While one had a meeting, the other answered. It was like a cordless phone, very fragile. (E8).

There were situations, however, in which the meeting was held monthly with the HU closed, or meetings in smaller groups where it was possible to discuss problems, align teams and make joint decisions.

> *The meetings took place once a month when the Unit would close. There were agendas, we would align them and make decisions. Usually* [the team's problems] *were discussed in the meetings, or if there was no team meeting, in micro-meetings with small groups.* (E9).

The need for communication between workers was emphasized in this study as a crucial point for the development of teamwork. As there was no possibility to meet for discussions, WhatsApp groups were the alternative to align and organize workflows, which was reiterated by residents as a communication barrier for teams.

> *There are no team meetings. Decisions are shared via the WhatsApp group. I don't think that's the ideal way because it's not an official means of communication. It's there and the person won't read it, you can't ask for feedback. It's not like a meeting where you look someone in the eye. [...] You send it via WhatsApp and it's very vague, you don't know if the person has read it.* (E1).

It is also worth noting that the dynamics of the educational and work process in the residency were also marked by changes in the administration of the municipality's PHC, which is now managed by a civil society organization[30]. As a result, the teams were reorganized, with a turnover of professionals and residents. For the residents, this change came as a surprise and affected their on-the-job learning process.

> *[...] the outsourcing of PHC* [sighs]. *It was something that took us by surprise [...]. Outsourcing threw me a little off track, I think it destabilized other people as well.* (E6).

IPE in the Residency Curriculum from the Resident's Perspective: Shared Learning 'about' and 'between' Different Professions and Users

For residents, IPE occurs when "*professionals from different categories collaborate, communicate, integrate, and strive for the best care for the patient*" (E5). It is "*teaching and learning between different professions and disciplines, [...] an opportunity to learn things from others that you have never seen yourself and to teach things that they will never see either*" (E3).

They recognized IPE moments in their residency training when they learned 'about' and 'between' the different professions by sharing the same healthcare workspaces, through case discussions, care with other professionals in the HU, and home visits.

> *In case discussions, you see the perspective of another professional. That's very enriching, you learn a lot.* (E1).

> *I had a patient who was taking a medication for diabetes. In my previous experience, I wouldn't have known what that medication was. Because of my experience with the pharmacist, I now know [...] I gained this knowledge by listening to the pharmacist and the nurse.* (E3).

> *I don't know anything about oral health, but during a home visit I can see how the dentist assesses candidiasis and the next time I can recognize the same problem in someone else and know what to do.* (E4).

> *We* [pharmacy residents] *have also taught medical students to recommend the use of inhalers to their patients.* (E6).

The 'doing health together', with a focus on people's needs, brought with it the power to perceive the role of each professional in the process of joint care and teaching-learning.

> *We did it collectively. We were able to discuss his case. That was very enriching. With this one patient, we had an overview of what is important in each profession, and together we were also able to learn.* (E8).

The ability to listen to and observe other professionals in PHC, during consultations/

interconsultations or during the team's home visits, was also a manifestation of IPE in the residency curriculum.

> *I didn't go to the book to learn it, I learned it by listening to the other experts talk. [...] I have the feeling that interprofessional education is already in the curriculum.* (E3).

This shared learning between residents and PHC professionals goes hand in hand with the residents' desire to involve people – the users – as participants and stakeholders in decisions about their care process.

> *Centering, putting the user at the center of the action. In the consultations I always go back to this part, so as not to always leave control to the professionals, so that the patient also understands what is happening and can make the decision he or she thinks is right.* (E8).

> *The user expresses his opinion about his/her treatment, especially in the Health Council meetings, [...] in the unit, the user does what is best for him/her, what he/she thinks is right at that moment. You can offer the best treatment, but adherence to treatment depends on the user.* (E9).

Learning amidst the challenges and opportunities of daily life at PHC was also perceived as "*positive*" (E9) by the residents. It taught the team to "*talk*" (E8) and encouraged the development of collaborative conflict resolution skills.

> *When there is a conflict, we listen, see if it is a personal conflict or a team conflict. [...] In a conflict, we have to listen, try to understand what the conflict is.* (E6).

The theoretical activities of the transversal axis of the Residency curriculum, in which classes took place with residents and professors from different professional centers, were perceived as positive by the residents.

> *I found it very interesting to have classes with other professionals. It's a different world. It makes a difference to have classes with other professionals, because it adds to our training, so that we don't just focus on our training. [...] We had classes with nurses, dentists, doctors, occupational therapists and pharmacists.* (E5).

> *We held seminars, projects, trying to 'mix' with different professionals. We had classes with dentists, pharmacists and doctors.* (E8).

However, the theoretical-conceptual foundations of IPE, such as the pedagogical intention of the training – expressed through teaching activities that articulated texts of reference authors of IPE with practical activities in PHC, debates/problematization of concepts and practices of teamwork – were not identified by the residents in theoretical activities.

Discussion

The present study aimed to understand whether IPE is associated with the training of health professionals in Multiprofessional Residency in PHC based on the perceptions of residents.

The theoretical-methodological perspective of the phenomenology of perception allowed us to understand the studied phenomenon in the context of the residents' lives, through the reflection of the events, experiences, essences, subjectivities and interaction of these residents with the world[21].

Experience with meaning, sense and purpose refers to the critical thinking of transformative education through a political perspective. Thinking about educational practices based on the meaning of experience leads to the creation of realities that reinforce subjectivization and thus touch the subject. If, on the other hand, there is an excess of meaningless information, no knowledge is produced and no learning is made possible[31].

Education and in-service teaching practice must enter into dialog with the experiences of resident students.

IPE, the central theme of this study, has its conceptual basis in the intentional interaction of two or more professionals from different fields learning together[3,11]. In this educational proposal, it is not enough for different professionals or students to be in the same space; intention/action is required to interact to improve the quality of health care for person-family-community[3,4,7,11].

The results of this study showed that the PHC is an important space for the SUS, where residents can meet, learn and collaborate with the different professionals that make up the teams. In this sense, it enabled the implementation of a variety of health actions oriented to the needs of the users – knowledge of the territory, participation in consultations, home visits, PSE actions, care for pregnant women, vaccination campaigns, with nurses, pharmacists, doctors and community health workers. It also highlighted the training challenges posed by the turnover of professionals in the practices, which has a direct impact on the team's work process.

The constant search for comprehensive care, the epidemiological changes and the complexity of health needs make IPE an alternative that qualifies the training of health professionals[1,3,7,8,19] in the MHR proposal. Research and experiences with IPE in the Brazilian context – such as courses with interprofessional curricula, PET-Saúde and integrative curricular subjects/components in undergraduate programs, with the SUS network as a learning scenario – reinforce the interprofessional nature of the SUS[14,32-34]. The integration of IPE into the principles of SUS contributes to greater comprehensiveness and equity in both the education and qualification of health care[34-36].

In the accounts of the residents who participated in this research, the meetings with the multidisciplinary teams and SUS users – characterized by listening, knowledge sharing, interactive discussions, and a willingness to learn and collaborate with others – point to the principles of interprofessionality in the residents' curriculum. For the organization of work based on the social determinants and subjectivity of each subject, family and territory, appreciative listening and the strengthening of professional-resident-community bonds make an important contribution.

The involvement of different professionals in the joint resolution of health problems with a focus on people's needs through collaborative work and the development of collaborative skills is essential for interprofessional learning and action.

Interprofessional communication based on the joint development of a common language, shared goals and proposals – communicative action[37], recognition/assessment and (re) recognition of professional roles, resolution of interprofessional conflicts and patient/user/family/community-centered care – is a collaborative competence[9] perceived by residents that goes beyond cooperation between professionals.

Cooperation refers to the division of labor through the meeting and summation of individual activities with collective outcomes[38]. Interprofessional collaboration, as identified by residents, enables progress towards comprehensive care and is understood as a process in which workers from different professional groups coordinate collective actions aimed at people's health status[39].

This study helps to emphasize the importance of IPE in multidisciplinary residency programs in PHC as an opportunity to integrate teaching, service, and community that allows for the learning of collaborative skills necessary for teamwork. It also promotes care practices that are built in an articulated, collaborative manner and with meaning for and with residents and users, leading to better health outcomes. Effective interprofessional learning must include the participation and involvement of all members of the health services – including the users of the areas – to

share the responsibility/protagonism of care and adapt the therapeutic plan to their reality, taking into account their subjectivities[13,19,40], which was observed in this study.

The change in the management of PHC of the community under investigation[30] was also evidenced by the results of this research. This change led to a turnover of professionals in the teams and the prioritization of care procedures linked to quantitative contract targets[41], which had an impact on the teams' work process as perceived by the teams. Added to this is the valorization of individual care and spontaneous demand, as well as the fragility of the community-based and multiprofessional territorial focus introduced on the basis of the 2017 National Primary Care Policy[42], which reconfigures the PHC care model[43]. These are movements in the field of work that may create barriers to IPE and interprofessional collaboration and need to be monitored[41].

Although IPE appears in residents' reports as part of the activities developed in PHC, it must be included in the curriculum of this residency with educational intent, as an educational strategy with the definition of teaching-learning objectives, theoretical foundations, content, teaching-learning and assessment strategies[6,13]. This study shows that the curriculum of the residency program examined cannot guarantee this intentionality. The curriculum should include moments of knowledge exchange between the different professional groups in which concepts – such as teamwork – are discussed from the perspective of interprofessional collaboration.

IPE is understood as transversal and grows across the different levels of training[13] and promotes the development of interprofessional identities[8]. The undergraduate curricula, which are still essentially geared towards uniprofessional training and structured according to professional categories in the MHR, hinder integration between the different professions that will work together. Residency is a stage in professional training that enables learning, teaching and developing skills for teamwork and strengthens comprehensive care and quality of healthcare for individuals, families and the community[19,44]. Understanding the theoretical framework of IPE is critical to implementing change[45].

If practicing professionals do not experience IPE during their undergraduate/residency training, it may impact their professional future by reinforcing uniprofessional practices that fragment care. For IPE to be recognized as an educational strategy that promotes collaborative teamwork and problem-solving health care, it must be experienced from the beginning of training and developed throughout the health professional's career as an articulated and transversal axis in continuing education spaces[6,20,36,46].

In this sense, teaching-learning processes based on interprofessionality are a challenge because they question the fragmented work in the field of health-disease, which is centered and uniprofessional. It is a requirement of this time to consider IPE as a strategy for permanent affective education[46] involving residents, SUS workers and faculty who provide community-based care, integrated into the life context of the territories and based on horizontal and collaborative work relationships.

Efforts to change curricula at this scale require institutional support. Health services, educational institutions, health professionals, faculty, and residents must support them by committing to changes in teaching and service delivery to better link theory and practice[47]. To this end, it is essential to manage the healthcare work process, create work conditions for teams that allow interaction, and apply participatory, dialogic and horizontal strategies in the implementation of the teaching-learning-evaluation process of residents. Considering the sustainability of these proposals, it is essential to guarantee financial resources to adequately support such actions[48].

This study has shown that multidisciplinary residencies in PHC have the potential to promote collaboration as a guiding axis for comprehensive care practice to articulate

knowledge, skills and practices in services, with a focus on users and their families, from a territorial and community perspective. It is assumed that political, organizational and team efforts are required to enable collaboration[6,7].

The limitations of this study lie in the need to widen the scope of research participants and to include the perceptions of other residency stakeholders, such as users, preceptors, tutors and managers. In addition, the results found should be complemented by new research that examines the autonomy of users in their care process, the bond between user and team and among team members, and furthermore observes education and interprofessional work practices in this context of contractual goals in PHC. The importance of a PHC model that enables longitudinal and comprehensive care is reaffirmed, as well as the importance of in-service training that enables interprofessional learning and promotes IPE as a transformative and powerful strategy for teamwork in SUS.

Final considerations

Using phenomenological qualitative analysis, this research has underpinned the importance of PHC as a place of interaction, knowledge exchange and shared learning 'about' and 'between' different professions, and furthermore, the development of collaborative skills essential for interprofessional education and work. Among collaborative skills, residents cited interprofessional communication, team dynamics, recognition of professional roles, conflict resolution, and care that focuses on the person, family, and community.

The activities shared by the residents and the health team – case discussions, consultations, home visits, area recognitions, groups, prenatal care, actions of the School Health Program (PSE), vaccination, testing for COVID-19, care of patients with respiratory symptoms – were powerful learning experiences for teamwork and for the residents' lives.

Team meetings were described by residents as strategic spaces for dialogue, organization of workflows, and shared decision-making within the team. However, when they did not take place (during the pandemic) or took place quickly, they weakened team interaction and communication. Communication was highlighted as a fundamental element for collaboration between the different PHC professions. Involving people - the users - in decision making regarding their care proved to be an integral part of this shared learningand care process.

Although IPE is linked to the training process of residents and is perceived in the activities in PHC, it was not mentioned in the theoretical activities of the course. It is recommended to include and reflect on the theoretical/conceptual foundations of IPE in the curriculum and to explore the perceptions of the preceptors, tutors and coordinators of the Multiprofessional Residency and their understanding of IPE.

Collaborators

Medeiros AV (0000-0001-9563-277X)* and Toassi RFC (0000-0003-4653-5732)* contributed equally to the preparation and approval of the final version of the manuscript. Forte FDS (0000-0003-4237-0184)* contributed to the critical review, writing and approval of the final version of the manuscript. ■

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References

1. Frenk J, Chen L, Bhutta ZA, et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. Lancet. 2010;376(9756):5-40. DOI: https://doi.org/10.1016/s0140-6736(10)61854-5

2. World Health Organization. Transforming and scaling up health professionals' education and training: World Health Organization guidelines 2013. Geneva: WHO; 2013.

3. Organização Mundial da Saúde. Marco para ação em educação interprofissional e prática colaborativa. Genebra: Organização Mundial da Saúde; 2010.

4. Peduzzi M, Agreli HLF, Silva JAMS, et al. Trabalho em equipe: uma revisita ao conceito e a seus desdobramentos no trabalho interprofissional. Trab Educ Saúde. 2020;18:e0024678. DOI: https://doi.org/10.1590/1981-7746-sol00246

5. Freire Filho JR, Silva CBG, Costa MV, et al. Educação Interprofissional nas políticas de reorientação da formação profissional em saúde no Brasil. Saúde debate. 2019;43(esp1):86-96. DOI: https://doi.org/10.1590/0103-11042019S107

6. Reeves S. Why we need interprofessional education to improve the delivery of safe and effective care. Interface (Botucatu). 2016;20(56):185-197. DOI: https://doi.org/10.1590/1807-57622014.0092

7. Costa MV. A potência da educação interprofissional para o desenvolvimento de competências colaborativas no trabalho em saúde. In: Toassi RFC, organizadora. Interprofissionalidade e formação na saúde: onde estamos? Porto Alegre: Rede Unida; 2017. p. 14-27.

8. Frenk J, Chen LC, Chandran L, et al. Challenges and opportunities for educating health professionals after the COVID-19 pandemic. Lancet. 2022;400:1539-1556. DOI: https://doi.org/10.1016/s0140-6736(22)02092-x

9. Canadian Interprofessional Health Collaborative. A national interprofessional competence framework [Internet]. Vancouver: Canadian Interprofessional Health Collaborative; 2010 [acesso em 2023 fev 8]. Disponível em: https://phabc.org/wp-content/uploads/2015/07/CIHC-National-Interprofessional-Competency-Framework.pdf

10. Barr H. Competent to collaborate: towards a competency-based model for interprofessional education. J Interprof Care. 1998;12(2):181-187. DOI: http://dx.doi.org/10.3109/13561829809014104

11. Reeves S, Fletcher S, Barr H, et al. A BEME systematic review of the effects of interprofessional education: BEME Guide No. 39. Med Teach. 2016;38(7):656-668. DOI: https://doi.org/10.3109/0142159x.2016.1173663

12. Reeves S, Perrier L, Goldman J, et al. Interprofessional education: effects on professional practice and healthcare outcomes (update). Cochrane Database Syst Rev. 2013;3:CD002213. DOI: https://doi.org/10.1002/14651858.cd002213.pub3

13. Barr H, Low H. Introdução à educação interprofissional. [local desconhecido]: CAIPE; 2013.

14. Ely LI, Toassi RFC. Integração entre currículos na educação de profissionais da Saúde: a potência para educação interprofissional na graduação. Interface (Botucatu). 2018;22:1563-1575. DOI: https://doi.org/10.1590/1807-57622017.0658

15. Toassi RFC, Olsson TO, Lewgoy AMB, et al. Ensino da graduação em cenários da atenção primária: espaço para aprendizagem interprofissional. Trab Educ Saúde. 2020;18(2):e0026798. DOI: https://doi.org/10.1590/1981-7746-sol00267

16. Samarasekera DD, Nyoni CN, Amaral E, et al. Challenge and opportunities to interprofissional education and practice. The Lancet. 2022;400(10362):1495-1497. DOI: https://doi.org/10.1016/s0140-6736(22)02086-4

17. Silva C, Dalbello-Araujo D. Programa de Residência Multiprofissional em Saúde: o que mostram as publi-

cações. Saúde debate. 2019;43(123):1240-1258. DOI: https://doi.org/10.1590/0103-1104201912320

18. Barreto LDSO, Campos VD, Dal Poz MR. Interprofessional education in healthcare and health workforce (HRH) planning in Brazil: experiences and good practices. J Interprof Care. 2019;33(4):369-381. DOI: https://doi.org/10.1080/13561820.2019.1646230

19. Casanova IA, Batista NA, Moreno LR. Interprofessional Education and shared practice in multiprofessional health residency programs. Interface (Botucatu). 2018;22:1325-1337. DOI: https://doi.org/10.1590/1807-57622017.0186

20. Fernandes SF, Freitas RJM, Silva MRF, et al. Elementos da educação interprofissional no currículo das residências multiprofissionais em saúde: estudo documental. Texto Contexto Enferm. 2023;32:e20230105. DOI: https://doi.org/10.1590/1980-265X-TCE-2023-0105en

21. Merleau-Ponty M. Fenomenologia da percepção. 3. ed. São Paulo: Martins Fontes; 2006.

22. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007;19(6):349-357. DOI: https://doi.org/10.1093/intqhc/mzm042

23. Ministério da Saúde (BR); Conselho Nacional de Saúde. Resolução nº 466, de 12 de dezembro de 2012. Aprova as diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos e revoga as Resoluções CNS nos. 196/96, 303/2000 e 404/2008. Diário Oficial da União, Brasília, DF. 2013 jun 13; Seção I:549.

24. Ministério da Saúde (BR); Conselho Nacional de Saúde. Resolução nº 510, de 7 de abril de 2016. Dispõe sobre as normas aplicáveis a pesquisas em Ciências Humanas e Sociais cujos procedimentos metodológicos envolvam a utilização de dados diretamente obtidos com os participantes ou de informações identificáveis ou que possam acarretar riscos maiores do que os existentes na vida cotidiana. Diário Oficial da União, Brasília, DF. 2016 maio 24; Seção I:44.

25. Secretaria Municipal de Saúde de Porto Alegre (RS). Relatório Anual de Gestão 2020 [Internet]. Porto Alegre: Secretaria Municipal de Saúde; 2021 [acesso em 2023 dez 3]. Disponível em: https://lproweb.procempa.com.br/pmpa/prefpoa/sms/usu_doc/relatorio_anual_gestao2020.pdf

26. Secretaria Municipal de Saúde de Porto Alegre (RS). Manual da Residência Multiprofissional em Atenção Primária à Saúde [Internet]. Porto Alegre: Secretaria Municipal de Saúde; [2021] [acesso em 2023 dez 3]. Disponível em: https://drive.google.com/file/d/153uhZAAX0rNZ_ePlIIso4HC0tErIipDB/view

27. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2016.

28. Secretaria Municipal de Saúde de Porto Alegre (RS). Instrução Normativa 019/2020. Institui medidas complementares de prevenção ao contágio pelo COVID-19 (novo Coronavírus) e manutenção dos serviços e atividades prestados pela Secretaria Municipal de Saúde (SMS). Diário Oficial Eletrônico de Porto Alegre [Internet], Porto Alegre, RS. 2020 maio 7 [acesso em 2023 dez 3]; Edição 6245:10-11. Disponível em: https://dopaonlineupload.procempa.com.br/dopaonlineupload/3366_ce_20200507_executivo.pdf.

29. Porto Alegre (RS). Portaria GS SMS 1467/2020. Aprova e institui o Guia de Organização para as Unidades de Saúde da Atenção Primária do Município de Porto Alegre (GO-APS). Diário Oficial Eletrônico de Porto Alegre [Internet], Porto Alegre, RS. 2020 set 25 [acesso em 2023 dez 3]; Edição 6348:2. Disponível em: https://dopaonlineupload.procempa.com.br/dopaonlineupload/3626_ce_20200925_executivo.pdf

30. Porto Alegre (RS). Edital de chamamento público 002/2022. Edital de chamamento público Atenção Primária. Diário Oficial Eletrônico de Porto Alegre, Porto Alegre, RS. 2022 jun 1 [acesso em 2023 dez 3]; Edição 6771:45. Disponível em: https://dopaonlineupload.procempa.com.br/dopaonlineupload/4396_ce_20220601_executivo.pdf

31. Bondía JL. Notas sobre a experiência e o saber de experiência. Rev Bras Educ. 2002;(19):20-28. DOI: https://doi.org/10.1590/S1413-24782002000100003

32. Rossit R, Batista SH, Batista NA. Formação para a integralidade no cuidado: potencialidades de um projeto interprofissional. Rev Int Hum Médicas. 2014;3(1):55-64. DOI: https://doi.org/10.18848/2254-5859/CGP/v03i01/55-64

33. Costa MV, Patrício KP, Câmara AMCS, et al. Pro-Health and PET-Health as interprofessional education spaces. Interface (Botucatu). 2015;19(supl1):709-720. DOI: https://doi.org/10.1590/1807-57622014.0994

34. Neves M, Toassi RFC. Integrated health practices: Scenarios for interprofessional experiences in the Brazilian health system. J Dent Educ. 2022;86(supl1):855-857. DOI: https://doi.org/10.1002/jdd.12857

35. Peduzzi M. O SUS é interprofissional. Interface (Botucatu). 2016;20(56):199-201. DOI: https://doi.org/10.1590/1807-57622015.0383

36. Prevedello AS, Góes FSN, Cyrino EG. Educação interprofissional na formação em saúde no Brasil: scoping review. Rev Bras Educ Méd. 2022;46(3):e110. DOI: https://doi.org/10.1590/1981--5271v46.3-20210006

37. Peduzzi M. Equipe multiprofissional de saúde: conceito e tipologia. Rev Saúde Pública. 2001;35(1):103-109. DOI: https://doi.org/10.1590/S0034-89102001000100016

38. Soares CB, Souza HS, Campos CMS. Processo de trabalho e enfermagem: uma contribuição a partir da saúde coletiva. In: Souza HS, Mendes A, organizadores. Trabalho & saúde no capitalismo contemporâneo: enfermagem em foco. Rio de Janeiro: DOC Saberes; 2016. p. 43-61.

39. Uchôa-Figueiredo LR, Silva CG, Faria NMS, et al. Prática interprofissional colaborativa: reflexão do constructo à prática. In: Batista NA, Uchôa-Figueiredo LR, organizadores. Educação Interprofissional no Brasil: formação e pesquisa. Porto Alegre: Rede Unida; 2022. p. 36-62.

40. Silva JAM, Peduzzi M, Orchard C, et al. Educação interprofissional e prática colaborativa na Atenção Primária à Saúde. Rev Esc Enferm USP. 2015;49(nesp2):16-24. DOI: https://doi.org/10.1590/S0080-623420150000800003

41. Paula GB. Educação interprofissional em cenários de aprendizagem do Sistema Único de Saúde: repercussões para o trabalho em equipe [dissertação]. Porto Alegre: Faculdade de Medicina, Universidade Federal do Rio Grande do Sul; 2023. 80 p.

42. Ministério da Saúde (BR), Departamento de Atenção Básica, Secretaria de Atenção à Saúde. Portaria nº 2.436, de 21 de setembro de 2017. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes para a organização da Atenção Básica, no âmbito do Sistema Único de Saúde (SUS). Diário Oficial da União, Brasília, DF. 2017 set 22; Edição 183; Seção I:68.

43. Giovanella L, Franco CM, Almeida PF. Política Nacional de Atenção Básica: para onde vamos? Ciênc saúde coletiva. 2020;25(4):1475-1482. DOI: https://doi.org/10.1590/1413-81232020254.01842020

44. Torres RBS, Barreto ICHC, Freitas RWJF, et al. Estado da arte das residências integradas, multiprofissionais e em área profissional da Saúde. Interface (Botucatu). 2019;23:e170691. DOI: https://doi.org/10.1590/Interface.170691

45. Anderson ES, Hean S, O'Halloran C, et al. Faculty development for interprofessional education and practice. In: Steinert Y, editor. Faculty development in the health professions: a focus on research and practice. New York: Springer; 2014. p. 287-310.

46. Figueiredo EBL, Souza AC, Abrahão A, et al. Continuing Health Education: an interprofessional and affective policy. Saúde debate. 2022;46(135):1164-

1173. DOI: https://doi.org/10.1590/0103--11042022135151

47. Hammond KM, Morgan CJ. Development of interprofessional healthcare teamwork skills: mapping students' process of learning. J Interprof Care. 2021;36(4):589-598. DOI: https://doi.org/10.1080/13561820.2021.1936470

48. Shrader S, Ohtake PJ, Bennie S, et al. Organizational structure and resources of IPE programs in the United States: a national survey. J Interprof Educ Pract. 2022;26:100484. DOI: https://doi.org/10.1016/j.xjep.2021.100484

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