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Challenges and potential of interprofessional communication in collaborative practices in the Family Health Strategy

Desafios e potencialidades da comunicação interprofissional nas práticas colaborativas na Estratégia Saúde da Família

Desafíos y potencialidades de la comunicación interprofesional en las prácticas colaborativas en Estrategia Salud de la Familia

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Abstract

Objective: To analyze the perception of Family Health Strategy professionals about interprofessional communication. **Methods**: This was a descriptive study, with a qualitative approach, carried out in October 2021, with nine professionals from a Basic Health Unit in the municipality of Fortaleza, Ceará, Brazil. A sociodemographic questionnaire was used to collect data and a focus group was held. The subjects' speeches were recorded and later analyzed using IRAMuTeQ® software. **Results**: Work overload, staff turnover, mismatches in professional behavior, fragile communication with patients and the lack of formal communication spaces were identified as the main challenges compromising interprofessional communication in the health unit. On the other hand, interpersonal relationships and the use of messaging apps were highlighted as communication enhancers. **Conclusion**: Ineffective communication weakens collaborative practices in Primary Health Care. This highlights the need to reorient the work process in this area of care and expand spaces for interprofessional dialog and collaboration.

Descriptors: Communication; Interprofessional Relations; Patient Care Team; Interdisciplinary Placement; Primary Health Care.

Whats is already known on this?
Effective interprofessional communication contributes to the continuity and safety of health care and is an essential element of interprofessional collaboration and teamwork.

What this study adds?
Work overload, staff turnover, weak communication with patients and the lack of formal spaces for dialog are all challenges for interprofessional communication in the Family Health Strategy.

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Resumo

Objectivo: *Analisar a percepção de profissionais da Estratégia Saúde da Família sobre a comunicação interprofissional.* ***Método:*** *Estudo descritivo, com abordagem qualitativa, realizado em outubro de 2021, com nove profissionais de Unidade Básica de Saúde do município de Fortaleza, Ceará, Brasil. Para a coleta de dados utilizou-se um questionário sociodemográfico e realizou-se um grupo focal. As falas dos sujeitos foram gravadas e posteriormente analisadas no software IRAMuTeQ®.* ***Resultados:*** *Identificou-se a sobrecarga de trabalho, a rotatividade de profissionais, os desencontros de condutas profissionais, a comunicação frágil com o paciente e a ausência de espaços formais de comunicação como os principais desafios que comprometiam a comunicação interprofissional na unidade de saúde. Já o relacionamento interpessoal e a utilização de aplicativos de mensagens foram destacados como potencializadores da comunicação.* ***Conclusão:*** *A comunicação ineficaz fragiliza as práticas colaborativas na Atenção Primária à Saúde. Deste modo, salienta-se a necessidade de reorientar o processo de trabalho nesse âmbito de cuidados e ampliar os espaços para o diálogo e a colaboração interprofissional.*

Descritores: *Comunicação; Relações Interprofissionais; Equipe de Assistência ao Paciente; Práticas Interdisciplinares; Atenção Primária à Saúde.*

Resumén

Objetivo: *Analizar la percepción de los profesionales en Estrategia Salud de la Familia sobre la comunicación interprofesional.* ***Métodos:*** *Estudio descriptivo, con enfoque cualitativo, realizado en octubre de 2021, con nueve profesionales de una Unidad Básica de Salud de la ciudad de Fortaleza, Ceará, Brasil. Para la recolección de datos se utilizó un cuestionario sociodemográfico y se realizó un grupo focal. Los discursos de los sujetos fueron grabados y posteriormente analizados mediante el software IRAMuTeQ®.* ***Resultados:*** *La sobrecarga de trabajo, la rotación profesional, los desacuerdos en la conducta profesional, la débil comunicación con los pacientes y la ausencia de espacios de comunicación formal fueron identificados como los principales desafíos que comprometían la comunicación interprofesional en la unidad de salud. Por su parte, las relaciones interpersonales y el uso de aplicaciones de mensajería se destacaron como potenciadores de la comunicación.* ***Conclusión:*** *La comunicación ineficaz debilita las prácticas colaborativas en la Atención Primaria de Salud, por lo que se destaca la necesidad de reorientar el proceso de trabajo en esta área de la atención y ampliar los espacios de diálogo y colaboración interprofesional.*

Descriptores*: Comunicación; Relaciones Interprofesionales; Grupo de Atención al Paciente; Prácticas Interdisciplinarias; Atención Primaria de Salud.*

INTRODUCTION

The National Primary Care Policy (*Política Nacional de Atenção Básica*, PNAB) emphasizes the Family Health Strategy (FHS) as the preferred model for qualifying, expanding and consolidating Primary Health Care (PHC) in the Unified Health System (Sistema Único de Saúde, SUS). It also defines PHC as a group of health actions carried out at individual, family and collective levels, which include promotion, prevention, protection, diagnosis, treatment, rehabilitation, harm reduction, palliative care and health surveillance.[1]

These activities are carried out by multidisciplinary teams, which assume health responsibility for an assigned population corresponding to a geographically defined territory. The work of these teams contributes to the reorganization and reorientation of the care offered, improving access to health and resolving the population's complex demands.[2] In this context of care, it is important that there is a culture of effective interprofessional collaboration between health professionals in order to guarantee the quality, comprehensiveness and longitudinality of the care provided.[3-4]

Among the elements inherent to collaboration is Interprofessional Communication (IPC), which can be understood as the ability to communicate effectively between individuals, especially from different professions, in a collaborative and integrated manner.[5] In addition, it is an intrinsic component and key element of teamwork that should be strengthened and valued, since it favors the breaking down of power barriers, the sharing of decisions and knowledge, and the conversion of individual knowledge into collective knowledge.[6]

Communication is a process indicator and a highly relevant professional skill that encourages interpersonal interaction and increases the level of collaboration between team members. This consequently increases their capacity to develop safe and integrated care.[6-7]

However, communication failures are common among PHC professionals, which hinders joint decision-making and compromises their ability to collaborate. The less capacity there is for dialog in working relationships, the more fragmented the work dynamics of health teams can become.[6]

Consequently, the sharing of information and the construction of knowledge through dialogical practice can become fluid, misinterpreted and/or dissociated, leading to fragmentation and the weakening of care.[8-10] Studies also reinforce that communication failures are among the main elements related to the occurrence of health care errors in PHC.[3,8,11-12]

In view of this, it is important for PHC/FHS health teams to create opportunities and spaces to cultivate dialog, a process which, although complex, becomes possible as interpersonal encounters take place and the other person is actively listened to.[4,13] It is therefore important to identify and evaluate the challenges and strategies for developing IPC as a way of (re)signifying care practices in PHC and strengthening communicative action among the subjects involved in the care process. To this end, studies involving the various actors in PHC/FHS are necessary in order to comprehensively understand the multi-professional perspective on how the dialogic process occurs in this care context, as well as to raise awareness among managers and health professionals about the IPC's relevance in primary care.[13,14]

Understanding how this element of care takes place can help to generate new reflections and subsidies for the development of policies, as well as educational and managerial interventions to promote improvements in the exercise of collaboration and interprofessional communication in the FHS, as it can identify its facilitators and hindrances. This will help managers and professionals in family health units to mobilize and develop collaborative skills, promoting effective interprofessional work and the production of safe, effective and qualified care. In addition, SUS users will benefit, facilitating better resolution of demands, the achievement of better health results and greater customer satisfaction with the care offered.

In view of the above, the question arises: How does interprofessional communication take place in PHC/FHS? What are the difficulties and potentialities experienced by PHC/FHS health professionals in team communication? Thus, the objective was to analyze the perception of Family Health Strategy professionals about interprofessional communication.

METHODS

This is a descriptive study with a qualitative approach, carried out in accordance with the recommendations of the Consolidated Criteria for Reporting Qualitative Research (COREQ). The research was carried out in October 2021, in a Basic Health Unit (BHU) belonging to Regional Secretariat VI in the municipality of Fortaleza, Ceará, Brazil.

For the composition of the study sample, subjects were selected for convenience, who were chosen because they were most available during their work shift to participate in the research at the time of data collection. Professionals with at least six months' experience working in the BHU teams were included, as they could have a broader perception of IPC in the service. Subjects who were off work due to health problems or on vacation during the data collection period were excluded.

Data was collected using a semi-structured sociodemographic characterization instrument, containing variables such as: name, age, gender, marital status, profession, schooling and length of time working in the FHS. In addition, a Focus Group (FG) was carried out in order to understand the perception of the professionals at this health unit about the process of team communication in the workplace.

The FG was conducted by a lead researcher who moderated the meeting and two previously trained assistant researchers who acted as observers. Only one meeting was held, lasting four hours, in a reserved and adapted room at the BHU. The meeting began with an icebreaker to promote group interaction and participation. A video was then shown to encourage reflection on team communication and its relevance to interprofessional practice in the FHS.

The mediating researcher then posed the triggering question: How do you see communication between professionals in your work? During the course of the activity and group interaction, trigger questions were used to stimulate conversations, debates and reflections on IPC in working practice.

With the participants' authorization, the meeting was recorded. Subsequently, their speeches were faithfully transcribed in their entirety and transferred for textual analysis and data compilation in the *Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires* (IRAMUTEC®) software.

For textual analysis, the Descending Hierarchical Classification (DHC) was used, in which the text segments were classified according to their respective vocabularies, through grouping by semantic similarity called occurrence.[15] The software divided the text into 245 textual segments, 1297 forms, 8618 occurrences, with 75.10% of the text being used.

The study was submitted to and approved by the Research Ethics Committee (CEP) of the Municipal Health Department of Fortaleza and the University of the International Integration of Afro-Brazilian Lusophony (UNILAB), under CAAE 47664121.0.0000.5576. The participants signed the Free and Informed Consent Form (FICF). Confidentiality and secrecy were guaranteed to the subjects by coding

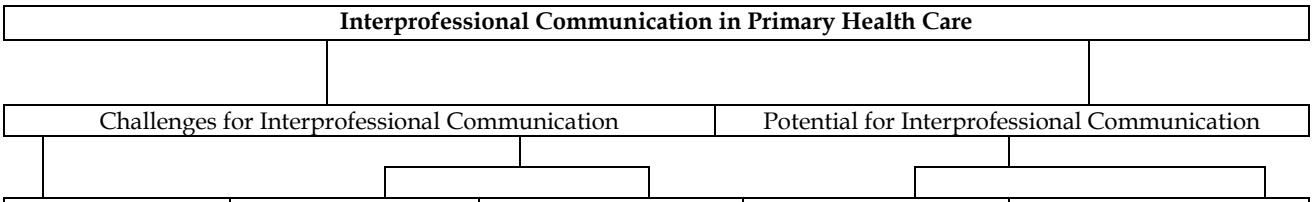
their names with the letter P followed by an Arabic number, numbering them according to the order in which they took part.

RESULTS

The FG consisted of nine female participants aged between 40 and 50, two of whom were dental surgeons, two nurses, one oral health assistant and four community health workers. As for education level, specialization predominated, with four participants, followed by high school, with three participants, and master's and undergraduate degrees, with one participant each.

The IRAMUTEQ® analysis produced the dendrogram shown in Figure 1, which is distributed into five classes, which were grouped into two analytical categories.

Figure 1. Dendogram with the classes obtained from the Descending Hierarchical Classification. Fortaleza, CE, Brazil. 2021.



Words	X²	Words	X²	Words	X²	Words	X²	Words	X²
Know	59.58	Team	36.9	Time	49.76	Understand	21.73	Pass	18.47
PhD	43.18	Management	29.95	Consultation	37.06	Major	17.09	Only	15.91
God	32.69	Category	26.4	Schedule	33.15	Union	14.16	Way	14.21
Now	27.39	Feel	21.91	Time	32.42	Align	14.16	Help	12.27
Come	26.87	Precise	21.88	Week	27.47	Here	14.1	Ask	11.26
Grace	26.01	Lack	20.79	Confirmation	27.47	Challenge	11.54	Remember	11.26
Patient	25.66	Space	18.92	Minute	27.47	Inside	11.27	Being	9.86
Population	13.13	Moment	17.84	Nurses	20.2	Major influence	10.53	So	9.31
Open	13.13	Meeting	17.01	Dentist	11.29	Very much	10.49	Whatsapp	9.15
Example	12.14	Difficulty	16.65	Pregnant	10.81	How	9.03	Sell	9.15
Physician	7.61	Agenda	12.97	Day	7.77	Month	8.4	Back	8.76
Say	7.57	General	12.41	Say	7.64	Quality	8.4	New	8.76
Leave	7.37	Meeting	11.72	Patient	7.36	Best	8.4	Opinion	8.29
Movie	7.32	Shape	8.32	Failure	5.95	Want	8.2	When	8.08
Area	6.28	Gather	8.2	Prenatal	5.95	Improve	7.49	Girl	6.91
Enter	5.31	Sit	6.87	Information	5.95	Respect	7.49	Change	5.74

Source: The authors (2023).

Class 1: Insufficient human resources and weakened quality of care

When asked about the challenges to effective IPC, the participants emphasized the lack of time to develop qualified care and the lack of appreciation on the part of management for meetings to promote dialogue, alignment and agreement on care strategies.

> *My challenge [...] is still time and for management to give more value to these moments when we meet, not just to attend, attend and dispatch, right? [...] they need to understand that there needs to be time to be able to align ideas. (P5)*

> *I also think there's a lack of time; professionals are overloaded. (P6)*

> *A consultation in a short space of time. You don't get to know your patient because you need to communicate more. (P7)*

The participants drew attention to the consequence of the lack of time as a factor that generates ignorance of patients' care needs.

> *In my prenatal care, I take a long time with patients, I take 30 to 40 minutes and the management wanted us to do prenatal care in 15 minutes. (P6)*

> *There really isn't enough time, because you have to have a consultation that has a result, and if it's too short, there won't be a result, sometimes something goes unnoticed that's happening with that pregnant woman or that child that you don't see because the service is too fast. (P7)*

In addition, it was pointed out that the lack of time, generated by insufficient human resources, leads to professional overload and overcrowding in the health unit, which also compromises the focus on person-centered care.

> *There's the crowding problem, it's not their fault. So, they tell us to do this, do that, and what about our visits? It's a lot of people and more and more people. If you don't have the support to deal with this many people, you can't [...] if my team of two thousand people can't cope, can you imagine a team of six thousand? (P7)*

> *We have a very high agenda, a very high demand. (P9)*

According to the participants, the unavailability of time for qualified care directly influences the spread of the biomedical culture and, consequently, the abandonment of PHC principles and objectives, whose actions need to be, as a priority, directed towards health promotion, with an emphasis on self-care and the autonomy of the subjects, with user-centered care.

> *The users themselves don't value it, [...] am I going to leave the house to see a doctor and get some medicine? He'll come right away! Am I going to leave my house to go to the clinic and listen to them talk? This is a waste of time for them, it ends up mischaracterizing primary care. (P6)*

> *In my opinion, the health center's biggest challenge is because it's no longer a PSF, right? And the whole service is education, it's health, it's prioritizing health education, because here in dentistry there's a lot of urgency, urgency. (P8)*

The participants mentioned the staff turnover caused by insufficient human resources, since professionals are constantly transferred for administrative reasons, as a limiting factor for effective IPC.

> *The challenge is to have a professional to work with me [...] our team doesn't have a doctor, so the challenge is very big, how are we going to work well if we don't have one [...] it's incomplete, right? (P2)*

> *The professional turnover we're experiencing here, especially doctors, and the management turnover is a very negative point in this communication. (P6)*

> *Nurses change all the time. (P7)*

Class 2: Lack of dialogic spaces for team communication

The participants also reported the unavailability of conversation circles with all the professional categories as a limiting aspect for effective IPC. In addition, they mentioned that meetings between

nurses and CHAs, which only take place once a month, when they do take place, are limited in time and stop at solving bureaucratic issues, which hinders communication and integrated care planning.

> *There's no communication in my team [...] when we meet, it's so quick that it's just to hand over the referral papers - I don't think that's communication. (P7)*

> *The challenges are the lack of these spaces, these moments for communication, for meetings. (P9)*

They added to the discussion that the existence of these dialogical spaces would act as a catalyst for continuous, patient-centered care, with the various professional categories sharing their views on care needs and possible interventions for patients' multiple conditions, as well as facilitating communication between the health unit and the community. They also highlighted barriers related to the medical category not adequately adhering to the team meeting agenda.

> *I think we need more moments of communication between the whole team [...] a meeting between the whole team is a productive meeting. (P4)*

> *I also miss these meetings, especially because sometimes we want to align some things with the doctors and there are doctors who aren't accessible. Because they don't open up, so I think there's this barrier between different categories as well, some are very resistant. (P6)*

> *That's why it's good to have a team meeting to find out how you dentists are doing, to find out about childcare, I don't know if there's a child in my community, I don't know how it is. (P7)*

> *So, I think in terms of interpersonal relations, we ended up talking only about the categories and didn't include the NAC [...] it's a big challenge for us to communicate with them. (P9)*

Class 3: Weak communication between health professionals and patients

Communication with patients was also a challenge identified, which was linked to conditions such as the lack of time and turnover of professionals, influenced by insufficient human resources and the absence of spaces for the whole team to align care plans, which hampers effective communication with patients and leads to mismatches in referrals to other professionals.

> *I feel the need to improve communication with patients [...] I cut them off a lot, we end up having to optimize the consultation, [...] otherwise there's no time. (P5)*

> *Because things happen here at the door and sometimes, due to a lack of communication, patients are left running around inside the clinic. (P8)*

> *The nurses are there in the office and they say to the pregnant women: go to the dentist's office and they'll make an appointment, so there has to be good communication between the dentist and the nurse about the pregnant women, how they're going to be seen, how we're going to make an appointment? [...] Sometimes the dentist isn't here." (P8)*

Class 4: Interpersonal relationships as an enhancer of interprofessional communication

When asked about the potential for IPC, the participants reported a good interpersonal relationship as a driver for improving communication within the team and stressed that despite the challenges mentioned, respect and empathy between professionals mitigate the barriers to effective communication.

> *But I think that the people here at our health center are very united, everyone who comes here says that it's a different kind of health center, anyone who's never worked at a health center here, why? Because all the professionals who work here get on very well. (P6)*

> *Because we have respect, we listen to each other. But there is this unity, and I think that this is a very strong potential of communication here in this unit... (P7)*

Class 5: The use of instant messaging applications as a facilitator for passing on information

Digital media, in particular the instant messaging application WhatsApp Messenger, were mentioned by the participants as enhancing the transfer of information, since they allow quick access to information, which also facilitates communication between health professionals and patients. Therefore, it can also contribute to overcoming weaknesses in professional-client communication, which was cited as a challenge for IPC between team members.

> *I think that the media are potentialities in communication. (P4)*

> *I think the girls have already said it all, Whatsapp, [...] the union of professionals here in the unit are the greatest potentialities we have. (P5)*

> *I'm really trying to use the Whatsapp tool as an ally [...] in this communication issue. (P6)*

DISCUSSION

This study analyzed the perception of FHS professionals about the potential and barriers to establishing IPC in collaborative practice. The aspects identified reinforce that work overload, mismatches between the actions of each professional, weak communication with the patient and the need to strengthen formal communication spaces with the participation of all team members were critical nodes that compromised IPC in the health unit.

In this sense, the participants highlighted challenges such as the lack of time to develop qualified health care, turnover and the reduced number of professionals in the health service. In line with these findings, research has shown that lack of time and overload are among the main factors hindering the process of interaction between FHS professionals.[16]

Lack of time leads to care focused on exacerbating problems and does not favor the implementation of preventive and health promotion actions within PHC. These situations are also reflected in the distancing of collaborative multi-professional care centered on the person, the community and family approach, resulting in discontinuity of care and weakening of the bond with the community.[17]

In addition to these factors, the lack of dialogic spaces in the team was a notable aspect, in which difficulties were highlighted in promoting conversation circles with the multi-professional team, especially with medical professionals. This problem hinders interprofessional collaboration, as well as dialog about the health practices developed, the health needs of the population, strategies to improve care and the multiprofessional discussion of cases that require greater attention from the teams.

The study highlights that these dialogic spaces are essential for tackling the problems experienced by the health team, in which professionals are required to be open and willing to be different, to act communicatively, to respect singularities and to bring together diverse knowledge, with the aim of promoting the collective construction of solutions to the population's health needs, as well as to the problems and conflicts experienced between professionals.[18]

From this perspective, various factors can have a negative impact on the communication process, such as the competitiveness of the different professional categories; conflicting interests; academic training based on unidisciplinary work; the prioritization of traditional practices with fragmented actions and the high turnover of certain professional categories.[19]

This creates obstacles to establishing a culture of collaboration and communication, as it compromises the establishment of solid interpersonal relationships, increasing the potential for uniprofessional assistance and fragmentation of care, with a greater focus on attention to the exacerbation of the population's health problems.

Therefore, in order to overcome this problem, communication between team members needs to be strengthened as an essential condition for a collaborative work environment, given that dialog promotes greater aggregation of different types of knowledge, the meeting and recognition of the specificities of each team member's work, and joint action in pursuit of common goals, thus providing opportunities for safety, quality and resoluteness in the care provided.[17,19-20]

Improving IPC reflects on the communication process between professional and client. From this perspective, the participants' comments showed that the fragility of communication between professionals and patients was related to the challenges discussed earlier, i.e. the lack of time and turnover of professionals, influenced by insufficient human resources and the absence of spaces for aligning care between the whole team.

This problem can stem from inaccurate or absent care flows, which lead to mismatches in behavior and become a communication barrier in the process of referring patients to other professionals. This hinders the flow of users in the service, overburdening them and generating potentially avoidable problems and conflicts if clear and appropriate information and flowcharts were made available.[21]

In line with this, researchers reinforce that guidelines and clinical protocols of care are crucial to the coordination and organization of care, since they guide health care and work processes by providing care articulation and defragmentation.[22] To this end, these guidelines and flowcharts need to be agreed and built collectively through spaces for dialog.

In relation to the elements that enhance the IPC, interpersonal relationships stand out as enhancing communicative and interactive action. The participants reported good interpersonal relationships as being conducive to improving the IPC and emphasized that, despite the challenges mentioned, respect and empathy between professionals slowed down the obstacles to effective communication, as well as fostering the process of bonding and interaction with the population.

The results of an integrative review, which aimed to identify the factors that contribute to the satisfaction and dissatisfaction of health professionals working in PHC, corroborate this aspect by emphasizing that appropriate and positive communication between professionals provides greater job satisfaction, above all because there is an intertwining between efficient communication and interpersonal relationships, which can make the work environment more satisfactory and with less tension. On the other hand, poor interaction generates insufficient levels of collaboration and can lead to the exclusion of professionals from the decision-making process.[23]

In light of this, researchers also point out that recognizing the boundaries and specificities of each profession allows for the resolution of interprofessional conflicts, shared and dialogued decision-making, clarity about the roles of each member, health care focused on the user/family/community and effective IPC, thus favoring the development of a living work in action.[24]

It should be noted that relationships based on interaction, socializing and communication create a sense of team belonging. Thus, activities that provide opportunities for this practice, such as formal and informal moments, can strengthen teams and enable greater skill in resolving conflicts and making decisions, as well as generating greater satisfaction among PHC professionals.

From this point of view, another factor that informally boosted IPC was the use of instant messaging applications, which allow information to be shared and accessed quickly. Similarly, a study carried out in Paraíba, Brazil, found that 20.5% of participants used informal communication through Information and Communication Technologies (ICTs). However, in the perception of these professionals, this process was a mere passing on of information and informal messages using tools such as WhatsApp®, e-mail, cell phones and telephones.[25]

In this way, the act of communicating, when permeated only by the informal transmission of messages and information, can hinder dialogic reflection and communicative action on the part of the team. This represents a barrier to effective communication and interprofessional collaboration, since it interferes with the agreement of responsibilities and attributions between professionals and between teams, which can lead to duplication and mismatches in care.[25-26]

Technological solutions occupy an increasingly prominent place in primary care, with a trend towards greater incorporation of these resources into the process of communication, diagnosis and therapeutic planning.[27] However, considering that ICTs can contribute to passing on information in a superficial way without transformative potential, as well as that the dialogic communicative process requires deeper levels of interpersonal relationships, it is important to emphasize the importance of face-to-face and personal spaces for dialogue and interaction, since the absence of these can lead to the

distancing of the professionals involved in care, thus compromising IPC, the reorientation of the service, the quality of care and communication with patients.

In line with this, researchers emphasize that workers who do not have the space to reflect on their work process do not produce analysis and end up merely repeating established practices, with little room for creativity and innovation in care, which leads to mismatches with the real potential of the teams and the needs of users.[28] Dialogue between team members and between health teams must therefore be strengthened in order to enhance the production and quality of care, as well as to encourage active user participation in recognizing health needs and formulating care plans.[29]

In light of these findings, this study can contribute to understanding the challenges and potential of IPC in PHC/FHS. It also provides support for the development of interventions aimed at improving dialogic and collaborative skills, attitudes and abilities in primary care. Furthermore, they can foster a culture of collaboration and teamwork by highlighting the importance of communication in this process.

A study limitation was the lack of participation by other professional categories, which may have made it impossible to identify other nuances of the work process at the BHU. This reinforces the importance of more comprehensive investigations with other methodological approaches on the subject, in order to promote new reflections on IPC and collaborative practices in PHC/FHS.

CONCLUSION

It was clear that the small number of professionals, their turnover, lack of time, limited spaces for dialog and fragile communication between professional and patient were the most notorious difficulties in establishing effective IPC. However, interpersonal relationships and the use of messaging apps were highlighted as enhancers of communication between subjects.

In view of these findings, the need to expand dialogic spaces, such as meetings, is reinforced, as well as implementing ongoing education actions on the communicative and collaborative process to favor the strengthening of interpersonal relationships and more solid and consistent teamwork. Furthermore, other strategies such as shared consultations and the implementation of protocols and care flows should be encouraged and strengthened in PHC/FHS.

CONTRIBUITIONS

Contributed to the conception or design of the study/research: Castelo RB, Sá GGM, Barros LM. Contributed to data collection: Castelo RB, Fernandes CS. Contributed to the analysis and/or interpretation of data: Castelo RB, Fernandes CS, Cavalcante FML, Araújo DV, Sá GGM, Galindo Neto NM, Barros LM. Contributed to article writing or critical review: Castelo RB, Fernandes CS, Cavalcante FML, Araújo DV, Sá GGM, Galindo Neto NM, Barros LM. Final approval of the version to be published: Castelo RB, Fernandes CS, Cavalcante FML, Araújo DV, Galindo Neto NM, Sá GGM, Barros LM.

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