

The thinking and acting of health professionals on the coordination between the assistance levels of the health care network

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Abstract *The study aims to understand the thinking and acting of health professionals about the coordination between levels of care. Qualitative research from an international multicenter study Equity-LA II. Audios were retrieved from eleven interviews of doctors/nurses of two levels of care in Recife, 2014. A content analysis of the theoretical framework of coordination was performed in the light of the hermeneutic approach. Most professionals knew the duties of coordination, without identifying its execution. The primary care physician was not recognized as responsible for the clinic, nor for his role by the specialist physician, while the primary care physician resented it. Failures in the use/completion of reference/counter-reference mechanisms and organizational barriers emerged. The unavailability for the “conversation game” and “fusionality” was evidenced in the lack of recognition of authority in the authoritative character of the primary care physician by that of the specialized, feeling of less value for that and technician and specialized posture in everyone’s practice. The coordination in on professionals’ view revealed the “there-to-be-understood” condition that needs to be launched in the “game of comprehension” to build dialogical practices focused on integral care.*

Key word *Health Care Levels, Clinical Management, Hermeneutics, Qualitative Research*

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Introduction

The initial experiences of integrated health systems inducted the constitution of Healthcare Networks (HN) which spread in Western Europe and Canada¹. These initiatives sought to break the segmentation of national health systems and the fragmentation of the care process, as strategy of challenging inefficiency and low quality of care².

Few countries have universal public systems, for instance, Spain and United Kingdom. These countries, with variations among themselves, privilege full access, equity, integration, regionalization and network hierarchization^{1,3,4}. In Brazil, in spite of undeniable improvements, the healthcare system still fragmented and focused on acute illnesses and acute-on-chronic illnesses, reaffirming the need for organization in HN^{5,6}.

The HNs are arrangements constituted by services and actions, with technological conformations and various assignments, complementarily organized. Among their main characteristics it is highlighted the sanitary accountability by continuous and integrate care; share of objectives; centralization of the health needs of the population, having Primary Healthcare (PH) as the center of communication and care ordainer; and horizontal relationships between the points of attention and multiprofessional care⁷.

In Brazil, difficulties for the implementation of HNs are related to scarce resources associated with the financial imbalance between the PH and the Specialized Care (SC); the availability; the training and links of professionals and the regional inequities^{6,8}. The PH, as the ordainer of longitudinal care, needs to share tasks between the physicians of its level of care, clinically responsible for the patient, and those from SC^{5,9}.

The coordination refers to the harmonious connection between different services and levels of care, with synchronization of procedures addressed to the user, which are necessary to its continuous care, in obtaining common, free of conflicts and articulated goals. A better integration in HNs is linked to the higher success of care coordination, with organizational determinants, professionals and needs in user health, which influence collaboration and responsibility between PH and SC¹⁰⁻¹².

In order to investigate the coordination between levels of care, various approaches are available, such as the one used in a multicentric research to evaluate strategies of enhancement and quality of care in Latin American HNs (Eq-

uity-LA II)¹³, which considers three types of coordination: information, clinical management and administrative management¹⁴. However, analyses under theoretical perspective are unusual, as philosophical hermeneutics, which interprets the sense attributed by Being and science comprehension as a discourse, characterized by the search for intersubjective validation, based on the commitment with truth, which involves uncertainties and is produced in the subject-object relationship¹⁵⁻¹⁸.

In this conception, truth is a hermeneutic experience which refers to the revelation in the junction between familiar and unknown, resulting from sociohistorical and cultural constructions (tradition, prejudices, horizon)^{15,16}. The assistance coordination would occur in a dialogical, intersubjective and reflexive relationship, characterized by "good practice"^{15,18}, reached when two beings dialog agreeing about something, even without complying with each other's perspective, but keeping themselves in touch with the other's horizon. Thus, the construction of truth is an experience open to resignification, which demands mediation between technical-scientific knowledge and self-knowledge^{16,19}.

The comprehension of phenomena implies in reveal what is the sense attributed by the actors which compose them, identified by professionals as authority, which constitute and are constituted by health services, processes and by the others with which they are related. These, express the legality of the horizon of tradition of this knowledge engineered by assumptions and prejudices which characterize its action^{16,17,19}. The objective of this article is to comprehend the thinking and acting of professionals about the coordination of assistance between levels of care.

Methods

This is an evaluative research of qualitative approach, whose theoretical references concerning coordination between levels of healthcare¹⁴ were articulated to those of philosophical hermeneutics^{15,19}.

The survey was a cutout from the qualitative strand of Equity-LA II Research baseline¹³, which analyzed the dimensions of information coordination (transfer of clinical and biopsychosocial information; coordination of clinical management (adequate patient follow-up, accessibility between levels and care coherence) and management coordination (established administrative

circuits and access ordination). Eligibility criteria to select informers were: physicians and nurses acting for at least six months in PH and SC, the latter attending reference centers specialized in care of patients with chronic diseases and who agreed participating in the research.

In this study, audio records from eleven semi-structured interviews were used, by means of a script built from the theoretical framework of coordination¹⁴, which were applied to the physicians (three from PH and five from SC) and nurses (two from PH and one from SC) in Recife, in the years 2014 and 2015.

Empirical material was analyzed in order to comprehend meanings expressed in the participants' discourse by means of hermeneutic interpretation^{15,19}, considering the researcher as subject implied in the survey and that this action is done in a relational continuum, by means of interpretative dialog, yet the comprehensive totality cannot be fully reached by limits inherent to the methodological course in point, which hindered the intersubjectivity process of the actors that composed it.

A content analysis was performed, a systematic, comprehensive, interactive and cyclic process²⁰ developed in three phases: 1) pre-analysis of material by re-listening of audio records from interviews, in order to perform discourse analysis of the actors, including paralinguistic characteristics, with registration of silence periods, laughter, and elements of analytic interest; 2) comprehensive reading of new transcriptions for approximating the totality of each report and its latent content; followed by organization of the material, identification of information and separation of discourses according to characteristics of the actors (age, gender, etc.); grammatical units (sentences or paragraphs); by temporal evolution of narrative or combination of many of these aspects; 3) elaboration of empirical categories or units of meaning, resulting from identification of patterns, data related to each other, corresponding to a given theme, created on a inductive manner resulting from the re-listening of audio records, from the interviews' script or the combination of both (Chart 1).

The analysis was performed in the first to third phase in each one of the interviews and comparatively between actors, by levels of attention, for establishing dissent, contradictions and emerging consensus. Finally, description and interpretation of results were performed, as well as establishment of relationships and development

of explanations and/or hypothesis constituting the gadamerian theoretical framework, which made possible the attribution of meaning to the findings, enabling the comprehension/interpretation dynamics to occur.

The definition of the sample size was reached by saturation, which is related to convenience-pertinence criteria, and informs about quality and sufficiency of information, when its set presents completeness to achieve research objectives and expresses saturation, characterized by redundancy and absence of new aspects on discourses, evidencing its exhaustion²⁰. The informants were presented by codes which assured confidentiality and origin of information.

The study followed ethical principles, according to Resolution n° 466/2012 of National Health Council and was approved by the Ethics and Research Committee of the Integrative Medicine Institute Prof. Fernando Figueira.

Results

The sample was composed by 11 informants, ten women and one man, being two nurses and three physicians (four women and one man) from PH and one nurse and five physicians (all women) from SC; ages from 45 to 68 years old; experience in service from one to 19 years; ten of these professionals with residency training or specialization. The exposition follows the order of emersion of categories/subcategories comparatively between the levels of care in which the actors worked.

Almost all of the participants knew the attributions of coordination, without identifying its execution in the network. The discourses in two levels of care revealed the non-recognition of the PH physician as the clinic responsible. Flaws in the usage and filling of mechanisms of reference/counter-reference are highlighted, as well as the non-existence of others, as clinical meetings and organizational barriers.

Aspects related to organization in health care levels

A little more than half of professionals did not know the terms "clinical responsible", "clinical and administrative management" and "coordination of information"; some confused the terms with management attributions or did not adequately refer the executed actions (Chart 2).

Chart 1. Coordination of care between levels: categories and subcategories of analysis. Recife, 2014/2015.

Categories of analysis		Subcategories of analysis
Aspects related to the health system		Subcategories did not arise
Aspects related to the organization between levels of healthcare		- Clinical responsible; - Problems in clinical management; - Problems in administrative management; - Problems in coordination of information.
Aspects related to professional:	Praxis in primary healthcare and specialized care	-Theoretical attributions and primary health care and specialized care; -Attitudes which influence coordination of care between levels
	Mechanisms of coordination	-Knowledge; -Utility; -Utilization; -Informal mechanisms

Source: Modified from the theoretical framework of the Equity-LA II research¹³.

Clinical responsible

Even with medical recognition from the PH as clinical responsible for two physicians of these level and three from SC, only one from each level of care knew the concept and its importance to the adequate development of care, although they mentioned this function as not being developed in health network.

One nurse from the PH attributed to the ESF (Family Health Strategy - Portuguese acronym) team the clinical responsible function, and two SC physicians knew the term but did not identify it as being the PH physician.

Problems with clinical management

Four physicians from SC reported problems in clinical management due to inadequate forwarding in PH, resulting in unnecessary displacement of users and needless occupation of vacancies.

Problems with administrative management

All interviewed professionals pointed organizational aspects which hindered the coordination between levels, emerging oftenly flaws in appointment consultations, insufficient vacancies, equipment and professionals in both levels of care, resulting in professional overwork and lengthy wait for assistance, mainly specialized care.

The National System of Regulation (Sisreg - Portuguese acronym) was recurrently pointed among all the actors as an organizative instrument which hindered coordination between levels by inadequate operationalization, yet a nurse from PH perceived it promisingly.

The disproportionality between population's request and the offer of consultations and exams also emerged uniformly between interviewees of both levels. In the point of view of SC professionals, this contributed to reduce consultations length, compromising quality, adequate registration and counter-reference.

Problems with coordination of information

The speech of four physicians from SC revealed problems with misinformation in the profile of the referenced unit, resulting in mistaken forwarding to specialized centers. In the perspective of a physician from PH, the problems are due to the lack of communication between levels of care.

Aspects related to professionals: praxis in primary healthcare in specialized care

Theoretical and practical attributions of PH and SC

Most of professionals demonstrated being familiar with the role of the PH as care coordinator, approaching the sanitary responsibility shared in the territory (family, social and cultural aspects). Not always that the speeches were clear or secure, existing pauses for their expression, pointing restrictions to the performance of this role, with complaints in interpersonal, administrative and organizational relationships (Chart 3).

Among those who were not aware of the PH role, speeches were restricted to the control of the disease, emphasizing medical intervention to avoid worsen. There was consensus between informants about the acting of the specialist be

Chart 2. Aspects related to the organization between levels of care. Recife, 2014, 2015.

Categories/ Subcategories	Citations
Clinical responsible	<p>“If we had a physician to manage these specialty referrals I think the amount of unnecessary consultations would decrease. [...] would avoid the specialist investigate something that already was for [...] go further into his [patient] treatment.” (P7-SC).</p> <p>“Look [...] the majority of cases, that is, 85-90% should be the physician from basic care, [...], the responsible for all of this” (P2-PH).</p> <p>“I think that the responsible should be the PH physician, because it’s him who will see the patient as a whole. He will receive information from other specialties which are necessary” (P4-SC).</p> <p>“See us down here [...], in PSF we always work in team, we don’t have that thing of [...] It’s like, the physician does the diagnosis, but he needs the NASF, he needs us, the nurses, the technicians, the dentists [...] A service, he is not a physician’s patient, he is a patient of all of us” (N2-PH).</p>
Problems in clinic management	<p>“Sincerely, I don’t know [...] A great number of patients don’t bring any exam [...] they say that it wasn’t even requested... In others, the physician [PH] requests the follow-up to be done there, and, when, I don’t know who is able to squeeze in the appointment here [SC] the examination wasn’t even done, because... he would be assisted by the professional in charge there (PH) who already does the follow-up [...]. [...] it is completely messed up... It’s like, you ask how the coordination is? Really [...] I don’t have any idea! Because it’s all uncoordinated [...] It’s really messy, there isn’t” (P6-SC).</p> <p>“[...] I realize that things are missing [...] a very complex harmony between basic medicine and the more specific one [...] I would have to act in many points, it doesn’t work when one acts and the other don’t..., then a huge difficulty is created because the service begins to get uncharacterized. The service that works, it begins to absorb everything and the role that it initiated starts to get uncharacterized. (P7-SC).</p>
Problems in administrative management	<p>“Because they [patients] are having severe difficulties in exam appointments... we have patients that take months to do it” (N1-PH).</p> <p>“The problem is that the result (of the exam) takes too long. Sometimes it delays like this, sometimes a month, there are patients who came here to get it several times and didn’t get it” (N3-SC).</p> <p>“[...] they [managers] would have to shrink the [Specialized Center]. We will take these patients and send to the primary care! They don’t do it, the hypertensive patients there [SC] medications that the physician [PH] can prescribe. [...] have to take patients that really need endocrinologist, with severe diabetes [...] the management is for this... got to be uniting secondary with primary. [...] the management is also to blame for that once it doesn’t exist... and we cannot come out and ask to the colleague: let’s schedule a meeting” (P1-PH).</p> <p>“It’s like, a huge overload, the system [Sisreg], the vacancies available there aren’t enough and is only one professional for this, [...] there is a lot of briefs and patients of six, seven months for specialist [...]. There is a large amount of patients, so, that use this small amount of exams.” (N1-PH).</p> <p>“We already got a large amount of permanent patients. And it is increasing, and the amount of physicians does not increase. [...] Not even nurses to support us” (P5-SC).</p> <p>“Now Sisreg came... to regulate our reference. And like I call it, sometimes it is a virtual queue,... but I think that it is getting better, still not perfect, you sometimes take two, three, five, four, six months to forward them to the specialist,...” (N2-PH).</p>
Problems in coordination of information	<p>“[...] They sometimes refer with [...] what is available in contacts, the story of the patient and the intercurrentence that she is suffering, “patient needs to control better his blood pressure, got swollen feet”. These things it [PH] provides, this referral informing is what is available. Basically this” (P5-SC).</p> <p>“There is no communication [...] only when we send to a known colleague, [...] he’s my friend so I asked him for a feedback, but not when we sent all correctly in a paper” (P1-PH).</p>

Note: PH: Primary Healthcare; SC: Specialized Care; NASF: Center of support to Family Health (Portuguese acronym); PSF: Family Health Plan (Portuguese acronym)

Source: Elaborated by the authors.

supportive and in cases of major complexity, continuity of care.

None of the speeches expressed shared action between levels, the majority showed restrict comprehension about the role of SC, reducing it to diagnosis, examination request and drug

treatment, without approaching its responsibility with the orientation of users and information to PH, being an obstacle to the care, in the perspective of all PH professionals.

All actors of both levels informed the non-accomplishment of their duties adequately, agree-

Chart 3. Aspects related to professional: praxis in primary healthcare and specialized care. Recife, 2014/2015.

Categories/ Subcategories	Citations
Theoretical and practical attributions of PH and SC	<p>“[...] I think that we [PH] perform a very good control of patients in more than 90% of them, with hygiene-dietetic orientations, of changing lifestyle, even medication itself, we can control it well, about 90% of them” (P3-PH).</p> <p>“The role of PH [...] start giving education for all, patients and family, once you can embrace people, manage to go in their houses to see the conditions in which they live, the conditions that would need follow-up and monitor better [...] medical care [...] and initial care [...] tracking of complications could [...] be done entirely in PH” (P6-SC).</p> <p>“[...] to give initial care for patients, and in moment that [...] they start to show something more complex and notice there is no structure available to do their follow-up in that service they [PH] refer to a service which have better structure to absorb them.” (P7-SC).</p> <p>“[...] it is necessary [SC] [...] Thereafter, when diabetes is too advanced, leaving sequels, the patient didn't care him/herself” (N1-PH).</p> <p>“Currently, I believe that we have a huge problem [...] you have patient sometimes that would not have much necessity of being assisted by specialists [...] they are occupying, let's say things this way, the vacancy of a patient of complicate treatment [...]” (P3-PH).</p> <p>“[...] the majority of those who come here, referred from the network, wouldn't have indication, [...] of being here. [...] He [PH physician] sent them, the impression that comes to us, is that they are overcrowded there, and he wants to get rid of the maximum amount of patient that is possible, [...] It's like, “go ahead and refer them”. Because we hear that here is too good (the patient), [...] everything is well controlled, didn't even have indication... (P6-SC).</p> <p>“I won't send the sick patient back, in the diabetes perspective he is mine now... He stays with us. Wasn't he referred? It's like, in my opinion, there [in PH] they couldn't control the patient and sent him here, so I'll be doing the follow-up” (P8-SC).</p>
Attitudes which influence the coordination between levels	<p>“[...] that which I use to call and some people criticize is the “to the to the physician”, that doctor who assists and only refers to the dermatologist, to the cardiologist, to the general practitioner, to the pediatrician, [...], when it should be himself who had to resolve [...]” (P2-PH).</p> <p>“[...] matter of preparedness or training of physicians to assist and really only refer the doubts [...]. Many times these new patients [...], some doesn't have anything to do with leprosy, pass far away [...] it depends a lot of your technical competence” (P4-SC).</p> <p>“the patient doesn't like the physician [...] in PH, so because of that he won't go to the hypertension and diabetes group, and then he is not treated here, and the he searches for another place, and where it is? With the specialist” (P3-PH).</p> <p>“[...] Since we had all the caution when doing the referral, to refer with conscience [...] and a well written stuff [...] and if the colleague also had the kindness of reading the referral (...). And making his/her reference in the same manner [...] would be a lot better” (P2-PH).</p> <p>“Sometimes the PSF personal do the basic very superficially, and when they refer to us, we also need to make an orientation that could be done there, by the nursery, by the health agent [...] Because sometimes the patient comes very disoriented [...] The PH is responsible for this integration, of advising the patient better, not the specialist” (P5-SC).</p> <p>“[...] these two patients [diabetic and COPD], they need to have a change in lifestyle. So we have the difficult task of making understand, making allow, to create this change of behavior.” (N2-PH).</p>

Note: PH: Primary Healthcare; SC: Specialized Care; PSF: Family Health Plan (Portuguese acronym); COPD: chronic obstructive pulmonary disease.

Source: Elaborated by the authors.

ing that the excessive amount of attended users is higher than preconized, resulting in overload and overcrowding.

All the informants revealed dissatisfaction with the performance of networks, with accusations and criticism between levels. The mutual re-primations referred to the lack of commitment of professionals and negative interfering due to the non-accomplishment of correspondent roles, non-recognition of PH's technical competence by SC, barriers in the access of specialists due to flaws on Sisreg, leading to informal search for access to SC.

Attitudes which influence coordination of care between levels

The speeches of three PH physicians showed annoyance due to the disrespect of SC colleagues for not considering or reading their referrals, whilst all of the specialists complained about mistakes from PH colleagues in references and procedures.

Another difficulty to the coordination between levels pointed by three physicians and a nurse from PH was the unavailability of SC professionals for the orientation of cases which needed associated care, whilst for all the specialists this problem is due to the non-accomplishment of the adequate function of the PH physician, passing along non-complex cases to the secondary level. In the specialists' perspective, this would be an alternative for the PH physicians to deal with the high request of service or to insufficient technical knowledge for accomplishing their tasks.

One physician from PH pointed lack of concerning from the colleagues of the same care level regarding commitment and clinical responsibility in the investigation and resolution of user's requests, resulting in discomfort, annoyance and discontentment.

All SC professionals related flaws in the PH actions of promotion and prevention, in contraposition, three physicians and one nurse from PH identified resistance from patients to change lifestyle and lack of recognition with professionals of that level. In the perspective of one PH physician, there is lack of ability in professionals of this level regarding the adequate link with user when not considering biopsychosocial aspects in care providing, resulting in the search for SC.

The criticism to the lack of technical competence of PH professionals in the use of the reference form arose in the speeches of five specialists and a physician of the same level, which high-

lighted the importance of "well done and readable" referrals.

The conditions of work, understood as "structure" by one SC physician, were pointed as barriers by PH teams, prompting them to mistaken referrals to the specialized network.

Aspects related to professionals: mechanisms of coordination

Knowledge

All the interviewees knew the reference and counter-reference forms as a preconized instrument to the communication between levels, other mechanisms were quoted by only two PH physicians: clinical meeting, matrix team (Nasf), hospital discharge summary, institutional phone number and the Sisreg.

Utility

The utility of coordination mechanisms, in the perspective of a nurse and two physicians from PH, is to promote higher trustworthiness to the information about health conditions of the patients and possibility of knowledge building, whilst to four SC physicians, it favored the communication between levels.

Utilization

Some presented narratives were affirmed by the majority of actors as obstacles to the utilization of mechanisms: malfunction of Sisreg, deferring appointment scheduling in SC and transcription of patient's transcription in a row; referrals from the PH without clinical information and exams; absence of clinical meetings between levels and unavailability for counter-reference.

All the professionals from both levels affirmed that the reference/counter-reference mechanisms are relevant, even though they are not used and its filling is incomplete and inadequate.

All the physicians from PH affirmed that they did not receive counter-reference and regardless of executing the reference, they believed it was not read, whilst five physicians from SC did not counter-referred and did not use the other mechanisms, with only one affirming that he stimulates the patient to show the PH physician the prescription when there is therapeutic modification.

Informal mechanisms

It was mentioned the usage of personal telephone and Whatsapp social network by a phy-

Chart 4. Aspects related to professionals: mechanisms of coordination. Recife, 2014/2015.

Categories/ Subcategories	Citations
Knowledge	<p>“[...] to facilitate... the district sometimes makes meetings to discuss [...] to where are made the referrals, in the sense of trying to improve. [...] here in the network we have the matrix [support], but then it comes working more to the psychological area, [...] because of the NASF team” (P2-PH).</p> <p>“Unless we have a hospital stay, then sometimes we have the hospital discharge summary, but it's not always.” (N2-PH).</p> <p>“They [PH professionals] send, [...] in the referral summary, but [...] sometimes without anything written, almost nothing, [...] in my practice I don't find anything, only paper” (P7-SC).</p> <p>“Now they are sending a, a form, only for regulation [regulation form] [...] there is no more [case discussion], between levels, at least not here.” (P8-SC).</p>
Utility	<p>“[...] I think it would improve a lot, since we, we have the attention when writing the referral, [...] with conscience and well written and if the colleague also had the kindness of reading the referral, [...] make his/her reference in the same way [...] it would be a great benefit for the patient” (P2-PH).</p> <p>“[...] in my opinion, it's better when it's printed because I reply. Then for those who receive and also for some who sent me, the sent with details, the cases. So I think it facilitates and also communication by phone.” (P4-SC).</p>
Utilization	<p>“Then he [patient] tells me that the cardiologist has done that, the endocrinologist has done that, but not because the endocrinologist sent me a counter-reference. So we never receive, never, never, really.” (P3-PH).</p> <p>“If physicians [from SC] read the referral, for example, they would have an idea of what that patient really has, didn't have to ask [...] So [...] it would really help and avoid loss of their time [...] it would be good and I think it would help the patient as well” (P3 PH).</p> <p>“[...] called [management] this way, in this case, physicians and nurses, to bring cases to be discussed there in a meeting [matrix team] and this meeting was being monthly and was very good because in this way, we brought complicate cases which we couldn't get the demand and in time we discussed and things worked a little, they even manage to get exams, appointments and we could resolve it in some cases.” (P1-PH).</p> <p>“[...] because you come and there is a lot of patient for you to look upon [...] there is no way for you to stop and talk with someone, send a message and stuff like that. Because you won't have when you receive this reply back.” (P6-SC).</p> <p>“To tell the truth I don't have much contact [with professionals from primary care], because the amount of patients here is huge and we keep dealing with the demand. I don't really fell that this feedback... exists” (P7-SC).</p> <p>“[...] counter-reference doesn't exist. [...] we only have the prescription made by him, when the patient manages to go there.” (N1-PH).</p> <p>“Matrix support in the network I don't really think that it exists, they can even claim that it does [...] I never saw a meeting.” (P8-SC).</p> <p>“So we see that, not always, the information from the patient is trustworthy, so if we really have it written, it will be easier. It can really generate this issue of double treatment.” (P4-SC).</p>

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sician and a nurse from PH and two physicians from SC, by means of friendship links, to perform the follow-up of patients, clarifying doubts, discussing cases and provide orientation to professionals from other levels.

The medical prescription used to the referral to another level was referred by three physicians (two from PH and one from SC), who recom-

mended the patients to show it to the destined colleagues.

Discussion

The trajectory of unveiling occurred by the action of trying to occupy the space of hermeneu-

Chart 4. Aspects related to professionals: mechanisms of coordination. Recife, 2014/2015.

Categories/ Subcategories	Citations
Informal Mechanisms	<p>“[...] when it is necessary, I use exactly the best reference and counter-reference which is the cell phone, I call the colleague directly [...] it works a lot better than sometimes the paper does, because sometimes the colleague doesn't read the paper, right? And when we call and identify ourselves, he sometimes remembers who is that patient and we talk about he/her [...]” (P2-PH).</p> <p>“[...] counter-reference doesn't exist. [...] we only have the prescription made by him, when the patient manages to go there.” (N1-PH).</p> <p>“[...] the channel of care is the whatsapp, [...] while is not being demanded, is my method of communication.” (N3-SC).</p> <p>“[...] they [PH physicians] ask to come, I think it is a more informal way, [...] then they come, like, two, three, ambulatories or more. Then we know each other, as well, and start asking questions.” (P4-SC).</p> <p>“I can do it because of friendship in (reference unit) with my cardiologist friends, then I can do it, but it is very difficult through network” (P8-SC).</p> <p>“Then we always ask him (patient) to show the prescription to the other physician [PH] [...] check out the changes the specialist did. Which they usually accept because it's usually the specialist who is sending” (P5- SC).</p>

Note: PH: Primary Healthcare; SC: Specialized Care; NAS:- Center of support to Family Health (Portuguese acronym).

Source: Elaborated by the authors.

tic interpreters attempting the fusion of horizons with those of the interviewees in order to apprehend the meaning about the thinking and acting with relation to the coordination between levels of care. The majority of professionals knew the attributions of coordination, without identifying its execution on network. The PH physician was not recognized as clinical responsible by the majority of actors in both levels, associated to the unfamiliarity of his role in the perspective of the specialist, whilst the one from primary healthcare resented. Flaws in usage and filling of mechanisms of reference/counter-reference are highlighted, as well as the non-existence of clinical meetings, besides organizational barriers.

The emphasis to the supremacy of specialist physicians in detriment to those of primary healthcare reflects the tradition of teaching and medical care strongly linked to the medical paradigm of privatist assistance, generating the indefiniteness of roles and the magnification of conflicts in the care network²¹. In order to face problems which demand attention and continuous follow-up, the model of health surveillance proposes redefinition of policies and sanitary practices, which may assume specific configurations according to the necessity in health, organizing processes in health work²². The study evidenced reciprocal transfers of responsibilities

between physicians from the network due to failures of mechanisms of reference and counter-reference, which reflected severe communication and professional performance problems that pervade value judgments, postures and conceptions historically determined²¹.

Regarding the role of primary care, it became evident in the discourse of the majority of the participants of this level the recognition of its authority in the authoritative dimension, the “being-able-to-know-how”^{19,23}, encompassing the technical knowledge and the praxis of healthcare providing.

A partial perspective of the SC professionals about the primary level arose, restricted to the early treatment or the medical work and limiting the action regarding the possibility of resolution in/of team actuation. The attributed sense was of questioning and non-recognition of PH authority, denoting a perspective of technician healthcare limited to the action in its own specialization dimension, separating the disease of the being in its totality, where the care is provided under the notion of “case - the part that fits you”¹⁹. The relation was proven not being dialogic, but covered by methodic auto-conviction and auto-concept, given that it was guided by a superior knowledge (SC) in detriment of recognizing the other (PH) in the condition of authority as well, predomi-

nating the usage by the interviewees of the “art of cure” in the philosophical hermeneutics conception¹⁹.

The unavailability of SC professionals for the “conversation game” with their PH colleagues revealed to be present in their discourse about their roles as health authorities, attitude comprehended as authoritative, non-reflexive and without genuine auto-criticism or critical liberty, when perceived through the gadamerian assumption of tradition and prejudice^{18,19,23}. It was recurrently evidenced barriers to fusionality which allowed the dialog of actors in their continuous “becoming” process, by the anticipation of the horizon of senses which promotes the comprehension of the “to-be-comprehended”^{16,18} the coordination between levels. The “truth” emerged through tradition and technical knowledge, due to the hermeneutic circle appropriate and inherent for the re-opening of new meanings have remained attached to the conscience which does not renew itself by means of dialogicity^{16,23,24}.

In the horizon of PH professionals a self-looking was unveiled, as well as a condition of “be-there-in-the-world” loaded of discontentment or indignation by their authority in healthcare. The historicity itself of their condition of ontological being is harmed by the dynamic relationship with the world which is anointed by the technical success of the SC physician and questions their practical success^{23,24}.

Intertwined to the exposed, it prevailed amongst all SC physicians the posture of not counter-referencing, which was justified by service overcrowd and lengthy, non-objective instruments, that however important, could be filled by nurses^{3,21,25}. Likewise, they related not using references from PH physicians due to mistaken referrals. The speeches of specialists showed unbelief and discouragement regarding the utility of mechanisms and related to the flow of communication established among the levels^{3,25}.

The speeches repeatedly expressed behaviors which fragmented the network, with negative consequences to care integrality, for the usage of information available in the referral report contributed to more secure diagnosis and coherence in handle, besides reflecting respectful attitude when know about the PH physician, whilst the counter-reference would ratify him^{15,16}. The discourses denounced damages to the care continuum, and, concomitantly, evidenced ruptures in the responsibility shared between levels which assumed horizontalized and fragmented postures in their assistance praxis^{26,27}.

The valorization of practices focused in hard or soft-hard technologies in detriment of soft ones²⁸, revealed by informants, mainly from SC, pointed to the non-development of “good practice” in healthcare^{19,23,24} and to the fact that the coordination was affected by “bureaucratization of life” and minimally reflexive and creative practices^{19,23}. The overestimation of specialization is linked to the medical educational culture, which represents the national tradition, which repercussions on the imaginary of the society, reaffirming prejudice to PH.

Even when professionals were invited to perform the exercise of critical-reflexive freedom in order to question the hermeneutic circle, tradition and prejudices prevailed, when they attributed meanings to healthcare coordination and its facilitating and deterrent aspects. The emerging speeches did not meet auto-criticism, as participants of services or regarding their spaces of ‘be-there-in-the-world’ in distinct levels of care^{18,19,23}, demonstrating to be bonded to their previous comprehension and revealing themselves to be resistant to transformative dialog^{15,16}.

The reports in all interviews was permeated by high tension, discouragement, annoyance and interpersonal discomfort negatively interfering in the intersubjective relationship of professionals of different levels, showing incipient exercising of alterity among them, evidencing that there is no negotiation, in this relationship, as attitude to comprehend the coordination between levels^{15,29}. This flaw in the exercise of alterity was evidenced in relation to the patient, in speeches which blamed the users for the worsening of their health conditions done by the majority of professionals²⁹.

Philosophical hermeneutics proposes the opening to dialog producing the experience as inversion structure, experience of negativity of what is known or what is possessed to search for a meeting point and reach a “mutuality” of genuine conversation which promotes transformation^{15,29}. The meeting between professionals would promote more agility, development of information exchange between the levels of care, strengthening of care coherence and adequate follow-up^{5,30-32}.

It is important to mention the challenge of re-listening to audio records from interviews whose script was not idealized from philosophical hermeneutics assumptions. However, an interpretative dialog proceeded, in which was searched a comprehensive totality about coordination between levels to retrieve elements which

guaranteed the hermeneutic circle, avoiding relativism as refused by Gadamer. On the other hand, the limit imposed to this study was minimized when conceptual mediation of the theoretical referential of care coordination was used¹⁰⁻¹⁴. The limitations stimulated an even closer look for the categories of philosophical hermeneutics to arise, besides the triangulation of researchers in order to ensure internal validity²⁰.

The unavailability for the “conversation game” and “fusionality” expressed by all the professionals showed the unfamiliarity with the authority, in its authoritative character, of the PH physician by the SC physician, feeling of less value of the first and technicist attitude and “specialization” in the praxis of all, which demonstrated their desire of domain of diseases by the

“art of cure”. The coordination between levels under the perspective of these actors is on the condition of “there-to-be-understood”, which requires their immersion in the “comprehension game”, so that practices focused on integral care are built through dialog^{15,19}.

The task of engage in the search for comprehension on acting and thinking of professionals regarding to the exposed aspects did not intend unveiling meanings attributed in a complete or definitive manner, given that this would be presented as contradictory to the essence of philosophical hermeneutics. The horizon used for the circle of comprehension is exactly open to resignifications which are possible by new fusions of horizons and new openings of meanings for the truth arising from the praxis of other readers.

Collaborations

MCMH Araujo, LCM Vanderlei and MFM Mendes participated in all stages of the article's authorship: conception, planning, analysis and interpretation of data, writing, critical review of the content and approval of the final version. PG Frias participated in the following stages of the article's authorship: conception, interpretation of data, writing, critical review of the content and approval of the final version.

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