


## Shared management in emergency care services: mixed methods study

Gestão compartilhada em serviços de pronto atendimento: estudo de métodos mistos

Gestión compartida en servicios de emergencias: estudio de métodos mixtos

Elaine Cantarella Lima<sup>1</sup>  <https://orcid.org/0000-0001-9592-9493>José Luís Guedes dos Santos<sup>2</sup>  <https://orcid.org/0000-0003-3186-8286>Alexandre Pazetto Balsanelli<sup>3</sup>  <https://orcid.org/0000-0003-3757-1061>Rosângela Andrade Aukar de Camargo<sup>1</sup>  <https://orcid.org/0000-0002-4872-2331>Ariane Maria Machado Maximiano<sup>1</sup>  <https://orcid.org/0000-0001-9486-2944>Jaine Novais da Silva<sup>1</sup>  <https://orcid.org/0000-0002-3966-7094>Andrea Bernardes<sup>1</sup>  <https://orcid.org/0000-0002-9861-2050>

## How to cite:

Lima EC, Santos JL, Balsanelli AP, Camargo RA, Maximiano AM, Silva JN, et al. Shared management in emergency care services: mixed methods study. *Acta Paul Enferm.* 2023;36:eAPE01483.

## DOI

<http://dx.doi.org/10.37689/acta-ape/2023A00148333>



## Keywords

Emergency medical services; Health management; Organization and administration; Health services; Health services administration

## Descritores

Serviços médicos de emergência; Gestão em saúde; Organização e administração; Serviços de saúde; Administração de serviços de saúde

## Descriptores

Servicios médicos de urgencia; Gestión en salud; Organización y administración; Servicios de salud; Administración de los Servicios de salud

## Submitted

27 July, 2022

## Accepted

16 May, 2023

## Corresponding author

Andrea Bernardes  
E-mail: [andreaab@eerp.usp.br](mailto:andreaab@eerp.usp.br)

## Associate Editor (Peer review process):

Ana Lúcia de Moraes Horta  
(<https://orcid.org/0000-0001-5643-3321>)  
Escola Paulista de Enfermagem, Universidade Federal de São Paulo, SP, Brazil

## Abstract

**Objective:** To analyze the management model adopted in Emergency Services in municipalities that are part of a Regional Health Department.

**Methods:** Mixed methods study with a concomitantly incorporated design. It was conducted in 2017 with six managers and 223 health workers (physicians, nurses and nursing technicians/assistants) from ten Emergency Care Units in eight municipalities of the Regional Health Department XIII, São Paulo. The data collection instrument composed of six closed questions and four open questions was delivered to participants. Quantitative data were analyzed using descriptive statistics; qualitative data were developed using the Collective Subject Discourse technique and analyzed using the DSCSoft<sup>®</sup> software.

**Results:** There was a predominance of female professionals, 173 (75.2%), in the position of nursing assistants, 78 (33.9%). Managers evaluated the institution's management model as contemporary and participatory, enabling workers to participate in decision making and giving them autonomy to decide on day-to-day issues, while workers evaluated it as traditional management, highlighting its formal structure.

**Conclusion:** It was observed that managers and workers have a different view of the management model of health institutions. The assumptions of the shared management model encompass valuable concepts, such as dialogic communication, decentralization of power and greater autonomy for decision making. However, when analyzing the opinion of most workers who participated in this study, the wide use of a hierarchical model in institutions is still observed.

## Resumo

**Objetivo:** Analisar o modelo de gestão adotado nos Prontos Atendimentos dos municípios que integram um Departamento Regional de Saúde.

**Métodos:** Estudo de métodos mistos, com desenho incorporado concomitante, realizado em 2017, com seis gestores e 223 trabalhadores de saúde (médicos, enfermeiros e técnicos/auxiliares de enfermagem) de dez Prontos Atendimentos de oito municípios do Departamento Regional de Saúde XIII, São Paulo. Foi entregue o instrumento de coleta de dados composto por seis questões fechadas e quatro questões abertas. Os dados quantitativos foram analisados por meio de estatística descritiva; os dados qualitativos, desenvolvidos por meio da técnica do Discurso do Sujeito Coletivo, foram analisados com o apoio do *software* DSCSoft<sup>®</sup>.

**Resultados:** Predominaram profissionais do sexo feminino 173 (75,2%) e que ocupavam o cargo de auxiliar de enfermagem 78 (33,9%). Enquanto os gestores avaliaram o modelo de gestão da instituição como

<sup>1</sup>Escola de Enfermagem de Ribeirão Preto, Universidade de São Paulo, Ribeirão Preto, São Paulo, SP, Brazil.

<sup>2</sup>Departamento de Enfermagem, Universidade Federal de Santa Catarina, Florianópolis, Brazil.

<sup>3</sup>Escola Paulista de Enfermagem, Universidade Federal de São Paulo, São Paulo, SP, Brazil.

**Conflicts of interest:** Although Balsanelli AP is an Associate Editor of *Acta Paulista de Enfermagem*, the Editor did not participate in the peer review process of the article.

contemporâneo e participativo, possibilitando que os trabalhadores participassem da tomada de decisão e dando autonomia aos mesmos para decidirem sobre questões do dia a dia, os trabalhadores avaliaram como gestão tradicional, destacando-se por sua estrutura formal.

**Conclusão:** Foi possível observar que gestores e trabalhadores têm visão destoante sobre o modelo de gestão das instituições de saúde. Os pressupostos do modelo de gestão compartilhada englobam concepções valiosas, como comunicação dialógica, descentralização do poder e maior autonomia para a tomada de decisões. Contudo, ao analisar a opinião da maior parte dos trabalhadores que participaram deste estudo, observa-se que o modelo hierarquizado ainda é muito utilizado nas instituições.

## Resumen

**Objetivo:** Analizar el modelo de gestión adoptado en los servicios de emergencias de los municipios que integran un Departamento Regional de Salud.

**Métodos:** Estudio de métodos mixtos, con diseño incorporado simultáneo, realizado en 2017, con seis gerentes y 223 trabajadores de la salud (médicos, enfermeros y técnicos/auxiliares de enfermería) de diez servicios de emergencias de ocho municipios del Departamento Regional de Salud XIII, São Paulo. Se entregó el instrumento de recopilación de datos, compuesto por seis preguntas cerradas y cuatro preguntas abiertas. Los datos cuantitativos se analizaron mediante estadística descriptiva. Los datos cualitativos, elaborados mediante la técnica del discurso del sujeto colectivo, se analizaron con ayuda del *software* DSCSoft®.

**Resultados:** Predominaron profesionales de sexo femenino 173 (75,2 %), que ocupaban el cargo de auxiliar de enfermería 78 (33,9 %). Mientras los gerentes evaluaron el modelo de gestión de la institución como contemporáneo y participativo, que permite a los trabajadores participar de la toma de decisiones y les da autonomía para decidir sobre cuestiones del día a día, los trabajadores la evaluaron como una gestión tradicional, con énfasis en su estructura formal.

**Conclusión:** Se pudo observar que los gerentes y los trabajadores tienen visiones discordantes sobre el modelo de gestión de las instituciones de salud. Las premisas del modelo de gestión compartida engloban concepciones valiosas, como comunicación dialógica, descentralización del poder y mayor autonomía para la toma de decisiones. Sin embargo, al analizar la opinión de la mayoría de los trabajadores que participaron en este estudio, se observa que el modelo jerárquico aún es muy utilizado en las instituciones.

## Introduction

After the Second World War, participatory management models emerged, establishing conduct competencies and skills with an emphasis on customer satisfaction and institution excellence.<sup>(1)</sup> Unlike traditional management models, in participatory models, called shared management, everyone makes decisions and seeks solutions to problems.<sup>(2)</sup>

Even though changing the management model is not simple, Brazil has invested in the adoption of flexible models. The establishment of one of the most significant aspects of shared management, decision making, implies changing established processes.<sup>(2)</sup>

Practices that value the team's participation in decision making are being implemented as a strategy to achieve higher levels of quality, increasing the efficiency, efficacy and effectiveness of health actions.<sup>(3)</sup> Studies conducted nationally and internationally indicate that the implementation of shared management allows more dialogue between the team and encourages the decentralization of power, achieving a better sharing of decision making.<sup>(2,4)</sup>

Investigations on this topic can enhance the adoption of more contemporary and innovative models and influence the performance of health or-

ganizations and the results of care. However, some services still remain rooted in principles of traditional management, for example, the Emergency Room (ER).<sup>(5)</sup>

The ER concentrates a repressed demand from the rest of the system, and these services are a reflection of the management of Municipal Health Secretariats. These units are designed for urgent and emergency care and operate 24 hours a day with a qualified multidisciplinary team.<sup>(6,7)</sup>

Given the above and considering the need for investment in shared management in this scenario, the intention was to answer the following question: is the participatory management model implemented in Emergency Services of the municipalities integrating the Regional Health Department XIII?

The adoption of more participatory management models should allow for an increase in the quality of health services, benefiting professionals, patients, families and the community. Considering that several health institutions still adopt traditional management models and there is an urgent need for a paradigm shift, the aim of this study was to analyze the management model adopted in Emergency Services of the municipalities that are part of the Regional Health Department under study.

## Methods

Mixed methods study with a concomitantly incorporated design conducted in municipalities that make up the Regional Health Department XIII (Portuguese acronym: DRS XIII). This is a descriptive study in which quantitative and qualitative data were collected concomitantly. Greater weight was attributed to the quantitative approach: QUAN (qual). The qualitative study was developed using the Collective Subject Discourse (CSD) technique and played a complementary role. Data were combined at the end by means of incorporation, as qualitative data were used to complement and deepen the quantitative analysis.<sup>(8)</sup>

The theoretical model focused on management in organizations and based on four classifications (structure, human resources, policy and symbols) was adopted.<sup>(9)</sup>

Eight out of the 26 municipalities included in the DRS XIII that have Emergency Services linked to the Health Department in the interior of a state in the southeast of Brazil were selected to participate in the study. Given the heterogeneity of employees in ERs, a probabilistic cluster sample was chosen, using the Probability Proportional to Size (PPT) method. The R program (R Core Team, 2017), version 3.4.1, was adopted for sample calculation. The significance level of 5% ( $\alpha=0.05$ ), precision of 11.25% ( $d = 0.1125$ ), design effect (*deff*) of 2.19, number of Emergency Care Units ( $m$ ) = 25 and expected loss of 30% were adopted, reaching the number of ten Emergency Services and eight municipalities, comprising a total number of 347 employees.

Of these, 229 (67%) agreed to participate in the study; six municipal managers from different professions and 223 health workers (physicians, nurses and nursing technicians/assistants).

The study was performed between August and November 2017; a data collection instrument was delivered in a sealed and numbered envelope, and a four-week deadline was established for return. This instrument was composed of questions related to sociodemographic data, six closed questions and four open questions addressing the adoption of the

management model by the institution, the involvement in the implementation of this model and the level of satisfaction, the possibility of participation and autonomy in decision making, the use of dialogic communication, as well as the identification of potentialities and difficulties in relation to the management model adopted by the institution.

The questionnaire was prepared by researchers from the Research Group, and underwent apparent and content validation with judges from the management area. After validation, a pilot test was carried out in order to allow adjustments before the definitive data collection.

All professionals hired by the Health Department were included in the sample. Subjects admitted to the institutions less than six months earlier were excluded, since they could not have had sufficient experience with the adopted management model.

Regarding quantitative data, in order to proceed with the diagnostic evaluation of the management model, quantitative and qualitative variables were analyzed, among them: adoption of the participatory management model, involvement with the implementation of the model, level of satisfaction, decision making, autonomy and communication. For qualitative variables, absolute and relative frequencies were calculated. For quantitative variables, mean and standard deviation (SD) were calculated. Data were entered into Microsoft Excel® spreadsheets (double typing) and analyzed using descriptive statistics and the IBM SPSS Statistics software, version 25.

Qualitative data were fully transcribed into Microsoft Word® digital files and analyzed using the DSCSoft® software. An association test between the different categories and the management model adopted was performed. The Fisher's exact test was used to check the existence of an association.

The Collective Subject Discourse (CSD) technique was used in the analysis of qualitative data. The Key Expressions (KE), which are literal excerpts or transcripts that constitute the essential content of the representations, were identified. These expressions were organized according to the Central Ideas (CI), which are the linguistic expression that describes the meaning present in KEs in the most syn-

thetic and precise possible way. From this analysis, the CSD that represents summary speeches written in the first person singular, composed of KEs with similar CI was formulated; sometimes the CSD is composed of a KE with only one answer.<sup>(10,11)</sup>

The managers and other professionals who participated in the study signed the Informed Consent form, as stipulated in Resolution n° 466/12 of the National Health Council. Codes were assigned to specify managers (M01, M03...) and workers (W11, W20...) and to specify their professions (nurse - N, physician - P, nursing technician - T and nursing assistant - A) in order to guarantee their anonymity. This was also done for municipalities (M1, M3...), Health Departments (H11, H15...) and Emergency Care Units (U01, U05...). The project was approved by the Research Ethics Committee of the proposing institution (Official Letter No 064/2017 of 28/03/2017) (Certificate of Presentation of Ethical Appreciation n° 65035517.0.0000.5393).

## Results

Of the 229 professionals who participated in the study, six (2.6%) were managers and 223 (97.4%) were health workers, 173 (75.2%) were female and 56 (24.3%) were male, mean age of 42.3 years (SD 10.2) and 97 (42.2%) worked in municipality number six. Regarding profession, 76 (33%) were nursing technicians and 78 (33.9%) were nursing assistants. When considering the work shift, there was a predominance of professionals (108=47%) who worked 12 hours a day, with high school education as the highest level (108=47%).

The proposed questions evaluated were related to the following: management model adopted in the institution, involvement with the implementation of the shared management model, level of satisfaction with the current management model, decision making, autonomy and communication.

Of the six managers who participated in the study, three (50%) reported that the institution adopts a participatory management model. Of these, all reported full involvement with implementation of the model.

Regarding the level of satisfaction with the current management model, most managers (four=66.7%) were satisfied with the institution's model. Similarly, qualitative results according to the CSD show that the level of satisfaction with the current management model indicated by managers is linked to the qualification of the professional team.

*CSD: I am satisfied with the current management model, the health professionals are qualified and involved with their work, the team is great (MAD2/H12, MN7/H18, MN1/H11).*

Regarding decision making, most managers (four=66.7%) reported enabling workers to participate in decision making. Regarding autonomy, most managers (four = 66.7%) also indicated giving autonomy to workers for decision making on day-to-day issues.

*CSD: We participate in team meetings to solve problems. The participation of everybody is important to reduce errors in decision making (MN1/H11, GAD2/H12).*

Regarding communication, all managers reported that communication occurs through dialogue.

Unlike the managers' reports, most workers in all Emergency Care Units, i.e. 165 (74.0%), reported that the institution does not adopt a participatory management model. Only nine (4.0%) out of the 41 (18.4%) workers who reported the adoption of the shared management model by the institution are fully involved with the implementation of the participatory management model.

Regarding level of satisfaction, most workers (102=45.7%) reported dissatisfaction with the institution's current management model given the lack of participation in decision making.

*CSD: Decisions are taken vertically. They are taken by senior management, by senior positions, and we are always informed after decisions are taken by them (WN332/U2, WA327/U2, WA305/U2).*

The discourse clearly shows the adoption of a traditional management model as there is no involvement of workers in decision making.

As for participation in decision making, most workers (131=58.7%) confirmed they did not participate in this process. Regarding autonomy, most workers (114=51.1%) reported not having autonomy to decide on day-to-day issues.

*CSD: No, no autonomy to decide, none, bosses are the ones who decide, an excuse is always found to accept the opinion (WA327/U2, WN428/U3, WT187/U7).*

Once again, the CSD refers to the traditional management model in which only the manager has autonomy for decision making and imposes the rules to be followed.

Regarding communication, most workers (90=40.4%) reported that communication in the institution occurred through dialogue.

Table 1 illustrates that a significant association was not found only between occupational category and level of satisfaction with the institution's management model, corroborating the analyzed speeches.

## Discussion

The results of this study showed that most managers mentioned the adoption of a shared management model at the institution and involvement with the referred model. In the implementation of shared management, when changing from a traditional and more formal structure to a more contemporary and participatory structure, both structural and political changes are necessary and power relations must be reviewed. Therefore, participation and involvement are essential strategies so that a change in the management model really takes place.<sup>(9)</sup>

**Table 1.** Association of occupational category with variables on the management model of eight municipalities belonging to the Regional Health Department XIII

Variables	Manager (n = 6) Frequency	%	Worker (n = 223) Frequency	%	p-value*
Institution adopts the participatory/shared management model					0.003
Yes	3	50.0	41	18.6	
No	1	16.7	165	75.0	
In process of implementation	2	33.3	14	6.4	
Engagement with implementation of the participatory/shared management model**					0.031
Totally	3	100.0	9	22.0	
Partially	0	0.0	11	26.8	
Rarely involved	0	0.0	14	34.1	
Not involved	0	0.0	7	17.1	
Level of satisfaction with the institution's current management model					0.396
Very satisfied	0	0.0	8	4.0	
Satisfied	4	80.0	71	35.9	
Dissatisfied	1	20.0	102	51.5	
Very dissatisfied	0	0.0	17	8.6	
Participates in decision making at work					0.001
Yes	4	66.7	37	16.7	
No	0	0.0	131	59.0	
Sometimes	2	33.3	54	24.3	
Autonomy to decide on day-to-day issues					0.007
Yes	4	66.7	49	22.2	
No	0	0.0	114	51.6	
Sometimes	2	33.3	58	26.2	
Communication in the institution occurs through dialogue					0.014
Yes	6	100.0	90	40.9	
No	0	0.0	42	19.1	
Sometimes	0	0.0	88	40.0	

\* Fisher's test; \*\* Valid for those who adopt the shared management model



Sharing information through communication and dialogue becomes essential, since that is how health professionals share opinions, intensifying their work and involvement in the teamwork process, which allows equalizing the importance of all professionals in order to value them, increasing the level of job satisfaction.<sup>(2,9)</sup>

The level of satisfaction of managers with the management model adopted by the institution is related to the qualification of the professional team. Professional qualification is responsible for job satisfaction as it contributes to the acquisition of skills and competencies needed to better perform the functions. It is a way to compensate for the gaps left by academia in the training of professionals working in the health system.<sup>(12,13)</sup>

In this context, continuing education is necessary as a teaching-learning practice and health education policy aimed at daily work. Continuing education, valuing teamwork, decision making and communication are fundamental to the success of the shared management model.<sup>(13,14)</sup>

The results presented revealed that managers' discourse is in line with the shared management model, in which communication is open and meeting spaces offer opportunities for dialogue and decision making. Managers still retain their authority and make key decisions, but power is distributed among all team members.<sup>(9)</sup>

According to the theoretical framework, giving autonomy to workers is a basic strategy related to the human resources area, while autonomy for decision making is considered a motivation to perform a job with quality.<sup>(9)</sup>

Regarding communication, as previously mentioned, all managers reported that in the institution where they worked, communication occurred through dialogue. As the effective communication takes place through an agreement between subjects, the communication for mobilization must be dialogical insofar as it defends a cause of mutual interest.<sup>(15)</sup>

Contradictorily, the responses of workers related to the management model adopted in the institution differ from managers' perception. When the shared management model is implemented in the

organization, this new management model must be recognized by all professionals involved with the institution.<sup>(16)</sup> However, this did not happen in the health institutions participating in this study, given the notorious different view of managers and workers regarding the management model adopted.

In this study, workers emphasized their dissatisfaction with the institution's current management model due to lack of participation in decisions. Individuals who work in an organization have their own values and preferences, which are characterized as symbols.<sup>(9)</sup>

Values, preferences and experiences are taken into account when making a decision. Therefore, when decision making is performed only by people who hold greater power within an institution, subordinates end up considering the values and preferences of those who exercise authority, which makes choices unequal and limited.<sup>(17)</sup>

In the results of this study, the workers' discourse showed their lack of autonomy to decide on day-to-day issues. This fact refers to the traditional management model in which only the manager has autonomy for decision making and imposes the rules to be followed.

According to the theoretical framework adopted, the lack of autonomy is related to both political and symbolic frameworks, since members of the organization occupy different hierarchical positions and historically, there is a belief that decisions should be taken by people at the top of this hierarchical scale.<sup>(9)</sup>

Regarding communication, workers reported that communication in the institution occurs through dialogue, which contrasts with the previous answers. Most professionals mentioned not having autonomy to decide on day-to-day issues, not participating in decision making at work and being dissatisfied with the institution's current management model.

Communication interferes with the performance of organizations and is fundamental for the development of work.<sup>(5)</sup> In the shared management model, communication facilitates the relationship between people within the organization. For a working environment where everyone collaborates,

communication must be effective, open and without noise.<sup>(18,19)</sup>

Dialogical communication becomes a facilitating agent for decision making, autonomy and, consequently, contributes to worker satisfaction in their work environment. Paradoxically, in the verticalized management model, in which communication is verticalized and informative, the participation of workers in health actions becomes restricted, a fact occurring in Emergency Services that were scenarios of this study.

The team's understanding of communication is often related to the transmission of information. This is a mistaken understanding, as the action of communicating is complex and demands structure, processes, flows and care.<sup>(20)</sup> Note that although managers reported that communication occurs through dialogue in the institution, there is little listening from their part, evidenced by the lack of autonomy and participation of professionals in health actions, reinforcing important aspects of the traditional management model in the municipalities investigated and demonstrating the fragility of the management model adopted. Thus, future studies on communication in health services can emanate from these findings. In this sense, the results of this study have the potential to promote changes in the practice of the interdisciplinary team based on the perception of disagreement between managers' perception and action, and more importantly, the implementation of actions in favor of modifying this reality.

The limitation of this study is related to the number of participants in each occupational category. The number of managers is considerably smaller compared to the number of workers, since there is only one health secretary in each municipality.

## Conclusion

Managers and workers have a different view of the management model adopted in health institutions. While managers claim that more participatory management models are being implemented, workers do not recognize this implementation in their daily activities. Thus, it is possible to consider that

the management model is still ordered by principles of traditional administration, exerting direct impact on the work of professionals. The change to a more participatory management model is related to the beliefs and values representing the organizations, which makes this transposition difficult. The implementation of a shared management model takes time, requires effort and collective commitment, and the role of training centers in preparing professionals on shared management models is of paramount importance. A lot of work and many attempts must be made in the current scenario so that professionals can overcome the difficulties faced and actually accept the demand of the Unified Health System in relation to the adoption of a more participatory management model.

## Acknowledgements

To the Fundação de Amparo à Pesquisa do Estado de São Paulo (FAPESP) – São Paulo – Brazil for the financial support. Process number: 2016/15007-9.

## Collaborations

Lima EC, Santos JLG, Balsanelli AP, Camargo RAA, Maximiano AM, Silva JN and Bernardes A contributed to the project design, data interpretation, relevant critical review of the intellectual content and approval of the final version to be published.

## References

1. Calfeffi JS, Crubellate JM. O Sistema Toyota de Produção: institucionalismo comunicativo e a cultura organizacional. *Rev Gestão Tecnol.* 2020;20(1):258-77.
2. Penedo RM, Gonçalo CS, Quelus DP. Gestão compartilhada: percepções de profissionais no contexto de Saúde da Família. *Interface.* 2019;23:1-15.
3. Almeida SL, Camargo C, Araújo KA, Alves AP, Barreto HC. Política de humanização (HumanizaSUS): uma política transversal na saúde. *Rev Eletr Acervo Saúde.* 2019;30:1-6.
4. McKnight H, Moore SM. Nursing Shared Governance [Updated 2022 Sep 19]. In: StatPearls. Treasure Island (FL): StatPearls Publishing; 2023. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK549862/>

5. Gómez CL. Risk communication in health: theoretical and methodological aspects for the control of sanitary public emergencies. *MediSan*. 2017;21(12):3386-99.
6. Rodrigues LG, Santos TV. Condições sensíveis à atenção primária na unidade de pronto atendimento de Manhuaçu/MG: impacto no serviço de saúde pública e fatores predisponentes. In: Seminário Científico do UNIFACIG – Sociedade, Ciência e Tecnologia, 7 a 8 de novembro de 2019. Munhuaçu. Anais... Munhuaçu: UNIFACIG, 2019.
7. Pereira JA, Ruas JP, Flausino VO, Barbosa AF, Ferreira TV, Correia TC, et al. Perfil epidemiológico da demanda em unidades de emergência hospitalar: uma revisão de literatura. *Rev Eletr Acervo Saúde*. 2019;32:e1178. Review.
8. Creswell JW, Clark VL. *Pesquisa de métodos mistos*. 2 ed. Porto Alegre: Penso; 2013. 264 p.
9. Bolman LG, Deal TE. *Reframing organizations: artistry, choice, and leadership*. 6 ed. San Francisco: Jossey-Bass; 2017. 512 p.
10. Lefevre F, Lefevre AM. The Collective Subject that speaks. *Interface*. 2006;10(20):517-24.
11. Lefevre F, Lefevre AM. *Pesquisa de Representação Social: um enfoque quali-quantitativo*. 2 ed. Brasília: Liber Livro; 2012. 128 p.
12. Moreira KS, Lima CA, Vieira MA, Costa SM. Educação permanente e qualificação profissional para atenção básica. *Rev Saúde Pesq*. 2017;10(1):101-9.
13. Santos MC, Frauches MB, Rodrigues SM, Fernandes ET. Processo de Trabalho do Núcleo de apoio à Saúde da Família (NASF): Importância da Qualificação Profissional. *Saúde & Transformação Social*. 2017;8(2):60-9.
14. Bezerra MM, Medeiros KR. Limites do Programa de Melhoria do Acesso e da Qualidade da Atenção Básica (PMAQ-AB): em foco, a gestão do trabalho e a educação na saúde. *Saúde Debate*. 2018;42(2):188-202.
15. Moreira FT, Callou RC, Albuquerque GA, Oliveira RM. Effective communication strategies for managing disruptive behaviors and promoting patient safety. *Rev Gaucha Enferm*. 2019;40(spe):e20180308.
16. van Veenendaal H, van der Weijden T, Ubbink DT, Stiggelbout AM, van Mierlo LA, Hilders CG. Accelerating implementation of shared decision-making in the Netherlands: An exploratory investigation. *Patient Educ Couns*. 2018;101(12):2097-104.
17. Silva IS, Arantes CI. Power relations in the family health team: focus on nursing. *Rev Bras Enferm*. 2017;70(3):580-7.
18. Tartaglia A, Silva MG, Portela SD, Santos RM, Mendes AC, Andrade EC. Communication, destructive behaviors and patient safety. *Rev Sobecc*. 2018;23(4):226-30. Review.
19. Pérez MA, Milian AJ, Puig PL, Cabrera PL, Victoria IP. Comunicación organizacional como dimensión necesaria para medir el clima en las organizaciones en salud pública. *Horizonte Sanitário*. 2017;16(1):28-37.
20. Nardi AC, Soares RA, Mendonça AV, Sousa MF. Health communication: a study of the profile and structure of municipal communication advisory services in 2014-2015. *Epidemiol Serv Saude*. 2018;27(2):e2017409.