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INTERPROFESSIONAL EDUCATION AND HEALTH CARE INTEGRATION: A CONTEMPORARY PHILOSOPHICAL READING OF CONCEPTS**SIMONE BEATRIZ PEDROZO VIANA¹**ORCID: <http://orcid.org/0000-0003-0121-0117>**REGINA CÉLIA LINHARES HOSTINS²**ORCID: <https://orcid.org/0000-0001-8676-2804>

ABSTRACT: This article intends to further concepts of interprofessionality and health care integration, in the light of contemporary philosophy, the theoretical construct of national and international researchers and the testimony of students in the health field about this matter. The methodology provides the study a qualitative character, whose philosophical theoretical support is based on discussions by Nietzsche, Foucault and Deleuze & Guattari, as well as field research, applied to 17 students starting undergraduate courses in the health area, through an interview on Google Forms digital platform. For data handling, the Content Analysis proposed by Bardin was chosen. The results indicate that interprofessionality is not a content or a technique to be taught, but attitudes to be developed both in the professional space and in health education, lined up by behaviors and interpersonal interactions for teamwork, in order to achieve integration of health care. The obstacles for implementation are related to the very establishment of the health field, the hierarchies installed as a device of domination, the spatialization of the disease, disregarding the human being and its complexity, and the ideological establishment of some concepts that need further delimitation for materializing themselves. It is concluded that there are no recipes or templates for the development of interprofessional education, nor universalizing concepts about the integration of health care and the result of this interaction. What do exist are doctrines, ontological and teleological principles that guide thoughts and actions, based on theoretical, cultural and social references associated with the experiences or emotions undergone.

Keywords: Interprofessional Education, Integration in Health field, Higher Education, Philosophy.

EDUCACIÓN INTERPROFESIONAL E INTEGRALIDAD DEL CUIDADO: UNA LECTURA FILOSÓFICA CONTEMPORÁNEA DE LOS CONCEPTOS

RESÚMEN: Este artículo tiene como objetivo profundizar los conceptos de interprofesionalidad e integralidad del cuidado, a la luz de la filosofía contemporánea, el constructo teórico de investigadores nacionales e internacionales y el testimonio de estudiantes del campo de la salud sobre el tema. La metodología da al estudio un carácter cualitativo, cuyo sustento teórico y filosófico se fundamenta en las

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discusiones de Nietzsche, Foucault y Deleuze & Guattari, así como en la investigación de campo, aplicada a 17 estudiantes que ingresan a cursos de pregrado en el área de la salud, a través de una entrevista por la plataforma digital *Google Forms*. Para el tratamiento de los datos se eligió el Análisis de Contenido propuesto por Bardin. Los resultados del estudio indican que la interprofesionalidad no es un contenido ni una técnica a enseñar, sino actitudes a desarrollar tanto en el espacio profesional como en la educación para la salud, a partir de comportamientos e interacciones interpersonales para el trabajo en equipo, con el fin de lograr un cuidado integral. Las dificultades que se relacionan con su efectividad están ligadas a la constitución del campo de la salud, a las jerarquías que se han instalado como dispositivo de dominación, a la espacialización de la enfermedad desconsiderando al ser humano y su complejidad, y a la forma ideológica en la que ocurrió la construcción de algunos conceptos que necesitan una mayor delimitación para convertirse en realidad. Se concluye que no existen fórmulas o modelos para el desarrollo de la educación interprofesional, ni conceptos universales sobre la integralidad del cuidado y el producto de esta relación. Lo que existen son doctrinas, principios ontológicos y teleológicos que orientan pensamientos y acciones, basados en referencias teóricas, culturales y sociales asociadas a las experiencias o sentimientos vividos.

Palabras clave: Educación Interprofesional, Integralidad en Salud, Educación Superior, Filosofía.

INTRODUCTION

More than 100 years ago, the studies on medical education, led by the Flexner Report of 1910, provoked a series of transformations in the teaching of health professions. Focusing on disease and human biology, the Flexner Report privileged the teaching of basic sciences, individual clinical practice and hospital training as the ideal space for learning. Called the biomedical model, this teaching format was considered essential for the modern physician and other health professionals, but insufficient to keep up with the health challenges of the 21st century, given the changes in the characteristics of the population's way of life and disease (FRENK et al., 2010)

These new modes of subjectivation, typical of contemporary society, have been requiring other training designs that overcome the isolated models of learning, the fragmentation of knowledge and, consequently, of the human being, and the independent and little collaborative way among health professionals in the care process. Frenk et al. (2010) call attention to the changes needed in the education of health professionals, based on teamwork, communication and interdependence of actions, in order to qualify the practices and strengthen the Health Systems. The author advocates institutional and instructional reforms to meet the demands of the 21st century, which together make up the third major reform of health education. In this sense, he highlights the development of curriculum designs based on local and global competencies, patient-centered and population-centered care, promotion of interprofessional education, improvement of collaborative practices and teaching focused on health systems.

Interprofessional education (IPE), therefore, constitutes one of the emerging themes in the field of health training, nationally and internationally, and has been widely supported by public policies, in view of the changes in the epidemiological profile of the population, especially of chronic health conditions, requiring collaborative professional practices of comprehensive approach (WHO, 2010).

Considered a style of education that prioritizes teamwork, the concept of IPE has been maturing and improving over time. In 1997, the Centre for the Advancement of Interprofessional Education (CAIPE) defined it as "occasions when two or more professions learn with, from and about each other to enhance collaboration and quality of care and services" (CAIPE, 2013).

Barr et al. (2005) took up the definition by saying that interprofessional education involves members of two or more professions learning side by side. More recently, they stated that IPE enables health workers to compare their perspectives and reconcile their differences, combining their energies and competencies for greater health system efficiency (BARR, 2019). From this relationship it is expected

availability for an expanded health care, based on teamwork and whose gaze is to understand the human being and their subjectivities.

When students and professionals from different professions meet in joint learning, promoted by IPE, they are affected by each other, firstly by the discovery of each other's knowledge, by the specific capacities and competences of each one and then by the possibilities that this affection may cause in the joint construction that they will be able to produce. By "affection", based on Deleuze, we understand the power in act, the meeting of bodies and minds, the relationships that are unleashed there, expanding the capacity to act. Deleuze (2002, p. 25), when theorising about Spinoza's ethics, argues that, "[...] when a body meets another body, an idea another idea, so much happens that the two relations compose to form a more potent whole, and on the contrary, when one decomposes the other, it destroys the cohesion of its parts".

This article seeks to deepen the concepts of interprofessionality and integrality of care, in the light of the matrix of thought of contemporary philosophy and the discourse of health students on the theme.

Using philosophy is a way of organising thought, understanding the nature of concepts and their essence, questioning current issues, raising new problems and outlining other possible paths. It is essential, however, to remember that philosophy is the discipline that creates concepts, but these are not entirely ready, they must be elaborated and reformulated all the time (DELEUZE; GUATTARI, 2010). This means that, in this study, philosophy lends its toolbox to think about health concepts and practices as an inseparable process of training and intersubjective action of subjects and their potential to act around life care.

METHODS

This is a qualitative research, whose philosophical theoretical support was based on readings and discussions of the works of Friedrich Nietzsche in *Ecce Homo* (2001) and *Human, All too Human* (2005); Michel Foucault with *The Birth of the Clinic: An Archaeology of Medical Perception* (2020), *The Hermeneutics of the Subject* (2006), *The Order of Discourse* (1999) and *The Government of Self and Others: Lectures of the Collège de France, 1982-1983* (2010); Gilles Deleuze and Félix Guattari in *What is Philosophy?* (2010); Gilles Deleuze in *Spinoza: Practical Philosophy* (2002). Some authors from the health field who deal with IPE and integrality of care, especially Hugh Barr, Scott Reeves, Ricardo Burg Ceccim, Juan José Beunza Nuin, and José Ricardo de Carvalho Mesquita Ayres, whose views constitute an open field for the dialogue with philosophy, add concepts to this discussion.

Deleuze and Guattari (2010, p. 5) state that: "according to the Nietzschean verdict you will know nothing by concepts if you have not at first created them, that is, built them in an intuition that is their own: a field, a plane, a soil, which is not confused with them, but which houses their germs and the characters that cultivate them".

Therefore, as well as the epistemological support mentioned above, we invited students who entered health courses at a university in the south of Santa Catarina to understand how the concepts of interprofessionality and integrality of care were constructed in the field of healthcare education and, on the basis of these, to further the discussion.

The study sample consisted of 17 students enrolled in the second period of the Biomedicine (2), Nursing (6), Physiotherapy (3) and Speech Therapy (6) courses, 16 female and one male, who freely and informedly agreed to participate in the survey by filling out a questionnaire sent through the digital platform Google forms. The research instrument was composed of two questions in order to identify the course of origin and gender, and six open questions related to the purpose of understanding the students' construction of concepts about: interprofessional and comprehensive care; concept and representation of interprofessionality; learning provided by interprofessional training, conception of comprehensive care and actions for its implementation; connection between interprofessionality and comprehensive care; challenges and difficulties of interprofessional training.

The research was guided by the ethical precepts of research with human beings and approved by the Ethics Committee of the Universidade do Vale do Itajaí under number 3,447,457/2019.

For data checking, we decided to use the content analysis proposed by Bardin (2011), which is structured into three phases: 1) the pre-analysis; 2) material exploratory analysis; and 3) codifying and

categorizing, thus facilitating the interpretation and meaning of the examined text. The thematic categories identified are linked to the construction of concepts of interprofessionalism, integrality of healthcare and the relationship established in the meeting of peers and the prospect of actions.

EPISTEMOLOGICAL CONSIDERATIONS ON INTERPROFESSIONAL EDUCATION AND INTEGRALITY OF CARE

The following considerations are not limited to concept citations on IPE and integrality of healthcare, as these are insufficient to examine the theme, and fragmented do not connect. The logic was to discuss the meanings of the concepts, their nature and meanings, based on the articulation between academics, philosophers and students, a kind of plane of immanence, as so well defined by Deleuze and Guattari (2010).

The discussions around the nature of IPE and its objectives are not as old, nor as new as they seem, they are simply contemporary (CECCIM, 2018). According to the author, in the 1960s, there were already international experiences that pointed to the need for interprofessional education, but in an isolated way. Moreover, the ontological desire to rescue the integrity of the human being, which the specialized and compartmentalized knowledge fragmented, dividing man into parts, dissociating him from his complex reality, does not date from today.

Reeves (2016) defined interprofessional education as the bringing together of two or more professions who learn with, from and about each other to improve collaboration and quality of care, and can be developed with both undergraduate and postgraduate students. To engage in interprofessional collaboration, all team members will need to be aware of the capabilities and limitations of their team members, as well as having a common language that enhances communication and interaction. Therefore, it is possible to develop a set of skills to coordinate actions and serve as a team. However, there needs to be feelings in this relationship, where one is affected by the other and together they transform the affections into actions. For Deleuze and Guattari (2010, p. 67), "affections are no longer feelings or affections, they overflow the strength of those who are crossed by them".

Under these assumptions, the aim of interprofessional learning is to deliberately prepare all students in the health professions to be able to work collaboratively and interprofessionally with the common goal of building a safer, patient-centred and community-oriented health system (SLUSERR et al., 2018).

However, for IPE to occur, it is necessary to do more than bring together students from different courses in joint activities. The students' cognitive, affective and psychomotor resources need to be stimulated (AGUILAR-DA-SILVA; SCAPIN; BATISTA, 2011).

IPE, therefore, is not simply shared learning, where students passively learn in an interprofessional group attending the same classroom and being exposed to the same content; their developments are active and the teaching strategies provide opportunities to share experiences, concepts and attitudes gathered around caring for the individual. Experiences that allow the interprofessional team to exercise the skills necessary for the complex process of care and problem solving (SLUSERR et al., 2018).

It is understood, therefore, that the IPE is not a content or a technique to be taught, but skills to be developed for interprofessional work during mutual learning, acquisition of attitudes guided by interpersonal interactions for teamwork, respect for ethical values, the definition of roles for proper decision making, effectiveness in interprofessional communication, so that one can, finally, by the meeting of coproduced knowledge, focus attention on the patient, the family and the community in an attempt to meet their needs with greater resoluteness and qualification (NUIN, 2019).

Interprofessional education is considered "a way to enhance the capacity of professionals and systems to develop a coordinated healthcare and thus achieve comprehensive care" (NUIN; MÉNDEZ, 2019, p. 10). In this context, the integrality of care is understood as an action that transcends the assistance practices, articulating health education actions as an element that produces a collective knowledge that translates the individual's autonomy and emancipation to care for themselves and their surroundings (MACHADO et al., 2007).

Foucault (2006), during his summer classes at the Collège de France in 1982, said that taking care of the self is a coextensive rule of life, in which the individual must take care of himself as a whole being, in his subjectivity, not only of the body, but also of the soul, of relationships, of choices, of what he considers best for himself, as a historical, political and social being.

According to the literature, when the concept of integrality emerged in the United States between the 1950s and 1960s, it came with a double meaning: integration of health services and comprehensive health care (KALICHMAN; AYRES, 2016). In Brazil, it was influenced by international experiences and organizations, such as the emblematic Alma-Ata Conference, held in Kazakhstan in 1978, and its proposal of "health for all in the year 2000", and made the defense of health rights of the population a goal, and the overcoming of dichotomies between prevention/cure, individual/collective that marked health policies until then. This struggle represented a counterposition to biomedical thinking resulting from the flexnerian model, which somehow contributed to the excessive specialization of medical practices, the fragmentation of care, the excessive incorporation of biomedical technologies and the limited view of the concept of health, seen until then as the absence of disease (KALICHMAN; AYRES, 2016).

It is not necessary to remember the existing duality between health and disease over the centuries, subjectivity and materiality, totality and reason, the being, its nature, culture, individuation and the standardisation of bodies as an end in themselves. In this perspective, we make use of Nietzsche's philosophy, in his work *Human, All Too Human* (2005, Prologue 4, p. 6), in which he approaches the great health as "overflowing health" that cannot do without the disease to reach knowledge:

From this morbid solitude, from the deserts of such trial years, the way is yet far to that great, overflowing certainty and healthiness which cannot dispense even with sickness as a means and a grappling hook of knowledge; (...) to that overplus of plastic, healing, imitative and restorative power which is the very sign of vigorous health.

It is in this relationship of opposites that Nietzsche (2001) believes that a typically sick being cannot become healthy, even less heal himself; for those who are typically healthy, being sick can, on the contrary, be even an energetic encouragement of life, of more life.

Defender of nature, the German philosopher opposes any kind of idealism that, by denying human nature, misrepresents and demeans life in its authenticity (PEREIRA, 2019).

In *Ecce Homo* (2001), for example, Nietzsche (2001, p. 81) makes a point of calling:

[...] brings to light that which is dangerous, that which corrodes and poisons life in our manner of pursuing scientific study: Life is diseased, thanks to this dehumanised piece of clockwork and mechanism, thanks to the "impersonality" of the workman, 1 and the false economy of the "division of labour." The object, which is culture, is lost sight of: modern scientific activity as a means thereto simply produces barbarism. In this treatise, the "historical sense," of which this century is so proud, is for the first time recognised as sickness, as a typical symptom of decay.

The author also heavily criticised the philosophers of the past for the influence they exerted on the West by superimposing rationality on instincts, converting life into a mere illness that makes it impossible to return to virtue, health and happiness (NIETZSCHE, 2001).

Thus, by exalting the ideal of rationality applied to the bodies, Western culture denied the nature, abandoned the conception of plurality of being, the constant transformation to which we are subject, the movement of life that makes us be what we are. In the clash between unity and the decomposition of the human being into parts, sometimes it is health that gains space and visibility, other times the emphasis is placed on illness.

Nowadays, integrality is emphasised, its multiple meanings conceiving the human being as a whole inseparable from the cultural, social and family context in which he/she is inserted. Its complexity implies the availability of an enlarged health system, whose political and organizational structures include actions from prevention to care at all levels, and requires professionals with skills and abilities to work in teams, focused on the human being and not on the disease (MAKUCH; ZAGONEL, 2017).

Integrality is, therefore, one of the most important doctrinal principles of the Brazilian Unified Health System (identified by the acronym SUS), and most likely the most challenging in terms

of conceptual and methodological construction. Lacking a specific concept, it refers to meeting the complex health needs of the population, closely imbricated in the biopsychosocial dimension and dependent on the formulation of public policies, the organization of services and the interaction between professionals, users and communities for their implementation. Mattos (2005) prefers to attribute to integrality a set of senses and meanings that are associated with the values and attributes desirable in health practices and in the configuration of health systems. Likewise, Oliveira and Cutolo (2018) believe that the meaning of integrality that matters most is that of "understanding a broad aspect of the subject", as social, biological, family and emotional beings, thus requiring an expansive view of the professionals who care for them.

Pinheiro and Guizardi (2008) argue that, although integrality presents instrumental activity linked to the organisation of assistance, its mission is ideological and focused on comprehensive healthcare, in a singular way, respecting the particularities and needs of each person. Therefore, the construction of comprehensiveness, also called integrality of care, occurs through the construction of effective daily professional practices. In this sense, Padilla (2019) cites, in the opening of his book *Working and learning together: for a team technique and ethics in health*, that any health system is effective through the workforce, represented by the set of professionals and workers committed to the health system and organized in order to respond to the rights assured to the population with the required quality.

Despite the undeniable advances of the SUS, the operability and apprehension of comprehensive care remain a challenge, both in terms of the instrumental and communicative dimensions, and the difficulty of translating the meaning of integrality into concrete actions ends up reducing it to the sum or the juxtaposition of actions of collective or preventive nature with those of individual healing nature. This finding was announced more than twenty years ago and is still a challenge, as recently reported by Kalichman and Ayres (2016). Also, the notion of comprehensive healthcare is not limited to procedures or technical acts, but encompasses attitudinal dimensions, whose purpose is to welcome and assist human beings in their suffering (PINHEIRO; GUIZARDI, 2008).

It is perceived that there is a lot of subjectivity in the context of comprehensive care and that the know-how associated with it is not linked to specific knowledge or act derived from the professional field, on the contrary, it is about attitudes and conceptions that need to be incorporated into everyday health practices and that have been lost over time, either by the automation of processes or by the supremacy of science.

Foucault (2020), when mapping the birth of the clinic, at the turn of the 18th century, pays attention to its identification with positivist science, the singular effect that the disease acquired on the patient and how "a grammar of signs replaced a botany of symptoms", as well as the representativeness of the use of language and its meanings, transferring the doctor to the status of an expert in the functioning of organs and systems, able to make a prognosis on the injury, and not on the damage it represents. Therefore, the question "what do you feel?" was replaced by "where does it hurt?", which implies the valorisation of a discourse on the disease that is now described and interpreted by the doctor.

The demand for care has been one of the greatest demands of the population, as well as many criticisms to health practices, institutions and discourses. For Pinheiro and Guizardi (2008, p. 23) "the criticisms arise in the form of fragmentation of knowledge in different space-time, in small genealogies and that do not always translate only into the identification of problems, but in the construction of solutions and answers that seek care, taking care of oneself, the other and us".

Based on the construction of these "small genealogies", the focus of attention overcomes the supremacy of the areas of knowledge, the overvaluation of professions and their field of action, to finally focus on patient safety, the welfare of the collectivity. Thus, investing in interprofessional education is also investing in interdisciplinary intersections, knowledge sharing, attitudinal skills, teamwork, humanization, in short, the integrality of care, giving new contours to health education (CECCIM, 2018).

THE STUDENTS AND THEIR CONCEPTS: AN ENCOUNTER WITH PHILOSOPHY.

The purpose of this topic is to present the thematic categories identified in the students' narratives, which relate to the construction of concepts of interprofessionality, integrality of healthcare, and the relationship established in the meeting of peers and the prospection of the actions, in order to establish a dialogue between the scientific literature and the philosophical reference previously selected.

Interprofessionality: teamwork

The students conceptualize interprofessionality as a teamwork, in which the combination of several knowledge contributes to a better qualification of the assistance. They also define it as an interaction between professionals from different areas who share knowledge and complement actions in order to achieve the best results, according to the narratives³:

“[...] exchange of experience, interaction, knowing more about the other profession, teamwork [...] one profession working with other professions aiming at more effective care [...] combination of several knowledge in order to provide a more qualified assistance [...]” (S4, S5, S6, S9, S10, S15).

The interviewees considered relevant the fact of having the opportunity to experience interprofessional training during graduation, as they believe that this coexistence will bring advantages in the job : “[...] important to prepare me for the internship or labor [...] greater understanding of the areas and decrease with the professional competitiveness in the labour market [...] will prepare professionals who will be able to relate in the workplace [...]” (S1, S7, S12).

Students consider that interprofessionality facilitates communication, improves interaction with other areas, represents a collective work in the course of the therapeutic process, essential for the health system and especially for the user, since it provides better patient care. The content of the speeches shows that the foundations of interprofessional education are under construction: “[...] improves interaction with other areas, provides more interactivity and ease of communication, important to improve care and more appropriate outcomes [...]” (S2, S4, S7, S8, S14, S16, S17).

If we consider interprofessionality as synonymous of interactivity and communication, it also shows the challenges and difficulties related to it, such as relational issues, individualism and competitiveness, according to statements:

“[...] lack of collaboration and understanding of students themselves in learning together [...] the ego of professionals hindering teamwork [...] the hierarchy of some professions over other professionals [...] the fear of area invasion [...] people's resistance to work together”. (S1, S3, S4, S7, S11, S16, S17).

This is about the agonistics between power and freedom: of the " egos", the "hierarchies", the "invasions", the "resistances". Seixas (2009), who writes about the relationship between a critical ontology of the present and the problematisation of the agonistic between power and freedom in Michel Foucault, talks about the new Foucaultian definition of the power, whose dimension is diffuse, i.e. it comprises a multiple and diverse field of power relations immanent to the domain where they confront each other, constituting the individuals' spaces of being and being.

In this context, the health field and the way it was constituted in the power-knowledge relationship present in the work process, with its hierarchies and institution of disciplinary practices of regulation of relationships and institutional space, strengthened the hegemony of some professions, spatialising the disease, the patient and the care in general (FOUCAULT, 2020). Thus, it is understandable the difficulty professionals have to establish relationships of trust, mutual respect, recognition of the professional role of different areas, interdependence and complementarity of

³ Henceforth, we will use quotation marks to distinguish between interviewee quotes and author citations that help us to discuss the theme of this paper. To highlight the participants of the field research, respecting the ethical aspects, we will use alphanumeric characters.

knowledge and actions, which are necessary for user-centred collaborative practices (D'AMOUR et al., 2008).

Integrality of health care: a field in delimitation

In the students' discourse, the association of integrality with the care of the whole appears very often, of seeing and understanding the person in their reality, their differences and singularities. For them, comprehensiveness is looking at the subject as the result of his/her history, of the environment in which he/she is inserted and for which more complex actions are required that go beyond the clinical aspects and the treatment of the disease:

“[...] integrality is cares for the subject as a whole, it is to see him as a whole and not only the problem itself, the disease. It is not taking him out of his reality [...] it is also looking at work, housing, leisure, family, food [...] it is a care focused on the individual, his family, his history, not only for the complications of the moment [...] it is thinking about the patient in a broad way and meet their needs [...]” (S10, S11, S13, S14, S17).

The narratives showed the incorporation of truths hitherto little considered by the biologicist paradigm. It is necessary, however, to pay attention to the conceptions that have been produced, since the integrality of the care, in the students' view, is identified with a theoretical construction based on an idealism that needs delimitation. It is clear, in the text clippings, the interrelation that is established between the concept of health, social determination of the health process, disease and integrality. Certainly, these are concepts that are connected and justified, however, integrality of care, in the quality of action of health professionals, cannot be confused with totalitarian care, otherwise it can never be achieved.

Oliveira and Cutolo (2018) warn about the contradictory feelings that the term integrality arouses in the health area, due to the multiple meanings it assumes in the linguistic vocabulary, and that it is necessary to clarify its physiology not as totality, as it could never be achieved, but as a mediating process of a path in which professionals and patient can walk together in search of solutions.

Likewise, Kalichman and Ayres (2016) refer to the integrality of care as a construction in progress, an experience produced in act, built on the basis of dialogue by all subjects in everyday practices.

However, some misconceptions can be produced, thus compromising the learning process, when the Brazilian Ministry of Health itself, based on the Law (number 8.080/1990) and the legal order that regulates the SUS, publishes on the Virtual Health Library website: "integrality - this principle considers people as a whole, meeting all their needs" (BRASIL, 2020). The scope of the concept, the polysemy of the term and the absence of guiding elements as to the integrality of care cause other discourses and truths are produced, causing disbelief and little hope of achievement, as we see in this statement: "[...] to understand the SUS and its importance, in practice we lose some of the theory [...]" (S1).

Larrosa (1994), based on the studies of Foucault, mentions that the optical mechanisms and the discursive procedures exercise the function of regulators of social life and allow to judge, normalize and channel individuals. Therefore, the discourses that in theory are perfect, but in practice do not work, are being constructed as truth in the social environment. For Foucault (1999, p. 10), "the discourse is not simply that which translates the struggles or the systems of domination, but that which is fought for and because of, the power of which we want to take possession".

Nevertheless, and with the purpose of deepening the discussions, it seems appropriate to reflect on the representation of the integrality of care, which is present in most of the students' speeches and in the literature in general, as we can read in the following statement: "[...] the integrality of care is the act of treating a patient as a whole and not just curing him/her of a disease [...]" (S14).

"Treating", "assisting" the patient as a whole, "meeting their needs", may become an even greater form of domination of professionals over "patients" and, at the same time, of dependence on the patient, since professionals are now caring for the whole, and not only the part of the patient and the illness. It is necessary to reflect on these pitfalls, so that, once again, the person is not excluded from

their life process, their choices and their responsibilities. Their inclusion in self-care, the sharing of knowledge and practices, and respect for their choices, is a way to achieve the autonomy of the subject, the true owner of themselves. Integrality of care also means including the "patient" in the care process.

Only a student made explicit in his statement the involvement of the patient during the moment of professional intervention, but even so, it cannot be said that the patient's position is that of protagonism, according to the following fragment:

“[...] it is necessary to have a comprehensive approach to patients, to be able to listen to them and not discard them if no pathology is found, as they may be experiencing other difficulties [...] it is necessary to have a professional perspective” (S2, S15).

In this context, it is appropriate to strengthen, during pedagogical activities, the teach strategies that encourage listening, valuing the patient's speech, as the protagonist of his own story, so that the professional is not the one who classifies signs and symptoms, a designer of geographies and solutions, which Foucault (2020) has called secondary spatialization of pathology.

It is necessary, therefore, that in the process of construction of the concept of integrality of care, theoretical and methodological resources are included that lead students to reflect on the three modes of domination identified by Foucault (1995, p. 235) and which we should fight "against ethical, social and religious domination; against the forms of exploitation that separate individuals from what they produce; or against what binds the individual to himself and thus submits him to others (struggles against the forms of subjectivation and submission)".

Regarding the practice of comprehensive care, that is, the actions for this to become effective, the students' statements focus on the need for the presence and joint work of the most varied areas of knowledge, the importance of teamwork that includes planning and joint action itself, respect for singularities and patient-centered care.

It is observed in the students' discourse a certain rhetoric, a theoretical discourse that is repeated and that certainly makes sense for the moment of training, that is, in the first years, in which the disciplines work mainly the basic theoretical principles of the theme than the practice itself. Thus, the discourses lack examples, situations or even actions linked to professional practice that concretize the integrality of care in the practical application.

The established relationship in the encounter of peers and the prospection of actions

The students' statements identify a close relationship between interprofessional coexistence and the practice of integrality of care. The feelings indicate a complementary work, whose beneficiaries are at the same time the professionals, the patients and the community in general, suggesting positivity in improving healthcare and resoluteness of assistance, although the manifestations are more concentrated in the theoretical field, as can be noted:

“[...] allows to look more comprehensively when care is provided by more than one professional, without fragmentation or superiority [...] work together for the well-being of the patient [...] one (integrality of care) does not exist without the other (interprofessionality). [...] to achieve integrality and overall care of patients, you must have the professionals together [...]” (S5, S13, S15).

Obviously, patient safety, the integrality of care, and the humanization of health practices are among the reasons why interprofessional training and, consequently, teamwork have been invested in. Ceccim (2018) asserts that interprofessionalism increases the safety of assistance, reduces risks and damages, improves the satisfaction and comfort of users, as well as the relief and well-being of workers.

The partnerships that are formed and transformed in the daily practice result in collaborative actions that add resoluteness to the health work and sense of belonging to the team, in view of the collective action (CECCIM, 2018). This can be seen in this statement: “[...] having more than one professional looking at the same patient helps in the diagnosis, being more accurate, so one complements the other taking care of the individual as a whole and not only the pathology” (S13).

Being willing to provide a more qualified care based on teamwork, to recognise and accept the knowledge of others, to prioritise life, the community's well-being, is certainly breaking with the self-sufficiency and deification of the professions which, for centuries, have inhabited human dreams and submitted them to each other.

In this relationship (professions x professionals), of overlapping knowledge, subjection and domination devices are installed, culturally perpetuated by class institutions and society in general, which Foucault (2010) called the power-knowledge and which need to be deconstructed.

The students' thoughts in this study lead us to believe that their experience of interprofessional education has collaborated not only with the construction of concepts on interprofessionalism and integrality of care, but also with the formation of new identities. Hence, what matters is not the field of knowledge, but for what and to whom it is intended.

CONCLUSION

There are no internationally accepted formulas or models for the development of interprofessional education or for the exercise of interprofessionalism, nor are there universalizing concepts on integrality of care and the product of this relationship. Doctrines and teleological principles that guide our thoughts and actions based on theoretical, cultural and social references associated with experiences and feelings experienced do exist.

The encounter with the theoretical framework allowed conceptual deepening, providing argumentative support in the defense of the IPE for the consolidation of the integrality of care. Its discussion goes beyond the health field to refer it to a broader philosophical approach that understands interrelationships, and the care and integrality as ontological expressions of the human being. The entire modern scientific construct on which the duality health-illness, body-soul, doctor-patient, subject-object was built has deep marks in the constitution of health with serious repercussions in the training of health professionals. Severing this pattern of relationship requires more than the mastery of a conception; it requires a change in attitude and patterns of behaviour based on a hierarchical relationship of power between professionals and patients.

Therefore, in the face of a uniprofessional, competitive, fragmented and technical training, the action will probably be prescriptive, classifying, focused on the disease, not on being sick and disqualifying the multiprofessional knowledge. On the counterpart, when relationships are horizontalized and knowledge is intertwined, in a mutual learning, what is expected is the existence of the collaborative spirit, teamwork and care centered on the person and their uniqueness.

In order to reach the integrality of care, it is necessary to overcome the hegemony of the areas of knowledge, the respect for subjectivity, the valuation of singularities, the care of the self, of the other and of ourselves, the reworking of languages and signs that value the instincts, the plurality of being and its transformations, crossed by ethics.

The challenge, however, is to awaken these affections, whether at undergraduate or postgraduate level, and for which the use of integrative methodologies and philosophical foundations that explain the nature and aims of the life sciences is suggested.

To conclude, it is important to say that this study does not represent an exhaustion of the theme and that, in the face of so many nuances and processes under construction, it is, before arriving, a starting point.

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AUTHORS' CONTRIBUTION

Author 1 Conducting the research process and methodological design of the research. Data collection and curation, data analysis. Preparation, creation, writing and presentation of the published work.. (Data curation, Formal analysis, Investigation, Methodology, Visualization, Writing – original draft)

Author 2 – Supervision in the planning and execution of research activity. Guidance in the formulation of objectives, Conceptualization. theoretical-methodological references and goals of the research. Review and editing - critical review, commentary or revision - including pre- or post-publication stages. (Supervision, Conceptualization, Methodology Project administration, Writing – review & editing).

DECLARATION OF CONFLICT OF INTEREST

The Authors declare that there is no conflict of interest with this article.

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