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Communication in the dialogical perspective of collaborative interprofessional practice in Primary Health Care

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The objective of this study was to analyze communication as a collaborative interprofessional health practice domain in the workflow of primary healthcare teams. It was a qualitative study with a descriptive and interpretative approach, and its data constitute part of a master's thesis. It was conducted in in Primay Health Care Units (UBS) of a Brazilian city in the northwestern part of the state of Paraná, with 84 professionals of primary healthcare teams. Data was collected by focus groups and organized in hierarchical descending order using software IRaMuTeQ®. They were submitted to lexical analysis and discussed based on the Theory of Dialogic Action. Five lexical classes were obtained. When grouped together, they revealed how communication among primary healthcare teams occurs. Collaborative interprofessional communication is still a challenge for health teams when leading a joint transformative and dialogical work process.

Keywords: Communication. Interprofessional relationships. Collaborative behavior. Health staff. Primary healthcare.

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Introduction

Collaborative interprofessional health practice is one of the most important methods to improve results in health practice worldwide[1], particularly because it positively contributes to perception, comprehension, and efficiency of teamwork relationships, similarly to what happens in healthcare[2]. In this regard, it is affirmed that collaborative interprofessional health practice enables a synergistic influence on care; improves health access, use of resources, and efficiency of services; analyzes results; and rationalizes healthcare costs[3].

Since it has a complex polysemic construct with multiple determinants to professional work[4], it implies changing multiprofessional work to interprofessional, requiring collaboration. Multiprofessional work is usually marked by care fragmentation and characterized by juxtaposition of different disciplines, where specialized knowledge comprises the grounds of each professional's work. On the other hand, interprofessional work is conducted by reflecting on professional roles and making joint decisions based on which knowledge is dialogically built respecting singularities of all different professional practices[5].

In this sense, in order to achieve collaborative interprofessional health practice, some domains were determined as essential. Among them, interprofessional communication was acknowledged as fundamental and is increasingly found in other domains, namely: patient, client and family-centered care; clarification of professional roles; team dynamics; interprofessional conflict resolution; and collaborative leadership[6].

It is therefore justified that communication is a crucial aspect for the development of a group culture and to create a common sense of accomplishment within the team, which enables an effective interprofessional collaboration[7]. Likewise, it places interprofessional communication under the spotlight in the collaborative interprofessional health practice domains. An open and effective communication channel among health teams provides professionals with opportunities to share their anxieties and daily victories. This contributes to improved health results and increased user satisfaction[1,8]. Such assertion provides an educational perspective to interprofessional communication, i.e. an authentic dialog. This perspective favors learning through daily practice and transforms it through reflection and questioned knowledge[9].

In this sense, given the complexity of care, such as desired healthcare resoluteness and overcoming fragmented practices based on the broader concept of health[10], one can affirm that communication as a collaborative interprofessional health practice domain is a fundamental principle to primary healthcare[11]. It is necessary to clarify that the Brazilian primary healthcare is organized according to the precepts of Brazilian National Health System (SUS). It is delineated by the joint work among Family Health Strategy (ESF) teams and by Support Family Health Support Centers (NASF). Together, they seek comprehensive care and health actions resoluteness permeated by interdisciplinarity[12].

The communication context is considered a collaborative interprofessional health practice domain focused on qualified health in primary healthcare in line with SUS ideologies. Therefore, this article aims at addressing the following question: "Does interprofessional communication exist in the work process of NASF and ESF teams?" If so, does it have authentic dialog characteristics able to provide learning, and consequently foster transformations in these teams' work process? Furthermore, the study aimed at analyzing communication as a collaborative interprofessional health practice domain based on the work process of APS teams.

Methodology

A qualitative approach study with descriptive and interpretative characteristics was conducted. Its data constitutes part of the Master's Degree dissertation entitled "Domains and competencies of collaborative interprofessional health practice in the work process of primary healthcare teams." The investigation process was conducted in Primary Care Units (UBS) of a Brazilian city located in the northwestern region of the state of Paraná. These units have nine NASF teams supporting all 74 ESF

teams, reaching 65% of the population – approximately 250 thousand from a total of four hundred thousand inhabitants. The study's target audience were professionals from all nine NASF teams and one reference team from each NASF. Altogether, 84 professionals from primary healthcare teams participated in this investigation, representatively distributed among different working area categories that met previously-determined inclusion and exclusion criteria.

For NASF professionals, the following inclusion criteria were used: be a professional designated to NASF and be related to National Registration of Health Establishments System (SCNES) in the research city. For this same audience, two exclusion criteria were applied: not working in the professional role in NASF team and not working professionally during data collection (due to vacation, leave, or unavailability). Among 57 qualified professionals, 44 were selected and participated in the study. Five social workers, four pharmacists, four physiotherapists, six speech therapists, eight nutritionists, six physical educators, eight psychologists, and three occupational therapists were selected.

As to ESF professionals, two inclusion criteria were taken into consideration. The first one was to belong to a team designated by NASF in order to develop actions and practices in partnership and integration with NASF team. The second one was to be registered in the research city's SCNES. The exclusion criteria were: not working professionally and not working in NASF roles during data collection. Among all 59 working professionals in ESF teams designated by NASF to the research, forty were selected and participated in the study. Those who met the inclusion and exclusion criteria were: 26 community health agents, eight nurses, three nursing technicians, two doctors, and one oral health technician. Lack of participation from the professional medical class in ESF teams deserves special attention, since their point of view was not visible in all group discussions, only the other ones'.

Data was obtained from February to April 2017 using the Focus Group (FG) technique. FG is a data collection technique used in qualitative research and results from group interviews. It enables the collection of information through communication and group interactions. Group interactions are developed to collect perceptions from participants about a specific topic[13]. In this study, the topic was related to communication as a collaborative interprofessional health practice domain and the joint work process of NASF and ESF professionals.

The data collection tool was a set of questions sent to FGs, which described the collaborative interprofessional health practice domains. Only practices related to communication were relevant to this study. The script was adapted by judges with experience in the area, who followed a tool in order to correctly adapt the questions[14]. This script was subsequently submitted to a pilot FG in order to ensure the required methodological rigor. Nine FGs were thus conducted: one with each NASF team with its respective ESF. However, only eight were considered in the study, since it was necessary to remove the pilot group, thus avoiding unnecessary bias in the research.

ESF and NASF professionals who formed the FGs were previously invited in-person and by printed invitations. An average of ten professionals attended the meetings. Dialogs were held in UBS meeting rooms, which had good acoustics and lighting, ensuring adequate conditions to the conversations[13]. Communications were conducted by a moderator (the researcher herself) with the support of a rapporteur and an observer.

FG discussions were recorded using two simultaneous recorders. Audios were subsequently transcribed in full and then included as part of the research database. The communication process was organized based on only one file called corpus. This process was considered a collaborative interprofessional health practice domain among APS teams. Therefore, each FG characterized a text. Together, these texts constituted a research analysis corpus.

Data was organized using software *Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires* (IRaMuTeQ®) version 0.7 alpha 2. IRaMuTeQ® is a free program based on Software R that provides statistical analyses on textual corpora using different organization types for textual analysis. In this study, we used the Descending Hierarchical Classification (DHC)[15] to process data.

DHC uses corpus to dimension text segments or elementary units of context (EUC). EUCs, in turn, are classified in relation to the most frequent vocabularies and highest chi-square values within a class, since they understand these are significant to further analysis. IRaMuTeQ® organizes words

in a dendrogram representing the quantity and lexical composition of classes based on a group of terms. It provides the absolute frequency of each one of them and the aggregate chi-square value[15]. The dendrogram enabled the creation of a chart that provides a better view of the classes. This chart qualified EUCs regarding their respective vocabularies with a specific terminology, enabling a subsequent lexical analysis[16].

In order to conduct an interpretative discussion, the Theory of Dialogic Action[9] was used based on praxis and authentic dialog. Likewise, use of this theoretical perspective refers to the transformation of knowledge and practices permeated by dialog, which incorporate communication precepts. Communication, in turn, is understood as a collaborative interprofessional health practice domain.

The research was submitted to the Ethics Committee for Research Involving Human Subjects and had a favorable opinion under number 1.903.172/ 2017 (CAAE: 63610916.1.0000.0104). All the research participants signed a consent document. Answers were anonymous, and all other indicated ethical precepts were guaranteed. Finally, all steps indicated in the checklist Consolidated Criteria for Reporting Qualitative Research (COREQ) were followed to present the text in order to ensure improvement of the research results presentation under a qualitative approach[17].

Results and discussion

A total of 5,894 occurrences of words were identified in the DHC distributed into 885 EUCs with 90.14% of corpus leverage, showing a great use of data. Five analysis classes originated from the corpus DHC dendrogram. The corpus was divided into two subcorpus. One of them resulted in class 5. The other resulted in class 4 and three other distributions that resulted in classes 1, 2, and 3. These classes, interpreted as communication processes consistent with the collaborative interprofessional health practice communicative domain, are presented in a chart for a clear understanding (Chart 1). Interpretations lie in the contradictions expressed in Chart 1 classes, since they convey polarity of potentialities or weaknesses to interprofessional communication, as well as engendered ones.

Chart 1. Classes related to interprofessional communication in the work process between NASF and ESF teams, listed in percentage decreasing order, resulting from DHC's textual corpus dendrogram.

Class number	Class terminology	% of the class in decreasing order	Lexicographical analysis		
			Words ($p < 0.001$)*	X^2	%
2	Interprofessional communication is focused on care provided to health service users	22.1	Patient	45.63	87.5
			Medical record	26.19	100.0
			User	25.48	65.8
			Community health agent	25.18	88.89
			Contact	17.47	100.0
			Care	17.47	100.0
			Service	13.76	83.33
			Look	10.86	100.0
5	Informal communication among teams is conducted via communicative technologies	20.5	WhatsApp	103.37	100.0
			Information	71.82	83.33
			Technology	61.12	100.0
			Send	60.51	74.07
			Informal	56.53	80.95
			Message	41.26	91.67
			Telephone	32.23	90.0
			E-mail	28.78	100.0
			Cell phone	24.46	100.0

it continues

Chart 1. Classes related to interprofessional communication in the work process between NASF and ESF teams, listed in percentage decreasing order, resulting from DHC's textual corpus dendrogram.

Class number	Class terminology	% of the class in decreasing order	Lexicographical analysis		
			Words ($p < 0.001$)*	X^2	%
1	There are difficulties of an effective dialog among professionals, but its importance is acknowledged	20.5	Exist	33.17	100.0
			Dialog	24.6	100.0
			Hinder	23.56	87.5
			A lot	17.38	55.5
			Solve	16.04	100.0
			Freedom	16.04	100.0
			Subject	15.28	83.33
4	Permanent education and matrix-based strategies provided by home visits and collective work are interprofessional communication strategies	18.9	Home-based	50.92	92.31
			Matrix-based	46.58	100.0
			Interprofessional	46.1	65.38
			Opportunity	44.06	66.67
			Visit	40.75	100.0
			Permanent	34.22	100.0
			Education	31.82	70.59
			Group	27.03	100.0
			Appointment	17.72	92.03
			Difficulty	17.72	100.0
			Opportunity	41.57	100.0
3	Meetings to discuss cases and plan actions among teams are formal moments of interprofessional communication	18.1	Meeting	13.89	100.0
			Discussion	49.21	84.62
			Formal	49.21	84.62
			Moment	24.32	62.5
			Action	18.68	100.0
			Plan	13.89	100.0
			Exchange	13.44	80.0

Source: the authors.

Communication between NASF and ESF implies considering it part of the work process. Therefore, praxis has the potential to transform reality[9]. This study's findings show that there is communication among teams with aspects that enhance interprofessionality and transformation of actions. However, we noticed weaknesses and challenges that hinder an effective collaborative interprofessional health practice.

As an interprofessional communication driver, class 2 (22.1%) indicates that "interprofessional communication is focused on care provided to health service users," highlighting the main objective of communicative practices between NASF and ESF is the user. This signals a team initiative towards care strategies that aim at an ideal dialog. Therefore, these were the highlighted words: patient, user, care, contact, and service. The means of communication with this focus were: medical records and community health agents. This is clarified by the speeches that support this interpretation based on a lexical analysis:

> The main objective of communication among teams is the resolution of patient cases, to solve critical nodes [...] (NURSE – FG1)

> [...] Medical records are a source of interprofessional communication because even if I do not have direct contact with ESF, or ESF with NASF, if all professionals evolved and noted everything down, we are able to know what was done [...], which professionals cared for the patient, and the service is cross-referenced and capable of a solution [...] (PSYCHOLOGIST – FG2)

> We, community health agents, are the bond between patients, and NASF and ESF teams. [...] we see what users need and put teams in action, and this is collaborative, because it helps patient care [...] (COMMUNITY HEALTH AGENT – FG6)

Under this perspective, it was highlighted that the main objective of communication among teams, represented by professionals, is the user of health services. Therefore, this finding suggests this domain is possibly collaborative. If accomplished, it results in improved safety and healthcare quality regarding decisions agreed upon between professionals and users[18,19]. Teamwork communication focused on the user also reinforces the domain of a person-centered care, since it avoids care omissions or duplicates, waiting, or unnecessary postponement[3].

In this sense, the means presented by professionals to conduct a user-focused interprofessional communication were community health agents and medical records. Despite being strong allies in communicative practice to support care, they cannot be considered exclusive and decisive means to achieve this domain.

Community health agents indeed represent a strong bond between community and other primary healthcare professionals. They are considered important mediators of communication in the sense of finding out about the users' life and health reality. Their contribution can be dialogical towards questioning contexts and combining resolutive professional practices, enabling action-reflection-action[9]. Their routine practices, permeated by connection and embracement of the population, favor the identification of issues through attentive listening, praising the need for collective interprofessional moments in order to produce knowledge and actions that result in benefits[20].

Therefore, community health agents instigate professionals from NASF and ESF teams to communicate in order to find solutions to user cases. Likewise, community health agents encourage the practice of care in the population. Prominence of community health agents in the communication between users and the team indicates a team effort to put into practice care strategies towards the ideal dialog.

Use of electronic medical records, identified in this study as a user-focused means of communication, was considered an indirect tool of information exchange among professionals. Despite being an important tool to safety when making decisions and to quicker responses to adverse events, its use can reduce face-to-face communication among professionals from the teams[19].

Under this perspective, use of electronic medical records can damage dialogical communication, which creates opportunities of knowledge exchange and transformation of actions[9]. Therefore, in this study's context, medical records seem to be used as a core means, not as a communication accessory, distancing the team's dialogical relationship, since it is understood as a replacement of direct contact, and often professionals, distancing interprofessionality[5].

It is well-known that interprofessional communication requires a solidary conversation capable of reflecting and fostering transformations in actions, aimed at promoting humanization, creation, and freedom of work processes by interlocutors[9]. In this sense, where the dialogical perspective is emphasized, users should not be merely the focus of communication among professionals, as learned in this research. Although mediation is established by community health agents or medical records, the user's participation should be effectively guaranteed. However, in this study's context, we could not find any prominence of users in the interprofessional communication process. Since the lack of this event is a fact, it can have consequences, such as work alienation followed by its decontextualization, translating an antidialogical health relationship[9] of action.

In this sense of dialogical and collaborative focus between NASF and ESF professionals and users, we also highlight the importance of building and discussing Individual Therapeutic Project (PTS). PTS is a set of articulate therapeutic proposals aimed at the singularity of communities, users, and their families. It is the result of a collective discussion of an interprofessional team where all opinions are considered important to help understand an individual who needs healthcare, and determine action proposals[12]. Therefore, PTS reinforces the relevance of collaborative interprofessional communication focused on the user, who is considered an active being in their care process.

The research showed a potential weakness in collaborative interprofessional health practice. It was observed that "informal communication among teams is conducted via communicative technologies," present in class 5 (20.5%). This study's target professionals considered that communication is marked by the informal transfer of information and messages, especially using messaging technologies, which was evidenced by the following words: WhatsApp, information, technology, send, informal, message, telephone, email, and cell phone. The following accounts reinforce these findings:

> We use informal means of communication a lot, particularly WhatsApp, to send a message, an information [...] this decharacterized an effective interprofessional communication because there is no exchange. (PHYSIOTHERAPIST – FG4)

> I think communication among teams mostly occurs through written messages, WhatsApp, cell phone [...] but not always do we receive a reply because there is a huge demand, so they are mostly a simple transfer of information related to cases. (NUTRITIONIST – FG8)

Considering only the transfer of information, the communication act is characterized by pure verbalism, which hinders action and dialogical reflection. This informal communication also complicates the effectiveness of professional commitment to transformation of the reality where professionals are inserted[9], resisting to a strictly communicative collaboration among teams.

Communication technologies are being increasingly used nowadays, and teamwork also follows this contemporary trend. Their use is justified by the easiness in transferring information[19]. However, their excessive and exclusive use can hinder and/or reduce interprofessional collaboration. This can occur because the type of conversation that characterizes dialogical communication depends on deeper personal relationship levels. Superficial communication constitutes, in its *modus operandi*, a communicative barrier of dialog among professionals and teams from different backgrounds[21].

It is thus understood that in order to consider collaboration and interprofessionality as means of communication, the so-called "information technologies" (means for the simple transfer of information) should be overcome. In other words, it is necessary to focus on the search for a communicative process based on exchange of information and joint actions[6,7], thus overcoming antidialogicity[9].

Interpreted as cohabiting potentiality and weakness, class 1 reaffirms "there are difficulties of an effective dialog among professionals, but its importance is acknowledged." This is evidenced by the following terms: exist, dialog, hinder, and a lot. However, the words solve and freedom show the importance attributed to dialog in order to achieve interprofessional communication among teams. Some accounts exemplify this class:

> [...] with some teams, we are free to talk to [...] others, the dialog is more difficult, we face more resistance [...]. (PHYSICAL EDUCATOR – FG2)

> The difficulties in communication between NASF and ESF teams are greater than its easiness [...] dialog does not occur, neither does interprofessional and collaborative communication. (PSYCHOLOGIST – FG5)

> [...] there is no opening for dialog, there is not this knowledge exchange, there is not this opening to talk. (NUTRITIONIST – FG7)

> ESF has so many bureaucracies to solve that sometimes we end up having dialog and communication issues with NASF; and in the end, there are failures in collaboration. (NURSING TECHNICIAN – FG8)

Dialog, considered a tool to consolidate interprofessional communication, is essential to collaborative interprofessional health practice[18]. In this assertion, it is worth highlighting the pedagogic concept of horizontal dialog[9] in health practices, since it enhances professional learning, and improves work relationships and healthcare[22].

On the other hand, the dialog difficulty indicated by interviewers concentrates on the assertion of antidialogicity. This antidialogicity tends to activism and verbalism[9], which in turn build professional relationships with little collaboration and hinders the achievement of a collaborative interprofessional practice among teams (structured towards joint support)[12].

The interprofessional dialog challenge referred to by participants of this research corroborates with the fragile communication issues among primary healthcare professionals. These issues result in damage to the comprehensiveness of care in ESF and NASF work in the national context[23]. This reinforces the dialogical weakness as a striking aspect to be overcome in the joint work process of these teams. Existing requirements and demands in health services, such as improving health indicators and the number of procedures, can bureaucratize them and hinder an authentic dialog among different professional categories[24], consequently weakening interprofessional communication.

Class 4 (18.9%) unveiled that "permanent education and matrix-based strategies provided by home visits and collective work are interprofessional communication strategies." The following terms can be observed in this class: home visit, matrix-based strategies, permanent education, groups, and opportunity. However, the word difficulty was significant, showing that, although these strategies occur, there are challenges to their effectiveness. These challenges, in turn, compromise interprofessional communication and indicate, once again, contractions in potentialities and weaknesses within the same class. These are the discussions that clarified these findings:

> Joint home visits are important interprofessional communication moments [...] dialog with users and among ourselves creates opportunities of permanent education and professional clarification, and facilitates interprofessional communication. (OCCUPATIONAL THERAPIST – FG2)

> We, from NASF, were able to talk and dialog with ESF professionals through matrix-based strategies and permanent education. Although this is a challenge in some teams, it is a means of communication. (PHARMACIST – GF 3)

> I think the groups our ESF relies on with NASF's help enable interprofessional communication, from the organization to the implementation of groups. (DOCTOR – FG8)

We found out that permanent education, matrix-based strategies provided by home visits, and collective work were referred to as contributors to avoiding the self-sufficiency feeling of ESF professionals, which also requires dialogical communication with NASF. In these actions, this dialog helps in times of communion, trust, and collaboration, which provide a collaborative characteristic to communication among primary healthcare professionals.

In this sense, matrix-based strategies and permanent education are facilitators of interprofessional communication and elucidate the fulfillment of NASF's role, promoting changes in ESF's work process. Such changes enable intersectoral and interdisciplinary actions to health promotion, prevention, and rehab[12].

Matrix-based strategies conducted by NASF with ESF teams are a favorable aspect to interprofessional communication. This is due to the fact that it is a set of technical and pedagogical support actions that aim at building a horizontal relationship among professionals. This relationship should occur in order to revert the governing logic in specialization's verticality, which provides isolated and fragmented assistance, not integrated among primary healthcare teams[25]. Therefore, matrix-based strategies enable dialog and knowledge exchange among different categories[24] in the reality found in this research.

Home visits particularly create opportunities of interprofessional communication, since they maximize knowledge and experiences of each professional. This maximization enables them to collaboratively provide coordinated and integrated home care[26], similarly to what participants revealed.

However, the difficulty of matrix-based strategies among primary healthcare teams was present in the investigated context, which does not differ from national healthcare. There is evidence of fragmented practices among these professionals that are based on the hegemonic medical model concept to manage matrix support. Consequently, there is a segregated health assistance where individual interventions overlap the dialog among professional categories and thus prevents collaboration in communication[24].

Contrary to this difficulty, permanent education is an existing condition in routine work, as identified in this study. The dialogic horizontal relationship determined by permanent education is capable of improving resolubility of primary healthcare actions, since it questions practices it wants to change[27]. Therefore, we understand that, when conducted by professionals from primary healthcare teams, National Policy for Permanent Health Education (PNEPS) helps achieve collaborative interprofessional health practice[28].

In order to implement PNEPS, it is necessary to establish interprofessional communication, since it is an educational practice that materializes in the teams' routine. Communication as a dialog of different knowledge provides a daily reflection on roles and contributions of each team member. Interprofessional communication also favors collaborative work[26], since it provides teaching and learning by acknowledging the inherent complexity of daily practice[9].

Class 3 (18.1%) also evidenced the coexistence of weaknesses and potentialities with indication that "meetings to discuss cases and plan actions among teams are formal moments of interprofessional communication." In other words, they indicate a strategy adopted by the teams to establish the desired dialog towards collaborative interprofessional health practice. The terms characterized in this class were: meeting, discussion, formal, moment, action, plan, and exchange. However, meetings were described as a challenge, due to their scarcity between NASF and ESF. Such evidence can be observed in extracts from group discussions:

> We [ESF] are trying to keep monthly meetings with NASF to discuss cases, plan joint actions [...] it is when we are really able to establish an interprofessional communication with actual exchanges. (NURSE – FG4)

> Team meetings are an interprofessional communication means, but they are a rather common weakness, since not all ESF and NASF teams are able to frequently meet. (SPEECH THERAPIST – FG5)

Meetings are a tool to perform health praxis, since they provide an action-reflection-action process based on an authentic dialog[8]. These formal meetings among professionals from health teams create interprofessional communication opportunities, since they facilitate discussion of user cases. This discussion occurs in a systematic way, providing an opportunity to delineate collaborative care plans[29].

However, the difficulty to hold regular meetings with different primary healthcare professionals minimizes interprofessional communication. Consequently, team efficiency in terms of time, learning, and professional integration[30] is reduced. This communicative weakness is indicated as a consequence of lack of collaborative leaderships in health teams. Technically speaking, the presence of these leaderships would help clarify the importance of frequent meetings and adequately conduct them in a joint effort[30]. Leadership is an important tool because it enables to combine reflection-theorization processes experienced in real life with contributions to the construction of knowledge[31]. However, we noticed that, despite the existence of a collaborative leadership among some teams, it still is a difficult domain in the work process, being a challenge to professional meetings and actual collaborative communication.

Final remarks

Collaborative interprofessional health practice is currently presented as an extremely important strategy in the health scenario, since it enables to revert back to a hegemonic healthcare model, consequently increasing teamwork resolubility regarding comprehensive care. Therefore, this study analyzed communication as an essential interprofessional collaboration domain in the work process of NASF and ESF teams, enabling to unveil its potentialities and weaknesses.

The antidialogical aspects of communication among primary healthcare teams were highlighted. They were marked by the transfer of one-sided information in the work process using technological apparatus, such as electronic medical records, social networks, mobile apps, and sporadic meetings. This reality moves teams away from the communicative act based on praxis.

In turn, the main focus of communication potentialities was on user care. In this study's context, users were considered the main objective of communication among professionals, even when not active in the communicative process. The means of communication used were mostly home visits and collective activities.

Therefore, this research's contribution is the production of scientific knowledge related to interprofessional communication in the work process of NASF and ESF teams. This study reinforces the importance of the collaborative interprofessional health practice domain as a dialogical opportunity to (re)construct knowledge and actions that emanate from primary healthcare routine work.

In this sense, we suggest primary healthcare teams create spaces and opportunities to foster the art of dialog, overcoming the teaching and learning dichotomy. It is specifically recommended to explore potential opportunities of interprofessional communication, i.e. conduct frequent team meetings, discuss cases, make joint decisions, and aim at permanent education with moments of interprofessional clarification. It is also suggested to aim at practical learning, and to overcome communication exclusively via social networks and technological apparatus. These actions can increase the chances of a collaborative health practice.

Finally, new political guidance is expected based on these findings, in the national, regional, and local levels. Consequently, empowerment of dialogical spaces is expected, which materialize interprofessional collaboration and transform knowledge and practice. Additionally, new studies on this topic can be conducted with managers and other agents in order to elucidate interprofessional communication in the work process of primary healthcare teams. This can eventually result in new knowledge in this field of study.

Authors' contributions

All authors actively participated in the discussion of the work's results and in the review and approval of its final version.

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