REVISTA CEFAC
SPEECH, LANGUAGE, HEARING SCIENCES AND EDUCATION JOURNAL
Rev. CEFAC. 2016 Set-Out; 18(5):1230-1237
doi: 10.1590/1982-0216201618519615

Revision articles

Facial paralysis and quality of life: a critical review of literature in the scope of interprofessional work

Paralisia facial e qualidade de vida: revisão crítica de literatura no âmbito do trabalho interprofissional

Rayné Moreira Melo Santos[1]
Brasília Maria Chiari[2]
Zelita Caldeira Ferreira Guedes[3]

[1] Secretaria de Estado da Educação de Alagoas, SEDUC, Maceió, AL, Brasil; Centro de Referência Estadual em Saúde do Trabalhador de Alagoas, SESAU, Maceió, AL, Brasil.
[2] Universidade Federal de São Paulo, UNIFESP, São Paulo, São Paulo, Brasil.
[3] Departamento de Fonoaudiologia da Universidade Federal de São Paulo – UNIFESP, São Paulo, São Paulo, Brasil.

Conflict of interest: non-existent

ABSTRACT

Concern about the quality of life seeks the appreciation of it in a broader movement than controlling symptoms, decreasing mortality rate or increasing lifespan. In this context, the quality of life of individuals affected by facial paralysis, a common disease in the world, is inserted with no distinction of gender or age. The integrated work of professionals can enhance the healthcare process thus generating changes in the treatment towards the patient's quality of life. This study was carried out through electronic search in the databases of Pubmed, via the National Center for Biothecnology Information (NCBI); Lilacs (Latin American and Caribbean Health Sciences), and SciELO (Scientific Electronic Library Online). A search tool was offered by the National Library of Medicine, by means of which the combination of the descriptors facial paralysis, quality of life, health workers, interprofessional relationship, cooperative behavior, patient care team was performed in a varied way in order to detect the largest possible number of publications. Evidence showed up few studies regarding to a relation among all addressed words. In general, the literature review indicated that the interprofessional work can favor the resizing of the relations among different contents, thus contributing to the overcoming of knowledge fragmentation. The interprofessional work is reckoned to be essential for the development of a workforce in the scope of which professionals work together in order to properly assist the integral healthcare.

Keywords: Facial Paralysis; Quality of Life; Health Personnel; Interprofessional Relations; Cooperative Behavior; Patient Care Team

RESUMO

A preocupação com a qualidade de vida ocorre num movimento de busca da valorização de parâmetros mais amplos que o controle de sintomas, a diminuição da mortalidade ou o aumento da expectativa de vida. Dentro desses parâmetros, insere-se a qualidade de vida de indivíduos acometidos por paralisia facial, doença frequente no mundo, sem predileção quanto ao gênero e à faixa etária. A atuação integrada dos profissionais pode potencializar o processo de cuidado, gerando deslocamentos no tratamento à qualidade de vida do paciente. Este estudo foi realizado por meio de busca eletrônica nas bases bibliográficas *Pubmed*, por meio da *National Center for Biothecnology Information* (NCBI); *Lilacs* (Literatura Latino-Americana e do Caribe em Ciências da Saúde) e *SciELO* (Scientific Electronic Library Online). Nesta investigação, utilizou-se o mecanismo de pesquisa oferecido pela *National Library of Medicine*. A combinação dos descritores paralisia facial, qualidade de vida, pessoal de saúde, relações interprofissionais, comportamento cooperativo, equipe de assistência ao paciente e seus respectivos em inglês foi executada de diversas formas, com a finalidade de detectar o maior número possível de publicações. Evidenciaram-se poucos estudos referindo a relação entre todos os temas abordados. De uma forma geral, a revisão bibliográfica apontou que o trabalho interprofissional pode favorecer o redimensionamento das relações entre diferentes conteúdos, contribuindo para que a fragmentação dos conhecimentos possa ser superada. O trabalho interprofissional é referido como essencial para o desenvolvimento de uma força de trabalho, na qual os profissionais trabalham juntos com o objetivo de prestar assistência no âmbito da integralidade do cuidado.

Descritores: Paralisia Facial; Qualidade de Vida; Pessoal de Saúde; Relações Interprofissionais; Comportamento Cooperativo; Equipe de Assistência ao Paciente

Received on: December 03, 2015
Accepted on: May 10, 2016

Mailing address:
Rayné Moreira Melo Santos
Rua Engenheiro Mário de Gusmão, 674/902 – Ponta Verde
Maceió – AL – Brasil
CEP: 57035-000
E-mail: raynefono@yahoo.com.br

INTRODUCTION

Facial movements along with the vocal ability differentiate man from other animals in their form of communication, facilitating the transmission of subtext in the expression of feelings and thoughts[1]. The movements of the facial muscles,which constitute what is called the expression or facial movement, allow non-verbal communication, aimed at the externalization of human emotions. The limitation of these movements is called facial paralysis (FP)[2]. Society values aesthetics related to facial appearance since the face is most prominently exposed to the environment and its traces mark the individuality of human beings[3]. Quality of life (QOL), in this perspective, reflects the perception that individuals' needs have been met, or even they are being denied opportunities to achieve happiness and self-realization, regardless of their health and physical as well as social and economical status[4].

In Health area, concerns in the quality of life's concept partly stems from new paradigms that have influenced the policies and practices of services in recent decades. Determinants and conditions of health-disease process are complex and multifactorial. The improvement of QOL has become one of the expected results, from both the care practices and the public policies for the sector, in the fields of health promotion and disease prevention[5].

Multi-professional intervention in cases of facial paralysis allows the amount of information of different specificities to obtain the comprehensive care of the patient. This action requires the experts to share their knowledge to build an effective treatment strategy, besides taking into consideration the demands and needs presented by the patient, which is different from a fragmented care in specialiation[6]. Thus, it is suggested that the work in multidisciplinary team leverages treatment favoring the evolution of the cases[7].

Unlike the overvaluation of technical specialties of health professionals, the integrated operation enhances the care process; it generates displacement at all involved in the treatment (health professionals, family and the patient himself) toward the quality of life paciente[6-8].

The pursuit of comprehensive care has as a main challenge the restructuring of establishments and health sector organizations, which should occur either through the organization and coordination of these services with each other and through the reformulation of health professional practices in their respective teams[9].

The World Health Organization reports that professionals will effectively collaborate and improve health outcomes, two or more of them, with different professional experiences, they must first have opportunities to learn about the other, with one another[10].

Whereas the inter-professionalism and collaborative practice can play an important role in reducing many challenges they face, this study aimed to perform a critical review of literature on the relationship between facial paralysis and quality of life in the scope of the interprofessional work.

METHODS

The electronic search was conducted in the databases: Pubmed, through the National Center for Biothecnology Information (NCBI); Lilacs (Latin American and Caribbean Health Sciences) and SciELO (Scientific Electronic Library Online). The present research made use of PubMed, a search tool offered by the National Library of Medicine (NLM), because it not only indexes all the journals contained in the Medline, but also indexes other databases such as PREMEDLINE and HealthSTAR.

To detect descriptors related to the objective of the research, we made use of structured and trilingual vocabulary DeCS - Health Sciences and Medical Subject Headings (Mesh). The descriptors selected for this research were facial paralysis, quality of life, health personnel, interbranch relations, cooperative behavior, patient care team.

The research followed the following inclusion criteria: complete scientific articles; free; pdf; published in the last ten years. The descriptors must be in the title, the keywords and / or methodology (Figure 1). Exclusion criteria were: repeated articles by being published in more than one language or located in more than one database.

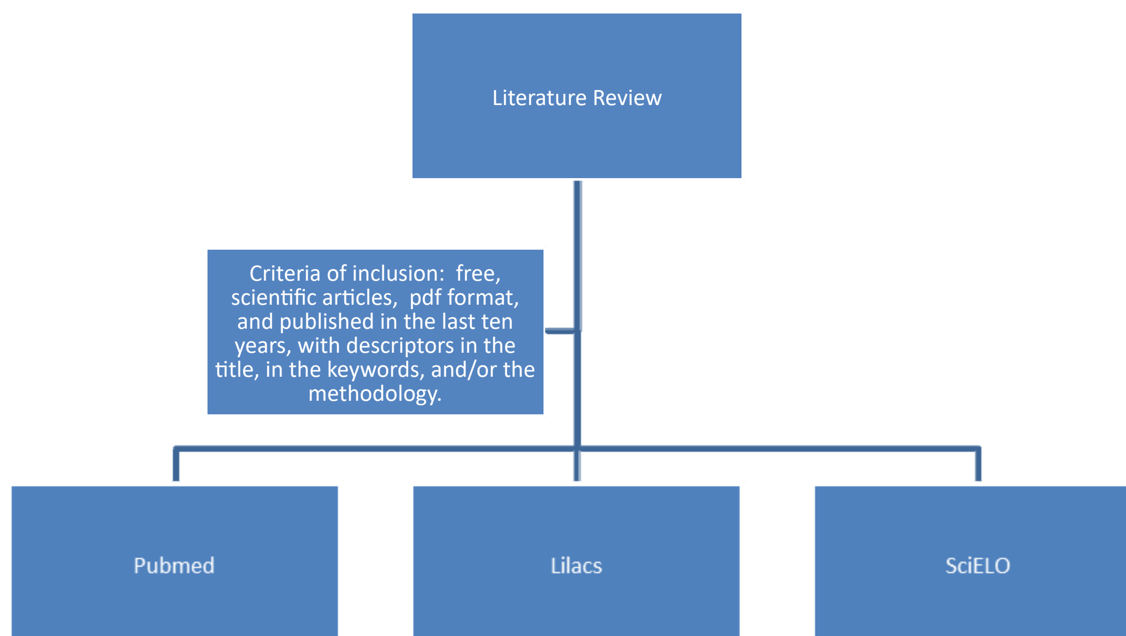

Figure 1. Description of the applied methodology

The combination of descriptors was run in several ways in order to detect the largest possible number of publications. The descriptors were used alone and grouped, using the Boolean operators AND and OR.

It is noteworthy that the analyzed articles had their lists of references checked in order to identify other studies related to the themes of this study and possibly not identified by electronic search.

LITERATURE REVIEW

It was evident that few authors mention the relationship among the three topics: facial palsy, quality of life and interprofessional work. It was also observed that in most publications they are considered in isolation. The interprofessional work is studied in a general way and is not related to the relation referred to in this study. However, there was the interest of the researchers to record the considerations, concepts and reflections detected in some studies, especially in two selected ones.

Authors	Year	Contents related to the addressed issues
Barros JN, Melo AM, Gomes ICD	2004	In the literature, among the thirteen factors reckoned as influential in the prognosis of facial paralysis, the interdisciplinary action was pointed out as contributing to a comprehensive and effective treatment.
Silva MFF, Brito AF, Campos MF, Cunha MC	2015	The joint effort of a team contributed to the process of treatment of facial paralysis. The clinical plan adopted by the team showed results favoring the case while, encompassed the demands from the patient in both functional and psychosocial aspect. The case report replies to the objective of highlighting the positive effects of multidisciplinary approach. However, it is necessary to consider conducting further research with considerable study, so that the effectiveness of the treatment carried out with the multidisciplinary team can be demonstrated.

Figure 2. Contents on the relation between facial paralysis and quality of life in the scope of Interprofessional Work from selected studies for the review of the literature.

The research allowed to observe that facial paralysis is a relatively common disease worldwide, affecting all age groups, without preference as to gender, with full recovery, depending on the etiology. Kasse et al. (2005)[11] reported that a not inconsiderable proportion of patients maintains a functional deficiency, sometimes permanent, causing psychological, social and professional changes.

Tessitore et al. (2008)[12] reported that the care of patients with facial paralysis should be done by a multidisciplinary team involving some medical specialties such as ENT specialists and neurosurgeons, and other health professionals such as speech therapists and occasionally psychologists.

Valente (2004)[13] found that about 10% of the population have a facial disfigurement, like a scar, blemish or deformity that severely affects the ability to lead a normal life; and 2-3% have a visible defect. People may have depressive symptoms associated with disfigurement and end up looking for plastic surgery to repair it.

It was evident that in addition to organic matter, there are other factors that lead to a greater or lesser nuisance, such as psychosocial factors. Freitas and Goffi-Gomez (2008)[14] found that in cases classified as mild by clinical assessment, symptoms were reported to be very uncomfortable for the patient, as well as severe grades were reported with little discomfort to the patient. Calais et al. (2005)[2] highlighted the importance of the participation of the speech therapist in the multidisciplinary team, who treats the patient with peripheral facial palsy, which also contributes with the most appropriate treatment to be offered to the patient, thus resulting in an improved quality of life.

Santos and Guedes (2012)[15] concluded that the acquired chronic facial paralysis interfered with the quality of life of individuals in more serious degrees. In the study of Coulson et al. (2004)[16], aspects of emotional expression affected by facial paralysis with a significant reduction in social relationship were identified. Moreover, a study conducted by Ryzenman et al. (2005)[17] reported that facial paralysis is considered a significant psychosocial morbidity; for Rondon (2009)[18], the causes that generate it are multiple, producing an aesthetic and functional deformity, as well as emotional, social and professional disorders. The successful results of rehabilitation in patient satisfaction improve self-esteem and quality of life.

Bernardes et al. (2004)[19] reckon speech therapy as a resource to treat patients affected by peripheral facial paralysis. In the literature review this work is already established. However, There are still difficulties in obtaining an evaluation method that is practical, objective, low cost and can be used by speech therapists in monitoring and determination of discharge.

Silva et al. (2015)[20], on account of the effects of a multidisciplinary intervention in the patient's functional recovery with peripheral facial palsy, pointed out the participation of three professionals (physiotherapist, speech therapist and medical acupuncturist), in both a simultaneous and complementary manner, with no prioritization of clinical procedures. In this case, the joint action of a multidisciplinary team contributed to the process of paralysis treatment, as follows: recovery of mimes and expressive movements, improvement in speech, chewing and swallowing. At the conclusion of the study, The authors suggest further research with considerable study, so that the effectiveness of the treatment carried out with multidisciplinary team can demonstrated.

Barros et al. (2004)[21] conducted a study in order to identify the main factors influencing the prognosis of patients with facial paralysis, based on the opinion of speech therapists, physiotherapists and doctors to find that among such factors was the work done by a multidisciplinary team.

This literature review also found the WHO (2010)[10] reporting that the interprofessional work provides health professionals with the necessary skills to coordinate the provision of assistance. In the study by Batista (2012)[22], the work performed under the Interprofessional Education is committed to the development of three competencies: common skills for all professions, specific skills of each professional field, and collaborative skills, that is, respect for specificities of each profession, participatory planning, exercise tolerance, and negotiation in a movement of collaborative networks.

Batista (2012)[22] also states that the changes in epidemiological profile, with the increasing in life expectancy and chronic health conditions that require prolonged follow-up, enhance the need for a comprehensive approach addressing the multiple dimensions of user and population health needs. Integration understood from the perspective of new interactions at work in interprofessional team, exchanging experiences and knowledge, and position of respect for diversity, therefore enabling cooperation for the exercise of transformative practices, partnerships for building projects and ongoing exercise dialogue.

Peduzzi et al. (2013)[23] pointed out that on behalf of having an integrated team instead of a grouping team, a gathering of professionals from different fields is necessary, considering that all professions have their individual relevance. This new construction requires coordination of actions and interaction of the agents involved in the process, being the latter the most difficult one in that it has not been "normalized" yet and requires ethical commitment and respect for the other, with each other and for all the staff, and above all respect for the patients, thus understanding that the action of all will result in a greater efficiency of care as well as meeting the patients' health needs, according to the Unified Health System guidelines.

For Hammick et al. (2007)[24] comprehensive care goes beyond the treatment of disease itself, and such care should be considered in its technical political, social, economic, cultural and spiritual dimensions. For Freitas and Goffi-Gomez (2008)[14], there are other elements that are fundamental: the clarity of roles and responsibilities of each partner, besides the recording, broadly disseminated, of the collective actions, documents which make it real.

The WHO (2010)[10] states that an international mapping conducted in 2008 by the World Health Organization Study Group on Interprofessional Education (IPE) and Collaborative Practice, aimed to obtain information about the current interprofessional activities worldwide, pointed out that the IPE occurs in many countries and health care facilities in several countries' income categories. The countries studied include 46.9% developed ones and 36.8% in development, comprising students and professionals of a wide range of associated subjects.

Buring et al. (2009)[25], in search of the evolution of IPE, stated that the need of the EIP is internationally recognized since the mid-1980s, initially in the UK and Canada, where there was an increased involvement of the health community. This evolution, however, is still sluggish.

Peduzzi et al. (2013)[23], Motta and Pacheco (2014)[26] and Thannhauser et al. (2010)[27] considered the need for IPE, an increasingly important issue that needs to be studied in depth, so that the impact of the results can be identified. Assega et al. (2010) [28] reported a poor university education as a difficulty found among health professionals in the redirection of actions within the needs of integral actions. It was found in the study of Peduzzi et al. (2013)[23] that in the Brazilian context, training in health has mainly a uniprofissional perspective, in which the IPE initiatives are still shy and mostly referred to the multidisciplinary actions both in undergraduate field and post graduate one(*Lato sensu*).

Cardoso and Hennington (2011)[29] found that at meetings referred as multi-professionals, the discussion with clear medical centrality was of predominance. Professionals from other areas usually participated only through listening and limited intervention. It is therefore remarkable to reiterate that the spaces of multidisciplinary meetings are essential as facilitators and interprofessional exchanges. However, the same authors point out that it should be emphasized that the meetings of the various professionals in the same space of discussion, does not necessarily guarantee interaction and labor relations among staff.

In this sense, the research of Souto et al. (2014)[30] points out that the interprofessional work is seen as a crucial component not only for shared learning proposal, but also for triggering new types of work and new forms of subjectivity of the professional roles, since it rearranges the tasks' flows and the responsibilities in the context of the interprofessional team.

For Bilodeau et al. (2010)[31], the collaborative skills enables to clearly establish the roles and responsibilities of each profession, respecting the powers and limitations of its roles. Working in coordination with other professions in various types of services implies knowing how to deal with differences among between the professions, investing in the staff integration, as well as in both identifying and understanding the concerns of other professionals regarding patient care.

In the study by McCallin (2006)[32], health work entails doing together in everyday health care. By adopting an attitude of cooperation / collaboration rather than competition and competitiveness, professionals become allies and develop a relationship of mutual respect among themselves.

Diels (2000)[33] reported that the rehabilitation of facial paralysis is often neglected and patients are left untreated. The successful results of rehabilitation in patient satisfaction improved self-esteem and quality of life. Guedes (1994)[34] points out that the participation of the speech therapist in the multidisciplinary team is needed, as it has been found to minimize the sequelae caused by facial paralysis due to the performance of such professional.

Tiemstra and Khatkate (2007)[35] reported that in the national literature, there are still professionals views demonstrating a tendency to choose only one of the

rehabilitation approaches, and that the work carried out by the physiotherapist and speech therapist are commonly referred to. Customarily, the authors claim that simultaneous practices can harm the patient's recovery. However, more recent studies have reported the importance of continued integration of the professionals involved, adding that in doing so, the integrality, as a fundamental concept of the health system organization, requires an organization of professional practice, work process and public policy on health.

For Campos and Amaral (2007)[36], the concept of expanded clinics is based on the construction of individual responsibility and stable link between health team and patient. Sporadic and vertical contact of different professionals has entailed a number of obstacles to effectiveness and efficiency of therapeutic processes.

It is also important to mention the need for health care professionals ally to epidemiology in order to better understand the population they assist. Santana et al. (2010)[37] report that it is crucial to support the most appropriate decision-making regarding the health of the population, because it enables a better understanding of the real needs and associated factors. In addition, systematic data related to the characteristics of specific population assisted in health services should be systematically evaluated when proposing actions for prevention, diagnosis and treatment.

To Peduzzi (2016)[38], the context which the IPE emerges from is, on one hand, the gradual recognition of the complexity and broadness of what health and disease are, its multiple organic, genetic, psychosocial, cultural dimensions and social determination, since the health-disease process is also an expression of life and work, that is, how individuals, family and social groups are integrated into society; on the other hand, and related to the first, stems from the complexity of the network of health care and the necessary coordination and collaboration between professionals and the services themselves.

Some challenges are highlighted, such as the articulation of inter-branch and specific activities of each professional field, as both allow integrated learning of the set of skills needed for teamwork and collaborative interprofessional practice.

The national scene Peduzzi (2016)[38] also states that the IPE is incipient and the results of its implementation are little known. Although the NHS (National Health System) and the National Curriculum Guidelines focus on teamwork, the predominant model of education and development of health workers is still uniprofessional. In this context, Feuerwerker and Capozzolo (2013)[39] mention that the IPE is characterized by a focus on disciplines, developing into the fragmentation of care, knowledge and practices, professional corporatism, and reinforces the hegemonic biomedical practice with professional isolation.

For Santana et al. (2010)[37], to strengthen both the IPE and the collaborative practice is to be aware of the resistance, herein the risk of reiterating traditional concepts and models of strict self-regulation and biomedical approach, as well as independent and isolated professional performance in an increasingly complex, interprofessional and interdisciplinary healthfield.

Thus, WHO (2010)[10] concludes that the interprofessional work is essential to the development of a collaborative health workforce prepared to practice in which professionals work together to provide health care services. This is the scope where the greatest advances can be made towards increasingly strengthened results.

CONCLUSION

Few studies in the literature referred to the relation among facial palsy, quality of life and interdisciplinary work. In a number of publications they are considered in isolation.

In general, the research found that interprofessional work can facilitate the resizing of relations among contents, thus contributing to have the fragmentation of knowledge overcome.

The interprofessional work is referred to as essential for the development of a workforce within which professionals work together in order to assist the context of comprehensive care. In this respect, health professionals should enter the interprofessional context, not limiting themselves as solely part of a multidisciplinary team.

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