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Multiprofessional healthcare team: concept and typology

ABSTRACT

This paper introduces concept and typology to teamwork as well as criteria to identify types of teams. The concept and the typology were developed based on the literature and research on multi-professional work in healthcare, based in the theory of studies on work process in healthcare and in the theory of communicative action. According to this theoretical proposition, teamwork is a form of collective work characterized by a reciprocal relationship between technical interventions and the interaction of agents. The proposed typology refers to two forms of teams: integrated teams as opposed to groups of people. The criteria to identify the types of team are related to communication among work agents; technical differences and inequality in social recognition of specialized works; formulation of a common care program; specificity of each professional area; flexibility of work division; and technical autonomy.

DESCRIPTORS: Patient care team. Health manpower. Organization and administration. Health occupations. Interprofessional relations. Communication. Task performance and analysis.

INTRODUCTION

The team work proposal has been promoted as a strategy to face the intensive specialization process in the area of health. This process tends to deepen knowledge and intervention vertically in individualized aspects of health requirements, without simultaneously considering the interaction between actions and knowledge.

In the literature on health teams consulted, definitions of team were found to be relatively scarce. The bibliographic survey (Medline and Lilacs databases)[a] showed the predominance of a strictly technical approach, where the work of each professional field is viewed as a set of attributions, tasks or activities. According to this approach, a multiprofessional team is seen as an inherent reality, as professionals from different areas work together and the interaction of specialized types of work does not create the projection of problems of theme.

Fortuna & Mishima *apud* Fortuna[4] (1999) identified three distinct concepts of team work, each emphasizing results, relationships and interdisciplinarity. In the studies that focus on results, the team is conceived as a resource to increase productivity and service rationalization. Studies that focus on relationships use psychology concepts as reference, analyzing teams especially in terms of interpersonal relationships and psychological processes. Finally, studies that focus on interdisciplinarity are those that discuss the interaction between knowledge and work division, i.e. health work specialization. The studies performed by

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Campos[3], among others, follow this approach, enabling reflections about health teams as the main foundation of health service organization.

Theoretical studies on teams reveal that this has rarely been explored as an objective and subjective health work reality, especially in terms of empirical service research. Thus, in this study, a concept and typology of team work are shown, as well as the criteria to recognize types of teams, established from empirical investigation.[10]

The investigation mentioned here was developed in the form of qualitative research, and information was gathered using direct observation and semi-structured interview in four distinct health team situations (hospital intensive care units and clinical inpatient ward; general specialty outpatient clinic; and mental health outpatient clinic). This study aimed to (a) identify empirical evidence of team work and (b) understand the relationships between objective work situations and health professional concepts of multiprofessional team work. Analysis had Habermas' theory of communicative action (1989) and studies on health work as its theoretical framework.[5]

Habermas' perspective, distinguishing instrumental action from communicative action, and combined with health work process concepts, enables the complex multiprofessional action dynamics to be included, dialectically considering the structural dimension of persistent and fixed work arrangements and clinical rationality, as well as the subjective dimension of the individuals, expressed in the intersubjectivity. This theoretical framework was found to be consistent when dealing with the object of study and led to the proposal of empirical categories and explanatory concepts of a multiprofessional team, as subsequently shown. Thus, both the framework and the categories can contribute to future research on this topic.

THEORETICAL FRAMEWORK

The use of the analytical category "work", according to the Marxist view (Marx,[7] 1994), has guided health work studies in Brazil and Latin America. According to this view, the studies by Mendes-Gonçalves,[8,9] are especially emphasized, as they investigate the application of the Marxist work theory to the health field and the configuration of the elements comprising the work processes (object, instruments and agents). In addition, the studies by Schraiber[11] also stand out, as they deepen knowledge about the sub-totality represented by the worker in the work process.

As an element of the work process, the agent is understood in the relationships among object of intervention, instruments and activities, as well as in the work

division process. By performing activities that are inherent in their professional area, each agent operates the transformation of an object into a product that meets the purpose established, from the beginning, as intentionality of that specific type of work.

As regards technical work division, it should be emphasized that, on the one hand, this causes the same original work process to be divided, originating sections of work. On the other hand, it introduces aspects of complementarity and interdependence among specialized types of work pertaining to the same area of production. The technical and social dimensions of work division should be simultaneously considered, as all technical divisions reproduce in themselves the political and ideological relationships concerning individuals' unequal social inclusions.[2,7]

Habermas[6] introduces the separation of the concept of work into two components, which are, despite their interdependence in practice, analytically distinguishable and mutually irreducible: the work, as a rational action aimed at a purpose, and the interaction. The author points to the existence of a reciprocal relationship between work and interaction, with the impossibility of reducing interaction to work or deriving work from interaction.

Work consists of the teleological rational action, involving the instrumental action and the strategic action: the first one guided by technical rules and the second by maxims and values that seek to influence the definition of the situation or the other's decision. As an instrumental and/or strategic action, work seeks to succeed when a certain result is obtained.[6]

Interaction refers to the communicative action symbolically mediated and guided by mandatory norms, which define reciprocal behavioral expectations and which must be understood and recognized by at least two individuals. Thus, it is regulated by consensual norms and is founded on the intersubjectivity of understanding and mutual recognition, free from inner or outer coercion.[5,6] Habermas[5] defines communicative action as the interactions in which the people involved come into an agreement to coordinate their action plans. The agreement reached can be measured, in each case, by the intersubjective recognition of validity intentions, implicit in any act of speaking.

In an attitude aimed at mutual understanding, the individual who speaks raises, in all intelligible utterances, the following validity intentions: (a) the speaker's sincerity or authenticity, verified by the consistency of their behavior; (b) the proposed truth, which is the truth of the statements or affirmations made; and (c) the normative correction, i.e. the correction of norms that underlie the statements made.

In this interpretative picture, which presupposes the reciprocal relationship between work and interaction, there exists (a) the emphasis on the sphere of activity or technical intervention, from the work perspective, and (b) the emphasis on the intersubjectivity, from the interactive perspective,[a] which can occur in terms of the communicative action, as analyzed by Habermas. It is understood that, through this communicative practice characterized by the search for consensus, professionals can jointly discuss the routine work performed and build a common project relevant to user health needs, in addition to repeating the already existing technical project, whenever necessary.

As subjects of the work process, professionals have technical autonomy. This is conceived as a sphere of freedom of judgment and decision-making, considering user health needs.[12] The use of the concept of technical autonomy in health work analysis results from the impossibility of designing a care project which is already definite and unique prior to its implementation. Varied autonomies will be associated with higher or lower technical authority, not only technically established, but also socially legitimate, of the distinct professional areas and related scope of the intellectual dimension of work.[12]
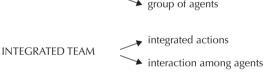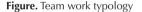
TEAM WORK TYPOLOGY

Based on the literature and theoretical picture shown (Table), the distinction between the two notions concerning the idea of a team is observed: team as a group of workers and team as work integration. The first notion is characterized by fragmentation, and the second by interaction in accordance with the proposal of health action comprehensiveness. Interaction is understood as the work situations where the agent makes correlations and shows the connections among the several interventions performed.

Based on this distinction, a typology referring to these two types of team work was constructed: group of workers, where actions overlap and agents are grouped together; and integrated team, where actions are integrated and agents interact with each other (Figure).

However, the technical differences of specialized work areas and the inequality of value attributed to these distinct work areas are present in the team work typology. This operates the transition from technical specialty to work hierarchy, thus causing recombination and integration to be different from the technical sum. In addition, tensions among the several concepts and technical autonomy practices are also present, as well as among concepts regarding the

Table. Criteria of recognition of types of team work: integrated team or group of agents.

Parameters	Integrated team	Group of workers
	Typology	
Communication outside work		X
Strictly personal communication		X
Work-related communication	X	
Joint care project	X	
Technical differences among specialized types of work	X	X
Discussion about specialized work inequality	X	
Specificities of specialized types of work	X	X
Work division flexibility	X	
Inter-dependent technical autonomy	X	
Full technical autonomy		X
Lack of technical autonomy		X

Figure. Team work typology

independence of specialized work areas or their objective complementarity.

In this sense, recombination requires action integration, communicative interaction among agents and overcoming isolation of knowledge. The criteria that can help to recognize work teams in terms of their type are described as follows, i.e. what characterizes an integrated team or a group of workers (Table).

Communication among work agents

All individuals interviewed in the empirical research,[10] on which the present article is based, express a notion of team work which converges to emphasize communication. Action integration, coordination, knowledge integration and agent interaction occurred with symbolic language mediation. Thus, communication among professionals is the common denominator of work team, which results from the reciprocal relationship between work and interaction. However, this communication is manifested in three different ways.

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[a] The existence of two plans of dialogical interaction in health work is emphasized, one of which refers to communication with the population and users, while the other one refers to communication with agents. This is the intersubjectivity the present study deals with.

One way is that in which communication appears outside work. Communication, though expected, is not carried out, or it is carried out merely as an instrument for the technique. In this situation, the restricted pattern of communication among professionals is observed, on the one hand, while communication occurs as a technique improvement resource, on the other hand. In both, the agents experienced tension between what is communicative and what is instrumental, with no communicative action.

Another way is that in which strictly personal communication occurs. Agents emphasize the dimension of personal relationships, based on the feeling of friendship and comradeship, and overlap the personal dimension with the technological one. To know the professional means to know how their work is performed and the technical knowledge it is founded on. The individual's dimension seems to be complete, when, in fact, with the total overlapping between technical agent and work, interaction is reduced, thus reducing the notion of team work accordingly: that of good interpersonal relationships, regardless of subordinate hierarchical relationships being repeated. In this case, once again, there is no communicative action, even though there is a certain type of communication.

The third way is that in which communication is conceived and practiced as a dimension inherent in the teamwork. Agents emphasize the joint preparation of common languages, common objectives, common proposals, and even common culture as characteristics of team work. Finally, they emphasize the preparation of a joint care project, built using an intricate relationship between technical intervention implementation and communication among professionals. This is the communicative action perspective in the technique, which, given the instrumental hegemony of the technical action, also ends up causing tensions.

The possible division or tension between work and communication among agents results from the distinct characters of the instrumental action and communicative action, as the former has a certain a priori purpose while the other seeks mutual understanding and recognition. It could be said that the communicative practice is a situation where mediation is the purpose itself, i.e. the purpose is to interact and, in this process, reach relevant consensus for each context, whereas a certain result is sought in the instrumental action, regardless of the vicissitudes that may appear on the way. That is why communicative action is the one where the purpose is defined and reached through a participative, intervention-based process.

Joint care project

The preparation of a joint care project was mentioned as an indicator of team integration. This constitutes the center around which the routine work dynamics and interaction occur. It should be emphasized that the joint project refers to a certain team, rather than all supposedly existing teams. It is a plan of action for a concrete situation of team work, which considers the hegemonic care project. This project cannot be ignored, as it is the dominant health care model, even though it originates another common project. Agents begin from an inherent reality and build, within the realm of possibilities and through work and communicative action, a project relevant to the health needs, as conceived by users and professionals. Such concepts, shared based on dialogue, enable the intersubjective recognition of validity intentions, implicit in the acts of speaking of all participants. The agents are in agreement concerning the proposed truth and normative correction content that constitutes the joint project.

It should be remembered that, by sharing the hegemonic biomedical model especially, consensus about one type of health care is reached and understood as relevant to all and every situation concerning the health-disease process in both the individual and collective spheres. Thus, professionals, in addition to their not sharing different values that could reveal other models, stop investing in the joint construction of a distinct care project that involves the complexity and multi-dimensionality of health needs.

Different types of work and unequal types of work

In terms of health work division, it is understood that the practice of doctors is the founder of the modern scientific practice in the area of health and, therefore, the initial center from which other specialized work areas originate. Different work areas that are separated from or added to the work of doctor comprise a diverse set of professional areas, necessary to implement all the actions that can enable comprehensive health care. However, this is not about different work areas that are technically different exclusively, but also unequal in terms of their social value.

Technical differences are due to knowledge specialization and to interventions among the several professional areas. Inequalities refer to the existence of social norms and values, causing technical differences among professions to follow a hierarchical and organized pattern. In other words, distinct technical authorities and social legitimacies correspond to different professional areas. This means that some professions are "above" others, and that there are hierarchical relationships of subordination among professionals. Thus, technical differences turn into social inequalities among work agents, and the multiprofessional team expresses both differences and inequalities among the areas and, concretely and routinely, among work agents-subjects.

Professionals from different areas, doctors and non-doctors, tend to repeat the unequal subordination relationships, even when they criticize work division and their possibilities of recombination. Everyone shares the common value attributed to the biomedical model, undervaluing knowledge and actions of other spheres of care provision, such as the educational, preventive, psychosocial and communicative spheres, which appear as secondary in comparison with the central work – individual medical care.

Thus, the repetition of subordination relationships can be understood, considering the tendency people have to repeat social practices from their historical time, and the agent's alienation concerning their own ability to be a subject, in the sense of their being actively involved in situations and making decisions, aware of the rules and values consensus is founded on.

In this sense, it is observed that in the collective work situation, where there is less inequality among different work areas and respective agents, more team integration occurs. As team work is effectively built, in the intrinsic relationship between work and interaction, the closer agents are to the ethical-social subject status, the more likely they are to interact in situations free from coercion and submission, attempting to reach consensus on the purpose and way to perform work.

Specificities of specialized work areas "versus" work division flexibility

Team work does not presuppose work specificities will be abolished, because technical differences show the possibility of work division helping to improve the services provided. This is because specialties enable knowledge and technical performance improvement in a certain area of work, as well as higher production. Health professionals emphasize the need to maintain specialized work specificities, which implies related technical differences will be maintained. However, they also show the need to make work division more flexible. In this study, flexibility was understood as the coexistence of respective professional areas' private actions with actions indistinctly performed by agents from different work areas. In other words, professionals perform interventions typical of their respective areas, but also perform ordinary actions, where knowledge from different areas, such as reception, welcoming service, educational groups and operational groups, are integrated.

It was observed that work division flexibility coexists with each professional area's specificities in team work. Such coexistence does not lead to another collective work arrangement being proposed, based on the dominant biomedical model. However, it comes close to doing this, raising questions about inequalities among different work areas and the relevance of adopting other approaches towards health needs.

The two types of activities, specific and ordinary ones, comprise the care project built by the team. However, the greater the emphasis on work division flexibility, the closer it will be to an integrated team; and the greater the emphasis on work specificities, the closer it will be to a group of workers.

Technical autonomy

In team work, three distinct concepts of technical autonomy are observed: in the first one, the professional works with the notion of full autonomy, seeking to achieve the highest level of independence when performing their interventions; in the second one, they ignore the sphere of autonomy in which they perform their work; and in the third one, they understand the inter-dependent nature of the group of agents' technical autonomy. Professional autonomy can be inter-dependent from another agent's judgment and decision-making, given the complementarity of specialized types of work.

It has been previously mentioned that autonomy is necessary in health work for the set of specialized work areas, and that its reach differs, depending on the technical and social legitimacy of the operating knowledge on which the action is founded. However, it is manifested in a distinct way in the two types of teams. Integrated team work was found to show complementarity and collaboration in the exercise of technical autonomy, without independent action projects of each agent. Team work characterized as group of workers showed objective complementarity of specialized work areas coexisting with an independent care project of each professional or even each agent, which reveals the concept of full technical autonomy of agents.

CONCLUSIONS

Based on the typology and recognition criteria of the types of teams described, a concept of team work was introduced, in the perspective of integration of specialized work areas.

Thus, multiprofessional team work was considered to consist of a collective team type, which is represented as the reciprocal relationship between multiple technical interventions and the interaction of agents from different professional areas. By means of communication, i.e. the symbolic mediation of language, the integration between multiprofessional actions and cooperation occurs (Peduzzi,[10] 1998).

Team work takes place in the context of objective work situations, as currently found, where the hierarchical relationships between doctors and non-doctors and different subordination levels are maintained, together with work division flexibility and technical autonomy

with interdependence. Thus, it is possible to build an integrated team, even in situations where asymmetrical relationships among distinct professionals are maintained. By means of communicative action, debate about technical interventions and the unequal social value of distinct work areas leads to different levels of integration, as this presupposes not only the sharing of technical premises but, above all, an ethical horizon.

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