


Interprofessional communication and user participation in the Family Health Strategy


Comunicação interprofissional e participação do usuário na Estratégia Saúde da Família

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Abstract

This study deals with collaborative competencies to strengthen teamwork and interprofessional collaboration in Primary Health Care services, supported by the framework of the health work process, interprofessional work and competencies. Its objective is to understand the conceptions and experiences of professionals from the Family Health Strategy teams regarding the core collaborative competencies: interprofessional communication and patient-centered care. This is an exploratory and interpretative qualitative study. A secondary database was used, with 34 interviews conducted with professionals from the teams of three health units located in two municipalities. Thematic content analysis was adopted, with support by the WebQDA software. The findings show the professionals' understanding of collaborative competencies as complementary and as impossible to being treated independently. Interprofessional communication is recognized as a focus on meeting the user's health needs, limited by unsatisfactory working conditions. Patient-centered care appears weak, since the sense of user participation prevails as a transfer of responsibility for their care to professionals and in a minority way, as sharing the construction of the care plan.

Keywords: Interprofessional Relations; Professional Competence; Primary Health Care; Family Health Strategy.

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Resumo

Este estudo trata sobre as competências colaborativas para o fortalecimento do trabalho em equipe e colaboração interprofissional nos serviços de Atenção Primária à Saúde, apoiado no referencial do processo de trabalho em saúde, trabalho interprofissional e competências. Tem o objetivo de compreender as concepções e experiências dos profissionais das equipes da Estratégia Saúde da Família sobre as competências colaborativas centrais: comunicação interprofissional e atenção centrada no paciente. Trata-se de uma pesquisa qualitativa exploratória e interpretativa. Foi utilizado banco de dados secundário, com 34 entrevistas realizadas com profissionais das equipes de três unidades de saúde localizadas em dois municípios. Adotou-se análise de conteúdo temática, com apoio do software WebQDA. Os resultados evidenciam o entendimento dos profissionais sobre as competências colaborativas como complementares, não podendo ser tratadas de forma independente. A comunicação interprofissional é reconhecida como foco no atendimento às necessidades de saúde do usuário, limitada pelas condições de trabalho insatisfatórias. A atenção centrada no paciente aparece de forma frágil, visto que o sentido da participação do usuário prevalece como transferência da responsabilidade pelo seu cuidado para os profissionais e de forma minoritária, como compartilhamento na construção do plano de cuidado.

Palavras-chaves: Relações Interprofissionais; Competência Profissional; Atenção Primária à Saúde; Estratégia Saúde da Família.

Introduction

This study deals with the interprofessional work of Family Health Strategy (FHS) teams, in particular, the core collaborative competencies, interprofessional communication and patient-centered care, in daily work, considering their potential for strengthening teamwork and collaborative interprofessional practice in Primary Health Care (PHC) services of the Brazilian Unified Health System (SUS).

The research is based on the conceptual theoretical framework of the health work process, interprofessional work and competencies. The analytical category of the health work process was consolidated in the field of Public Health as a reference, through interdisciplinary dialogue with Social Sciences, from which the category work and work process comes (Mendes-Gonçalves, 2017). This analysis allowed understanding health practices in their articulation with other social practices and the health work process constituted in the dialectic of its components: object of work, instruments, purpose and agents, as well as in the consubstantiality between work process and health needs (Mendes-Gonçalves, 2017).

Health actions, in FHS teams, maintain intersubjectivity as a characteristic - in the meeting and professional interaction with the user, the literature on teamwork shows that this requires social interaction and communication between professionals, as well as between professionals and users and the population. In this study, research on interprofessional work is supported by the conception of the health work process and also instrumental action and communicative action, assuming the reciprocal relationship between work and social interaction (Peduzzi et al., 2020).

The study also used the concept of competencies by Zarifian (2001), an author in the field of French sociology of work, who understands competency as inseparable from the professional's action. Furthermore, it defines competencies as the worker's taking initiative in the face of the situation brought by the user or population, mobilizing knowledge, skills, attitudes and values, beyond the mere technical response, with responsibility, which is

the counterpart of autonomy and decentralization of decision making (Zarifian, 2001).

Interprofessional work consists of different forms of organization, such as teamwork, collaboration, collaborative practice and networking. Teamwork constitutes the core of care production, as the team is responsible for a group of families and users attached to it, characterized by the existence of common objectives, intense interdependence of actions, clarity of roles and shared identity and responsibility between members (Reeves et al., 2010; Reeves, Xyrichis, Zwarenstein, 2018; Peduzzi; Agreli, 2018; Peduzzi et al., 2020).

Interprofessional collaboration concerns professionals from different areas who want to work together because they recognize that cooperation promotes better care and better results for users and the population. Collaboration, when implemented in the practice of care, constitutes an interprofessional collaborative practice, as well as when it refers to Health Care Network (HCN) and collaborative network work (Peduzzi; Agreli, 2018).

In the last two decades, teamwork and interprofessional education have gained renewed prominence worldwide, especially following the publication of studies that associate medical and health professional errors with communication difficulties between the different areas directly involved with patient care. When teams are effective, there is an improvement in the quality of care and patient satisfaction (Giardina et al., 2013; Schmutz; Manser, 2013). Therefore, health professionals need to develop collaborative competencies beyond those that are specific to their profession, and which they appropriate in their initial training and in daily work practice.

The reference to collaborative competencies brings into play what professionals and students in the health field are effectively able to perform, not only restricted to the scope of knowledge, but also encompassing the skills, knowledge, attitudes and values they are capable of to mobilize and put into action, in the face of situations brought up by users, families and communities (Thistlethwaite et al., 2014).

Thistlethwaite et al. (2014) consider that the implementation of health services, organized based on

teamwork and the related need for interprofessional education, made it necessary to develop benchmarks on collaborative competencies to build alignment and a common lens so that the different professions and disciplines in the health field could act in health care and in the training of professionals. The authors highlight that, despite some degree of confusion persisting on the topic, four reference frameworks on collaborative competencies have been developed that have helped to advance their understanding and interprofessional practice: The Interprofessional Capability Framework (2004), in the United Kingdom; The National Interprofessional Competency Framework (2010), in Canada; Core Competencies for Interprofessional Collaborative Practice (2011), in the United States; and the National Common Health Competency Resource for the Australian Health Workforce (2013), in Australia.

In this study, the collaborative competencies reference framework developed in Canada (CIHC, 2010) was adopted to address the conceptions and experiences of FHS health professionals. The Canadian framework defines six domains of collaborative competencies: interprofessional communication and patient-centered care, recognized as central, in the sense of constituting the nucleus around which interprofessional collaboration is established; and clarity of roles, team functioning, collaborative leadership and resolution of interprofessional conflicts.

The research was carried out in services with FHS, which constitutes the care model and priority strategy for the expansion and consolidation of PHC (Giovanella; Franco; Almeida, 2020), being the preferred gateway and the first level of health care, which results in becoming a health care coordinator in the HCN (Brazil, 2017). The FHS is internationally recognized as a model of excellence in PHC (Macinko; Harris, 2015), given its contributions to improving the health conditions of users and the population, evidenced in research (Macinko; Mendonça, 2018).

The study was developed based on the conceptions - as ideas, notions and concepts - and experiences reported by team professionals, in the sense of Larrosa (2016). In this way, experience is seen as "what happens to us, what touches us," not only in the sense of the technical subject, who performs the

work, and the critical subject capable of reflecting on the practice, but also as the implicated subject who, from their involvement with practice, shares the meanings of their daily work (Larrosa, 2016, p. 18).

The research aims to understand the conceptions and experiences of professionals from FHS teams regarding the central collaborative competencies: interprofessional communication and patient-centered care.

Methodology

This is an exploratory descriptive study, with a qualitative approach of the multiple case study type (Yin, 2014), which was carried out in three basic health units (BHUs), in addition to being derived from a broader research, developed by the research group to which the main researcher is linked. The larger investigation analyzed the competencies of PHC health professionals for teamwork and interprofessional collaborative practice, proposed a methodological path for building competencies, and mapped the actions of each category as a necessary step to advance in defining the domains of competencies.

The study was developed in two municipalities with different realities, in two BHUs in the city of Curitiba/PR and one BHU in the city of Guarulhos/SP. Both units presented, at the time of the research, incomplete teams, but with different scenarios and municipal management models. The municipality of Curitiba/PR had a wide network of PHC services, with 225 FHS teams and 158 oral health teams distributed across 110 BHUs and was experiencing changes in municipal management and the Municipal Health Plan (PMS), with an increase in the number of actions offered in the units, including the expansion of service opening hours, scheduled consultations and meeting spontaneous demand. The municipality of Guarulhos/SP had 69 BHUs, with 55 registered FHS teams and 61 FHS teams with oral health. According to the PMS, the local management's main guideline was to convert the care model to the FHS as a priority strategy for organizing and ordering the health system.

This study used the qualitative database from the aforementioned original research, which contains

interviews carried out with professionals from the three BHUs selected for this investigation.

The selection criteria for the three units, originally used, were: classification of excellent performance in the first cycle of the National Program for Improving Access and Quality of Primary Care (PMAQ-AB), location in a municipality with at least three BHUs with complete FHS teams and BHUs with two or more FHS teams. The selection of interviewees followed the criteria: professionals with at least one year of work at the BHU, with varying lengths of experience in PHC, active in activities and interactions with other professionals on the team, and inclusion of one or two professionals from each category based on the recommendation of the unit manager.

Professionals from FHS teams participated in the research: community health agents (CHA), nursing assistants/technicians, oral health assistants/technicians, dental surgeons, nurses and doctors.

The research was approved by the Research Ethics Committee of the School of Nursing of the Universidade de São Paulo (CAAE 45956515.4.0000.5392, opinion number 1,180,576), following the ethical precepts set out in Resolution no. 466, dated December 12, 2012, and was developed from January 2015 to January 2017.

To analyze the data, the thematic content analysis technique was adopted (Bardin, 2016). Floating reading and successive consultations of the empirical material were carried out, accompanied by listening to the records, which allowed the researcher to become immersed.

Based on this process, the coding and construction of categories was carried out following the systematic process of individual analysis of the interview, followed by analysis of the set of interviews from the BHU and, finally, cross-sectional analysis of the interviews from the three BHUs. In this process, we also considered the recording of the field notebook made during the data collection of the original research, to get to know the units.

In data analysis, the qualitative analysis software Web Qualitative Data Analysis (WebQDA) was used, as it facilitates the organization of research data. This enabled greater technical and methodological

rigor in the analysis of the interviews, as well as collaborative work between the main researcher and the supervisor, to validate the construction of the categories (Costa et al., 2019).

When presenting the results, the interviewees were identified by professional category and BHU identification letter (A, B, C), aiming to contextualize the professionals' reports.

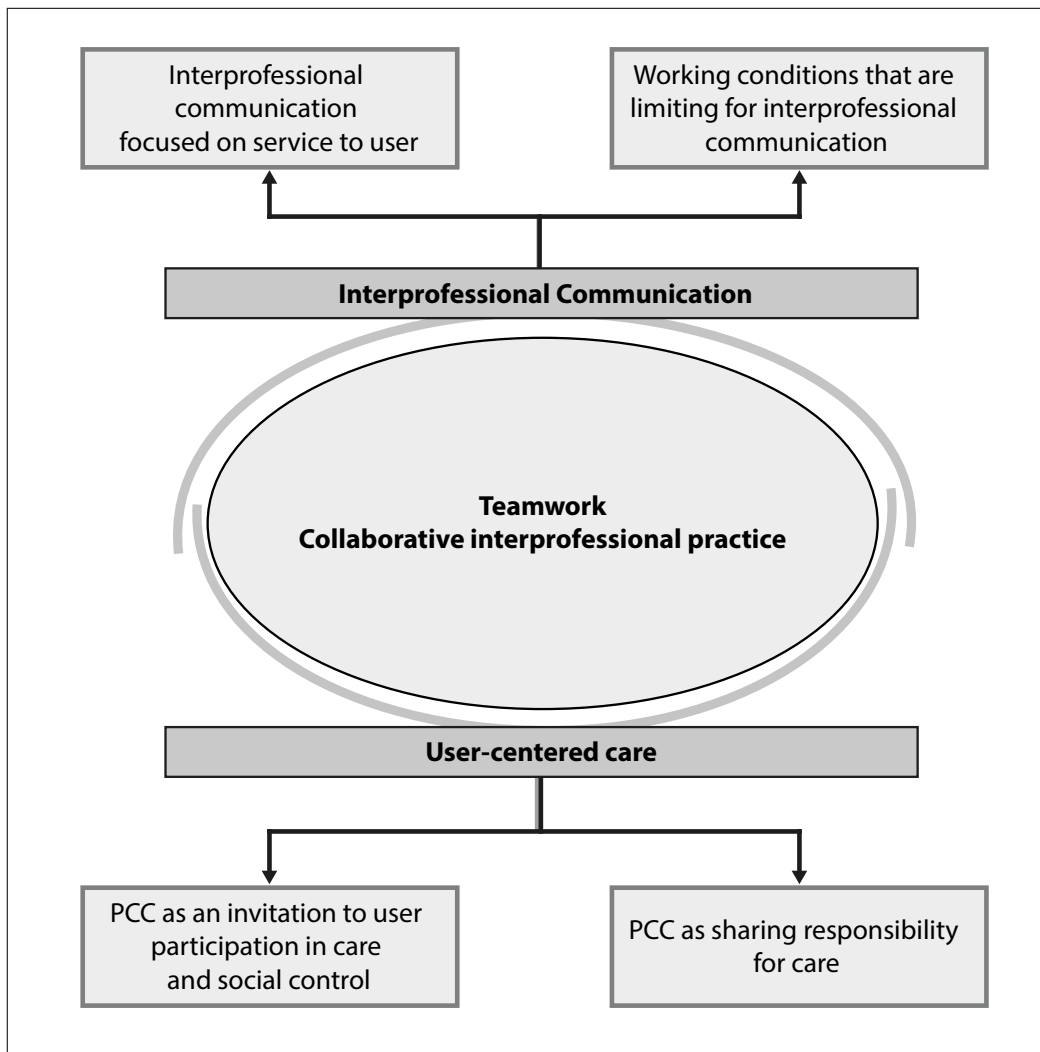
Results

The results begin with the characterization of the participants and continue with the presentation of the

conceptions and experiences of FHS team professionals regarding the core collaborative competencies.

In total, 34 professionals were interviewed, including six CHAs, six nursing assistants/technicians, five oral health assistants/technicians, five dental surgeons, six nurses and six doctors. The predominance of females stands out, with 28 (82%) participants, average age range of 46 years, varying between 26 and 57 years, time working at the institution with a 14 years mean, varying between 6 months and 28 years, and mean time working at BHU were 6.5 years, varying between 6 months and 17 years.

Figure 1 – Conceptions and experiences of FHS team professionals on core collaborative competencies



As for professionals' conception and experiences regarding interprofessional communication, two categories were identified that refer to daily health practices in PHC services: interprofessional communication with a focus on user care and working conditions that are limiting for interprofessional communication.

Interprofessional communication with a focus on user care was recognized in the teams of the three BHUs as the conversation that occurs between different team members regarding user care. The reference of the health work process and its reciprocal relationship with health needs allows to characterize interprofessional communication as one that is based on the health needs recognized by professionals (Mendes-Gonçalves, 2017).

The articulation of knowledge from different areas is based on the mobilization of specific skills for each category and the recognition of certain limits to deal with the situation presented by the user (Zarifian, 2001). This leads professionals to mobilize other team members to ensure resolution.

[...] when it's more complex it involves more areas, more professionals, when it's something simpler we end up not talking to everyone because it's usually something that we, as technicians, can solve.
(Nursing assistant/technician - BHU A)

Participants pointed out that the complexity of the cases leads to frequent specific discussions of the situations presented by users, in the search for exchanges and complementary guidance to meet health needs.

On the other hand, working conditions are limiting for interprofessional communication, especially the presence and maintenance of incomplete teams in units A and B, which were referred to as limiting for professionals and teams to find or create moments of interaction and communication between their members.

It is highly valued that you meet demand in quantity rather than quality. This means that your activities are basically meeting demand, but you need space and time to meet with the team and talk to people.
(Doctor - BHU B)

In BHUs A and C, professionals referred to work overload and perceived themselves as limited in meeting scheduled and spontaneous demand, given the reduced availability of time to communicate with other team members.

[...] you have to schedule fewer patients to be able to go to the meeting, but the patients that the dentist didn't see will have to be seen during the week [...] and then she is reminded of meeting goals. (Oral health assistant/technician - BHU C)

Faced with the scenario of incomplete teams, it is worth highlighting that at BHU B, the interviewees reported the absence of an agenda for holding team meetings that were previously part of daily work.

However, at BHU C, the discussion and sharing of information about user follow-up was recognized, during the team meeting, as a space that enhances interprofessional communication based on interaction between professionals:

[...] in team meetings we have the opportunity to exchange information regarding family health and be in touch with the nurse, the nursing assistant, so from that family, you can have additional answers, not just from the dentist appointment [...] We have this interaction at the team meeting.
(Dental surgeon - UBC C)

User-centered care

The conception of patient-centered care appears weakly, as few interviewees mentioned proposing an invitation for user participation in their own care, social control and sharing of responsibilities between professionals and users.

The majority of those interviewed in the three BHUs recognized user participation in the unit and with the team, through health prevention and promotion groups, as an opportunity that provides the strengthening of the bond between user and team, coexistence between users and other community members, the exchange of experiences, access to information about the disease and, also, as an opportunity to expand

guidance to the user and their family, according to the treatment and care needs.

[...] the family enters this work when the professionals on the team form a group [...] this patient has the opportunity to be with several professionals, clarifying doubts, receiving guidance (Dental Surgeon - BHU C).

However, BHU A and B pointed out that the prevention and health promotion groups had their agendas reduced, due to the instability in the composition of the teams and the reorganization of the municipal management work process, with an increase in service to spontaneous demand and centralization of the reception of acute complaints, to the detriment of actions focused on preventing diseases and health problems.

Regarding the activities in which users participate with the teams, professionals from the three BHUs recognized the monthly meetings of the Local Management Council as a space that allows the population to listen to the needs for improvements and positive points that must be maintained in the unit's and team work's routine. However, most of the interviewees pointed out that user participation is incipient. *"Only a few participate. We invite them a lot when we have a board meeting, but sometimes they come more when there is criticism (HCA - BHU B).*

The majority of interviewees highlighted the emptying of the Management Council as a space for participation. One of the participants highlighted the need to encourage users so that they understand the meaning of social participation.

Little user participation in the council [...] When it comes to a council, one must always be encouraging and the user understanding the result of this. It has to be something more tangible for the user, otherwise they [...] will turn away. (Nurse - BHU A)

Patient-centered care as sharing responsibility for care is brought by professionals in order to highlight a tension between two distinct perceptions. On the one hand, the understanding about the sharing of responsibility for care between professional and

user and, on the other, the understanding about the transfer of responsibility for care from the user to the professionals.

In the set of interviews, only three professionals pointed out encouragement for the user's participation in self-care through guidance, listening and valuing their role in care, configuring what, in this study, is called sharing of responsibility - partnership of care between professional and user.

[...] The users themselves, the family, the caregiver, works with us as a team [...] I believe that the users, in addition to being the center, now participates, they are co-participants [...] When we work as a team it makes it much easier when the family is empowered and understands the situation. (Nurse - BHU C)

Professionals from BHUs A and B teams reported the opposite, that is, in their perception there is a transfer of responsibility for user care to team professionals, a situation in which the user has difficulty in taking a leading role in self-care and focuses this responsibility on the team that accompanies them.

[...] they expect you to resolve all complaints, all demands and that's not how it works. So the health team has the responsibility to do the team's part, the person continues to be responsible for their personal care and the family is responsible for caring for their relatives, but that is not what is happening. (Doctor - BHU A)

In summary, interprofessional communication refers to communication between professionals from different areas, guided by and for health needs, however, without user participation. The limitation or exclusion of users in the conception of interprofessional communication restricts its scope to the sphere of professional knowledge and practices, therefore, tending to the predominance of instrumental action, in which the logic that underlies the interaction is that of technical-scientific knowledge. This has repercussions on care, as the complexity of users' needs - which cover the scope of clinical, psychological, social, epidemiological

and cultural care - requires openness from professionals also when acting communicatively, which seeks understanding between everyone involved, based on horizontal relationships and dialogue (Peduzzi et al., 2020).

The research also highlights the concept of interprofessional communication, with an emphasis on the individual dimension of care and separated from the territorial approach, as it does not consider the needs related to families and communities in the territories.

It was also evidenced that communication between professionals reflects the context of health practices, in the sense of working conditions that are inappropriate for the profile of users' needs, which constitutes a limitation to effective interprofessional communication, that is, one which allows recognition and response to the health needs of users, families and the community.

As for user-centered care, the results show that the predominant meaning for FHS teams refers to user participation in care and social control, although feebly, since most professionals recognize as a space for participation only the health prevention and promotion groups, and these had been reduced in units A and B.

User participation in decision-making about the care plan promotes the sharing of responsibility, which is highlighted in the literature as a key element of collaborative interprofessional practice. However, this conception appears restricted to the experience of few professionals. A study shows that, among participants, the sense of transferring responsibility for user care to professionals predominates - as if users had no interest or possibilities to participate. This shows that interprofessional communication is centered on professionals and teams, which contradicts the literature on the subject, which highlights the users' leading role in the construction and execution of their health care plan (CIHC, 2010; Fox; Reeves, 2015; Peduzzi et al., 2020).

Discussion

The results of the study bring four categories, which express the understanding and experience

of the 34 professionals, members of the 11 FHS teams from the three BHUs studied: two referring to interprofessional communication and two regarding patient-centered care.

As for interprofessional communication, professionals from the three BHU teams agree that this occurs between professionals from different areas, with a focus on user care. In other words, it is based on the recognition and attention to the health needs of users directly, which gives them their own and peculiar character. However, it is a concept of team communication that excludes user participation, compromising its potential as a competence for improving care and strengthening interprofessional work (CIHC, 2010; Metersky et al., 2022).

In one of the BHUs in the study, team professionals related interprofessional communication to frequent and specific interaction and communication between professionals from different areas, given the complexity of the situations presented by users. A literature review on the topic points out that frequent and informal communication is the main characteristic of interprofessional collaborative practice (Morgan; Pullon; McKinlay, 2015).

According to the theoretical framework adopted, interprofessional work consists of different forms of organizing health care activities. Thus, interprofessional communication is a requirement for all: teamwork, interprofessional collaborative practice and networking (Reeves et al., 2010; Reeves, Xyrichis, Zwarenstein, 2018; Peduzzi et al., 2020).

The study shows that not all communication between professionals from different areas has the characteristics of interprofessional communication. This occurs when the conversation or dialogue between professionals from a team, from different teams or even with the management of the service or HCN is guided by attention to the user and their participation.

This finding resumes the analysis that interprofessional teamwork consists of social interaction and communication between professionals, to articulate health care actions that constitute the daily practices of BHUs, and that all interaction is social, even if it is person-to-person (Peduzzi et al., 2020). It is noteworthy that interprofessional communication

coexists with personal communication, present in exchanges and interactions that concern other life domains and health practices. What is called, in this study, personal communication, refers to that which is not immediately oriented towards health care, in the broader sense that the SUS attributes to it, which encompasses: health promotion, protection, prevention, recovery and rehabilitation.

Interprofessional communication requires the construction of a safe environment, in which interaction occurs without constraints, which allows the sharing of ideas, doubts and knowledge, shifting the center of communication of professionals and the service to the needs of each user (Peduzzi; Agreli, 2018).

However, the understanding and experience of research participants does not include the user as a partner in the construction and implementation of the health care plan, as the focus is on individual care, especially of a biomedical nature (Davidson et al., 2022), and in exchanges and dialogues between professionals, excluding users.

The findings show that the conception of interprofessional communication also does not include family and community, although the FHS of PHC in the SUS was implemented and developed based on the expanded conception of health, which contemplates the social determination of the health-disease process, care and the dimension of subjectivity, which require a territorial approach. The performance of FHS teams focusing on user care, without reference to family and territory, attests to the emphasis on an individual, clinical and decontextualized approach contrary to comprehensive health, and corroborates recent federal policies from the perspective of restricted and selective PHC (Giovannella; Franco; Almeida, 2020). This finding is noteworthy, as the secondary data analyzed here refers to the database of interviews carried out in 2016 and at the beginning of 2017, prior to the publication of the current PNAB (Brazil, 2017).

It was also evidenced that the concept of interprofessional communication unequivocally points out that working conditions, when not adequate and pertinent to the needs profile of users and the population, constitute limits to communication itself, with a focus on service to the user, something which can compromise the

quality of healthcare. Reeves et al. (2010) analyze that teamwork needs to be understood based on two relevant components: the profile of the needs of users and the population served, and the working conditions in which the teams operate.

A literature review on the experience of PHC professionals with teamwork and interprofessional collaboration shows that interprofessional work constitutes a daily process, whose conditions and consequences refer to structural, ideological, organizational and interactional barriers. Organizational barriers include: workload; the lack of a satisfactory number of professionals according to the demands of the service; inequities in power relations and differences in contracts and salaries between professional categories (Sangaleti et al., 2017). The inappropriate working conditions in which FHS teams work are related to the chronic underfunding of the SUS, which worsened due to the freezing of financial resources resulting from Constitutional Amendment 95, of December 15, 2016, as well as the absence of public competitions and selection processes to replace teams, which compromises the performance of their activities in a safe and collaborative manner (Rede de pesquisa APS, 2022).

The undersizing of healthcare teams, especially in PHC, leads to work overload and compromises the time spent on each patient during the provision of care. Furthermore, the managerialism model (Paula, 2005), currently adopted by health services, envisages meeting increasingly audacious productivity goals, compromising the well-being of the professionals who make up the teams.

Regarding patient-centered care, the findings show that the conceptions and experiences of professionals from the three BHUs converge towards two main forms of manifestation: as patient participation in care and social control, with sharing of responsibility between professionals and users, and as transfer of responsibility for care from the user to the professional.

The invitation to patient participation in care was mainly related to participation in collective care spaces, of health prevention and promotion groups. The groups aim to promote supported self-care, a care management proposal that incorporates collaboration between patients and the healthcare

team, replacing prescriptive action. The proposal of health prevention and promotion groups dialogues with the expanded perspective of health care and recognition of the social determinants of the health-disease and care process, as well as the sphere of subjectivity present in health care.

However, contrary to possible advances in patient participation from an expanded perspective of care, interviewees report a decrease in the holding of health prevention and promotion groups, related to the expansion of care for acute complaints. Recent studies analyze that health actions are once again focusing on individual care, consultations and acute complaints (Giovanella; Franco; Almeida, 2020, Pinto et al. 2021). In this scenario, there is a return to conventional clinical practice, without focusing on the necessary spaces for information, reflection and investments so that users can make informed decisions about their care (Fox; Reeves, 2015). As analyzed by Fox and Reeves (2015), both patient-centered care and interprofessional collaborative practice can become mere discourses, without their effective incorporation into the changes that lead to integral health practices oriented to the needs of users and the population in a comprehensive way.

The invitation for users to participate in social control was present in their involvement in the SUS management sphere, especially in the Management Council meetings. Management councils are instruments of expression, participation and representation, with a view to political transformation, but users need to have opportunities to learn about spaces for social participation (Fox, Reeves, 2015; Metersky et al., 2022). Therefore, it is not just about the number of community participants (Gohn, 2019), although this is an indication of interest in participating. Regarding the low participation of users in meetings, Fernandes, Spagnuolo and Bassetto (2017) highlight that, in most cases, the community has little knowledge of the existence of the Council, unaware of how much they can empower themselves through an active Council.

The findings regarding patient-centered care show the double root of sharing responsibility for care between professionals and patients: on the one hand, professionals who do not recognize users

as genuine partners in care; on the other, patients who, having difficulty taking the lead in their self-care, transfer this responsibility to the team. Therefore, both professionals and users reiterate the latter's position in their role as "patient," in which professionals assume total control of health care, relegating users to a role of passivity, with an emphasis on instrumental action.

In a study on the role of users in PHC teams, Metersky et al. (2022) propose that users' participation in teams occurs as managers of self-care and co-participants in decision-making. To play such roles, users need to feel empowered by their accumulation of knowledge and respected by professionals, in order to develop an active role in their own care. The imbalance in power relations between professionals and users, as well as the absence of a culture that supports the sharing of responsibilities in care, are characterized as barriers to user and population participation (Agreli et al., 2019). Van Dongen et al. (2017), in an analysis of patient participation in PHC team meetings, describe that changing power relations in order to favor sharing responsibility for care can take time, as patients and professionals need to "unlearn" standards previously established in their care relationships that are merely prescriptive and subordinate to professional authority. The time for developing a bond between professionals and users is described by Metersky et al. (2022) as an essential condition for patient participation and communication in interprofessional teams.

Two limitations of the study were identified. One refers to the analysis of two BHUs in one municipality and just one BHU in another. The other is due to the development of the study based on secondary data, collected by other field researchers, which may have partially compromised the appropriation of the material by the main researcher. However, the process of impregnating the empirical material was carried out by listening to the interviews and analyzing the fully transcribed material.

Final considerations

The research addresses the proposed objective by presenting the understanding and

experience of professionals from FHS teams on the two central collaborative competencies. The first, interprofessional communication, was characterized as that which occurs when the focus is on meeting users' health needs, and the second competency, user-centered care, when the user participates in the construction of the care plan with sharing of responsibilities between teams and users. Therefore, the study shows that the two are complementary and cannot be treated independently.

The results allow us to raise the hypothesis that interprofessional communication between team and users will be more effective, in the sense of producing the best results in health care, if users' engagement in recognizing health needs and defining the health plan is promoted. It will also be more effective if the teams operate with adequate working conditions, that is, with a team of health professionals that matches service demands.

The study brings contributions to the management of the SUS and the specific management of BHU, as it highlights key elements of the collaborative competencies that need to be developed and mobilized for effective interprofessional work. This indicates the need for work management actions that seek to ensure working conditions relevant to the needs of users and the population, as well as ongoing education that supports interprofessional collaboration.

The study findings showed that FHS team professionals' conceptions about interprofessional collaborative practice and the core competencies for its consolidation, interprofessional communication and patient-centered care are in the process of being constructed and appear in the professionals' reports with tensions, contradictions and fragility. However, the FHS in SUS PHC constitutes a privileged space for learning and mobilizing the collaborative competencies investigated.

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Authors' contribution

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