REVISTA PORTAL SAÚDE E SOCIEDADE

Ensaio

VISITA MULTIPROFISSIONAL DE SAÚDE – UM BREVE ENSAIO

MULTIPROFESSIONAL HEALTH VISIT - A BRIEF TRIAL

VISITA DE SALUD MULTIPROFESIONAL - UN BREVE ENSAYO

Fellipe Alves Rocha da Cruz [1], Jefferson de Souza Bernardes[2]

RESUMO

Introdução: Este ensaio busca compreender, problematizar, ampliar e ressignificar o conceito de visita, a partir de diálogos com a literatura e atividades realizadas durante a Residência Multiprofissional em Saúde do Hospital Universitário Alberto Antunes da Universidade Federal de Alagoas. Partimos da problematização do conceito de multiprofissionalidade orientados pelo princípio da Integralidade do Sistema Único de Saúde e, também, pela Política Nacional de Humanização. Por meio da integralidade, problematizamos a racionalidade médica e a fragmentação dos saberes/fazeres. Por meio da humanização, problematizamos a noção de cuidado que vivenciamos em nosso cotidiano na Residência. Propomos pensar a visita como encontros marcados por dialogias, aproximando os diferentes atores/atrizes envolvidos/as e rompendo com uma lógica de distanciamento entre eles/elas na produção dos cuidados na saúde.

Palavras-chave: Visitas a Pacientes; Internato não Médico; Integralidade em Saúde; Humanização da Assistência.

ABSTRACT

Introduction: This essay seeks to understand, problematize, amplify and re-significate the concept of visit, based on dialogues with the literature and activities carried out during the Multiprofessional Health Residency of the Alberto Antunes University Hospital of the Federal University of Alagoas. We start from the problematization of the concept of multiprofessionality guided by the principle of Integrality of the Unified Health System and also by the National Humanization Policy. Through integrality, we problematize medical rationality and the fragmentation of knowledge. Through humanization we problematize the notion of care that we experience in our daily life in the Residence. We propose to think about the visit as meetings marked by dialogues, approaching the different actors/actresses involved and breaking with a logic of distance between them in the production of health care.

Keywords: Visitors to Patients; Internship, Nonmedical; Integrality in Health; Humanization of Assistance.

RESUMEN

Este ensayo busca comprender, problematizar, amplificar y resignificar el concepto de visita, a partir de diálogos con la literatura y las actividades realizadas durante la

[1] Psicólogo. Mestrando em Psicologia pela Universidade Federal de Alagoas (UFAL).
[2] Psicólogo. Docente do Instituto de Psicologia da UFAL.

Residencia de salud multiprofesional del Hospital Universitario Alberto Antunes de la Universidad Federal de Alagoas. Partimos de la problematización del concepto de multiprofesionalidad guiado por el principio de la Integralidad del Sistema Único de Salud y también por la Política Nacional de Humanización. A través de la integralidad, problematizamos la racionalidad médica y la fragmentación de los conocimientos. A través de la humanización, problematizamos la noción de cuidado que experimentamos en nuestras vidas diarias en la Residencia. Nos proponemos pensar en la visita como reuniones marcadas por diálogos, acercándonos a los diferentes actores/actrices involucrados/as y rompiendo con una lógica de distancia entre ellos/ellas en la producción de atención médica.

Palabras-clave: Visitas a Pacientes; Internado no Médico; Integralidad en Salud; Humanización de la Atención.

INTRODUÇÃO

In a large room of a European hospital, we see greyish-white painted walls, beds lined side by side on both sides of the room, covered with white sheets on which patients rest. Large windows with open white curtains, a crowd of about fifteen men, only a woman among them, dressed in ordinary clothes of the time and a white apron (predecessor of the coat) covering from the waist down, in a possible hygienic attitude, gather in front of a bed. On it lies a sick young woman, directly auscultated - stethoscopes would not appear until later - by a gray-haired man (the head doctor), who is helped to hold the girl by a slightly younger man. She looks faint, extremely debilitated. Another patient, lying on a bed nearby, watches the scene. Some of the men seem to be paying attention to the situation, while further behind, one of them looks at another corner of the room and another one takes notes. On the background, still in the doorway, two men whisper about something and on the right side, a woman dressed in larger white clothes walks to a bed.

It seems to be the description of a typical visit nowadays. However, this painting entitled *Una sala del hospital durante la visita del médico en jefe,* was painted by Luis Jimenez de Aranda in 1889. At the time, according to the Museo Del Prado website, during Paris Universal Exposition, Aranda wins his first medal and contributes to the social realism culmination.

***Una sala del hospital durante la visita del médico en jefe*, Luiz Jimenez de Aranda, 1889.**

Such a work helps us to consider some questions: What has changed from the nineteenth century on? What similarities and differences does this scene have with the visits nowadays? Is it possible to think of changes to such an old and, at the same time, current health practice? Do these scenes help us to improve our health practices? Apparently, it seems that little has changed. We keep entering the wards with a crowd - most unknown to the users; exploring the cases, talking about them in an unarticulated manner, fragmenting according to our specialties, often without including the users or family members themselves in the dialog.

Such questions are the basis for the elaboration of this essay, produced from the experiences in the Multiprofessional Residency in Adult and Elderly Health of the Federal University of Alagoas. It focuses on the discussions about the construction of joint, dialoged and ethical-politically implicated practices, with the visit as an important health care practice.

The motivating questions for writing arise in line with the various

trajectories, encounters (and mismatches), dialogs with public health policies and the everyday training and work in/for the Unified Health System (Sistema Único de Saúde, SUS) of the researchers. One of the authors has had such a trajectory since graduation and, subsequently, had already been included in the Multiprofessional Health Residency (Residência Multiprofissional em Saúde, RMS) program. This movement provided opportunities to work in a multiprofessional health team and to think about the development of practices based on joint work, dialogics and interprofessionality, centered on users' health needs, with focus on integrality.[1]

The multiprofessional team work in the RMS created a contact with the service dynamics and made it possible to realize how the health work process was sometimes fragmented. In it, each professional works in a separate and independent way, not talking to the others, which also expresses a long and intense isolated formation and restricted to one's own area.[2]

According to Ceccim[3], "the health area works with politics in a fragmented way" and:

> [...] this fragmentation has also resulted in specialists, intelectuals and consultants (experts) with a notion of knowledge concentration who eventually impose themselves on the professionals, services and society resulting in the expropriation of other knowledge and the elimination of local realities on behalf of knowledge/expertise.

Besides these nuisances, in the professional service with the team of residents we came across the different professional visit processes, from hospital visits to home visits, and from uniprofessional to multiprofessional visits. Such visits aroused some questions and concerns. Often because they are not focused on the users' specific needs, apparently focusing on the users as objects of study/investigation, serving the teaching-learning process of academics and professionals; because they are not based on the dialog with

people, often not allowing them to express themselves; because they use technical vocabulary, which does not allow for dialog among the participants of the visit; and because, at times, they generate anguish, fear, anger, among others according to reports of patients and their relatives.

We can exemplify our concerns by reports, as in a particular situation in which during the medical visit, one of the patients was not in his bed, because he was in the bathroom. Even so, the professionals presented the case and performed the "visit" - or a simulation of it - literally, without the participation/presence of the subject to whom that moment should be addressed to.

At other times, we have seen diagnoses and private information previously unknown to the patients (and expected for a long time) being exposed in a not very careful way, loud and clear, in a ward of approximately twenty professionals, apart from the others users and companions. At times, it aroused feelings of discomfort, anguish, irritation, fear and others in patients and their relatives and also in us as professionals. It is worth mentioning an action taken by one of the psychologists of the surgical clinic of the University Hospital Professor Alberto Antunes (Hospital Universitário Professor Alberto Antunes, HUPAA), aiming to minimize the effects of such kind of visit, before this moment, the psychologists of the sector would go to the wards giving information about the moment that would follow, asking questions and solving anguish in each bed.

From the questions related to the medical visit process, which actually was not only medical, as the other professionals of the service were also there, a visiting model to be performed by the multiprofessional residents was initiated in the surgical and medical clinics of the HUPAA, the multiprofessional visit, as named by the residents themselves, preceptors and tutors.

The multiprofessional visits began to occur regularly, daily, after moments of discussion and reflection about their objectives. They aimed

at modifications from the medical visit model previously performed. The main modifications were concerned with the centrality of care in the user's health needs. Thus, the moment was based on questions directed to users.

Initially, however, each professional asked the questions they wanted according to the scope of their specialty. In a movement with a clear attempt to demarcate space or encounter it, still constituting a divided practice, because each one took care of the part that was specific to their profession. We felt there was room for modification in our practices.

Taking into account the dynamic character of the visit and the peculiarities of each situation, each user, on specific days and times, produced different experiences in this daily practice. We tried to organize ourselves in different ways, testing modifications and ways of acting. For example, sometimes we assigned a professional beforehand to speak during the visit, varying according to the patients, which sometimes made no sense, as other professionals were asked to speak according to the needs. In this way, with time in the practice and a closer contact with other knowledge and practices, we were becoming familiar and possibly building a health action, which met the user’s demands in a more integral way.

The daily routine of conducting multiprofessional visits in the first year of residence made us realize that we frequently simply allowed the user to talk about what was important and necessary. At such times, we encountered sufferings that went beyond a physical injury or a diagnosis. Sufferings were related to the people who had stayed at home, to different personal (often socioeconomic) problems, to relational issues, or even to the fact that the companion was sleeping on the floor. These issues, previously not taken into account, gained a privileged place during multiprofessional visits. But we were insecure in this process. The next step, thus, was an attempt to find a safe harbor; the activity was to study what a multiprofessional visit was.

Professional Visits

The word visit is derived from the Latin *visitare,* and refers to the act of going somewhere to be with someone, or to see and appreciate (something); travel to meet with someone else.[4] In short, the concept of a visit is a relation process, an encounter with another person.

It is characterized as a daily activity, historically instituted, and that was exclusive to the practice and teaching of the medical profession for years. In this activity, a doctor directs a group of students and other less experienced professionals.[5]

We highlight the historical feature of the visit, which has been occurring since immemorial times and in different ways, generally linked to a teaching-learning process. The authors point to elements for the conceptualization of the "*pase de visita*" (term used in Spanish) process. For them, the visit is based on three fundamental ideas: the condition of human activity, assistential essentiality and formative intentionality.[6]

In the health context, there may be several kinds of visits, according to the context, objective, proposal, and professionals involved, among other criteria. We can distinguish between two large groups, according to the literature found: home visits and hospital visits, which can be uniprofessional or multiprofessional.

Two other kinds of visits are also identified: one with assistential focus and presenting teaching attributes, which may be multidisciplinary according to the care needs of users; and the other being the teaching-assistencial visit, which is characterized as a peculiar form of education at work, having objectives, teaching and care closely related.[5]

Regarding the home visit, in a multiprofessional team report on the case of an obese person, with locomotor limitations and need for health care, the authors have asserted the benefits and potentialities of this practice in terms of care for complex cases, as well as the possibility of approximation to the user's context.[7]

Some consider home visits as effective, positive, and widely accepted by users, claiming that they should be considered as mandatory and as a basic objective within health programs. The authors conducted a study about home visits to newborns and postpartum women, performed by a nursing and pediatric team in Spain.[8]

For others, the multiprofessional home visit is an action of the Family Health Strategy (Estratégia de Saúde da Família, EFS), enabling actions which offer the promotion, protection and recovery of people's health. It is also an instrument for promoting bonds among health professionals and families in their area of operation, enabling interdisciplinary and multiprofessional practices at home.[9]

Regarding the multiprofessional visit in particular, authors state that it values the role of communication among the professional caregivers, which helps in the complexity of care and the improvement of practices. In a study conducted in 2005/2006, the authors identified that daily visits by a multiprofessional team have reduced health problems and adverse events, also contributing to improved communication among professionals. For them, conducting a multiprofessional visit is to exercise permanent education in service in its fullest sense, as it consists of a continuous act of critical reflection about the practices.[10]

In relation to hospital visits, with a focus on nutritional assessment in multiprofessional teams for patients with Amyotrophic Lateral Sclerosis (ALS) in Spain, the visit is indicated as part of the care process. The authors state that patients' families evaluate the moment of the visit positively, due to the communication characteristics and the clarification of doubts.[11]

In a review of the teaching-assistential medical visit in the hospital context of Cuba, the authors concluded that this type of visit is the main teaching activity for undergraduate and postgraduate education, given its wide spectrum of communication, acquisition and consolidations possibilities, strengthening of values, performance and competences, as

well as varieties of interpersonal interactions and application of didactic principles to medicine.[12]

In a study aimed at building an intervention proposal for the health care of patients with chronic diseases', based on the concepts and principles of Palliative Care of the World Health and Pain Control Organization, the multiprofessional hospital visit was identified as a category of emerging practices in the discussions about actions for such context.[13]

In an experience report of multiprofessional residents about the pharmacist's role in multiprofessional visits in an Intensive Care Unit (ICU), the importance of the daily post-visit discussion is highlighted, in which each professional marks their place, giving specific contributions to each case. For the authors, greater integration of the team is noticed in the process of patient care and of understanding the peculiarities of their case, by sharing knowledge and views.[14]

Also in an experience report, the contributions of the multidisciplinary team for reducing the permanence of elderly patients in a university hospital are pointed out. They present the multiprofessional visit as a care practice, developed by the team, and performed weekly, with the objective of improving the quality of care.[15]

In a work focused on structuring a multiprofessional visit for the integral follow-up of the elderly in a university hospital, the absence of works proposing the definition or description of multidisciplinary visit process is stated. The authors also state that visits are important tools for the implementation of integral attention and of the assistance to monitor the health status of patients and identifying demands.[16]

From the diversity of experiences and concepts of visit, its types and characteristics, we propose to problematize such practice.

Reframing Visits

In order to make our way to the visits, we initially propose to discuss multiprofessionality. In most cases, multiprofessionality operates from a fragmented logic, arising from the compartmentalization of knowledge in strict disciplines, influenced by the classic paradigm of modern and rationalist science, which governs the knowledge and practices of health professions.[17]

From this logic, the multiprofessional teams reproduce positions historically occupied by the professions and perpetuate the fragmentation in the service provided. This implies a process divided in two complementary perspectives: the fragmentation of "knowledge" as a strategy of power; and the fragmentation of "doings" as a defense of the spaces of action; making the indivisible unit of health multifaceted.[17]

In order to overcome these movements, the author points to an integration (which does not mean an equalization of knowledge/doings, nor the submission of differences to a single and unambiguous truth), by adopting an attitude of understanding about the modes of structuring of other types of discursive practices and thoughts, different from ours, facing the contact barriers erected in the encounter with the different.[17] As a meeting of different professionals, the visit becomes a place of confrontation, due to such barriers, which must be overcome, aiming at the articulation of individual competences, rather than their breakdown. According to the author, "each one, rather than losing skills, must develop enough in order to articulate with those of others".[17]

The difficulties of integrality and the fragmentation of the SUS' practices can be understood from the discussion of the concept of medical rationality, as a set of specific practices and knowledge, integrated, structured and historically constructed, which implies in a peculiar way of understanding the world.[18] It consists of five interconnected dimensions:

> (...) a human morphology (anatomy in biomedicine), a vital dynamics (physiology), a diagnosis system, a therapeutic system and a medical doctrine (explaining what the disease or illness is, its origin or cause, its

> evolution or cure), all based on an implicit or explicit sixth dimension: a cosmology.[18]

Biomedicine is a hegemonic rationality, which was established in a fragmentation tradition, according to the logic of the specialties and the constant dismembering of the human body, influenced by the already mentioned rationalism of modern science, and prevails in the current ways of health, not only in medicine, but also in other professions.[18]

In this tradition, there was a progressive focus on the process of diagnosing and combating diseases, enhanced by the emergence of "hard" diagnosis technologies that traverse the healer-patient relationship, shifting the focus from the user and their life, resulting in a deindividualizing process.[18]

For Tesser and Luz, integrality, among other meanings, is characterized as the broadest possible global health action qualifier attribute, integrating dimensions of illness and life of patients, both from the users' point of view and the specialized knowledge which guides the healer.[18] This concept is epistemologically distant from biomedical-medical rationality, considering its operational and theoretical centrality in diseases and their risks, as well as the specialties logics. This is what the authors call "essential difficulties inherent to biomedicine in dealing with the question of integrality".[18]

Nevertheless, they claim that there is a certain but precarious conception of integrality in biomedicine, in which the integral care process is seen as a set of services, diagnoses and examinations offered to patients. Integrality is shifted from the relation with the healer to the set of services and healers of the health professions. Thus, it is expected that the amount of the various partial and specialized actions will result in an integrality, which generates frustration in professionals and users.[18]

In this way, the realization of integrality in a context of such fragmentation and specialization of knowledge and practices can be projected by a set of so-called institutional actions, such as the

implementation of multidisciplinary/multiprofessional teams. They affirm that, in this format, such a movement can only occur through the ethical and "artistic" action - a welcoming centered dimension - of the professionals in teams. These teams are indispensable for the construction of a minimum of integrality in health care.[18]

The debate on the different uses of the term integrality can occur from three major sets of meanings: attributes of health professionals' practices, which are considered a good practice; attributes of service organization; and governmental responses to health problems. For the author, thinking of integrality implies a refusal of reductionism, of the subjects' objectification and a possible openness to dialog. He also asserts that the reductionisms commonly seen in relation to the three major sets mentioned may result from a certain inability to relate with the other without objectifying and reducing them. Thus, integrality is only possibly realized in the establishment of a subject-subject relationship, based on dialog.[19]

About teamwork ways, the qualification of health practices, and the implementation of the SUS' principles, such as integrality, a redefinition of the humanization concept can be thought of, as well as the ways of building a transversal and public policy of/to health humanization, due to the problem of trivialization of the theme and the fragmentation of practices identified as related to it.[20]

For the authors, the redefinition would come from the qualification of health practices through a host-based access, an integral and equal care based on accountability and bonding, valuing workers and users, focusing on the democratization of management and participatory social control.[20] In other words, humanization must focus on the relations of all those who are part of the SUS, promoting protagonism, social control, and the strengthening of multiprofessional teamwork, thus fostering transversality and group work, co-management and better conditions for workers and users.

Still on health practices in the SUS, this time from the perspective

of interfaces with psychology, it is necessary that the modes of intervention surpass the founding traditions of psychology, based on dichotomies - sometimes linked to an objective-positivist perspective, sometimes to an internal-subjectivist one - that result in separations: individual/social, clinical/political, people/population health care, clinic/collective health; and that depoliticize psychology and leave it aside from a debate with the SUS.[21]

Thus, in order to contribute to a different possible public health, the author presents some ethical principles: a) principle of inseparability: we cannot split clinical from politics, individual from social, singular from collective, ways of taking care from ways of managing, macro from micro politics; b) principle of autonomy and co-responsibility: health practices must be situated and compromised, implying the production of autonomous subjects, protagonists, co-participants and co-responsible for their lives; and c) principle of transversality: refers to the need for intercession among knowledge/powers/disciplines[21]. Such principles discuss a way of thinking-making health policies that requires being with the other: user, worker, manager. From this dialog, within the limits of the very powers of knowledge, we have to contribute to another possible world.

In a discussion on the care that helps us to think about visits, this moment cannot be reduced to a simple act: it occurs in a productive meeting between the health worker and the user, in the establishment of the intercessor space between them, in which one can intervene over the other. In a meeting between those who need and those who have the knowledge/practice, producer of care, with the purpose of recovering a "way of life".[22]

In this sense, Merhy invites us to consider health practices from the notion of attitudes that each health professional uses to act in the intercessor process. Such cases are understood as technological toolboxes (knowledge and its material and non-material consequences). He points out three: one related to manipulation, concerned with the

tools the professional can use, such as a stethoscope, pens and others, constituting a toolbox, or "hard technologies"; one that is in our head, and concerns structured knowledge (epidemiology, clinical, pedagogy), constituting a box with "light-hard technologies"; and one that is in the worker-user relational space and that contains "light technologies", committed to the production of the relations.[22]

Different health practices guided by different principles may conform different technological arrangements based on prioritized attitudes. For the author, in technological medicine, we notice an impoverishment of the light technologies attitudes, which causes the axis of the technological arrangement to shift to a greater articulation between light-hard technologies with that of hard technologies attitudes.[22]

CONCLUSION

Finally, we suggest a possible visit proposal based on what has been presented and on the positions of the authors mentioned above. Understanding it as a productive meeting between actors/actresses that constitute the health care processes. It may be interesting that principles such as integrality, humanization, care and dialog may act as good guides for such practices. In order to foster the overcoming of fragmentation in care, non-isolation between care and teaching, refusal of reductionism and objectification of the subjects, centrality in the user's health needs, based on dialog and production of bonds, by investing in different technologies committed to the production of autonomous and protagonist subjects, co-participants and co-responsible for their lives.

Such shifts are close to a way of thinking and making health policies which require being with the other: user, worker, manager. A meeting process peculiar to the visit concept, in which there is an invitation to approximation and dialog, joint construction and health production.

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