

Interdisciplinarity: a utopia full of challenges and present in the discourse - perceptions of rehabilitation professionals**Interdisciplinaridade: uma utopia repleta de desafios e presente no discurso - percepções de profissionais da reabilitação****Interdisciplinarietà: una utopía llena de retos y presente en el discurso - percepciones de los profesionales de la rehabilitación**

 Ana Cláudia Fernandes¹,  Pedro Henrique Silva Carvalho¹,  Dolors Rodríguez-Martín²
 Rita de Cassia Ietto Montilha

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Objective: to verify the perception of professionals regarding interdisciplinary work in health care and rehabilitation of people with visual impairments. **Methods:** qualitative and descriptive study carried out between 2015 and 2018, through semi-structured interviews with professionals from a rehabilitation service in the interior of the state of São Paulo, Brazil. For data analysis, content analysis technique was used. **Results:** 11 professionals from the areas of: ophthalmology, speech therapy, psychology, guidance and mobility, occupational therapy, IT, pedagogy and social assistance participated. Two categories emerged: *Interdisciplinarity: a utopia?* and *(Multi) (Inter) (Trans)disciplinarity: concept*. The challenges to interdisciplinarity related to personal, group, structural and conceptual aspects were highlighted, which causes it to be characterized as a utopia. Also, an inconsistency was observed between discourse and professional practice, seen by a conceptual misunderstanding between interdisciplinarity and multidisciplinary. **Conclusion:** the need for continuing education actions is highlighted to facilitate the clarification of conceptual and practical doubts regarding the organization, construction and development of a team in an interdisciplinary way. **Descriptors:** Patient care team; Interdisciplinary communication; Rehabilitation; Health services for persons with disabilities.

Objetivo: verificar percepção de profissionais quanto ao trabalho interdisciplinar no cuidado à saúde e reabilitação de pessoas com deficiência visual. **Método:** estudo qualitativo e descritivo realizado entre 2015 e 2018, através de entrevistas semiestruturadas com profissionais de um serviço de reabilitação do interior de São Paulo. Para análise dos dados, utilizou-se técnica de análise de conteúdo. **Resultados:** Participaram 11 profissionais das áreas de: oftalmologia, fonoaudiologia, psicologia, orientação e mobilidade, terapia ocupacional, informática, pedagogia e assistência social. Emergiram duas categorias: *Interdisciplinaridade: uma utopia?* e *(Multi) (Inter) (Trans) disciplinaridade: conceito*. Apontou-se os desafios à interdisciplinaridade relativos a aspectos pessoais, grupais, estruturais e conceituais, o que faz com que ela seja caracterizada como uma utopia. Também, observou-se incoerência entre discurso e prática profissional, visto por equívoco conceitual entre interdisciplinaridade e multidisciplinaridade. **Conclusão:** aponta-se a necessidade de ações de educação permanente para favorecer o esclarecimento de dúvidas conceituais e práticas referentes à organização, construção e desenvolvimento de uma equipe nos moldes interdisciplinares. **Descritores:** Equipe de assistência ao paciente; Comunicação interdisciplinar; Reabilitação; Serviços de saúde para pessoas com deficiência.

Objetivo: verificar la percepción de los profesionales sobre el trabajo interdisciplinario en la atención a la salud y rehabilitación de personas con discapacidad visual. **Método:** estudio cualitativo y descriptivo realizado entre 2015 y 2018, a través de entrevistas semiestruturadas con profesionales de un servicio de rehabilitación del interior de São Paulo, Brasil. Se utilizó análisis de contenido para analizar los datos. **Resultados:** participaron 11 profesionales de las siguientes áreas: oftalmología, logopedia, psicología, orientación y movilidad, terapia ocupacional, informática, pedagogía y trabajo social. Surgieron dos categorías: *Interdisciplinarietà: ¿una utopía?* y *(Multi) (Inter) (Trans) disciplinarietà: concepto*. Se señalaron los retos de la interdisciplinarietà relacionados con aspectos personales, grupales, estructurales y conceptuales, que la hacen parecer una utopía. También se observó una incoherencia entre el discurso y la práctica profesional, como lo demuestra el malentendido conceptual entre interdisciplinarietà y multidisciplinarietà. **Conclusión:** Es necesaria una formación continuada que ayude a aclarar dudas conceptuales y prácticas sobre la organización, construcción y desarrollo de un equipo interdisciplinar. **Descritores:** Grupo de atención al paciente; Comunicación interdisciplinaria; Rehabilitación; Servicios de salud para personas con discapacidad.

Corresponding Author: Ana Cláudia Fernandes – dra.anaclaudiafernandes@gmail.com

1. Postgraduate Program in Health, Interdisciplinarity and Rehabilitation at the Universidade Estadual de Campinas (UNICAMP), Campinas/SP, Brazil.

2. Department of Fundamental and Clinical Nursing, University of Barcelona, Barcelona/Catalonia, Spain.

3. Department of Human Development and Rehabilitation of the Faculdade de Ciências Médicas at UNICAMP, Campinas/SP, Brazil.

INTRODUCTION

The concept of disability has been given a new meaning since the United Nations (UN) published the Convention on the Rights of Persons with Disabilities, which was ratified by Brazil through Decree 6949/20091. As the convention is a fundamental historical milestone for the social and political agenda of several countries, important changes have been observed in recent years in the disability paradigm, moving away from the biomedical/organic perspective to adopting a biopsychosocial perspective.

Therefore, disability is the product of the interaction between organic factors and environmental, physical, social and attitudinal characteristics¹, and are involved in a society that is not inclusive or structured, which is why, currently, the concept used is that of Persons with Disability (PWD), and not that of disabled persons.

Based on the Convention¹, the Brazilian Law for the Inclusion of Persons with Disabilities (*Lei Brasileira de Inclusão da Pessoa com Deficiência - LBI*)² was enacted in Brazil in 2015. According to this law, there are barriers that limit or prevent the full exercise of fundamental rights, such as communication, freedom of movement and expression, access to information, among others².

The LBI presents a division of the aforementioned barriers into six main types, namely: *urban barriers*, those existing in public or private circulation spaces, which hinder the exercise of the right of coming and going with autonomy and independence; *architectural barriers*, which make it difficult for people with disabilities to access public or private buildings; *barriers in transportation, communications and information*, related to any difficulty in receiving and/or transmitting messages and information through communication systems; *attitudinal barriers*, referring to attitudes and/or behaviors that prevent or hinder the participation of people with disabilities in society; and *technological barriers*².

In order to face such barriers and provide people with disabilities with a life of autonomy, independence, quality and equity, the habilitation and/or rehabilitation processes are essential. The qualification and/or rehabilitation process aims to favor and legitimize the subject's capabilities and possibilities, providing opportunities for the (re)construction of their personal and social identity, which is why this process goes far beyond training or carrying out training. It is a process that empowers people with disabilities and/or reduced mobility to perform their activities and social role with autonomy, independence and quality of life^{3,4}.

According to current Brazilian legislation (Ordinance 793/2012), habilitation and rehabilitation services for people with disabilities must rely on a multidisciplinary and interdisciplinary team, as well as act in an intersectoral manner and articulated with the other

services that make up the Care Network to Persons with Disabilities, in the context of the Health Care Network (*Rede de Atenção à Saúde - RAS*) of the Unified Health System (*Sistema Único de Saúde - SUS*)⁵.

Interdisciplinary work in the specific context of rehabilitation of people with visual impairment (VI) provides this group with comprehensive care as the relationship between professionals, in this organizational work model, becomes more horizontal⁴.

The interdisciplinary health team concerns group functioning based on dialogue, in which each discipline is transformed in its relationship with the others, in order to build collective care, considering the limits and potential of each discipline⁶.

It is necessary, however, to differentiate interdisciplinarity from multidisciplinary and multiprofessionalism, since the latter corresponds to the presence of professionals from various areas of knowledge in a given service, without, however, there being an interaction between them and a coordination that promotes such interaction, as happens in a team organized from an interdisciplinary perspective⁷. The lack of such interaction and interrelation contributes to the fragmentation of care⁶⁻⁸. In turn, the multidisciplinary perspective presents itself as a juxtaposition between several disciplines without the composition of a coordinated and cohesive team⁷.

Interdisciplinarity and interprofessionalism presuppose action based on the co-responsibility of the team as a whole, towards a common direction, with interaction, cohesion and interrelationship between knowledge, professionals and other key actors^{7,9}. Interprofessionalism is the practical correlation of interdisciplinarity, being understood as the performance of professionals as a team, in order to go beyond the integration of knowledge proposed by interdisciplinarity and achieve the integration of health practices in their constitution/practical construction in doing/promoting health¹⁰.

However, it is known that interdisciplinary work represents a constant challenge for healthcare teams, as it mobilizes professionals to articulate their knowledge and practices with other colleagues, which can generate tensions and disputes over power in making decisions regarding the treatment process of people under care¹¹. Therefore, for interdisciplinarity to exist, it presupposes the exercise of constant negotiations between the all of those involved (management and team)¹¹.

Furthermore, interdisciplinarity can be thought of as praxis, that is, as the exercise of an action on the world, based on theoretical reflections, which alters it and, simultaneously, transforms the acting human being¹².

This praxis must include three distinct but inseparable elements of interdisciplinarity: the *pragmatic*, in which methods/techniques are integrated to reach the solution of a certain practical problem, that is, in which there is a concern with the purposes of certain interdisciplinary approaches; the *epistemological*, which corresponds to reflections on the interaction between scientific knowledge from different disciplines for its transformation into knowledge of an interdisciplinary nature; and *humanistic/attitudinal*, in which the focus is on the dialogue between the subjects participating in a given interdisciplinary project and on their individual attitudes¹².

Thus, the present study aimed to verify the perception of professionals regarding interdisciplinary work in the health care and rehabilitation of people with visual impairments.

METHODS

The present study is part of a project entitled *O itinerário da pessoa com deficiência visual nos serviços de saúde e reabilitação em um município da Região Metropolitana de Campinas - SP, Brasil* (The itinerary of people with visual impairment in healthcare and rehabilitation services in a municipality in the Metropolitan Region of Campinas - SP, Brazil).

This is a descriptive phenomenological study of a qualitative nature, which in health sciences seeks to understand not only a phenomenon as an event related to the health/disease process, but the meanings that the subject, individual or collective, presents about this phenomenon experienced by them¹³.

Data collection supported the construction of a corpus of interviews, which were carried out from 2015 to 2018 with professionals from a Reference Service in Rehabilitation of People with Visual Impairments and Ophthalmology in the interior of São Paulo. The service in question was selected because it is a reference of and for the health network in the region in a broader project, which addressed other aspects related to the rehabilitation work of people with visual impairments in an interdisciplinary and intersectoral way in the field of public health.

We opted for semi-structured interviews, carried out by a speech therapist, using interviews according to a script constructed after pre-testing¹³⁻¹⁵. Semi-structured interviews seek to guarantee the freedom of the interviewee to express their opinions/thoughts regarding the topic about which they are being questioned, while maintaining the focus on that topic¹³⁻¹⁵.

During the data collection period, responses were selected from professionals from a multidisciplinary team from the service that is linked to the Unified Health System (SUS).

The project was approved in 2015 by the Research Ethics Committee and in 2017, after an amendment presented, under No CAAE 46001215.7.0000.5404 and opinion No 1.135.433/2015. All participants signed the Free and Informed Consent Form (FICF) according to the text presented and approved by the Ethics Committee. To identify professionals, the letter P was used followed by a number, in order to protect their identity and guarantee the protection of their personal data.

Data analysis was carried out according to the content analysis technique as proposed by Bardin¹⁶, defined as a technical arsenal of systematic procedures for analyzing and describing messages that aim to obtain indicators, which allow the inference of the conditions of production and reception of such messages. As it is based on the understanding of messages from research subjects, it can be said that content analysis is concerned with observing the textual units (words and/or phrases) that are repeated within a text, in order to categorize them, that is, characterize them using terms that represent them, as well as investigate their meaning(s)¹³.

This study, then, is an excerpt from a larger project, and therefore the data presented here is an excerpt responding to one of its specific objectives. To avoid bias in categories and data tabulation, the analysis was carried out individually by each of the researchers involved, with review by experienced researchers in the field of national and international qualitative research, until due consensus.

RESULTS

11 professionals participated, working in the areas of: ophthalmology, speech therapy, psychology, guidance and mobility, occupational therapy, IT, pedagogy and social assistance. Two categories emerged: *Interdisciplinarity: a utopia?* and *(Multi) (Inter) (Trans)disciplinarity: concept*.

Interdisciplinarity: a utopia?

In this category, it was found that all participants considered interdisciplinarity as fundamental in the habilitative and rehabilitative process. This does not mean, however, that it is a job free from setbacks and challenges, as illustrated by the reports in Chart 1.

Chart 1. Interdisciplinarity: a utopia? Campinas/SP, Brazil, 2018.

<i>Wow, I think it's fundamental, because these are areas that are interconnected, so work that always needs to happen step by step together. So I see everything connected, the area of occupational therapy, visual stimulation, because everything will favor the person's development. (P13)</i>
<i>It's very important, because if I don't know where they are, perhaps in literacy, or even an adult who is learning to read Braille, I will do an isolated work. (P10)</i>
<i>So, [...], if we look at the cases that are, yeah, yeah, yeah... pretty successful, right. We see success in the development of those assisted. (P3)</i>
<i>Before, we had a team meeting every week, but now, because each professional has a different schedule, we have to look for ways to bring the whole team together to do case studies... (P9)</i>
<i>[...] but I think we still need to improve this a lot, because, for professionals to be able to work in these services like this, I think they have to be prepared for this, you know, they have to be humble to know how to recognize and discuss a case, one needs to be willing to learn too; and if you don't have a team prepared for this interdisciplinarity, I don't think it happens, it gets very quarrelsome, you know, but I think it's a challenge for all health professionals, this teamwork. (P5)</i>
<i>[...] I think there is an issue that limits this service, which is, sometimes you go to work in an institution that SUS pays for. How will you receive this? So for them it's a loss. So this is something that makes interdisciplinary and multidisciplinary care difficult, because they don't want to, sometimes the company thinks it takes two professionals to serve one. So I think this is the biggest difficulty. (P4)</i>
<i>[...] except at the beginning it was more complicated, like, there were some fights there and now it's normal. (P7)</i>

(Multi) (Inter) (Trans)disciplinarity: concept

This category, in turn, brings another challenge to the implementation not only of interdisciplinary work, but above all of teamwork in the field of rehabilitation, namely: the conceptual aspects concerning what is multidisciplinary, interdisciplinarity and transdisciplinarity, in a way that is observed disagreement in these concepts, as shown in Chart 2.

Chart 2. (Multi) (Inter) (Trans)disciplinarity: concepts. Campinas/SP, Brazil, 2018.

<i>[...] everyone is friends, they talk right, everything helps, right. Then there are the meetings, you know, that one goes to another, you know, one area to another and it's always been normal like that... (P7)</i>
<i>The team, right, we have a weekly meeting, when the team takes each case to the round table, to discuss. "Look, I didn't like Joãozinho, Joãozinho arrived in my office, he was very rude, very much like that", so okay, I'm going to work with Joãozinho on the issue of this attitude. Ah, he came only visually, Joãozinho is lying on the table all the time, like, oops, the physical therapy will work with that, right. Ah, he didn't show that he seems like he's deaf, has hearing difficulties, he's going deaf, oops, that's what the speech machine is there for. (P6)</i>
<i>I believe that interdisciplinary work, everyone is in their own room providing care and has case discussions and everything else, you know, I think this is enriching and very important, but I think that multidisciplinary work is even better, because the professionals are so connected to each other, the service is so united that I think it is more enriching that way. Nowadays, you can't think of work without the team, without working on interdisciplinarity and multidisciplinary, because I think the patient loses a lot, you know, you working alone and everything. When you switch, you learn from the other professional, you learn to sometimes think from another point of view, look at the patient and say "Wow! I hadn't thought of that", or think "Wow! I thought... It's not so right... It's not so wrong..." (P5)</i>
<i>Very important too, this is essential. This multidisciplinary work is essential. (P12)</i>
<i>[...] and we also have this harmony of saying "Look, let's do it like this, or let's not do it like this..." [...] I've also worked outside of here with groups, a lot of groups with speech therapy, the little ones, we worked with OT and ST, where ST focused on the language part, on communication, and I on development, but, man, it was so cool, because the exchange was so great that there were times when I was working on communication and she development, you didn't know who is what, why that is, you know, that's what the human being is, it's a whole. (P4)</i>

DISCUSSION

Interdisciplinarity in rehabilitation care is considered fundamental by most professionals, however their discourse and practices do not always match the concept at hand.

The reports of professionals P3, P10 and P13 (Chart 1) address the undeniable importance of interdisciplinary work in the process of rehabilitation of people with visual impairment (VI). Such reports corroborate the fact that interdisciplinarity is fundamental in professional training and care for patients¹⁷. A study carried out with 26 health and education professionals showed that health actions in schools must be carried out continuously and in an interdisciplinary manner and also highlighted the need for investigations that problematize this issue to raise awareness of professionals towards interdisciplinary action¹⁸.

Interdisciplinary work for comprehensiveness can occur in care and in the exchange/sharing of information about cases treated between professionals from different areas⁸. However, case discussions and information sharing do not guarantee that there are in fact practices based on interdisciplinarity and, to verify this issue, it would be necessary to observe the daily practices of professionals in their work process⁸.

Interdisciplinarity is also seen as the solution to provide comprehensive and resolute care, so that the problem of disciplinary fragmentation in health would be resolved¹⁷. To this end, investment in professional health training and continuing education courses that consider the interdisciplinary perspective and interprofessional practice in the field of rehabilitation is necessary¹⁹.

The controversial conceptions regarding interdisciplinarity are notable. Therefore, it can be understood either as an implicit characteristic of scientific development, that is, the element responsible for the elaboration of new disciplines through the integration of those that already exist, or as a constitution external to scientific evolution, in which there is articulation between the spheres of science, technique and politics through social intervention practices, as is the case of health^{7,19,20}. Therefore, interdisciplinarity should not be considered as the panacea for resolving issues in both the epistemological and scientific fields and in health practices.

Interdisciplinarity can, then, be considered as a real utopia, alive and in motion, since it cannot be said to be a reality in itself, because like all utopia, it aims for an ideal, and for this reason, it carries barriers and difficulties in its implementation as a practice, especially because the utopian is precisely related to an issue whose solution cannot be achieved completely, only through approximations^{20,21}.

Challenges are inherent to utopias, since the closer one seeks to achieve their realization, the more challenges and setbacks they present. Thus, utopia can be understood as a kind of

“lighthouse” that guides the choices and actions undertaken to reach a place that is always moving away as it approaches²¹.

The reports of professionals P4, P5, P7 and P9 (Chart 1) highlight precisely the setbacks and challenges that the health team may face in its constitution and development as an interdisciplinary team, that is, in its attempt to achieve the aforementioned utopia. The setbacks brought by professionals are related to personal issues, that is, those related to each member of the team, structural aspects, which concern issues concerning the configuration of power relations specific to health services/institutions and group aspects, which correspond the dynamics of the team itself⁶.

Regarding personal issues, agreeing with the report of participant P5 (Chart 1), the professional who intends to work in a health team must be open to dialogue, learning, discoveries, exchanges of information, negotiations, among others matters^{6,22,23}. In other words, working as a team requires professionals to shift their own identity as a subject belonging to a specific core of activity (physical therapist, occupational therapist, speech therapist and others) to a broader foundation, made up of knowledge and practices specific to themselves as individual, so that they can contribute to the functioning of the group^{6,11,23}.

With regard to the functioning of health institutions/services (structural aspects), it is a fact that such services end up perpetuating the hierarchization of knowledge due to their own organization, so that, in many cases, the figure of the doctor appears as superior in the professional hierarchical chain, thus lacking the horizontality necessary for the functioning of a health team^{6,24}.

In the structural order, as can be seen from P4's report (Chart 1), it is the coping with the limitation of financial resources allocated to health, which does not allow for the hiring of sufficient human resources to establish a broad, multidisciplinary health team.

However, the argument used is based on interdisciplinarity as characterized only by joint care involving two or more professionals. This would be a plausible basis, were it not for the fact that joint care characterizes one of the possibilities of working as a team in an interdisciplinary manner^{10,23}.

Also of a structural nature⁶, it is impossible to hold team meetings to discuss cases, which occurs mainly due to the high demand for services, the lack of time to bring together all professionals to discuss cases and the fact that many of them working in more than one establishment; These obstacles make it extremely difficult to establish interdisciplinarity in the team^{25,26}.

Another structural challenge to the implementation of interdisciplinarity presents itself in the context of the work of professionals from the Family Health Support Centers (*Núcleos de Apoio à Saúde da Família - NASF*) together with the Family Health Teams (*Equipe de Saúde da Família - ESF*). The need to meet goals, that is, to carry out a given number of services in a given period, prevents professionals from having enough time for team meetings and the elaboration of Singular Therapeutic Projects (STP) constructed, considering interdisciplinarity and interprofessionalism effectively^{25,26,27}.

The issues concerning relationships, communication and group phenomena, as highlighted in the reports of P5 and P7 (Chart 1), are due to tensions existing in the group field itself, in which each participant projects conscious and unconscious reactions onto the other, the which can generate a tense relationship and, consequently, “some fights”, as reported by P7 (Chart 1)^{6,22,23}. In this sense, it is understood as necessary to assume the role of a coordinator among the team's professionals, without, however, excluding themselves from their role of sharing their experiences, their information and their knowledge with the group to build the follow-up therapy for each user of the service.

In this sense, considering the team as a group, the role of the coordinator is to think together with this group and, simultaneously, carry out a synthesis of the thoughts of the different professionals, with a view to facilitating communication and interaction between the team and consequently favoring the constitution of a truly interdisciplinary team²⁷.

With the presence of a coordinator, it is possible to carry out group activities as a way of resolving conflicts internal to the group, that is, concerning the interpersonal relationships between its members and, in this way, improving such relationships, in a search for joint construction, as well as for quality of the service offered to the population, since interpersonal development favors relationships at work and the work itself^{26,27}.

In the main challenges highlighted, it was observed that the main ones were personal, group and structural⁶. Intra and interpersonal tensions, egocentrism, individualism and competition are issues of a personal and group nature, which reinforce relationships of power and knowledge between professionals and between team and management. In the structural order, the lack of time and physical space, financial investment and the presence of protocols that advocate the achievement of goals (quantitative) to the detriment of the quality of care (qualitative) stand out.

Thus, it is inferred that interdisciplinarity presupposes a relationship between professionals themselves, who must be open to learning and grasping subjects from other

disciplines, valuing dialogue, interactions, reciprocal respect and the sharing of information and experiences in a context group, seeking comprehensive care^{7,11,12}.

However, in the reports of P6 and P7 (Chart 2), despite the importance of dialogical interactions being present, interdisciplinary work is seen as a meeting of professionals to divide tasks and responsibilities according to the core of each professional's activity; discussion and exchange of experiences between team members are not emphasized so that, during the dialogue, a common direction can be established for each case^{22,25}. The reports, on the contrary, further highlight the fragmentation of care that is so common in the Brazilian health system, as they argue in favor of "one area passing on to the other" the responsibility for resolving a particular issue raised by the patient, without that there is the establishment of a STP based on comprehensive care⁷.

In this sense, the difficulty of professionals in thinking/acting from an interdisciplinary and interprofessional perspective is evident, since they do not see interdisciplinarity as the sharing of responsibility and the exchange of ideas and points of view between professionals and disciplines with relation to each case, but rather as a division/segregation/fragmentation of their responsibilities.

For this reason, despite the professionals' statements bringing up the issue of dialogical interaction in the functioning of the team as one of the assumptions for achieving interdisciplinarity, there is still a gap between discourse and professional practice, even in the face of a legislative scenario that advocates action multidisciplinary and interdisciplinary rehabilitation of people with disabilities^{2,4,10,12}.

It can be seen from the reports of professional P7 (Chart 2), that despite referring to interdisciplinarity, he addresses aspects specific to multidisciplinary, as he highlights the presence of team members in case discussion meetings, but without the existence of an exchange of ideas that transform each discipline into contact with the others, to achieve a common path for each person served^{6,7,8}, just the division of tasks.

Other reports present this epistemological mistake between the concepts of multi and interdisciplinarity, such as those of professionals P5 and P12 (Chart 2). In them, it is observed that the conceptual mistake occurs in the use of the terms multidisciplinary and interdisciplinary not as different forms of relationship established between the members of a team, but rather distinct concepts are attributed to two possibilities of action in the interdisciplinary perspective: the discussion of cases and joint care⁶⁻⁹.

A study²³ in which two cases treated by a pair of therapists in joint care are reported, highlights that the interdisciplinary perspective must be based on the concept of common

therapist, defined as a degree of harmony, in which it is possible to achieve transdisciplinarity, in other words, joint care in itself is not enough to guarantee interdisciplinarity and transdisciplinarity in patient care, as these characteristics will be defined by the relationship established between professionals.

Transdisciplinarity is understood as the mode of working relationship in which professionals transcend their own disciplines, so that a new field of knowledge and practices emerges that is different from all the disciplines that make it up; that is, the resulting whole ends up becoming different from each of its parts and the mere sum of them^{6,7}.

This transdisciplinary perspective is present in the report of professional P4 (Chart 2), in which the breaking of the limits of practices established by the work centers in joint care situations is observed.

Also important is the concept of intersectorality mentioned in the Care Network for People with Disabilities⁵. It concerns the interaction between different services, whether education, health and assistance, aiming to offer comprehensive care to the patient^{18,28}.

This concept constitutes a key element for the reduction of what is called “social inequalities in health” (SIH) as it affects the health determinants of the population and can be configured, if implemented based on care management distributed among the different sectors, such as health, education and assistance, in a strategy to promote health and empower the community to deal with such determinants^{4,29}.

In the context of care for people with disabilities, this concept is understood, then, as the integration of sectors with a view to equipping the individual to deal with the inequalities imposed on them by the barriers already introduced, which will make them capable of fighting for their rights and those of their peers and, thus, participate in the continuous process of promoting inclusion^{2,4,5,29}.

It is understood here, however, that for the effectiveness of intersectorality, effective communication between sectors is necessary. To establish this communicative link and, consequently, the effectiveness of intersectoral work and comprehensiveness in patient care, the referral processes, referral of primary health care to a higher level of complexity and/or specialty, and counter-referral processes, return of the case to primary health care proves to be essential³⁰.

CONCLUSION

Interdisciplinarity was considered a fundamental step towards comprehensive and humanized care as recommended by current legislation. It is a real utopia and present in practices and discourses even with its countless challenges and this is highlighted here as a significant path for reflections regarding interdisciplinary work in the field of health and rehabilitation.

The challenges to interdisciplinary action highlighted were personal, group, structural and conceptual. Interdisciplinarity showed conceptual confusion as one of the main challenges for effective interdisciplinary work. In this way, the importance of continuing education actions is highlighted to facilitate the clarification of conceptual and practical doubts regarding the organization, construction and development of a team in an interdisciplinary way.

Although interdisciplinarity has been highlighted as essential for rehabilitation work, it cannot and should not be considered, in itself, as the solution to all health issues that arise, since it is illusory to imagine that this or that way teamwork is capable of always guaranteeing the best care for the individual assisted. This does not reduce the relevance of interdisciplinary work and, on the contrary, reinforces that, in addition to interdisciplinarity, an interprofessional and intersectoral perspective and action are necessary.

Reflection and discussion of intersectorality is necessary between the academic community and professionals in health, rehabilitation and other sectors. Therefore, the need for new research is emphasized that can propose solutions to face the challenges of interdisciplinarity in practice and studies that relate interprofessionalism and intersectorality to interdisciplinarity, highlighting their challenges and benefits.

As for the limitations of the study, there are those typical of a qualitative study, in which, in the case of interviews, there may be difficulties in expressing and communicating meanings in a clear and concise way. Also added is the impossibility of generalizations. However, it must be emphasized that studies with a qualitative approach tend to value the social phenomenon as it presents itself in reality, at the moment and in its context, which brings science countless provocations that give rise to other investigations, and this is what is expected to happen. The results of this study may generate.

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CONTRIBUTIONS

Ana Cláudia Fernandes collaborated in the design, collection and analysis of data, writing and revision. **Dolors Rodríguez-Martín** and **Rita de Cassia Ietto Montilha** contributed to the conception, writing and revision. **Pedro Henrique Silva Carvalho** participated in data collection and analysis, writing and revision.

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