The Physical Education professional and the intervention in multidisciplinary teams

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Summary: The objectives of this study were: (a) to assess the outlook of multidisciplinary teams view on the specific contribution made by the Physical Education professional (b) to identify how Physical Education professional carry out self-assessment when performing a multidisciplinary tasks (c) to ascertain the understanding of team members on issues necessary to support their intervention. The study comprised eight professionals. The semi-structured interview methodology was applied and content analysis was made based on a priori established categories. Under the investigation context, findings of interactions between the professionals were conflicting and competitive, subordinated to the dominant area (Medicine), where secondary professions in the Healthcare sector follow and hierarchy.

Keywords: Physical Education. Health care personnel. Legal liability. Conflict.

1 INTRODUCTION

Since the mid-‘70s, labor relations have undergone irreversible changes in different sectors due to various economic transformations. Of these sectors, there are professional groups that did not pass unscathed the flexible

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accumulation of capital, the changes in the means of production, the mergers between organizations, and especially the development of information technology. These aspects affect directly and/or indirectly: (a) the work relationship established between professionals of a particular area and other professionals, (b) the relationship between professionals and users of their services, and (c) the relationship between institutions that provide such services. In turn, these processes are complex and varied as they are related to the new demands of society, changing the manner how each group of professionals intervenes and where they intervene, changing their professional roles, and consequently, interprofessional relationships.

Given this scenario, it becomes more difficult for professional groups to maintain a clear picture of their users and clients(SCHEIN, KOMMERS, 1972). Nevertheless, the interplay between knowledge and professional actions are inevitable in daily work (SORIANO, 2003), i.e., in their attempt to solve an emergent situation, professionals appropriate a science or a technique from other areas of knowledge to give an opinion about the problem. In addition, it is clear that there are subdivisions and fragmentation of knowledge within a profession, which result from the development, accumulation and the specificity of academic disciplines (SCHEIN, KOMMERS, 1972), which often make up the syllabus of the initial academic education of various professional groups.

In this case, it should be taken into account that assessing the specialization of intervention of a given profession should be done in relation to another specialization, where the existence of a specialization is only confirmed if there is some kind of relationship established between both (FREIDSON, 2001). In other words, from the moment specific tasks performed by a professional group are identified, the emergence of another specialty is also identified, and the difference between the two emerge, where it becomes clear that each have different skills and distinct knowledge.

It is not any different in the case of Physical Education, as the increasing number of specializations makes it difficult to deal with important social and intervention issues, despite the different subdisciplines in the academic milieu, where each have specific associations, events and conferences, (RIKLI, 2006). That is,

> [...]knowledge produced in Physical Education met the needs of the mother of sciences (Anatomy, Physiology, and Psychology) and their respective subdisciplines (Biomechanics, Physiology Exercising, Motor Learning) (VERENGUER, 2004, p. 126),

rendering the investment and research on intervention ever scarcer. However these do not necessarily help to prepare professionals to deal with the issues under applied or pedagogical difficulties (BRESSAN, 1979). Given that many of the problems that society faces are very complex, it can be said that no profession alone can claim to solve them effectively.

Schein and Kommers (1972) argue that criticism of professional groups lies in the fact that under this context they have failed to both developing associations with other professional groups and preparing themselves for collaborative work with other professionals. However, professionals from different fields have come together to solve a given problem, thus filling the gaps in this process. This association of professionals called hereunder 'multidisciplinary teams' or 'teamwork' is the exchange between two or more fields of expertise attempting to overcome the fragmentation of knowledge. When experts from different professional groups exchange knowledge discussing a topic or solving a problem, they aim to improve the state of things (CAMACHO, 2002).

The characteristic of teamwork is that it fills gaps in the various aspects of human life: social, physical, psychological, and mental, to mention but a few (FREIDSON, 1998). Hence, teamwork leads to thinking of an ideal role model, e.g.

professionals exchanging knowledge to solve a particular case in a productive and defined manner. However, in practice this situation is not straightforward as it seems because the early intervention stage that involves experts from various areas is often isolated and competitive, evidencing the difficult interaction between different technical skills (SILVA 2002).

The health care sector is a field of intervention in which over a dozen professional categories operate (BOSI, 1996), such as Medicine, Physiotherapy, Nutrition, Psychology, Physical Education, Speech Therapy etc. However, within the same sector there may be a profession with a more consolidated knowledge base - technical autonomy - and with higher social status, which, consequently, will coordinate and monitor the actions (BOSI, 1996; FREIDSON, 1998). A hierarchy of power is, therefore, established, with implications for production control, type of training, selection of tasks and use of technical jargon. It is important to stress that the lower the inequality and the greater the flexibility in joint performances, the greater the interaction between the team (BOSI, 1996).

Thus, multidisciplinary health care teams express differences and inequalities between contiguous professions; professionals that work every day in this sector tend to reiterate the unequal relationship where they are subordinate to a dominant group in decision-making situations and processes (PEDUZZI, 2001; FREIDSON, 1998). Therefore, professional intervention in multidisciplinary teams points to the need to understand some aspects such as expertise and authority, flexibility in the proceedings and need for conflict management due to different professional cultures. Every profession gives a solution to a problem from a different perspective, which can be understood by construing communication as an intrinsic part of work that encompasses language, goals and common proposals (PEDUZZI, 2001; SCHEIN, KOMMERS, 1972).

Freidson (1998) outlines three key common denominators for professional groups to make an intervention, especially in a work team (which is hierarchized), where the frontiers of knowledge and professional actions intertwine daily: a) expertise; b) autonomy, and c) credentialism. According to this author, expertise represents knowledge with esoteric characteristics, or "accessible to few." Autonomy represents the judgment that the professional makes of his/her own actions and decisions. And credentialism represents the organization that regulates and legalizes a job, protecting the *expertise*.

Therefore, considering the complexity that guides multidisciplinary teams, the main characteristic of which is the intervention composed of several types of expertise to try to solve a particular case, the following issue was identified hereunder: how does a multidisciplinary healthcare team perceive the Physical Education professional? Guidelines for the study were: a)to verify the outlook of the multidisciplinary team on the specific contributions made by the Physical Education professional; b) to identify how Physical Education professionals carry out self-assessment when performing a multidisciplinary task and c) to ascertain the understanding of team members on issues necessary to support their intervention, e.g. specialized knowledge (expertise), professional autonomy (independence in the actions) and credentialism (regulatory mechanism).

2 METHODOLOGY

In order to expand the understanding of Physical Education field of knowledge and intervention, it is essential to apply different types of research. In this case, the qualitative research approach to the study was preferred because it allows understanding the uniqueness and context of facts and events. Based on Denzin and Lincoln (2005), emphasis was placed on quality of entities, processes and meanings to be elucidated.

These authors provide the basis of the argumentation here under as they ensure that the subject matter of the study would be measured or experimentally analyzed focused on what actually occurs in the field, including the assessment of the presence of the researcher as well as their approaches that could leave out the analysis and reporting of the characteristics of socially constructed reality.

Field work was based on the studies by André (1995) and Denzin and Lincoln (2005) to understand the operating scenario of a multidisciplinary team, as well as the insertion process of Physical Education professionals. Team selection was intentional, taking into account their essentiality for the investigator (HAMMERSLEY; ATKISON, 1996; TRIVIÑOS, 1987).

The group under this study comprised professionals from the Health sector that work in a multidisciplinary clinic of a city in the north of the State of Paraná. The determining condition for selecting this clinic was the presence of a Physical Education professional as a member of the multidisciplinary team. The clinic stands out for the design/implementation of physical fitness programs that address individuals with problems, e.g. obesity, hypertension, diabetes, individuals with disabilities and post-surgery rehab, to mention but a few. Furthermore, at the time of the study the clinic had twenty one professionals, namely: Physicians, Physical Therapists, Education Psychologists, Pedagogues, Physical Education professionals, Psychologists, Nutritionists and Speech Therapists. Eight professionals agreed to take part in the study, of which two physicians, two physiotherapists, two Physical Education professionals, one nutritionist and one psychologist that were members of the team. It should be noted that professionals that joined the study were duly informed of the purpose of the study. They confirmed their acceptance by signing a term of agreement that is adopted by the Research Ethics Committee of the State University of Londrina.

In order to protect the identity of the interviewees hereunder they are identified by the first letter that corresponds to the name of each professional group, where "PE" is for the two Physical Education professionals; "M" is for the two physicians (Medicine); "PT" for the two Physiotherapists; "P" for the Psychologist; and "N" for the Nutritionist.

Information was obtained via semi-structured interviews based on a predetermined script, where the interviewer was able to add questions when it was necessary to obtain further clarification (LAVILLE; DIONNE, 1999). The script of questions was based on the main theme associated with the theoretical-methodological reference under study. The predetermined subject matter was: Multidisciplinary work in Health.

Data collection (interviews) was carried out with a Panasonic mini recorder and micro cassette tapes. After the interviewing phase was concluded and recorded the interviews were transcribed in full without any editing. Data was treated according to the characteristics of the content analysis, which "appears as a set of communication analysis techniques, using systematic and objective procedures to describe message content" (BARDIN, 2004,p. 33). This type of analysis was preferred as it enables extracting from a text or transcription the meanings and representations that are present or absent in the interviewees statements.

This data analysis technique is characterized by establishing themes and categories, where both are strategies used to map data and facilitate their correlation and understanding. Under this study, the categories applied for future correlation with the major theme "Multidisciplinary work in Health" were predetermined. Categories were determined before data collection in order to establish the investigation path and to prevent deviating from the objectives. Categories arose from identifying three denominators that were considered essential in team work, to which Freidson (1998) refers as elements that characterize

professional teams. Predetermined categories were: 1) Expertise; 2) Credentialism; and 3) Autonomy.

3 DATA PRESENTATION, ANALYSIS AND DISCUSSION

3.1 Perspectives of the multidisciplinary team on the contribution made by physical education professionals

Information obtained from most interviews showed that the intervention of the Physical Education professional is classified under the Health sector. However, they were unable to identify precisely which were the professional skills performed exclusively by this group. The lack of clarity on the specific contribution of Physical Education professional can be attributed to how other professional categories perceive this area. In other words, although Physical Education professionals are considered Health professionals "because they have specific technical training to carry out activities closely related to Health-related activities" (MÉDICI *et al.* 1985, p. 97, *apud* BOSI, 1996), other professions could not stress their peculiarities: "[...] first and foremost, the Physical Education professional needs to focus on the person's health" (N) and "[...] when I think of a Physical Education professional I think about someone who works in the Health field" (P).

In relation to this issue, some of the interviewees were able to add meaning to the work carried out by Physical Education professionals, granting to this group of professionals the responsibility of curing injuries (ongoing treatment), monitoring students of physical activity programs, and in relation to weight-loss and fitness activities:

> I, for example will only work out at the gym with a personal trainer; it makes a big difference compared to when I used to do it on my own and did what I thought was right (M).He deals both with the appearance, like losing weight, and strengthening, ongoing

> rehab (PT).He's important in helping people to recover from articular injuries or the elderly, right; people that are ill for example, constructive or degenerative, or even to stay fit, to teach how to work out and stretch out the right way. I think it's important, and they have their own niche; it's just a matter of filling it, right? (M).

This statement shows that the physician has distinct opinions in relation to the specificities of the Physical Education professional. At first he states that the Physical Education professional is responsible for taking care of "people that are ill", and later he mentions that the Physical Education professional performs tasks related to helping people to "stay fit, to teach how to work out and stretch out the right way". This aspect denotes some misunderstanding in relation to the expected role of the Physical Education professional, where he or she is responsible for the following functions: a) to recover the health of ill people, where this task is inherent to their own field of intervention; b) to preserve physical fitness via doing the right workout.

It was also observed that the closing statement "they have their own niche; it's just a matter of filling it" the physician assumes the prerogative of limiting and evaluating the field of intervention of Physical Education. In other words, this case is an example of how a dominant field holds monopoly over the Health sector, assigning and assessing the tasks that should be performed by other professions (BOSI, 1996), and claiming specific tasks related to the Health sector (BOSI, 1996; FREIDSON, 1998, 2001;SORIANO, 2003).

Furthermore, the interviewees also denoted that Physical Education professionals were subject to the rulings of other professions. That is, there was always a professional from another filed, in this case a physician that dictated how the profession was to be exercised: "The O physician gives the diagnostics, the patient treats and the Physical Education professional continues this work for an extended period of time thereon" (PT).

In order to clarify the subordination to which Physical Education professionals are subject and to explain the monopoly of Medicine, we believe it is pertinent to present, however summarized under this study, how team work in the medical field takes place. Hence, it must be made clear that multidisciplinary work in the field of Health encompasses a series of technical specialties hierarchically determined, where different types of expertise are classified according to the rate of importance when the work at hand is allocated (FREIDSON, 2001). Given that the field of Medicine is more consolidated, its technical knowledge is stronger (BOSI,1996; FREIDSON, 1998) and socially accepted (health – illness) it ends up ruling, in the field of Health (FREIDSON, 1998) and leads actions in that field, as shown in the above statements.

Hence, we agree with Freidson's (1998) statements, that Health related professions are divided into two groups: a) the first one pertaining just to the field of Medicine and b) the second to other professional groups that support this field. Under this study, the latter professional groups are: Physical Education, Physiotherapy, Nutrition and Psychology, which are hereunder called contiguous or secondary professions to the field of Health.

We believe that the insertion of the Physical Education professional into the multidisciplinary work carried out on Health (investigated clinic)may have led the interviewees to this type of association. According to Casali *et al.* (1997), people identify themselves based on the relationship they establish with their peers. If relationships are established within the multidisciplinary context of the Health sector, results obtained from the abovementioned interviews denote a possible explanation for "Physical Education and Health" association. However, the statements were considered vague and superficial, where the clarity about the participation and importance of Physical Education professionals in Health sector teamwork is questionable. In turn, this association can be construed as a justification of the role played by the Physical Education professional in society (BECHER, 1996),

as their role was not identified in an accurate, clear and objective manner, denoting the absence of professional identity of that trade.

3.2 How physical education professionals carry out self-assessment of a multidisciplinary task

Many studies have attempted to establish the academic-scientific identity of the Physical Education professional (BRESSAN, 1979;RENSON, 1989; GIBBONS; BRESSAN, 1991; LIMA, 1994;VERENGUER, 1997; LAWSON, 1999; MASSA, 2002; REIS, 2002;LOLAND, 2006; RIKLI, 2006). However, the focus hereof is not to discuss this situation in further detail, but it is mandatory to clarify the difficulty in finding the identity of this field ensuing from a cultural-social and historical process that was conducive to the lack of clarity of Physical Education's social responsibility. This was evidenced by interviews of other professional groups that discern the specificity of the field.

Furthermore, Physical Education professionals also identified themselves as actors in the Health sector and were unable to clearly describe and identify their specific functions in theteam work, nor to describe their professional importance in society. Just the opposite – they merely reiterated what we expected to find: the association with the Health sector to thus justify its existence, (BECHER, 1996; BOSI, 1996; SORIANO, 2003): "I'm from Health [...] and Health is life quality" (PE).

Verenguer (2004, p. 128) shows his concern with the lack of identity and reports that the uniqueness of Physical Education professionals lies in:

> [...] diagnosing and identifying the needs, potential, possibilities and wishes of people in any age bracket in relation to motor behavior; selecting content, planning and giving strategic guidance to activities that meet the established needs, assessing the implementation of programs and redesigning

> when required. Fundamentally, and base on academic knowledge, knowing how to justify choices, decisions, behavior and actions in the professional's day-by-day.

Notwithstanding, Physical Education professionals failed to specify their functions and extended the scope of their work, i.e. also took responsibility for social wellness during their professional intervention:

> And we're really important because when we prescribe a workout to the student or a strengthening exercise we're not doing only that. We're playing with him or her, and then we're improving the system... And improving the social aspect... Then, we end up working with these three aspects much more than any other professional of the field of Health. (PE)

Furthermore, in many instances it was impossible to identify "to whom" the service is rendered and "how" their professional performance is important, as their activity is also oriented toward healing pathologies, where once again the focus of their intervention is shifted:

> [...] we can help you know, in the case of posture too at the fitness center we can work on the posture really well. I believe that 90% of all people have posture issues. (PE)

Then why do other professional groups relate Physical Education to Health? And why do even Physical Education professionals acknowledge themselves as professionals that intervene in this sector? When this study refers to professionals in the "Health" sector, Medicine is the leader and holds a privileged position, where credibility and acceptance have a higher rating by society due to the interest and concern of its study matter and intervention – "health and illness" (FREIDSON,1998). Hence, this proximity to the Health sector can be explained:

> The closer contiguous occupations are to the predominant occupations of a reasonably

> organized sector, the greater its control in ordering and organizing tasks. For example, this is what occurs with Physical Education identified with the field of Health, where the most hierarchically privileged team, in this case Medicine, will forcibly lead the sector's co-actors (SORIANO, 2003, p. 217).

The association of the Physical Education professional to the Health sector, as reported by those professional and members of other teams can be construed as a justification for their role in society and even in team work. In his summary, Bosi (1996) explains that professions contiguous to the Health fail to convince society of the complexity of their professional opinions, where there is also doubt about what the actual contribution of those professionals is. At the same time, once again it shows that this could be a survival strategy in society (BECHER, 1996; SORIANO, 2003) and the survival of the field of occupation.

3.3 Denominators: expertise, professional autonomy and credentialism

Data analysis of each category was carried out based on the acknowledgement of importance of the three essential and common denominators to each professional group, mainly under the scope of multidisciplinary teams: expertise, credentialism and autonomy (FREIDSON, 1998).

3.3.1 Expertise – expert knowledge

"Is expertise necessary?" (FREIDSON, 1998, p. 200). This is the question posed by the author in relation to expert knowledge: the importance of the professional to carry out "[...] professional work rather than amateur work". In other words, when Freidson (1998) refers to the difference between laymen knowledge and esoteric knowledge, he mentions "exclusiveness" to perform certain tasks and actions. Furthermore, he believes that expertise can only be acquired after intensive training, e.g. graduate courses.

Verenguer (2004) points out that Physical Education is probably one of the few fields that enable individuals that have not undergone intensive training, e.g. graduate courses to render services to society. This statement can be easily verified. How many former athletes are there who never went to college and yet are responsible for teaching children?

Hence, interviewees show incoherence when giving their opinion about the above theoretical findings. When the professionals were asked about specific knowledge and skills related to their field of intervention, they revealed a measure of insecurity and inaccurateness related to their particularities within the group as a whole:

> [...] I work more in the Orthopedics so I usually work with a larger number of patients with posture issues that are having foot pain, so I focus on that. So, I'm complementing the treatment, right? (PT)
>
> [...] because actually what happens is that we're available, and if your patient needs assistance, needs to see a psychologist and makes an appointment with me. So, of course that I can say that my purpose is to facilitate emotional wellness, but it's complicated to give you a list, right? (P)
>
> [...] working with muscle strengthening, right...And with stretching out to prepare the person's muscle tone. Hence the recommendation for aerobics, that we do on the treadmill, the bicycle (PE)

Statements made by the Physical Education professional show a slight orientation in their professional practice: in selecting and planning their activities (VERENGUER, 2004), i.e. muscle strengthening, aerobics and stretching out, respectively. However, due to the uncertainty professed by most of the professional it was observed that a same task was performed at the clinic by different professional groups:

> Fitness center: personal trainers, physical assessment, folds, circumferences,

> anthropometry and monitoring at the fitness center. (PE)
>
> I do the physical assessment, nutrition assessment, put the diet together and monitor the individual. I check the exams he or she brings me to see if they're normal, and when I see any change I send the individual to the physician. But basically that's it. (N)

Thus, the Physical Education professional and the nutritionist perform the same activity in a clinic (physical assessment). Furthermore, the following statements show once again that tasks performed by the nutritionist and the physician overlap (exam reading): "I see the patients, which is the purpose of the practice, isn't it? Seeing patients, talking to them about exam results and the treatment, guiding and referring them to a professional from another field when necessary" (M).

Who is responsible for the so-called common task to different professional groups? One of the interviewees mentioned that "knowledge does not belong to any person" (M). In this sense, Bosi (1996) purports that what determines the monopoly of specific actions within any given field of knowledge of a sector is the control over given scope of knowledge. Consequently, if a profession does not exert dominance or demarcation over this sphere of knowledge it will be at the mercy of other professions (SORIANO, 2003). Notwithstanding, the unrest raised by Bento (*apud* VERENGUER, 2004, p. 128) should be taken into account, namely: "[...] profession and the particular nature of functions and tasks are mutually implied. A profession is not established based on the scope, generality and lack of delimitation of its tasks, but rather on the importance and relevance of the particular aspects of its tasks."

However, it is easy to identify the "Health" professional that take over the expertise of other contiguous professions within the sector in order to perform their work. Becher (1996) reports that this type of appropriation is used to ensure the

sector's survival, where there are different contiguous professions fighting for their niche in a given sector, in this case Health.

Soriano (2003, p. 209) points out that overlapping knowledge and actions carried out by different professionals are unavoidable in the professional day-by-day. However, the author adds that it is very difficult to prevent the appropriation of knowledge, equipment and procedures from other fields. When appropriation takes place, the field that wishes to use such knowledge of procedures created by the contiguous knowledge should do it accordingly, i.e. "having the required skill to identify, understand and learn the codes, definitions and concepts, and only then literally consume whatever was created".

Hence, it is possible to conclude that the expertise detained by professional groups of the Health sector is not as specific (specialized) as believed. This fact can be explained by the advance in technology that enabled the dissemination and appropriation of more and more varied information that in the past used to be detained only by the more hierarchically dominant profession. However, nowadays there are more databanks, magazines and other media available that increase the possibility of professional groups to access different types of knowledge, technology and tools from different fields. This way they can incorporate these aspects to their own interventions (SORIANO, 2003).

Using this combination of techniques and instruments that occur far and free of legal and/or judicial obstruction of the professions is related to a type of knowledge different from formal knowledge, which is called by Freidson (2001, p. 31) "practical knowledge". This author defines it as "[...] knowledge largely exempt of formal concepts and theories, learned from experience and becoming instrumental to perform concrete tasks in concrete scenarios". Thus, it can be inferred that knowledge detained by contiguous professions of the Health sector has an instrumental nature (practical), i.e.

represented by a low-complexity body of knowledge that is charted by hands-on learning and development at the workplace (SCRIBNER, 1986 *apud* FREIDSON, 2001),where the mere repetition results in performing the task without necessarily requiring knowledge acquired after training, as observed in the aforementioned statements.

3.3.2 Professional autonomy (independence to decide)

Professional autonomy is the execution of actions or tasks by the professional, where he or she determines what will be done and how it will be done. That is, they emphasize the free-will that is part of their profession, where their performance is subject to their own judgment and responsibility (FREIDSON, 1998). We agree with the statements made by Freidson (1998) and Verenguer (2003) that professional autonomy represents sufficient authority over a task, whereby the professional has the freedom to perform a casual action as if it were normal, regardless of the institution where the activity takes place and its intention. This author further supports that over time professionals were able to impose to their consumers or clients their own concept of what is necessary for a given segment.

As mentioned above, Medicine has a privileged position in the Health sector, which can be easily confirmed: the legal authority detained by Medicine to diagnose and prescribe treatment based on the principle of autonomy ensures this profession the control over "division of labor, its content and technical evaluation" (MISOCZKI, 2005, p. 9).

By studying the interviews it was possible to infer that where teamwork is involved in the secondary professions in the Health sector they accept their condition of submission to the dominant sector, as if the hierarchy established by the Health sector were natural and immovable, where they are subject to the approval of other professionals, typically the physician that is responsible for diagnosing illness: "Sometimes my colleagues (referring to other professionals at

the clinic) will address the treatment to confirm if it is in agreement with the pathology" (PT).

Technical autonomy in Medicine has been notorious throughout the years, and at the clinic under study professionals also feel this supremacy in teamwork in the Health sector. It is possible to infer that contiguous professions at the clinic under study feel their autonomy threatened and questioned when they establish professional interaction with the sector's leaders in relation to discussing patients under a multidisciplinary context. In other words, expertise detained by these professions is put aside in detriment to medical superiority that determines what should be done and how it should be done, detracting authority from other professions in teamwork decision-making process: "But we still have problems with physicians that keep us at arms-length, you know? The big-boss" (PE); and "[...] When physicians go to medical school they think they're God; when they graduate, they're" (N).

The hegemony of physicians described by other professionals is also found in the dissertation by Granada (2004). He reports that nutritionists and psychologists feel a strong resistance from physicians in the decision-making process, where they underestimate the professional initiative of the two former groups of professionals. Bosi (1996) and Freidson (1998) point out that this situation occurs because in the Health sector the act of "diagnosing and prescribing" is what confers the greatest status and autonomy to the profession that performs both, in this case Medicine. Hence, the quasi-inexistent autonomy of contiguous professions becomes even more evident in face of the action performed by a small group of professionals.

The autonomy of Medicine described by the interviewees can be compared to what Freidson (2001) calls moral authority: norms established to determine and impose a certain type of behavior or ideology upon the professional's knowledge (FREIDSON, 1998). This author considers

knowledge ideology as an aspect associated with the requests and claims made by certain professional groups that fight for their own interests and try to control how an issue can be solved and conducted. In other words, such requests and claims refer to the competition between professions that wish to detain certain knowledge and competences.

Thus, in the Health sector it is "very difficult to identify cases where the physician's work is carried out under the technical command of another professional" (BOSI, 1996, p. 98). Quite the contrary – they are the ones who determine what needs to be done and how it should be done. This statement corroborates the following affirmation: "The physician gives the diagnostics, the patient seeks treatment and the Physical Education professional continues this task." (PT).

Thus, it is possible to pose some issues to be pondered: How much freedom contiguous professions have in order to do their job? What influences the lack of autonomy in teamwork? Studying the answers given by interviewees it was possible to identify the rivalry and implicit ongoing competition even between contiguous professions. Since they belong to the group of secondary professions of the Health sector, professionals are always striving to prove their technical autonomy. Furthermore, it should be noted that the professionals establish routine interventions with the other three groups in order to obtain their legitimate technical autonomy (GOMES; OLIVEIRA, 2005). The first is with the Health team itself, seeking mutual respect and reliability for their specific competences from the team. The second is with users, to solve their problems and thus show how important and useful they are for the team. The third is with the institution, seeking professional performance in a rational and efficient team that yields solutions and financial return.

The low level of autonomy of Physical Education can also be noted in relation to other professions, suggesting a reality under which those professionals always depend on someone or something showing what should be done

(VERENGUER, 2003), or yet, always associated with other areas to justify and complement the sector's actions.

> [...] we, the Physical Education professionals, play a very important role in rehabilitation, similar to physiotherapists and the physicians. We work shoulder-to-shoulder with them and in the end we're the ones in the team closer to them and that help them the most. (PE)

> [...] he/she [referring to the student] goes jogging or walking according to what we recommend. If it's a race they need good articulation, especially of the feet, that needs to be really good. So to me the physiotherapist is very important. The physician is also super important because they're responsible for the cardiovascular assessment; so you check the VO2 with them, with the MET you're going to work on, you have the prescription practically ready, and the psychologist is very important, even to change the behavior. (PE)

Hence, by observing the scenario under study it is possible to infer that the best-structured group in the Health sector (Medicine) exerts dominance over the other less structures groups, i.e. the secondary professions: Physiotherapy, Nutrition, Psychology and Physical Education. This dominance, in turn, is represented by a body of technical knowledge with greater support and social prestige, which holds a greater control over the decision-making process of these professions – autonomy; Becher (1996)affirms that when the discourse of the dominant group is adopt, which detains greater social status, there is a strategic possibility of the sector's survival. The relationship of subordination described for the professions of the Health sector found in references and proven by the study is shown in Figure 1. The category of Medicine (dominant group) holds sway over other professional groups in teamwork (dominated groups) and society.

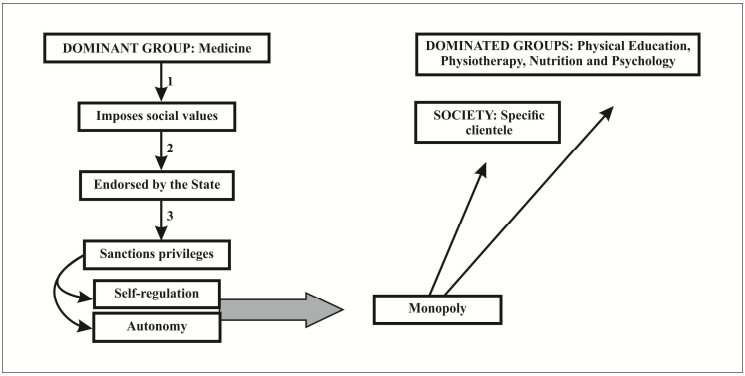

Figure 1. Implementation process of the Professional Monopoly in the field of Health, based on Freidson (1998).

Hence, with society acknowledging the importance of physicians and the endorsement by the State (2), this professional group gets stronger. In this manner the State legitimizes the professions and sanctions privileges (3), where professionals have the freedom to regulate their profession – credentialism (4). In that they "are the owners of their business", physicians acquire a certain measure of Independence in their actions and perform their activities that are submitted to the professional evaluation of their peers.

According to this perspective Medicine plays the role of spokesperson of the Health professions, where it holds the monopoly (5) of a field of knowledge that can hierarchize other professions of the sector (6), also taking over a specific society clientele.

3.3.3 Credentialism (regulating mechanisms)

Expert knowledge – expertise – must be protected and institutionalized, and accrediting agencies in general are responsible for the institutionalization. Professional certification granted by these agencies enables selecting professional from society, setting them apart from the

layperson. Hence, the nature of these entities is discriminatory (FREIDSON, 1998; VERENGUER, 2004).

This study and the context under which it was carried out do not propose to verify if these agencies are doing their job or not. However, parallel to this subject matter, our objective was to identify in the multidisciplinary clinic under study how professional groups of Health sector dealt with different types of knowledge – expertise – in face of their professional exercise. In other words, how they managed and used the knowledge, techniques and instruments overlapping in the different professional groups in the clinic. It is important to note that expertise represents a certain measure of power over a given territory, which increases the strength of a category in delimiting not only its own fields of competence, but also those of its competition (BOSI, 1996; FREIDSON, 1998, 2001). Hence, evaluating the expertise of a given intervention should be done by comparing it to another field of expertise, as the former can only be verified in relation to the latter (FREIDSON, 2001).

Relevant information obtained from the interviews about the relationship between knowledge (expertise) and professional performance established with both show that "We can discuss something about metabolism, how it works, but it's just giving some help, one is not interfering with the other's job." (N) and "Nobody owns knowledge, right? Sometimes one field of expertise can overlap with the other, right?" (M).

Both of the above statements show that professionals perceive clearly how knowledge overlaps in their professional daily lives. However, it was possible to identify two distinctive lines of thought related to the overlapping: the nutritionist explains that using knowledge from other fields helps the job, but that there is no intention of taking over knowledge from contiguous fields to subsidize their intervention. The physician on the other hand makes it clear that although there are different types of expertise knowledge is not owned by

anyone, inferring that he would have no qualms of appropriating knowledge from other fields in order to further his interventions.

There is a statement that stands out: “It depends a lot on the patient you’re seeing, understand? Sometimes the professional can’t solve the patient’s problem so he trespasses into another field of expertise and makes a big mistake.” (M).

The physician reported that in some cases there could be negative consequences for the patient when knowledge from other fields is appropriated. In other words, when he mentioned that “he trespasses into another field of expertise and makes a big mistake” he brings to light the issue of malpractice that could occur if the professional misuses techniques and instruments from contiguous fields. It should be noted that there are practically no students in the field of Physical Education investigating the evaluation of malpractice, where most studies (MARTIN, 1994; GOMES; FRANÇA, 1999) are the field of Medicine. This appropriation of knowledge was reported by a professional as a problem for him, unlike other professionals that did not take the same responsibility: “I find it very difficult because I trespass into their field quite a lot (referring to the other professionals in the clinic), and they do it a lot less frequently.” (PE).

Hence, this statement is concurrent with Bosi (1996)and Soriano (2003) that affirm: low complexity knowledge and little expertise require the appropriation of other types of knowledge to justify their professional performance and to ensure the survival (BECHER, 1996). According to Abbott (1988), professions are part of an independent system where each profession has its activities controlled by different laws. That is, in multidisciplinary work of the Health sector each professional category is subject to an agency that legalizes and “protects” their expertise; however, in practical terms the delimitation is not as clear as we believe due to the constant overlapping of different types of knowledge: “[...] so-and-so is a physiotherapist that works with pregnant women in pool

workout. Then she says" I need to go out, so forth and so on – could you cover for me?" (PE).

As can be observed, based on overlapping tasks it is unavoidable that different types of knowledge and professional routine activities would also overlap especially in teamwork (SORIANO, 2003): "When I started working at the hospital every nurse was a psychologist, every nurse assistant was a speech therapist, you know? So I believe that the professional needs to gradually build his or her niche in their filed, right?" (PT).

One of the strategies used by a professional group to justify their importance is to become closer to the dominant professional group and become associated to it, even if indirectly:

> There were countless times at the hospital when I wasn't attending a given patient and the physician would sit with me and would say," what do you think?" It wasn't my patient, but just talking about the patient's problem and everything, I would listen and give him some tips. (N)

This scenario reflects how difficult it was to define what is unique in the professional intervention (VERENGUER, 2004) of each profession and the difficulty of accrediting agencies to facilitate a qualified professional to be selected by society (FREIDSON, 1998).

4 FINAL CONSIDERATIONS

When the purpose of this study was defined a) to verify what was the perspective of a given multidisciplinary team about the specific contribution made by the Physical Education professional; b) to identify how Physical Education professionals do self-assessment for multidisciplinary work; and c) to verify how team members perceive the required aspects to subsidize their intervention we identified the

complexity of professional interaction due to the subordination to the dominant area (Medicine) and the hierarchy of secondary professions of the Health sector.

The type of study used (qualitative) enabled taking a closer look at the investigated groups, collection methodology (semi-structured interview) and data analysis (content analysis)were conducive to filling in some of the gaps in existing reference. However, we believe that other studies should be carried out within the multidisciplinary context in order to address elements that remained "obscure" under this study.

Studying the dynamics of work relations between Physical Education professional and different professional groups of the Health sector was challenging and unequivocal in face of the roles of each and by the eminence of development of public policies toward this direction. Theoretically, the purpose of teamwork is to fill in the gaps of existing knowledge of different fields in order to solve a given problem. However, under the studied context professional interaction has a conflicting and competitive nature among secondary professions in the Health sector compared to the dominant field, Medicine.

The three denominators proposed by Freidson (1998) and shared by the professional groups under study –expertise, credentialism and autonomy – are important indicators of trying to consolidate a profession and that should be taken into account in teamwork: as expertise represents the delimitation of knowledge detained by a professional group that is characterized as the detainer of a certain field of expertise; credentialism because it institutionalizes and "monitors" such knowledge; and autonomy that stands for the free will of making decisions in response to the demands posed by society and other professions as well.

This study brings to light some aspects related to how members of a multidisciplinary team work and their perspective in relation to the participation of Physical

Education professionals. However, we recommend that other studies be endeavored where the researchers would spend more time carrying out in-field work, such as ethnographic research, to find out how professional interaction actually takes place in teamwork.

O profissional de Educação Física e a intervenção em equipes multiprofissionais

Resumo: Tivemos como objetivos: (a) verificar qual a perspectiva da equipe multiprofissional sobre a contribuição específica do profissional de Educação Física; (b) identificar como os profissionais de Educação Física se autoavaliam junto à realização de um trabalho multiprofissional; e (c) averiguar a compreensão dos membros da equipe sobre aspectos necessários para subsidiar sua intervenção. O estudo foi composto por oito profissionais. Utilizamos a entrevista semiestruturada e a análise de conteúdo com categorias estabelecidas *a priori*. No contexto investigado as interações profissionais se apresentaram conflituosas e concorrentes, havendo a subordinação à área dominante (medicina) e hierarquização das profissões secundárias no setor da saúde.

Palavras-chave: Educação Física. Pessoal de saúde. Responsabilidade legal. Conflito.

El profesional de la Educación Física y La intervención en los equipos multiprofesionales

Resumén: Considerando que, junto con varios equipos profesionales, la intervención consiste en varios tipos de conocimientos especializados para resolver un tema específico, nuestros propósitos fueron: (a) verificar cuál la perspectiva del equipo multiprofesional acerca de la contribución específica del profesional del Educación Física; (b) identificar la auto-evaluación de los profesionales de la Educación Física junto a La realización del trabajo multi-profesional; y (c) comprobar el entendimiento de los miembros del equipo sobre los aspectos necesarios para subsidiar su intervención. El estudio fue realizado con ocho profesionales. Se utilizo la entrevista semi-estructurada y el análisis de contenido con las categorías establecidas *a priori*. En el contexto investigado las interacciones profesionales son conflictivos y competitivas, con la subordinación a La zona dominante (medicina), así como la jerarquización de las profisiones secundarias en el sector de la salud.

Palabras clave: Educación Física. Personal de salud. Responsabilidad legal.Conflicto.

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