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Interprofessional care and the relationship between nurses and physicians in the hospital setting: nurses' perceptions

Cuidado interprofissional e a relação entre enfermeiros e médicos no ambiente hospitalar: percepção de enfermeiros

Atención interprofesional y la relación entre enfermeras y médicos en el ámbito hospitalario: percepciones de las enfermeras

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ABSTRACT

Objective: To describe, from the nurses' perspective, the teamwork model and the interprofessional relationships established between nurses and physicians in healthcare in the medical and surgical ward of a public hospital in the Central-West Region of Brazil.

Method: A qualitative, descriptive study that used the case study method. The research was conducted between July 2024 and April 2025 in the medical and surgical ward of a public hospital. 140 instruments were applied to characterize the nurses' profile, 75 medical records were analyzed, 20 non-participant observation sessions were conducted, and 10 semi-structured interviews were carried out with nursing assistants. Thematic content analysis and data triangulation techniques were used.

Results: It was found that there is a devaluation of interprofessional care, low interaction between physicians and nurses from the perspective of patient care, in addition to the significant occurrence of conflicting relationships, affecting teamwork. Furthermore, despite the nurses' efforts to promote teamwork, the physicians continued the trend of monopolizing therapeutic decisions.
Final considerations: in the nurses' perception, collaborative practices were limited due to the existence of an organizational culture that normalizes the hierarchy and overlapping of knowledge and practices between physicians and nurses.
Descriptors: Physician-Nurse Relationships; Unified Health System; Hospitals; Professional Practice.

RESUMO

Objetivo: descrever, a partir da percepção dos enfermeiros, o modelo de trabalho em equipe e as relações interprofissionais estabelecidas entre enfermeiros e médicos no cuidado em saúde no setor de clínica médica e cirúrgica de um hospital público da Região Centro-Oeste do Brasil.
Método: estudo qualitativo, descritivo que utilizou o método estudo de caso. A pesquisa foi desenvolvida entre julho de 2024 e abril de 2025, no setor de clínica médica e cirúrgica de um hospital público. Foram aplicados 140 instrumentos de caracterização do perfil dos enfermeiros, analisados 75 prontuários, 20 sessões de observação não-participante e 10 entrevistas semiestruturadas com enfermeiros assistenciais. Utilizou-se a técnica de análise de conteúdo do tipo temática e a triangulação de dados.
Resultados: constatou-se que há desvalorização do cuidado interprofissional, baixa interação entre médicos e enfermeiros na perspectiva do cuidado ao paciente, além da ocorrência expressiva de relações conflituosas, afetando o trabalho em equipe. Ademais, em que pese os esforços dos enfermeiros para promover o trabalho em equipe, os médicos seguiram a tendência de monopolizar as decisões terapêuticas.
Considerações finais: na percepção dos enfermeiros, as práticas colaborativas foram limitadas em razão da existência de cultura organizacional que normatiza a hierarquização e sobreposição de saberes e práticas entre médicos e enfermeiros.
Descritores: Relações Médico-Enfermeiro; Sistema Único de Saúde; Hospitais; Prática Profissional.

RESUMEN

Objetivo: Describir, desde la perspectiva de las enfermeras, el modelo de trabajo en equipo y las relaciones interprofesionales establecidas entre enfermeras y médicos en la atención médica en el servicio médico-quirúrgico de un hospital público de la región Centro-Oeste de Brasil.
Método: Estudio cualitativo descriptivo con estudio de caso. La investigación se llevó a cabo entre julio de 2024 y abril de 2025 en el servicio médico-quirúrgico de un hospital público. Se aplicaron 140 instrumentos para caracterizar el perfil de las enfermeras, se analizaron 75 historias clínicas, se realizaron 20 sesiones de observación no participante y se realizaron 10 entrevistas semiestructuradas con auxiliares de enfermería. Se utilizaron técnicas de análisis de contenido temático y triangulación de datos.
Resultados: Se encontró una devaluación de la atención interprofesional, una baja interacción entre médicos y enfermeras desde la perspectiva de la atención al paciente, además de la significativa incidencia de relaciones conflictivas, lo que afecta el trabajo en equipo. Además, a pesar de los esfuerzos de las enfermeras por promover el trabajo en equipo, los médicos continuaron monopolizando las decisiones terapéuticas.

Consideraciones finales: En la percepción de las enfermeras, las prácticas colaborativas eran limitadas debido a la existencia de una cultura organizacional que normaliza la jerarquía y la superposición de conocimientos y prácticas entre médicos y enfermeras.
Descriptores: Relaciones médico-enfermera; Sistema Único de Salud; Hospitales; Práctica Profesional.

INTRODUCTION

Interprofessionality within the Unified Health System (SUS) represents an important milestone for improving care and emerges from a construction whose perspective aims to address health needs through collaborative practices in order to promote health, prevent diseases and rehabilitate people. As an expression of collective work in the health field, knowledge and practices, which are currently fragmented, must be recomposed, constituting a determining factor in the comprehensiveness of health care[1].

The way work is organized in health and its complex nature reinforces the need for the coordination of professional practices, since professional knowledge is segmented and specialized. The prevailing care model tends to meet social needs, however, but in a fragmented way. It reflects the form of work organization in society, which is especially expressed through the influences imposed by the social division of labor[2].

Regarding healthcare work in Brazil, it has been presented as a complex and dynamic challenge, considering the influences of social and economic aspects and the epidemiological profile of society, increasingly demanding care models that follow the trend of integrating practices. However, it is known that professions consist of a specific body of knowledge in a particular area of the field of knowledge; in this regard, their way of looking at the object involves the logic of especially meeting the needs of users within their scope of action and their technical and legal competence. These conditions reinforce that the lack of integration of knowledge implies the inefficiency of comprehensive care for the individuals[2-4].

Interprofessional care has been conceptualized as a work model that aims at integration and reciprocity between different professions, through the exchange of instruments, techniques and work methods. The article produced in Brazil[4] analyzed the work process in health and typified teamwork, highlighting the existence of two modes of collective work: the integration team and the grouping team. In the case of the first, the work is coordinated and there is interaction between the agents, while in the second, there is juxtaposition and

grouping of agents, reflecting the dichotomy of teamwork models that culminates in different results in the face of the work process in health, especially in the integrality of care[4].

Despite the recognized need for the coordination of professional practices and the significant presence of nurses and doctors in the hospital setting, studies still point to important challenges for the integration of work between these categories. Also, in the daily routine of hospital services, weaknesses in interprofessional interactions compromise the effectiveness of comprehensive care, negatively impacting the quality of care and patient safety, and increasing the risks of iatrogenic events[5-7].

In view of this scenario, the need to deepen the understanding of interprofessional care in the hospital context becomes evident, considering the essence of collaborative work, as well as the typology of teams[4]. From this perspective, critical reflections on the subject become essential, with a view to supporting debates and the formulation of public policies aimed at improving work processes in health in Brazilian hospitals. It is thus assumed that relational and communicational aspects constitute determining elements for the articulation of interprofessional care between nurses and doctors.

Therefore, the present study aimed to describe, from the nurses' perspective, the teamwork model and the interprofessional relationships established between nurses and physicians in healthcare within the medical and surgical ward of a public hospital in the Central-West Region of Brazil.

METHOD

This is a qualitative, descriptive study that used the case study method. The choice of this method was due to its suitability to the proposed object, considering the need to explore complex phenomena of a qualitative nature, based on the representation of part of the scenario in which the study problem occurs. Thus, it is necessary to precisely delimit the study scenario, as well as to use different data collection techniques to explore the object of investigation in depth[8].

Regarding the study location, the medical and surgical clinic sector of a public hospital located in the Central-West region of Brazil was chosen. The aforementioned sector was selected due to the number of professionals working there and the greater opportunities for events of interest to the study, as well as the expertise of the researchers. After defining the study setting, different data collection techniques were used to better understand the reality, following the recommendation of the case study method[8].

The choice of hospital took into consideration its physical structure, technological resources, and organizational structure, as it is one of the largest hospitals in the State of Mato Grosso, and a reference in several specialties, mainly for orthopedics and neurosurgery. It has a total of 315 beds, divided among 222 adult ward beds; 30 pediatric ward beds; 6 mental health beds; 50 beds for adult intensive care; and 10 beds for pediatric intensive care.

The research was conducted between July 2024 and April 2025. The research team was prepared before data collection began, and the fieldwork guidance materials were reviewed and printed. During the data collection period, the hospital had 175 nurses divided into different shifts and sectors, working 40 hours per week. Regarding physicians, there were 339 registered as having an active employment relationship, not necessarily in practice. These included general practitioners, specialists, and residents, with a prevalent work schedule of 20 hours per week.

The study participants consisted directly of registered nurses and indirectly of physicians, since the physicians' records in medical charts and their daily interactions with nurses were analyzed. The inclusion criterion for participants was all registered nurses working in the medical and surgical ward (N=76), regardless of their employment status or work shift.

The decision to develop a semi-structured interview guide exclusively for nurses considered the particularities that characterize the work of nurses, especially the fact that these professionals are close to patients, attending their needs, and their central role in managing care, sometimes becoming care coordinators[9]. Regarding data collection, a sociodemographic and professional profile characterization instrument was applied only to the hospital nurses in order to outline this profile, totaling (n=140) instruments applied, then the analysis of medical records was carried out (P).

The hospital's electronic system was used for sample selection and analysis of electronic medical records. Inclusion criteria were defined as: patients who were hospitalized in the medical and surgical ward between April and June 2024, who remained hospitalized for more than 10 days, and who were discharged for any reason. Based on these criteria, a sample size of 323 was obtained. Initially, 50 records were selected for convenience, identified by their admission number. A preliminary analysis and discussion of the collected data led the researchers to consider the need to expand the sample, totaling 75 records analyzed (n=75).

As a relevant part of the study, medical record analysis was performed by the researcher using a specific instrument that included fields for identifying medical records and recording subjective and objective data, serving as a guide and facilitator for record-keeping.

The tool used allowed us to understand the nature of professional records, compare nursing and medical records in search of patterns of annotations that expressed joint care actions, overlapping or juxtaposed knowledge practices, monopolization or coordination of care, as well as shared or unilateral clinical decision-making[4]. After data collection, the data were processed, constituting part of the study material and analyzed according to the steps recommended for content analysis[10].

Based on the documentation of the practice, non-participant observation (OBS) was initiated, observing the dynamics of the nurse's work with the doctor, in order to extract data from the reality of daily life that, in part, were not documented, but which represent relevant conditions for exploring interprofessional relationships. The observation data were recorded in a field diary and recorded in MP3 for later transcription and analysis[10]. A total of 20 sessions were conducted, lasting two hours each and divided into different shifts and hospitalizations.

Subsequently, 10 semi-structured interviews were conducted with the nursing staff, lasting an average of 43 minutes. However, before starting the interviews, a guiding interview script tailored to the study's objective was developed, considering the preliminary analysis of the previously collected data. Furthermore, a test interview was conducted to evaluate the adequacy of the script, and all interviews were audio-recorded and transcribed using the Transkiptor® software, followed by audiovisual review. The interview allowed for the elucidation and complementation of elements not covered by other techniques used, especially regarding aspects related to the perception and thinking of nurses in their daily work.

Preliminary analysis of all materials occurred concurrently with data collection, a condition that allowed the identification of patterns of agreement or disagreement regarding the collected content. These conditions allowed us to measure and analyze the frequency of occurrence of similar data, in order to jointly define the moment when the respective data reached saturation[10, 11], making the data without new elements important for the study.

The data were analyzed using thematic content analysis[11], encompassing five stages: 1) Pre-analysis, during which a floating and complete reading of the material was carried out to define the Corpus; 2) Exploration of the material, which included data coding, represented in this study as phrases, constituting the recording units following internal coherence within the universe of meaning. The data were referenced using the following examples: (ENF1) for the first interview, (P2) for the second medical record analyzed, and (DC3) for the field diary of the third observation session. 3) Categorization was developed from core meanings, which

encompassed considerable recording units, contributing to the framing of subcategories and subsequent consolidation of empirical categories, resulting in two categories; 4) Processing of results and 5) Inferences: the data were stored in Microsoft Word® files and processed individually for later integration, considering the core meanings and categories from other techniques [10, 11].

Therefore, data from medical records, observation, and interviews were subjected to data triangulation in order to integrate the analysis *corpus* to describe the complexity of these phenomena, with the aim of surrounding the object with different sources of information and obtaining a real product regarding the interprofessional relationships established in the daily work in the hospital environment.

The study followed the recommendations of the COREQ guide - Consolidated Criteria for Reporting Qualitative Research[12] The informed consent form was signed by the participants and the project was submitted to the Human Subject Research Ethics Committee of Universidade Federal do Mato Grosso, CAAE No. 78748624.1.0000.8124, which was approved according to Protocol No. 6.952.634/2024.

RESULTS

Regarding the profile of the nurses who worked in the study hospital, there was a significant prevalence of female nursing workers: 88.6% (n=124) compared to 11.4% (n=16) of male nurses. Most were aged 30-49 years, representing 62.9% (n=95) of the total. As for the Brazilian state of origin of the professionals, 77.9% of the nurses reported that they are from the State of Mato Grosso. Also, 73% of the total said that they did not live with a partner.

Regarding the operation time, it is crucial **to** note that the hospital unit was officially opened on November 18, 2019, and has been operating for just over five years. Therefore, the length of employment at the institution varied, in months, from 48 (38.3%) to less than 12 months (18.8%). Furthermore, 18.8% of respondents reported an experience of 12 to 24 months, while 24.1% were at the hospital between 25 and 48 months. All respondents (100%) have a temporary employment relationship with the institution through a public company.

Regarding education and qualifications, 28.5% stated they only had completed an undergraduate degree, while 70.0% completed a specialization course, and of these, 52.0% (n

= 51) have two specializations. A small percentage, 1.4%, reported having a stricto sensu postgraduate degree at the master's level in the area. Regarding lato sensu specializations, the majority (29.7%) are dedicated to emergencies in urgent and emergency care, followed by 18.3% in adult intensive care, 5.1% in obstetrics, and 4.1% in pediatric and neonatal intensive care.

Given the characterization of the general aspects related to the study participants, the next step was to explore qualitative data, considering the essence of collaborative work from the perspective of interaction among workers. Thus, we considered communication and interprofessional actions as the basis for the process of integrating knowledge and practices. In this sense, two empirical categories emerged from data triangulation, namely:

(De)valuation of interprofessional practice between nurses and doctors

The devaluation of interprofessional practices was more prevalent among medical workers compared to nurses. Furthermore, we observed established speech patterns, expressions, and behaviors during care that reproduce ideas and tendencies toward hierarchical organization and centralization of patient care in the figure of the physician, distancing them from collaborative work. Let's look at the following excerpts:

> *“The doctors in the internal medicine clinic trust us more. It’s more difficult in other specialties; there are specialties where it seems like we don’t even exist. They think we have no autonomy in the sector, that’s what they say, and that’s it.”* (ENF3)

> *"All care was provided as prescribed by the physician*. [Notes from nurses and nursing technicians]." (P39, P71, P75)

> [...] *I still see a flaw (...) we pass on information and it's not accepted, you see? I don't know if you understood me. We pass it on and in the end, the person [the doctor] doesn't do it, you know?”* (ENF4)

> *There are some doctors who are very helpful, right? And then there are those who have a lot of difficulty interacting with us, and most of the time they don't comply with what we ask for.* (ENF9)

> *I realize that doctors value the nurse's comments when it comes to matters related to the institution's workflow in certain situations, but there were no comments that referred to the idea of discussing the clinical case or situations of this nature. (DC4)*

The statements contained in the nurses' discourse express the need to gain the doctors' trust in their own expertise, so that it is considered at a given moment in healthcare work.

Furthermore, the lack of interprofessional collective awareness implies the absence of a common goal and exacerbates power conflicts in the context of professional practice.

However, based on data from empirical fieldwork, it is recognized that the nurses' statements and behaviors express daily efforts to achieve collaborative work, bringing their practices closer to those of physicians for shared care. Nevertheless, there is an emphasis on greater difficulty and distance in the interaction between nurses and specialist physicians.

Conversely, despite the significant prevalence of non-collaborative practices in the workplace, there were two record units that, in part, expressed positive aspects in the interaction between nurses and physicians, as described:

> *"They listen to us a lot, they take our opinions into account. We call them, talk, suggest some things and they accept them. They do comply. To this day I haven't had any problems with the on-call staff or the visitors" (ENF5)*

> *"We have a good relationship with the medical team. There's only one doctor who doesn't accept what we tell him. He investigates and looks for information." (ENF6)*

Thus, the relationships established in daily life reveal a certain relativity, indicating that, depending on the behavior and context in which the nurse works, interprofessional knowledge is considered. Regarding nursing participation, the nature and level of interaction, we highlight the following excerpts from the field diary:

> *The nurse's behavior towards the doctor varies, ranging from greater interaction and empowerment to less, depending on the doctor and the subject matter of the communication [administrative requests and confirmation of tests performed] (DC9)*

> *I realize that the nursing staff overvalues the doctor's work. However, this is not reciprocated, as the doctor did not take the nurse's gestures and words seriously, nor did he interact with her during his entire stay in the ward. (DC8)*

Based on the organizational culture, it was found that the nature of communication between these workers is predominantly related to institutional, administrative, and bureaucratic demands. To a large extent, nurses and doctors have unequal relationships; however, the construction of this relationship in daily life has been highlighted in the discourse as an important factor in ensuring that their words and practices are recognized and valued by doctors.

Professional identity is an important element in the context of teamwork and contributes to defining practices, consistently delimiting the field of knowledge and practices, so that other workers recognize the role and importance of everyone in the face of daily demands. Conversely, a lack of identity negatively impacts the value placed on teamwork.

In short, the individualism inherent in the behaviors of healthcare teams demonstrates a lack of interest in and devaluation of collaborative practices; above all, there is a conscious failure to appreciate the importance of coordinating interprofessional actions and their impact on the common goal of care.

Furthermore, claiming recognition of a professional space requires a great capacity for coordination and persuasion among the different agents involved in the process, especially when considering the field of health, where relationships are surrounded by conflicts of interest that permeate the dispute over jurisdiction and professional territory.

Difficulties in interprofessional relationships between nurses and doctors in the hospital setting.

In this category, the lack of coordination in the work between nurses and doctors becomes evident, represented by the conflicting relationships that extend across different shifts and teams, displaying the general and prevalent picture of unfavorable conditions in the daily routine of the medical and surgical clinic sector.

Thus, the excerpts taken from the different data collection techniques highlight the key elements for understanding the essence of the interprofessional relationship in the study environment:

> *[...]There are those (doctors) who have a lot of difficulty interacting with us (nurses).* (*ENF9*)
>
> *I pass the information on to the on-call doctor* [...], *then he starts questioning it, you can see that he's insecure, that he's not believing, right? (ENF2)*
>
> *[...]He (the doctor) will investigate and seek information. I think it's a lack of trust in nursing." (ENF6)*
>
> *The doctors at the medical clinic trust us more* (*ENF3*)
>
> *There is indifference and a lack of cordiality between doctors and nurses. (DC12, DC18)*

Lack of credibility, difficulty in interaction, lack of trust in nursing, and insecurity were terms used by nurses to describe conditions that could explain the difficulties doctors

had in accepting suggestions or valuing their words and actions in terms of integrating patient care.

In the context of the present study, we observed behaviors that point to invisibility among medical and nursing professionals, and, despite nurses and doctors being in daily contact in the inpatient unit, even on different shifts, there was a prevalence of behaviors consistent with the typology of the grouped team, sometimes promoting disharmonious and conflictual relationships.

Regarding relational difficulties, these are similar in nature and recurrent, and in this sense, the behavioral aspect of nurses and their actions in the face of difficulties present in daily life were explored. Thus, the nurses revealed that:

> *"There are many nurses who have knowledge, but are afraid, they feel intimidated when the doctor says no. But when you demonstrate mastery of what you are talking about, the approach becomes different." (NURSE 1)*

> *[...] I have a good working relationship with them. They respect me, and it's precisely about that, their attitude and their stance. But it depends, it depends a lot, I've already had clashes with several on-call doctors. (ENF10)*

> *Unlike other times, the doctor listened to the nurse and expressed appreciation for what she said. I understood that positive interaction for patient care depends on the nurse's attitude and the doctor's reciprocity and interest. (DC6)*

Among the positive aspects, the following words stood out: positioning, posture, behavior, knowledge, and mastery. In other words, the nurse needs to combine "know-how" to position themselves effectively in daily work interactions, considering that the social and organizational culture, in itself, places the physician in a hegemonic/hierarchical position regarding care.

Thus, work environments with qualified professionals and the existence of collective goals and objectives can result in interprofessional relationships of mutual respect and interdependence, contributing to the ideal model of teamwork, consequently improving patient care and safety in the hospital setting.

DISCUSSION

Organizational culture associated with the belief in the existence of hierarchy among members of health teams implies the overlapping of knowledge and practices and the disarticulation of collaborative work between categories. Nursing, in turn, occupies the central space in the context of health care, configuring itself as the category closest to users;

however, medicine, within its organizational structure, has ensured control and monopoly over practice (diagnosis and therapy), conditions that place medical practice in a hegemonic position in the hospital space, and, from this, therapeutic decisions tend to disregard the position and technical opinion of nursing[4].

In this regard, the contributions of the theory of communicative action elucidate ways to overcome this culture constructed and rooted in health services, whose influence goes back to the thoughts and practices of medical hegemony. Among the advances in discussions about the topic, the model of health teams is problematized, according to the typology and level of interaction. Thus, from Habermas's perspective, in addition to interaction, the involvement and cooperation between the different agents in the work process stands out[13, 14].

In terms of relationships and cooperation, the results of this study showed little interaction between nurses and doctors, mainly motivated by medical practices that devalue the nurses' work, reducing their participation in therapeutic decisions. It is known that interaction is an indispensable element for collaborative work, and, in this logic, they highlight the type of team called a grouping, characterized by the overlapping of knowledge and the absence of coordinated work[4].

Among the elements of an ideal team model, the need for effective involvement between different professions emerges, especially from a perspective where mutual dependence becomes the fundamental attribute for the development of efficient work, valuing the practices and knowledge established within a given field of knowledge. Thus, the significant occurrence of conditions opposed to interaction implies the absence of cooperation and an inefficient team model[14].

Regarding limitations for effective collaborative work between health teams, national studies have shown that difficulties in interactions between nurses and doctors are influenced by gender inequalities, since in the Brazilian scenario more than 84% of nursing workers are female and historical and ideological influences are determinants for the formulation of culture and way of life, considering the idea of women's submission to men[15].

Another limiting aspect pointed out in the scientific literature concerns theoretical distance, whereby physicians apply restricted sets of clinical knowledge in discourse and practice, a condition that prevents other workers from participating. In contrast, the under-dimensioning and excessive tasks of nurses outside the direct scope of care can promote low appropriation of the therapeutic decision-making space in the context of clinical practice[16,17].

In this same perspective, national and international studies have shown that organizational culture, workload, job satisfaction, employee turnover and lack of definition of

professional roles are variables of a different nature, but represent elements of great impact on the individual performance of each profession, and, consequently, on teamwork[16-19].

Beyond the Brazilian context, the challenges related to the effective implementation of interprofessional care between nurses and physicians constitute a complex problem of global scope, present in different contexts in the main countries of Europe, the Middle East, North America and the Asian Continent[20-23]. However, it is noted that such limitations permeate even countries with a high human development index. From this perspective, the various strategies used to achieve comprehensive care and minimize unfavorable conditions in the daily work of hospitals stand out. In Italy, a study describes the use of an interprofessional education tool as a strategy, emphasizing that this represents a vital mechanism for improving interprofessional practices, based on the promotion of professional communication and the encouragement of greater involvement in clinical decision-making[20].

In Jordan, strategies for promoting hospital culture, training, and continuing education to foster the integration of interprofessional knowledge and practices to improve care were highlighted[21]. In the USA, teamwork was positively evidenced, from a perspective of integrating practices among other professions. The North American study highlighted the presence of specific and consolidated multidisciplinary workflows, associated with organizational culture and definitions of professional actions. Thus, the precise delimitation of the scope of professional activity became evident in the context of practice, and, consequently, contributed to inhibiting subordination between different professions[22].

In Singapore, as a strategy to ensure the integration of patient care, monitoring and safety, a technological communication tool created from the Theory of Experiences in Healthcare Settings was presented. The artifact described in the study aimed to facilitate collaborative practice between nurses and doctors, through an interprofessional chat tool intended for the discussion of specific cases, and therefore, its purpose was to promote barriers to mitigate errors and facilitate interprofessional communication in hospital and outpatient settings[23].

In short, multiple mechanisms and efforts to establish interprofessional relationships in the health field stand out in various countries, especially recognizing interprofessional communication and cooperation as central elements for collaborative work. However, among the most frequently cited limiting factors were the influences of working conditions, organizational culture, lack of investment in continuing education, and the need for

professional qualification. These elements are necessary paths to make the practice environment conducive to interprofessional and collaborative work[19-23].

On the other hand, the dissociation between legal competence and technical competence has been mentioned as an unfavorable condition in health services, since the set of legal and jurisdictional competences, by itself, does not guarantee the qualification of the practice, highlighting the need for the appropriation of technical competence for the professional practice with quality, autonomy and the capacity for safe decision-making[24].

Finally, the present study has its limitations, since its development occurred strictly within the medical and surgical clinic sector, a condition that prevents comparative analyses between the different sectors in the hospital setting. Even so, the results revealed the significant occurrence of relational conflicts and the need to develop strategies to effectively implement interprofessional care within the Unified Health System (SUS), in order to achieve comprehensive care and minimize unfavorable conditions in the daily hospital work routine.

FINAL CONSIDERATIONS

The nurses' perception of the relationships established in care between nurses and physicians was represented by a conflictual relational pattern, and, as a consequence, a compromise in collaborative work is estimated. Furthermore, there is an expression of the non-existence of teamwork in the medical and surgical clinic sector, even with the efforts of some nurses to promote team integration and joint participation in patients' therapeutic decisions. Thus, the ideal typology of a health team has its elements centered on cooperation and interdependence around the care of users, conditions that directly influence the product of the work, potentially resulting in efficiency and comprehensiveness of care. However, in the study setting, these elements were far from reality, characterizing the team as closer to the model called "grouping," marked by the practice of overlapping knowledge and monopolization of care by physicians.

In light of the above, significant weaknesses were found in communication between doctors and nurses, and low interaction regarding patient care in the hospital setting. Therefore, it is believed that the contributions of this study can provoke reflection and change the perception of professionals and managers about investing and promoting changes in the organizational culture and in the management and care team model in health services.

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Availability of data and material

The data was not made available due to a commitment made with the partner institution. However, access to the dataset may be obtained upon request to the corresponding author.

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