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ORIGINAL ARTICLE

# Collaborative practice in pre-hospital care transfer based on the analysis of interprofessional relations

## Prática colaborativa na transferência do cuidado pré-hospitalar a partir da análise das relações interprofissionais

## Práctica colaborativa en la transferencia del cuidado prehospitalario a partir del análisis de las relaciones interprofesionales

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## ABSTRACT

**Objective:** to understand collaborative practice in the context of pre-hospital care transfer through the analysis of interprofessional relations. **Method:** a qualitative, case study research, conducted in an Emergency Mobile Medical Service (SAMU) and in the destination services for the care transfer performed by it, in a municipality in Rio Grande do Sul. Forty-four professionals participated, including doctors, nurses, nursing technicians, and ambulance drivers. Data were collected through non-participant systematic observation, document analysis, and semi-structured interviews. They were analyzed using content analysis in light of the Interprofessional Collaboration Model. **Results:** three categories emerged. The category "Coexistence and trust among teams in pre-hospital care transfer" addressed issues such as professional competence and confidence in technical skills. The category "Plurality in work objectives" discussed the occurrence of conflicts and the lack of attention to transferred information. The category "Difficulties faced in pre-hospital care transfer" addressed interpersonal relations, a feeling of superiority, professional hierarchy, and lack of dialogue among teams as hindering factors in the process. **Final Considerations:** difficulties in developing collaborative practices predominated. The need for building and strengthening interprofessional relations to develop collaborative practices during pre-hospital care transfers is evident.

***Keywords*:** *Emergency Medical Services; SAMU; Patient Handoff; Cooperative Behavior; Interprofessional Relations.*

## RESUMO

**Objetivo:** compreender a prática colaborativa no contexto da transferência do cuidado pré-hospitalar, a partir da análise das relações interprofissionais. **Método:** pesquisa qualitativa, tipo estudo de caso, realizada em um Serviço de Atendimento Móvel de Urgência e nos serviços de destino para a transferência do cuidado realizada por este, em um município do Rio Grande do Sul. Participaram 44 profissionais, entre médicos, enfermeiros, técnicos em enfermagem e condutores de ambulâncias. Os dados foram coletados por meio de observação sistemática não participante, análise documental e entrevista semiestruturada. Foram analisados conforme a análise de conteúdo à luz do Modelo da Colaboração Interprofissional. **Resultados:** emergiram três categorias. A categoria “Convivência e confiança entre as equipes na transferência do cuidado pré-hospitalar” abordou questões como competências profissionais e confiança nas habilidades técnicas. A categoria “Pluralidade nos objetivos de trabalho” abordou a ocorrência de conflitos e a falta de atenção nas informações transferidas. A categoria “Dificuldades enfrentadas na transferência do cuidado pré-hospitalar” abordou relações interpessoais, sentimento de superioridade, hierarquia profissional e falta de diálogo entre as equipes como dificultadores do processo. **Considerações finais:** predominaram dificuldades para o desenvolvimento de práticas colaborativas. Evidencia-se a necessidade da construção e do fortalecimento das relações interprofissionais para o desenvolvimento de práticas colaborativas durante as transferências do cuidado pré-hospitalar.

***Descritores*:** *Serviços Médicos de Emergência; SAMU; Transferência do Paciente; Comportamento Cooperativo; Relações Interprofissionais.*

## RESUMEN

**Objetivo:** comprender la práctica colaborativa en el contexto de la transferencia del cuidado prehospitalario, a partir del análisis de las relaciones interprofesionales. **Método:** investigación cualitativa, tipo estudio de caso, realizada en un Servicio de Atención Móvil de Urgencia y en los servicios de destino para la transferencia del cuidado realizada por este, en un municipio de Rio Grande do Sul. Participaron 44 profesionales, entre médicos, enfermeros, técnicos en enfermería y conductores de ambulancias. Los datos fueron recolectados mediante observación sistemática no participante, análisis documental y entrevista semiestructurada. Fueron analizados según el análisis de contenido a la luz del Modelo de Colaboración Interprofesional. **Resultados:** surgieron tres categorías. La categoría “Convivencia y confianza entre los equipos en la transferencia del cuidado prehospitalario” abordó aspectos como competencias profesionales y confianza en las habilidades técnicas. La categoría “Pluralidad en los objetivos de trabajo” trató la ocurrencia de conflictos y la falta de atención en la información transferida. La categoría “Dificultades enfrentadas en la transferencia del cuidado prehospitalario” abordó relaciones interpersonales, sentimiento de superioridad, jerarquía profesional y falta de diálogo entre los equipos como factores que dificultan el proceso. **Consideraciones finales:** predominaron dificultades para el desarrollo de prácticas colaborativas. Se evidencia la necesidad de construir y fortalecer las relaciones interprofesionales para el desarrollo de prácticas colaborativas durante las transferencias del cuidado prehospitalario.

***Descriptores:*** *Servicios Médicos de Urgencia; SAMU; Pase de Guardia; Conducta Cooperativa; Relaciones Interprofesionales.*

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## Introduction

In the current healthcare service landscape, changes are observed in the epidemiological profile and the complexity of care, indicating the need for a better understanding of health and disease processes. These changes highlight the urgency of an approach that considers the dimensions of users' health needs, requiring, beyond the curativist and biomedical model, professional specializations, and technological advances, interprofessional collaboration.[1]

Given the need for a new approach to health problems, the Urgency and Emergency Network (RUE) was created in 2011, with the goal of reorganizing, structuring, and organizing healthcare in emergency situations. The RUE is constituted by different points of care to handle the diverse actions required in these situations. It is fundamental that the components of the RUE operate in an integrated, articulated, synergistic, and collaborative manner.[2]

One of the main components in the RUE's organization is the Emergency Mobile Medical Service (SAMU), which, along with the Emergency Medical Regulation Centers, guarantees user access to the health system, establishing the interface between intervention at the scene where the injury occurs and the network of services that will receive the patient for subsequent care.[3] SAMU performs care transfer, a process involving the exchange of information, both verbal and documented, necessary to refer a patient between staff members of different services.[4]

This information, related to the care transfer from mobile pre-hospital services to emergency units, is a cause for concern due to non-conformities arising from conflicting information.[5] Loss of clinical information, failures related to the use of confusing language or jargon, unidirectional transfers—often imprecise, incomplete, and not pertinent to the patient's condition[6], and a lack of integration between health services are very common.[7] Therefore, the operationalization of interprofessional collaboration constitutes a challenge, especially in emergency services.

Fragile working relationships cause tension among teams, which can result in inadequate and ineffective care, including generating conflicts that can harm patient care.[8] Interprofessional collaboration presents itself as a fundamental approach to promoting more resolute care transfers. It refers to situations where professionals from different areas wish to work together to provide the best healthcare for users. Instead of reinforcing the expectation of full autonomy and independence for each profession, in Collaborative Interprofessional Practice (CIP), professionals seek to reduce competition and replace the

imbalance in power relations in healthcare with relations of interprofessional partnership and collective responsibility.[9]

The model and typology of interprofessional collaboration, initially developed by Danielle D'Amour, is highlighted as a theoretical subsidy that contributes to the operationalization of collaborative practice. This model is composed of four dimensions and ten indicators and was constructed to understand the structuring of interprofessional collaboration. It takes structural issues into account but focuses on the relations between individuals. It allows for the analysis of collaboration, identification of areas for improvement, and enables researchers to use the indicators to determine the level of collaboration in health services. Professionals and administrators can also use the model to perform a collaboration diagnosis and implement interventions to intensify it.[10]

The quality of care transfer is directly related to the interprofessional relation between pre-hospital and hospital professionals. A national study corroborates these findings, as it identified that the greatest difficulties for professionals working in the pre-hospital environment are related to personal interactions with other health services.[11]

Therefore, considering the importance of interprofessional collaboration in pre-hospital care transfer and the reflections of this CIP on the quality of health services provided, the present study aims to understand collaborative practice in the context of pre-hospital care transfer based on the analysis of interprofessional relations.

## Method

This is a qualitative, case study approach. The choice of a case study is justified by its allowance for an in-depth understanding of a real-life phenomenon, considering contextual conditions.[12]

The single case was defined as the Emergency Mobile Medical Service (SAMU), located in a municipality in Rio Grande do Sul with a population of approximately 300 thousand inhabitants. The study consisted of four units of analysis, namely: the SAMU, an Urgent Care Unit (UPA), a Municipal Emergency Care (PAM), and an Adult Emergency Department (PS) of a University Hospital.

The Mobile Emergency Care Service (SAMU) has four response teams, comprising three Basic Life Support (BLS) units and one Advanced Life Support (ALS) unit. Its workforce includes 32 healthcare professionals: five regulatory physicians, seven attending physicians, five nurses, and fifteen nursing technicians. In addition, the service has 20 ambulance drivers and performs approximately 1,000 calls per month.

The Emergency Care Unit (UPA) is among the facilities with the highest monthly patient volume in the state, providing around 10,000 consultations. It has 12 adult observation beds, two isolation beds, four pediatric beds, and four emergency beds. The team includes 14 nurses and 43 nursing technicians. A total of 160 physicians are also part of the staff, a number justified by the fact that some professionals work only one shift per month but maintain an active employment link with the service.

The Municipal Emergency Clinic (PAM) has a structure consisting of 12 adult observation beds, four stretchers in the emergency room, and 11 pediatric observation beds. Its team is composed of 11 nurses, 24 nursing technicians, and approximately 20 physicians. The service provides about 9,000 consultations per month.

The Emergency Department (PS) performs approximately 2,521 consultations per month. It offers 23 adult observation beds and an emergency room; the pediatric unit has six observation beds and one emergency room. The staff includes 29 nurses, 76 nursing technicians and assistants, and 29 physicians.

The research was conducted with the professionals involved in the pre-hospital care transfer and victim assistance: doctors, nurses, nursing technicians/assistants from SAMU, UPA, PAM, PS, and SAMU ambulance drivers. The selection criterion included all professionals who had been working in the aforementioned services for more than six months. The invitation was made through direct approach or via social media and WhatsApp to professionals who were active in these services during the data collection period.

The following sources of evidence were used: documentary research, non-participant systematic observation, and semi-structured interviews. Data collection occurred between February 2021 and April to August 2021.

Document analysis was conducted alongside systematic observation and semi-structured interviews. Thus, the documentary review was based on the care report delivered by SAMU to the receiving service, as well as on the nursing and medical notes recorded after the patient was admitted.

The study observed care provided to adult patients, children, and pregnant women by teams operating in both Basic Life Support (BLS) and Advanced Life Support (ALS) units. Non-participant observations were performed on different weekdays, during morning and afternoon shifts. Observations covered the entire process—from SAMU's care at the scene of the incident to handover at the receiving facilities—totaling approximately five hours per shift, which enabled the participation of as many professionals as possible in the observation stage. In total, six months of fieldwork were conducted, amounting to 449 hours of observation with the teams, and encompassing 104 prehospital care transfers.

For recording and organizational purposes, an observation guide was used to direct attention to dialogues (tone of voice, interruptions, arrival and departure of professionals, parallel conversations, among others), description of the setting and participants, events or activities related to the transfer of prehospital care, as well as the observer's personal impressions, feelings, and ideas. Observed events and the researcher's impressions were recorded as voice memos immediately after each care episode and later transcribed into a field diary.

The interview stage took place concurrently with the documentary analysis and observations. Interviews were conducted individually with professionals involved in care transfer, at previously agreed dates and times. Invitations to participate were made verbally. Some interviews were held at the institutions studied, in private rooms ensuring confidentiality, according to the date and time chosen by participants. Other professionals chose to participate outside their work hours, and these interviews were conducted online via Google Meet, at the participant's preferred time.

The semi-structured interviews, conducted by the principal researcher, were audio-recorded using a digital device and later transcribed. They followed a script developed by the research team, based on the domains, indicators, and empirical data of D'Amour et al.'s (2008) Interprofessional Collaboration Model and Typology[10].

The sample closure for the documentary analysis, observations, and interviews was determined by the sufficiency and quality of the information produced, until recurrence and complementarity of data related to the study object were achieved.[13] A total of 44 professionals were interviewed, with an average duration of 30 minutes.

Analysis of the material resulting from data production was carried out using content analysis.[14] Two of the domains from D'Amour et al.'s (2008) Interprofessional Collaboration Model[10] were employed, considering that the model seeks to understand how interprofessional collaboration is structured, taking into account structural aspects while focusing on the relationships among individuals and on the interaction between these relationships and organizational dimensions.[15]

The Interprofessional Collaboration Model comprises four dimensions and eleven indicators. In the present study, the dimensions involving interprofessional relationships and their respective indicators were used (Table 1).

**Table 1** – Definitions of the dimensions and their respective indicators in D'Amour et al.'s Model (2008). Santa Maria (RS), Brazil, 2025.

| Dimension | Indicators |
|---|---|
| **Shared goals and vision**<br>Refers to the existence of common goals and their appropriation by the team, as well as the recognition of divergent interests and motivations, the development of multiple partnerships, and the diversity of definitions and expectations regarding collaboration. | **Objectives**<br>dentifies common values and goals that converge to promote patient-centered care.<br>**User-centered orientation versus other orientations**<br>A complex structure of interests involving a variety of loyalties (to clients, to the profession, to the organization, to confidential interests, etc.). The result is asymmetry or partial convergence of interests among partners. Mutual adjustments are needed through negotiation; when interests are not expressed, the negotiation process does not occur. |
| **Internalization**<br>Refers to professionals' awareness of their interdependencies and the importance of organizing them. This process is expressed through a sense of belonging, recognition of the values of different disciplines, and mutual trust. | **Mutual acquaintanceship**<br>A sense of belonging to the group and familiarity with team members, including awareness of their personal values and professional competencies.<br>**Trust**<br>Collaboration is possible when professionals trust each other's competencies and ability to assume responsibilities. Trust reduces uncertainty, which—when excessive—may lead to resistance to interprofessional collaboration and hinder the construction of networks. |

Source: D´amour et al (2008).

The following stages were undertaken: pre-analysis, consisting of the organization and systematization of initial ideas; exploration of the material, which corresponds to the coding phase in which raw data are organized and grouped into units; and treatment of the results and interpretation, during which the researcher may propose inferences and interpretations based on the findings and in line with the study objectives. In this interpretative stage, the excerpts previously selected are analyzed according to the adopted theoretical framework.[14]

The first two stages were conducted using the qualitative data analysis software Atlas.ti 9 to support the coding of individual interviews, non-participant observations, and documents, given the large volume of material accumulated.

The study was approved by the Research Ethics Committee of the University of Santa Maria – RS, under approval No. 4.343.403. To ensure participant anonymity, alphanumeric codes were used: "E" for nurses, "TE" for nursing technicians/assistants, "ME" for physicians, and "C" for ambulance drivers, followed by a number corresponding to the order in which the interviews were conducted (1 to 44) and the service where the professional worked (Service 1 to Service 4). For observations, the letter "O" was used, and for documents, the letter "D", both followed by a number indicating the service observed (Service 1 to Service 4).

## Results

Forty-four professionals were interviewed: 19 from SAMU, eight from UPA, eight from PAM, and nine from PS. Among the participants, 57% were female. The average time since graduation was nine years, and the average time of service at the institution was seven years. The predominant work shift was daytime.

Based on the analysis of the interviews, observations, and documents, three categories emerged: Coexistence and trust among teams in pre-hospital care transfer; Plurality in work objectives; and Difficulties faced in pre-hospital care transfer.

### Coexistence and trust among teams in pre-hospital care transfer

This category reveals that non-material work instruments, represented by the Internalization dimension and its indicators (Mutual Coexistence and Trust), are pillars for collaborative work between urgency and emergency services. This category highlights the prerequisites for the presence of coexistence and trust among professionals.

Many professionals have a close coexistence, but this relationship was not established during pre-hospital care transfers; rather, it resulted from having worked together in other services:

> With the receiving team, since we work shifts, we already know most of the places, we are colleagues, normally the transfer is calm, there aren't big problems. This makes it easier, knowing each other, being colleagues makes it easier. (M11-SERVICE 1)

In addition to recognizing each other by name or appearance, some were identified only by voice. This usually occurs when the professional in the SAMU ambulance calls the destination service to notify them about the patient transfer. Furthermore, it was noted that acceptance could be influenced by friendship between professionals:

> A professional told another, jokingly, that he recognized his voice on the phone, which is why the transfer was allowed. Both laugh. (OT-SERVICE 4)

The influence of the work group on the behavior of the professional belonging to it was identified:

> Upon arrival at the receiving service, the person who comes to receive is a doctor. This person begins to question the SAMU team about the reason for transferring the patient there. Soon after, the nurse and nursing technician arrive, greet the SAMU team, ask how they are, and what the case they brought was. The doctor then no longer shows resistance to acceptance and begins to ask about the patient's clinical status. (O-SERVICE 3)

The following indicates that professionals in intra-hospital services trust the technical skills of those working in SAMU, as they request their help when necessary:

> The places where we take the patient vary a lot, as I told you. There at the UPA, since I worked there for a year and have an affectionate relationship with the staff, it's very good, they ask me for things. Sometimes I get there and there's a severe patient and no doctor, they ask me to do something [...]. (M04-SERVICE 1)

Among professionals who work together daily, or for many years, it is possible to follow their behavior long-term. Thus, experience regarding the person's reliability is accumulated:

> Look, here inside SAMU I get along well with everyone, and in the hospitals too, because I've had a lot of contact, I've worked in this area since I was 18 [...] with the firefighters, with the army, with SAMU [...] I know most of the staff, so we know who we are handing off to. (C12-SERVICE 1)

Therefore, in the SAMU work context, trust emerges as an essential component of collaborative practice, as it is necessary to know how to deal with complex situations, conflicts, and personal differences when performing activities. One must be able to communicate through words and gestures. Such factors strengthen the bonds of trust, with the exchange of knowledge and, especially, coexistence, whether in formal or informal settings.

**Plurality in work objectives**

This category discusses the Shared Objectives and Vision dimension and its respective indicators: Objectives and User-Centered Orientation versus Other Orientations. In the view of the interviewees, having shared objectives, related to improving the quality of care provided to patients, are important elements for collaborative work. However, achieving these objectives is not always an easy task, given the prevalence of personal interests, dissatisfaction with the position, function, or service, among others.

The following testimony identifies that differences in work objectives are related to professional motivation. There are groups of motivated teams and others who are demotivated:

> [...] in front of the patient, you provided great care, you were there in the street, you got hurt, entered a ditch, a gully, you rescued them. You arrive here and there is this discouragement, they don't even evaluate the patient and they are already saying they don't belong here, they don't want them, they are already quite demotivated there. (TE10-SERVICE 1)

Furthermore, it was reported that maintaining respect for the patient is not always a common goal for everyone:

> There is the inconvenience for us plus the patient who is listening. Then everyone speaks ill of SUS [Brazil's public health system] because of this, because the patient arrives at a location, SAMU attends, attends very well, arrives at the entrance door, and there is all this fuss, "no, because this patient doesn't belong here". All that good work we did was thrown down the drain, because the thought will be, "oh, because SAMU, the SUS is no good". (C12- SERVICE 1)

It was reported that each service has its own work objective. This leads to the segmentation/fragmentation of the continuity of care process:

> Many times, those in pre-hospital care seem to want to get rid of the patient, and so they arrive very quickly, "here's the patient, where's the stretcher, put the sheet on, sign here, done". So, it seems like I did my part, now you'll do yours. But, it seems that moment, which should be a moment of union between one team and another, asking if we can do something together for this patient, doesn't exist [...] it's truly the segmentation of the two processes, my moment, your moment, and the sooner I get out of my moment and leave the patient here for you, the better [...]. (E25- SERVICE 4)

This brevity in pre-hospital care transfer contributes to significant clinical information not being passed on to the services that continue the care. However, this brevity is often requested by the team receiving the patient from SAMU, as observed:

> The SAMU nursing technician begins to transfer information. It is understood through the receiving doctor's hand gestures and words that he should shorten it. He interrupts the technician and says: "Okay, okay, it's hyperglycemia". (O-SERVICE 2)

SAMU's attendance reports contained more information than what was verbally transferred in the observations (D-Service 1). A justification for this may be precisely the brevity requested by the recipient. The information that was written but not verbally transferred primarily referred to the patient's name and age, as well as their comorbidities.

In addition to brevity, the occurrence of conflicts was also related to the indicator User-Centered Orientation versus Other Orientations, as these were considered by participants to be detrimental to the existence of common objectives related to patients. Conflicts interfered with the quality of care and the health of the worker. Consequently, professionals need to learn to manage and control them more effectively so that the reported situation does not happen:

> So much so that in this case that happened in the team, where I wasn't present [...] it seemed that the professionals who were there at the time weren't even looking at each other: "if it's so-and-so who's bringing a patient from SAMU, I'm not even

> staying here, I'm leaving", because it was a very serious incident. So, what I told you, that the goal is the best care for the patient, it seems that when a conflict of this magnitude happens, sometimes people lose sight of their objective. (E25- SERVICE 4)

A feeling of devaluation of SAMU professionals regarding the case they were transferring was also revealed, as if it were just another patient arriving by their own means, making SAMU "invisible". Therefore, the presence of common objectives among the teams is hindered, given that the receiving team trivializes SAMU, as reported in the following observation:

> After arriving at the destination service, the SAMU nursing technician transfers care to the local nursing technician and goes to the doctor's office to transfer the information. Initially, the doctor did not look at us, continuing to write on the computer. Halfway through the technician's handover, she stops writing and starts listening. She says, "Okay, alright". (O-SERVICE 2)

It is not only the trivialization of SAMU that occurs, but the receiving professionals also underestimate the severity of the patient's condition brought by them. Trivializing the complaint leads to unsafe care. Therefore, the lack of user-centered objectives was identified in several observed situations:

> The SAMU nursing technician goes to the doctor's office to transfer the information. The doctor sees him arriving, her facial expression changes, and she says: oh no! He details what happened, the doctor says nothing. He starts talking about vital signs, she stands next to him and looks at the attendance report. She sees that a blood glucose test was performed and says she can't believe they wasted a blood glucose test strip on this, something so expensive [speaking in a mocking tone]. The SAMU nursing technician says: indeed, doctor! (O-SERVICE 2)

Clinical severity is also a factor that interferes with pre-hospital care transfers. The testimony of TE-01 indicates that receiving professionals give little importance to the case and the care provided by SAMU professionals when they believe that certain patients could have been treated in the basic health network, such as in Basic Health Units or Family Health Strategies. Attention is mostly directed towards severe patients who require more complex care:

> Most of the time, there is no such questioning, only if it is something very serious will they question you about anything. They sign the form, but they don't even read it, apparently. You only fill it out to have information there, they don't read it. They don't even want to know [...]. (TE01-SERVICE 1)

When personal orientations prevail over user-centered ones, it ultimately weakens the safety and quality of the care provided:

> Here it is awful, because we don't find the doctor, the nursing staff doesn't want to receive the patient. To pass the case to the doctor, I have to go after him, enter the office, wait for the doctor to look, or deal with this back-and-forth of receiving or not receiving, they have to receive, the entrance door is open, anyway, it's really bad here, both nursing and medical teams have difficulty accepting a case, there are no facilities, you have to go after them, it's complicated. (M17- SERVICE 1)

However, even in the face of the plurality in work objectives, it was possible to identify some shared objectives. These were related to helping each other in situations of physical effort, replenishing supplies, and an interest in the patient's improvement:

> Upon arriving at the destination, the SAMU team was well received by the doctor, resident, and medical student. They helped the driver and the SAMU nursing technician move the patient from the stretcher and remove the straps. (O-SERVICE 2)

> Motorcyclist swerved to avoid a dog. Only had scrapes. Upon arriving at the destination, the professional responsible for local security quickly opens the door and the receiving doctor asks what happened. The SAMU nursing technician explains the incident. The doctor evaluates the patient, asks the SAMU technician a few more questions, and says the patient is fine, and that they will release our material soon. The receiving service technician checks vital signs, and afterward, the SAMU technician and driver remove their material from the patient [cervical collar and rigid stretcher]. (O-SERVICE 3)

Therefore, the presence of common objectives is characterized as a highly important strategy for collaborative interprofessional practice, thus enabling an increase in the effectiveness of teamwork and respecting the integrality of care.

It is noted that no documents (such as workflows and regulations) were found to support the shared objectives and vision, coexistence, and trust between the teams at the time of pre-hospital care transfer. Furthermore, issues related to interprofessional relations were not identified in the medical and nursing notes of the receiving services. These were centered on technical and clinical data related to the patient and the transfer, such as, for example, the patient's neurological status upon SAMU's arrival, whether they were using any immobilization, peripheral venous access, or oxygen use.

**Difficulties faced in pre-hospital care transfer**

This category demonstrates the difficulties perceived between services during pre-hospital care transfer, whether due to interpersonal relationships, feelings of hierarchy, superiority, and lack of dialogue between professionals.

Professional groups tend to isolate themselves in the services where they work. This is evident in the following testimony:

> Quite difficult, because, look, there is a lot of friction between SAMU and us, there is a lot of complaining, they complain a lot about us, and we hear about the complaints. So much so that we have no connection with them. SAMU is over there and we are here, only a few meters separate us, and we are two teams, I don't know who they are, I don't know who works there. There is this thing of them being over there and us being here. We are interconnected, we work together, but unfortunately, we older staff don't see it that way. We only had to grow, both of us would grow. (AUX 27 – SERVICE 2)

In addition, professionals state that coexistence between teams is permeated by difficulties, such as a lack of dialogue and professional superiority, reflecting the hierarchy of the professions. This contributes to them not feeling part of the team:

> [...] we know who the older staff are and the newer ones, and especially the doctor coming in with an air of superiority, that ends up making it difficult because we already feel that block, the person barely looks you in the face, then you drop everything and let them do it, since you are being insignificant to the SAMU doctor, then let them do it. I have also witnessed this, it has even happened to me, having this, wanting to be more, wanting to show off. (TE26- SERVICE 2)

Another difficulty in the coexistence between teams was the presence of comments considered unnecessary and unpleasant during the pre-hospital care transfer. Part of this occurred because the professionals receiving the patient view SAMU as a service responsible for the overcrowding of the intra-hospital unit:

> After the transfer, the SAMU nursing technician says goodbye and the doctor says she hopes they don't show up there again. The SAMU nursing technician tells me that this doctor is much worse, that today she was "being nice". (O-SERVICE 2)

When there is a lack of coexistence among professionals in the Urgency and Emergency Network, this contributes to them not knowing how the other services operate:

> [...] people need to understand that SAMU's service has a regulation, we have legislation that governs SAMU's normative. Even if you don't have the doctor present during the transfer, this patient has undergone a medical procedure. People look down on us, getting into friction with the teams, questioning why they took that patient there. (E18-SERVICE 1)

The lack of knowledge about the functioning of the Urgency and Emergency Network services, even by the professionals who are part of it, also weakens trust between the teams, especially related to the competence and skills of their colleagues:

> Many times, we pick up an unstable patient, they will fluctuate, for example, their level of consciousness. At home, it will be one level of consciousness. So, this leads us to look for a place with better resources for this patient. During transport, the patient showed improvement, with volume replacement, administration of oxygen. There is a series of procedures that were done, invasive or non-invasive, during the care. We end up choosing the place with better resources, for example, for a lower level of consciousness, and arriving at the location with the patient, for example, with an improved Glasgow level of consciousness. And, many times, the intra-hospital staff will understand that we assessed this patient poorly. This is one of the main things that happens in our day-to-day, in pre-hospital care. (TE38- SERVICE 1 and 4)

Given the testimony above and the following observation, the dynamism of SAMU, often unknown to RUE professionals, is noted:

> A victim of a motorcycle fall, SAMU's regulation directs the SAMU nursing technician to transfer the patient to a specific service. Midway through the journey, the patient's consciousness level drops. the SAMU nursing technician calls the regulating doctor, who changes the destination to the hospital with the highest complexity. (O-SERVICE 1)

Therefore, knowing the role of the other is fundamental for coexistence and trust between professionals. For this to occur, the interviewees suggested conducting joint training sessions among the urgency and emergency services in the municipality:

> Perhaps training, continuing education so that we can, for example, perhaps, know the colleague's service. I think that would help a lot. So, understanding who the professional is, the regulator, what their service is like, why they take that action of sending them to us. I think that knowing the colleague's side would be quite pertinent, interesting. Understanding the process of how it occurs, from the SAMU regulation call [...] I think that would help and facilitate this communication during the transfer of the patient, the victim. (E20-SERVICE 3)

## Discussion

The research findings evidenced that the coexistence among teams influences pre-hospital care transfers. Study participants reported a lack of coexistence among professionals in the urgency and emergency network, which contributed to a lack of knowledge about other services and professionals. Friendly relationships are factors that help establish healthy interpersonal relationships and contribute to the improvement of workers' mental health. In the hospital environment, these relationships are signaled as an important tool for establishing effective interpersonal bonds, contributing to the provision of health services from the perspective of comprehensive health care. Good relationships in the workplace can positively act to strengthen and broaden trust among colleagues and, consequently, generate greater opportunities for interaction and closer, more organized ways of dealing with the care offered.[16]

To clarify roles, participants in the present study suggested conducting joint training sessions. Research conducted with Family Health Strategy (FHS) professionals concluded that team meetings were important for strengthening relationships among members and for better team performance and planning. It was also reported that the training sessions enabled professionals to learn about each other's work with greater proficiency, so that everyone could understand the difficulties the other encounters in their daily responsibilities.[17]

Another national study with health professionals corroborates the findings of the present study, indicating that training qualifies pre-hospital care transfers. It concluded that care transfers were not precise due to the lack of training regarding the information that must be shared. Furthermore, professionals attributed great importance to the standardization of transfer processes and related effective communication to patient safety.[18]

Beyond training, spaces constituted by informal gatherings, such as parties, held during or outside of work hours, foster the construction of bonds that reflect team unity. Even daily meals and dialogue are essential recreations for achieving a healthy work environment.[19] It is noteworthy that, from the moment everyone gains knowledge of the other's work and understands the importance of each member's insertion in the team, roles and functions become clearer for all professionals, and the work process flows better.[17]

Coexistence among teams was also permeated by difficulties, such as a lack of dialogue and respect, superiority, mainly by the medical professional over other health professionals, and conflicts between teams. For D'Amour et al. (2008)[10], the frequency and presence of territorial conflicts occur, in large part, due to the risk of hierarchization among professions, translated in the testimony of TE26-SERVICE 2 by the term "air of superiority". For these authors, professional groups tend to define their territory in opposition to other groups and to defend their boundaries, as dictated by the logic of the professional system.

A study on patient safety during pre-hospital care transfer identified that power relations between professional categories can have negative effects on the safety of the care provided. Analyzing these relations from a communication viewpoint, it was understood that they are often determined by hierarchical identities and professional privileges.[20]

A case study conducted with professionals working in an emergency service also identified hierarchical relationships and the absence of bonding between professionals, especially between distinct categories. Information sharing usually occurred between doctors and nurses, while the nursing technician remained silent beside these professionals, performing delegated tasks. This finding highlighted the lack of appreciation and the feeling of inferiority as factors that hindered the interprofessional relationship.[21]

The persistence of hierarchical and unequal practices among different professional categories in the health area, silos (groups of professionals who work in isolation), power, conflicts at work, and the difficulty in understanding the role of the other favor professionals acting in parallel, to the detriment of teamwork.[21]

These factors also contribute to a detachment from attitudes of respect, common language, willingness to learn, shared responsibility, and unity.[22] These were considered challenges that emerged in the present study through unnecessary and unpleasant comments during the care transfer.

Interest in the personal dimension of each member of the work group, the establishment of a cordial interaction and respectful communication, facilitating the process of trust, are factors that can be worked on individually by each team member with the goal of building good bonds in the workplace.[22] It was noted that the distrust among the professionals in the present study was mainly due to the lack of knowledge of the functioning of other services. These relationships, based on distrust and misunderstandings during care transfer, compromise the continuity of safe care. Furthermore, according to D´Amour[10], when professionals do not trust the other's service, they tend to take it all upon themselves, becoming overloaded.

Trust constitutes a crucial requirement for collaboration, being linked to ethical demands. It does not concern friendly relationships between workers, but the conviction that the other is capable of doing a good job and respecting common values. It is trust that offers some predictability to people's behavior, who will tend to seek congruence between what they believe and their effective behavior.[23]

In the present study, trust primarily referred to the technical skills of the professionals. The procedural skills, cited by the interviewees, lead to interprofessional trust and the effectiveness of the processes involving the relationships between the teams. They are integral and relevant procedures in the individual training of professionals.[24] Knowledge, experience, and professional competence are important factors for achieving collaboration. Furthermore, the lack of scientific and technical knowledge of the team is considered one of the reasons for difficulties in care transfers, as well as collaboration challenges.[25]

It can be identified, mainly through the testimonies, that coexistence referred to the issue of trust. For collaboration to exist, it is important that workers feel secure enough to make their savoir-faire visible to the working collective, revealing and transmitting their knowledge in a climate of solidarity, collective learning, and mutuality. Therefore, trust needs to rest on the certainty that the other is capable and adopts an ethical stance.[23]

Good coexistence is understood through a set of values experienced among the teams, such as social justice, solidarity, respect, trust, care, reciprocity, friendship, affection, involvement, and the freedom to be who one is and who one would like to be, valuing spontaneity, joy, differences, and collectivity.[26]

Therefore, in the context of pre-hospital care transfers, trust emerges as an essential component of collaboration, as one must know how to deal with complex situations, conflicts, and personal differences when performing activities. One must be able to communicate through words and gestures. Such communication prospers and becomes sophisticated with the experience of practice, with the strengthening of trust bonds, the exchange of knowledge, and, especially, in living together, whether in formal or informal spaces. With this, workers can optimize and synchronize their actions.[23]

In the present study, motivation was cited by interviewees as a difference in work objectives. Those who work in SAMU consider themselves more motivated than those working intra-hospital. International studies also identified that some professionals were not willing and motivated for the transfer. Health teams form, dissolve, and reform continuously in shifts. Therefore, there are difficulties in building relationships and trust among team members.[27]

In the scope of the relational dimension, D'Amour et al. (2008)[10] point out that it is necessary to have a shared vision and objectives, while also recognizing the existence of divergent motivations and multiple alliances among workers. Shared objectives and vision are reflected in the degree to which professionals integrate the goals and results of their collaboration into their interactions. The following principle is implicit in the idea that the more professionals adhere to the objectives of the action system, the more they are ready to assume collaborative commitments that produce better results.

However, the present study revealed a divergence of objectives, among which is respect for the patient. An integrative review on humanization in urgency and emergency care concluded that several factors were evidenced as barriers and difficulties for the use of the precepts of the National Humanization Policy. These include the lack of structural resources, the poor functioning of health care networks, with low resolution of basic care, and the absence of a referral and counter-referral system, which leads to overcrowding in hospital emergency units.[28]

Furthermore, the trivialization of non-severe cases transferred by SAMU was reported. This generates consequences for patient safety, given that professionals do not pay due attention to the information transferred by SAMU when patients do not have a severe clinical condition. Transfers occur through conversations between professionals, or

by reading the patient's record at their bedside. It is a moment where the discontinuity of care can exist when information about the patient's health status is not shared completely and efficiently.[29]

A study that described the communication process among nursing team professionals during shift handover identified that, among the elements that weaken this process, is the low valuation of data on assessment, care plan, and information about the patient's clinical status. Interruptions (such as late arrivals or early departures, side conversations, and mobile phone use) were communication noise among the nursing team, sometimes causing information discontinuity and data loss.[29]

Through the testimonies and observations, it was possible to conclude that when other orientations prevail over user-centered ones, this ultimately weakens the safety and care provided. The participation of the multiprofessional team is necessary during patient transfer to offer support and sustenance, this being an opportunity for interventions by team members so that failures do not occur during the continuity of care for patients. In this sense, the lack of adherence of multiprofessional team members in care transfer represents a decrease in the quality of care provided to patients and families and compromises the bond with the rest of the team.[30]

Some professionals requested brevity in transfers, given that they have other objectives not centered on the patient being transferred. One justification for this is that receiving teams have demands other than those from SAMU, facing service overcrowding and a lack of professionals, which implies requesting brevity. The brevity requested by the SAMU team is justified, in some cases, because the regulator requests it, as other calls are already pending for the team performing the care transfer.

However, through the observations, it was identified that shared objectives were related to help among teams in situations demanding physical effort or material replenishment and an interest in the patient's improvement. D'Amour and authors (2008)[10] cite two main elements of collaboration: meeting client needs and meeting professional needs. Thus, the construction of a collective action that addresses the complexity of client needs and the construction of a "team life" that integrates the perspectives of each professional are fundamental for collaborative interprofessional practice. The two purposes seem inseparable, insofar as one cannot collaborate without taking time to develop a collective life, and it is useless to develop a collective life without first establishing the need to collaborate to respond to patients' needs.

Unconditional adherence to organizational goals and cohesion in an interprofessional team are utopian. Professionals always maintain a certain autonomy that puts them in a

bargaining situation. Exchange relationships appear to be very diverse, that is, both commercial and individual in nature. The negotiation process aiming for greater harmony of conceptions therefore constitutes a major stake for the success of interprofessional collaboration.[10]

The limitations of the study centered on the impossibility of inference to other contexts, making theoretical replication unfeasible due to it being a single case study. Furthermore, the document analysis was restricted to the SAMU Attendance Reports and the medical and nursing progress notes upon patient admission, as no other document was found that could serve as a reference for either interprofessional collaboration or pre-hospital care transfer.

## Final considerations

The results showed that coexistence among teams influences pre-hospital care transfers. Through the three categories that emerged in the present study, it was possible to understand collaborative practice in the context of pre-hospital care transfer based on the analysis of interprofessional relations.

In the category "Coexistence and trust among teams in pre-hospital care transfer", the fact that professionals in the urgency and emergency network do not know the functioning of other services and the competence of other professionals emerged, which hinders their coexistence and, consequently, collaboration. Thus, the presence of unnecessary and unpleasant comments, lack of dialogue, and superiority among some professionals, mainly doctors, was identified. However, some professionals do trust the technical skills of colleagues, as they request their help when necessary.

In the category "Plurality in work objectives", differences in work objectives prevailed, related to the lack of motivation of professionals receiving patients brought by SAMU, the occurrence of conflicts, and the lack of attention from the receiving teams to the information transferred by the SAMU teams. However, in some situations, it was possible to identify shared objectives, which were related to mutual assistance between teams in situations requiring physical effort or material replenishment and an interest in the patient's improvement—factors that contributed to the strengthening of interprofessional collaboration.

In the category "Difficulties faced in pre-hospital care transfer", interpersonal relationships, feelings of superiority, hierarchy, and the lack of dialogue among professionals are factors that directly impact the quality of pre-hospital care transfers.

In light of the results obtained, the study highlights the relevance of collaborative work in the Urgency and Emergency Network, emphasizing the need for managers and professionals to reflect on their interprofessional practices and adopt strategies that promote shared decision-making. The study underscores contributions to the reorganization of services, the formulation of institutional policies, and the improvement of the quality and safety of care. It also emphasizes the importance of interprofessional education in the training and practice of nurses, strengthening the teaching-service integration and the articulating role of nursing in consolidating collaborative and humanized practices within Brazil's public health system.

## Authors' contributions

**Study conception:** Jeanini Dalcol Miorin and Silviamar Camponogara. **Data collection:** Jeanini Dalcol Miorin. **Data analysis and interpretation:** Jeanini Dalcol Miorin and Silviamar Camponogara. **Manuscript writing:** Jeanini Dalcol Miorin and Silviamar Camponogara. **Critical review of the manuscript:** Jeanini Dalcol Miorin, Silviamar Camponogara, Bárbara Mendonça Siqueira, Etiane de Oliveira Freitas, Rosângela Marion da Silva, Elaine Cristina Novatzki Forte. **Approval of the final text version:** Jeanini Dalcol Miorin, Silviamar Camponogara, Bárbara Mendonça Siqueira, Etiane de Oliveira Freitas, Rosângela Marion da Silva, Elaine Cristina Novatzki Forte.

## Conflict of interest

The authors declared that there is no conflict of interest.

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