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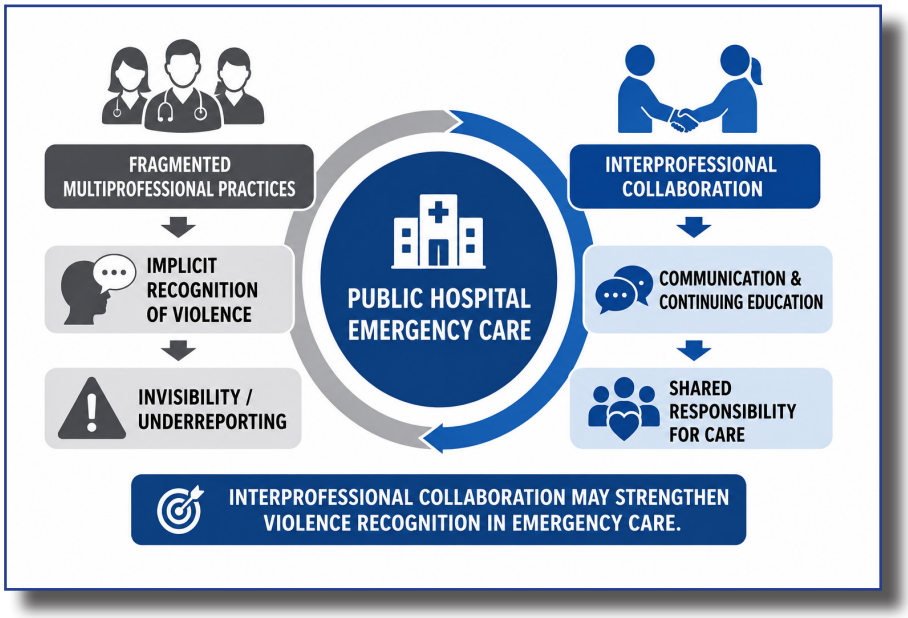
Multiprofessional collaboration in recognizing situations of violence in public emergency services: limits to interprofessionality

Sandra Souza da Silva[1] **Luiza Jane Eyre de Souza Vieira**[1] **Raimunda Magalhães da Silva**[1]
Débora Rodrigues Guerra Probo[1] **Samira Valentim Gama Lira de Alencar**[1]

[1]Universidade de Fortaleza – UNIFOR. Fortaleza/CE, Brasil.
E-mail: sandrasouzafisio@gmail.com

Graphical Abstract



Highlights

- *Fragmented multiprofessional performance predominates in public emergency care.*
- *Violence is recognized implicitly and frequently silenced.*
- *Qualified communication favors the identification of violence.*
- *The absence of protocols limits interprofessional collaboration.*
- *Permanent education strengthens interprofessional care.*

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Abstract

Interprofessional collaboration constitutes an essential strategy for comprehensive care in urgency and emergency services, especially in recognizing situations of violence, which are frequently veiled and underreported in daily hospital routine. The objective was to analyze the verbalizations of the multiprofessional team regarding collaborative practices in recognizing different situations of violence identified within the context of care at a tertiary public emergency service in Ceará. A qualitative study was conducted in a public tertiary referral hospital for cardiopulmonary care. A total of 34 health professionals selected through the snowball sampling technique participated. Data were generated through semi-structured interviews between May and July 2025 and subjected to thematic content analysis. Participants reported sporadic collaborative efforts, albeit with a predominance of fragmented multiprofessional performance. Communication, reception, and qualified listening were highlighted as central elements to identify situations of violence, even though frequently recognized in an implicit and silenced manner. Work overload, absence of protocols, structural limitations, and insufficient training were identified as the main barriers to the consolidation of interprofessional practices. Findings reveal a gap between the ideal of interprofessionality and the concrete organization of work, contributing to the institutional invisibility of violence in emergency services. The recognition of violence remains supported by individual initiatives and informal workflows. Consolidation of interprofessionality requires reviewing care workflows, strengthening cross-category communication, and investing in permanent education to enhance care and reduce underreporting in highly complex health services.

Keywords: Emergency Hospital Services. Interprofessional Education. Exposure to Violence. Violence.

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INTRODUCTION

The organization of healthcare work has historically been marked by the performance of different professional categories within the same care environment, which is not always supported by effectively integrated practices[1]. In the context of the Unified Health System (Sistema Único de Saúde – SUS), interprofessionality emerges as a strategy to qualify care, promote comprehensiveness, and address the complexity of user demands[2]. In urgency and emergency services, where time, clinical severity, and case unpredictability impose daily challenges, collaboration among professionals becomes even more necessary to ensure rapid and comprehensive responses to health needs[3,4].

Among these demands, violence is understood as the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation[5]. From this perspective, it presents as a social and public health phenomenon of high magnitude, with repercussions on mortality, disability, and demand for healthcare[6].

Studies conducted in emergency services, particularly in the context of intimate partner violence, demonstrate that situations of violence may remain unidentified due to barriers related to approach and disclosure, privacy, care workflows, work overload, and professional training[7,8]. In this scenario, structured identification strategies, associated with team preparation and coordination, can expand recognition and response to individuals experiencing violence[7].

Despite regulatory advances in addressing violence, weaknesses persist in its recognition and reporting within health services, evidenced, among other aspects, by the underreporting of violence against women[9]. Multiprofessional practice, characterized by the presence of different professional categories, does not necessarily imply integration between their knowledge and practices; interprofessionality presupposes interaction, shared construction of care, joint decision-making, and co-responsibility among professionals[10]. In this context, limitations in communication, professional preparation, and coordination of care practices can hinder the identification of and response to situations of violence in health services[7,8].

Interprofessional education constitutes a relevant strategy for strengthening interprofessional knowledge and favorable attitudes toward collaboration by promoting understanding and respect among professionals from different fields[11]. However, its implementation in the emergency context presents its own challenges, related to the integration between different professionals and services and the characteristics of the work process in this setting, demanding educational strategies adapted to its specificities[12].

Given this context, it is relevant to understand how professionals working on the frontlines of public emergency care perceive and experience collaboration in recognizing violence. Analyzing these experiences can contribute to identifying the potential and weaknesses of existing practices and guiding management, training, and care organization strategies.

Thus, the present study aims to analyze the verbalizations of the multiprofessional team regarding collaborative practices in recognizing different situations of violence identified within the context of care at a public tertiary emergency service in Ceará.

METHODOLOGY

This is a qualitative study designed to understand health professionals' perceptions and experiences regarding collaboration in recognizing violence in emergency services. Qualitative research was adopted because it allows the apprehension of meanings, intentionalities, and social constructions present in healthcare practices[13].

The study was conducted at a public tertiary hospital affiliated with the Health Secretariat of the State of Ceará, a reference center for the diagnosis and treatment of cardiac and pulmonary diseases, and an integral part of the emergency care network. The institution serves as a high-complexity reference center in cardiology and pulmonology, receiving patients from various municipalities across the state. The research was carried out in the cardiovascular surgery service, which integrates the institution's specialized cardiology care. This setting was selected because it concentrates highly complex care and allows for the identification of situations of violence that are frequently rendered invisible in the emergency context.

A total of 34 health professionals working in the emergency unit, aged ≥18 years and with a min-

imum of three months of experience in the sector, participated in the study. Selection occurred via chain-referral sampling (snowball technique), a strategy indicated for recruitment through participants' relationship networks[14]. Data collection was concluded upon reaching data saturation, which was considered achieved when interviews began presenting recurrence of meanings and contributed no further relevant elements to understanding the investigated phenomenon[15].

Data generation occurred through semi-structured interviews conducted between May and July 2025 in a private room at the institution. The interview guide covered questions regarding the recognition of violence situations, team preparation, collaborative practices, interprofessional communication, and institutional challenges. Situations of violence were addressed comprehensively without prior delimitation of typologies, considering those identified or perceived by professionals in the context of their work in the emergency service. Interviews were audio-recorded with participants' authorization, transcribed verbatim, and reviewed to ensure the accuracy of the empirical material.

Data organization and analysis followed the stages of thematic content analysis: pre-analysis, material exploration, and result interpretation[16]. Transcripts underwent skimming/floating reading, and the textual corpus was organized and processed with the support of IRaMuTeQ software (Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires), utilized as a tool to assist in systematizing empirical material[17]. Data interpretation and the construction of analytical categories were performed by the researchers, guided by the framework of interprofessionality and collaboration in healthcare work. To support analytical systematization, a coding matrix containing codes and subthemes was developed, which informed the construction of the categories presented in the Results and Discussion sections (Supplementary Material 1). Participant statements were identified by alphanumeric codes (P-01, P-02, ...) to ensure anonymity.

Methodological rigor was pursued through strategies aiming for credibility and interpretive consistency of findings, including investigator triangulation between researcher and advisor during categorization and interpretive validation of results[18].

The study was approved by the Research Ethics Committee of the University of Fortaleza (CAAE No. 83069024.8.0000.5052, Opinion No. 7,111,532), in accordance with Resolutions No. 466/2012 and No. 510/2016 of the National Health Council[19,20]. All participants signed the Informed Consent Form, ensuring data confidentiality and anonymity.

RESULTS

This section presents the empirical findings of the study, organized around participant characterization and thematic analysis of the interviews, which led to the identification of the central theme and analytical subthemes.

Characterization of participants

A total of 34 health professionals working in the emergency unit participated in the study. The predominant age group was 30 to 39 years (41.17%), followed by 40 to 49 years (29.41%). Regarding gender, the majority identified as female (61.76%), 29.41% declared as male, and 8.82% identified with another gender.

Regarding race/color, there was a predominance of brown/multiracial (pardo) professionals (55.88%), followed by white (23.53%), Black (14.71%), and Indigenous (5.88%). Regarding marital status, an even distribution was observed between married (44.12%) and single (41.18%) participants, with a smaller proportion of divorced individuals (14.71%). Concerning religion, the majority identified as Catholic (64.71%), followed by Evangelical (17.65%), Christian (5.88%), no religion (5.88%), Spiritist (2.94%), and Protestant (2.94%).

Regarding academic background, lato sensu specialization predominated (73.53%), followed by undergraduate degree holders only (14.71%), Master's degree holders (8.82%), and PhD holders (2.94%). Concerning professional category, nurses constituted the majority of the team (55.88%), followed by physical therapists (23.53%), psychologists (8.82%), social workers (8.82%), and physicians (2.94%). Mean time since professional graduation was 11.63 years (ranging from 1.5 to 40 years), while mean professional experience in their respective area was 8.78 years (ranging from 1 to 35 years). Regarding monthly income, 61.76% of participants reported earning between four and six minimum wages, the predominant range in the sample.

The characterization of the multiprofessional team allowed for an understanding of the sociodemographic and professional profile of the participants, serving as a contextual basis for analyzing the perceptions and practices reported in subse-

quent subsections.

Central theme and subthemes

The thematic analysis of the interviews converged on the central theme "Healthcare team perceptions on multiprofessional collaboration", which expresses the fragility of collaborative practices and the institutional invisibility of violence in daily emergency service routines.

Five analytical subthemes emerged: (1) Recognition of violence; (2) Team preparation; (3) Collaborative practices and leadership; (4) Interprofessional communication and contributions; (5) Institutional challenges to multiprofessional collaboration.

Recognition of violence

Identification of patients with suspected violence was denied by 11 of the 34 participants. However, 23 professionals reported having encountered, during patient care, individuals who revealed, subtly or explicitly, situations associated with violence.

"Yes, with reservations regarding psychological violence." (P-08)

Reports revealed silences, hesitations, and faltering responses, indicating that in many cases violence is intuited, but neither named nor formally recorded.

Team preparation from an interprofessional perspective

The majority of participants (n=23) do not consider the team to possess the necessary preparation to handle situations involving violence. Another 11 participants stated that the team is prepared, albeit with limitations.

"No, I believe the team needs training in case resolution." (P-03)

"Not always." (P-11)

"Sometimes, there is a lack of perception regarding how to identify types of violence." (P-18)

"Partially... I think there is a lack of training and time." (P-27)

Collaborative practices and leadership

Recognition of the importance of joint performance in recognizing cases of violence was unanimous among participants.

"It plays a prominent role in identifying physical and behavioral signs, notification, and case follow-up." (P-01)

"Importance of an overall, physiological, and social outlook." (P-06)

"The importance is that there will be quality, comprehensive, and empathetic care." (P-02)

"Because from the moment everyone is aware: we can avoid or try to find a way to prevent it from happening again." (P-04)

"Provide psychological, physical, mental, and spiritual support to the victim, instilling trust in them." (P-28)

Regarding adopted practices:

"Generally, cases are identified and aligned within the team for better resolution." (P-03)

"Notification, promoting privacy, welcoming listening, follow-up with psychology." (P-08)

"Support from social work and psychology. Enabling an approach to the patient. Providing mechanisms to exit the situation." (P-09)

"Guiding on rights, facilities, and responsible services." (P-20)

Accounts of lack of knowledge also emerged:

"I haven't witnessed it yet, but I am unaware of collaborative leadership practices." (P-27)

"I haven't gone through this problem yet and I don't know what to do." (P-30)

Interprofessional communication and contributions

Communication was recognized as the foundation of teamwork.

"Important so that upon identifying violence, the case is resolved as soon as possible." (P-25)

"Without communication, there is no multiprofessional team." (P-17)

"In the context of improvement and quality of care." (P-23)

"It is important for quality care. For the patient to be seen as a whole, when there is also communication." (P-27)

"Fundamental. Since there are nuances that are sometimes not noticed by the entire team." (P-09)

"Effective communication from everyone on the team to work on care individually." (P-29)

Regarding specific contributions:

"In identification, building rapport with the victim, finding resources that can support them upon leaving the hospital." (P-09)

"Listening, welcoming, reporting, and educational actions." (P-02)

"Each professional in their area (nursing, physical therapist, physician...) would need to know about a problem and try to identify it." (P-13)

"Through a concise perspective, which is specific to each professional." (P-04)

"Each team member has an important role to develop. Specialized care for the context." (P-29)

Communication weaknesses:

"There is still a taboo about asking about the event, lack of communication." (P-06)

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"Deficient and insufficient." (P-24)

"I perceive there is a contribution, but it should be done more attentively across all categories." (P-12)

"They are few, almost zero, many do not speak up due to lack of support or not knowing how to deal with it." (P-30)

"There is still little knowledge on how to act." (P-31)

"It is still a very timid action, perhaps due to lack of knowledge, fear of retaliation or violence from the aggressive family itself." (P-32)

Institutional challenges to multiprofessional collaboration

"Inadequate space, lack of professionals focused on the issue of violence, implementation of specific committees for active case searching." (P-01)

"Particularly in the urgency and emergency context, it is complicated by service dynamics." (P-03)

"Communication, lack of training and guidance on types of violence." (P-18)

"The process of awareness and knowledge about the types of violence that may arise in urgency and emergency services. I think these are factors that go beyond challenges to implementing interprofessional collaboration." (P-27)

"Omission in some cases due to fear, not reporting, low involvement." (P-31)

DISCUSSION

Results demonstrate that the multiprofessional team recognizes the importance of collaboration in addressing violence; however, daily practice remains marked by fragmentation, lack of protocols, and institutional silencing.

The implicit recognition of violence, coupled with formal denial of cases, expresses the existence of a "gray zone" between what is perceived and what is institutionally acknowledged. Evidence generated in emergency services, particularly in the context of intimate partner violence, demonstrates that professional, institutional, and systemic barriers can hinder the identification of and response to situations of violence, including limitations in knowledge and training, insufficient time and privacy, high care demand, and weaknesses in organizing care workflows[7,8,21]. In this sense, the gap between perceiving signs of violence and formally incorporating them into care can foster their continued invisibility in daily care practice.

The perception of insufficient team preparation converges with recent studies identifying gaps in professional knowledge and training as barriers to screening, recognizing, and managing violence in emergency services[8,21,22]. Overcoming these weaknesses, however, depends not solely on individual knowledge acquisition, but also on educational processes linked to concrete work conditions, available resources, and institutional organization[11,12]. Thus, addressing violence requires training that fosters collaborative competencies and prepares different professional categories to jointly recognize and respond to complex situations. Recent literature on emergency care identifies a lack of knowledge and infrastructure among barriers reported by professionals themselves, whereas preparation, availability of institutional policies, and adequate resources act as facilitators[8,21,22].

Although professionals recognize the importance of joint work, findings reveal that the predominant practice configures referral-based multiprofessional collaboration, concentrating responsibility within the psychology and social work units. The simultaneous presence of different professional categories does not, in itself, imply integration between knowledge and practices, since interprofessionality presupposes interaction, shared goals, recognition of role complementarity, and co-responsibility for care[1]. In the emergency environment, the quality of interprofessional work also depends on the team's ability to share information, establish trusting relationships, and coordinate actions in the face of complex situations[4]. Thus, referral can integrate care, but when it assumes the form of transferring responsibility to another category, it tends to preserve the multiprofessional fragmentation identified in the accounts. Milton *et al.*[4] identified communication, trust, and coordination precisely among the elements associated with the functioning of interprofessional work in a high-risk emergency setting.

Communication was recognized as a structural element of teamwork, yet understood in a predominantly instrumental manner. This finding warrants attention because interprofessional communication extends beyond the simple transfer of information and is influenced by relationships among professionals, assumed roles, hierarchies, and organizational work conditions[4,23]. Literature reviews and studies conducted in hospital and emergency contexts indicate that collaborative interprofessional relationships, trust, information sharing, and coordination foster teamwork, whereas hierarchical environments

and organizational difficulties can compromise communication and collaboration[4,23].

From this perspective, communication constitutes a key mechanism for transitioning from multiprofessionality to interprofessionality. When contact between categories is restricted to passing on information and forwarding demands, professional boundaries and relatively isolated responsibilities are preserved; when it involves dialogue, perspective sharing, role negotiation, and joint decision-making, possibilities for integration and co-responsibility for care expand[1,4,23.] In the context of violence, this articulation assumes particular relevance, as physical, behavioral, and social signs may be perceived differently by distinct professional categories, such that integrating these perceptions can contribute to a more comprehensive understanding of the situation and shared definition of conduct. Thus, the communication weakness observed in the accounts represents not merely an operational difficulty, but a potential barrier to constructing interprofessional practice.

Institutional challenges – absence of protocols, insufficient training, work overload, and inadequate infrastructure – reveal that omission in the face of violence stems not solely from individual attitudes, but also from organizational conditions under which care is produced. Recent evidence on intimate partner violence care in emergency services identifies barriers at various levels, including insufficient professional knowledge, time and privacy constraints, high care demand, infrastructure limitations, and difficulties accessing specialized resources[7,8,21,22]. Conversely, training, availability of policies and protocols, institutional support, and access to appropriate resources are highlighted as elements capable of fostering professional response[8,21,22]. These findings reinforce the understanding that recognizing violence requires technical and organizational support, rather than relying solely on individual professional initiative.

In this scenario, interprofessionality represents a desired normative horizon, yet remains distant from observed practice. Consolidating this model requires articulated actions involving professional qualification, communication strengthening, shared definition of responsibilities, and organization of care workflows capable of sustaining recognition of and response to situations of violence[1,4,11,12,23]. Furthermore, evidence from emergency and trauma services indicates that adopting structured screening protocols can increase the identification of individuals experiencing intimate partner violence compared to non-standardized approaches[24]. However, isolated protocols do not replace building a collaborative culture in which different professionals have conditions to share information, discuss identified situations, and jointly assume responsibility for care.

CONCLUSION

This study analyzed the perceptions of the multiprofessional team at a tertiary public emergency service regarding collaboration in recognizing situations of violence. Results demonstrate that although professionals recognize the importance of joint action, daily work remains predominantly multiprofessional, with fragmented practices dependent on individual initiative.

The absence of institutional protocols, systematic training, and formal spaces for collective discussion limits the consolidation of interprofessionality and contributes to the invisibility and underreporting of violence in the emergency context. Communication, although recognized as essential, proved fragile and insufficient to sustain shared decision-making and co-responsibility for care.

In conclusion, strengthening interprofessional collaboration to address violence in urgency and emergency services requires investments in permanent education, definition of clear care workflows, and construction of an institutional culture that recognizes care for individuals experiencing violence as a collective team responsibility. Findings contribute to informing strategies for qualifying comprehensive care for individuals experiencing violence in these settings.

CRediT author statement

Conceptualization: Silva, SS; Vieira, LJES. Methodology: Silva, SS; Vieira, LJES. Investigation: Silva, SS. Data curation: Silva, SS. Formal analysis: Silva, SS; Vieira, LJES. Writing – Original draft: Silva, SS. Writing – Review & editing: Silva, SS; Vieira, LJES; Silva, RM; Probo, DRG; Alencar, SVGL. Validation: Vieira, LJES; Silva, RM; Probo, DRG; Alencar, SVGL. Supervision: Vieira, LJES. Project administration: Silva, SS; Vieira, LJES. Visualization: Silva, SS.

All authors have read and agreed to the published version of the manuscript.

Data availability statement

The analytical coding matrix is available as Supplementary Material 1. The raw interview data are not publicly available due to ethical and confidentiality reasons.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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SUPPLEMENTARY MATERIAL 1

Material Suplementar 1 – Codificação usada na análise dos dados, Fortaleza, Ceará, Brasil, 2025.

Q.1	Utilizou **S (Sim**) *reconhecimento* da violência, **N (Não)** *invisibilidade da violência* e **P (Parcial)** *dificuldade de identificação* (“às vezes” ou “parcialmente”).
	Subtemas: Reconhecimento (clareza na identificação), Invisibilidade (negação/identificação) e Dificuldade de identificação (respostas parciais ou incertas).
Q.2	**N-LF, N-FP e N-FO** para indicar respostas *negativas ligadas a lacunas, falta de preparo ou formação profissional;* **S-RP** para *reconhecimento parcial*; **P-II, P-FT e P-PS** para respostas *parciais ou hesitações*; e **R-VP** para *ressalvas sobre a violência psicológica*.
	Subtemas: *Lacunas na formação, Reconhecimento parcial, Oscilação na identificação e Ressalvas específicas.*
Q.3	**I-SF, I-AC, I-AT, I-CN, I-FL, I-BP, I-RP, I-PR, I-RE, I-AF, I-DC, I-SM, I-NF, I-AP** e **I-DN**, representando respectivamente identificação de sinais, atendimento acolhedor, atribuições específicas, consciência coletiva, fluxo e protocolos, visão biopsicossocial, respostas genéricas de importância, proteção/rapidez, prevenção da recorrência, acolhimento familiar, diálogo, sensibilidade multifatorial, necessidade de formação, apoio psicológico e denúncia.
	Subtemas: *Identificação de sinais, Atribuições e condutas, Acolhimento/apoio, Comunicação e Formação/qualificação.*
Q.4	N (notificação), E (encaminhamento), A (acolhimento), C (conversa/diálogo), SS (serviço social), Psi (psicologia), Eq (equipe multiprofissional), R (resolução/condutas), O (orientação), Se (serviço de segurança) e ND (não descreve práticas).
	Subtemas: *Notificação/encaminhamento, Acolhimento/direitos/notificação, Trabalho em equipe, Serviço Social/Psicóloga.*
Q.5	**C-AQ** (comunicação, acolhida, escuta qualificada)**, C-CL** (comunicação clara/objetiva), **C-FI** (fundamental/importante), **C-UT** (utilidade para resolução), **C-FA** (falha/deficiente), **C-TB** (tabu/dificuldade de abordar), **C-RA** (rápida/eficaz), **C-AS** (assertiva/ética), **C-EM** (empática), **C-CO** (confiança/segurança ao paciente), **C-RE** (resolução de problemas), **C-DA** (diálogo/alternativas), **C-SQ** (sem comunicação não há equipe), **C-PA** (atuação específica), **C-RP** (rede de apoio), **C-MQ** (melhoria/qualidade do cuidado), **C-CD** (coleta de dados), **C-IE** (comunicação integrada, efetiva) e **C-NF** (necessidade de fortalecimento da comunicação).
	Subtemas: *Importância da comunicação, Comunicação clara, Falhas/barreiras, Acolhimento/ escuta.*

Q.6	**ID** (identificação), **A** (acolhimento), **AE** (ações educativas), **OE** (olhar específico), **LG** (lacunas na gestão), **FC** (falta de capacitação), **DC** (desfecho clínico), **NV** (necessidade de valorização), **RE** (resposta evasiva), **SS-Psi** (serviço social e psicologia), **PC** (pouca contribuição), **PK** (pouco conhecimento), **AM** (ação tímida/medo de represália) e **SM** (preservação da saúde mental).
	Subtemas: *Especificidade profissional, Avaliação/assistência, Ação tímida, Pouca contribuição.*
Q.7	**EA** (estrutura/ambiência), **CF** (comunicação frágil), **FQ** (falta de qualificação), **DS** (dinâmica do serviço), **FT**I (falta de tempo/interesse), **B-PM** (baixa participação multiprofissional), **DV** (desconhecimento sobre violências), **PPA** (problemas pós-alta), **BU** (burocracia), **PH** (percepção humanizada), **CP** (capacitação), **PP** (proatividade), **EDS** (educação em saúde), **ADE** (adesão das equipes), **PR** (preservação da vítima), **DO** (desorganização), **FRI** (formação insuficiente), **DI** (demora institucional), **RIF** (resistência familiar), **OM** (omissão/medo), **SE** (sensibilização) e **AH** (abordagem humanizada).
	Subtemas: *Dinâmica do serviço, Comunicação/formação; Sensibilização/conhecimento, Desorganização/colaboração.*

Fonte: Dados da pesquisa (2025). Legenda: Q = Questão.