

(Bio)ethics and Family Health Strategy: mapping problems

(Bio)ética e Estratégia Saúde da Família: mapeando problemas

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Abstract

This article presents the results of an investigation aimed at outlining the main (bio)ethical problems identified by members of the Family Health Strategy (FHS) teams in the town of Viçosa, Minas Gerais, Brazil. This study has a qualitative approach, and it is situated in the social research field. The investigation was conducted by applying a semi-structured questionnaire with open and closed questions to professionals - physicians, nursing professionals, and community health workers - working in the FHS. The responses were addressed using the content analysis technique - more specifically, its thematic modality -, due to its suitability for qualitative investigation in the health field. The investigation relied on the participation of 73 professionals from 15 FHS teams. It was observed that a large part of respondents had some difficulty identifying problems of a (bio)ethical nature in their work process. Even so, it was possible to categorize five major groups of (bio)ethical issues experienced by teams: those related to unequal access to health services; those related to the teaching-work-community relation; those related to secrecy and confidentiality; those related to conflicts between team and users; and those related to conflicts between team members. It is concluded that, although apparently more subtle - when compared to the (bio)ethical issues taking place in hospital institutions -, there are moral conflict situations belonging to the domain of primary health care that undermine the work process and the scope of promoting comprehensiveness in care.

Keywords: Primary Health Care; Family Health Strategy; Ethics; Bioethics.

Resumo

Este artigo apresenta os resultados de uma investigação dirigida ao delineamento dos principais problemas (bio)éticos identificados pelos membros das equipes da Estratégia Saúde da Família (ESF) do município de Viçosa (MG). Trata-se de estudo com abordagem qualitativa, situando-se no campo da pesquisa social. A investigação foi realizada por meio da aplicação de questionário semiestruturado com perguntas abertas e fechadas aos profissionais - médicos, profissionais de enfermagem e agentes comunitários de saúde - que atuam na ESF. Realizou-se a apreciação das respostas pela técnica de análise de conteúdo - mais especificamente, sua modalidade temática -, em razão de sua adequação à investigação qualitativa na área da saúde. Participaram da investigação 73 profissionais de 15 equipes da ESF. Observou-se que grande parte dos entrevistados tinha dificuldade para identificar problemas de cunho (bio)ético em seu processo de trabalho. Ainda assim, foi possível categorizar cinco grandes grupos de problemas (bio)éticos vivenciados pelas equipes: os relacionados à desigualdade de acesso aos serviços de saúde; os relacionados à relação ensino-trabalho-comunidade; os relacionados ao sigilo e à confidencialidade; os relacionados aos conflitos entre equipe e usuários; e os relacionados aos conflitos entre membros da equipe. Conclui-se que, mesmo que aparentemente mais sutis - se comparadas às questões (bio)éticas que se passam nas instituições hospitalares -, existem situações de conflitos morais atinentes ao âmbito da atenção primária à saúde que corroem o processo de trabalho e o alcance da promoção da integralidade do cuidado. **Palavras-chave:** Atenção Primária à Saúde; Estratégia Saúde da Família; Ética; Bioética.

Introduction

The Family Health Strategy (FHS) is a health care model - implemented by the Brazilian Ministry of Health from 1994 onwards - that intricately articulates (1) health promotion and (2) health care - diagnosis, treatment, prevention, rehabilitation and recovery - for the sick¹. Originally conceived as a program (The Family Health Program - FHP), the FHS has contributed decisively to reorganizing Primary Health Care (PHC) and to fully developing, within the ambit of the services, the principles of the Brazilian Unified Health System (SUS): universality, fairness, comprehensiveness, decentralization, resolution, regionalization and hierarchization, popular participation and private sector complementarity². These processes have been made viable based on the tireless work of the FHS teams, made up of a physician, a nurse, a nursing assistant and four to six community health workers (CHWs). It should also be noted that Oral Health professionals, a dentist, dental assistant and hygienist may also form part of the team (Brasil, 2012). With the aim of improving FHS activities, in 2008 the Ministry of Health approved the creation of the Family Health Support Center (FHSC) including the following professionals: social care worker; pharmacist; physiotherapist; speech therapist; acupuncturist; gynecologist; homeopath; pediatrician; psychiatrist; nutritionist; physical education professional; psychologist; and occupational therapist (Brasil, 2012). In this form, the FHSC is linked to between five and 20 FHS teams (Brasil, 2012).

With these professionals from different areas of health care, the FHS multi-disciplinary teams face a series of ethical issues in creating bonds between themselves and with individuals in the collectivity, issues that may pass unnoticed and unidentified (Motta, 2012). In such terms, Zoboli and Fortes (2004), describe different types of (bio)ethical problems³ in the FHS, highlighting ethical problems in the relationships

1 Information obtained from: BRAZIL. Ministry of Health. Department of Primary Care. Family Health Strategy. Available: <http://dab.saude.gov.br/portaldab/ape_esf.php>. Accessed on: 17 Dec. 2012.

2 Information obtained from: BRAZIL. Ministry of Health. Department of Primary Care. Family Health Strategy. Available: <http://dab.saude.gov.br/portaldab/ape_esf.php>. Accessed on: 17 Dec. 2012.

3 We chose this term to avoid entering into the intricacies of the theoretical debate on the differences and similarities between ethics and bio-ethics (Rego; Palácios; Siqueira-Batista, 2009).

with users and their families; in relationships within the team; and in relationships with the health care organization and system. Such issues can be approached through a process of ongoing and permanent education that would assist professionals in constructing the own knowledge, which is related to the capacity to identify and resolve issues using moral principles and concepts that can support better decision making (Zoboli, 2007). It is in this context that investigations into evaluating and outlining (bio)ethical problems within the FHS become necessary and relevant. This is an essential stage in order to later implement and then evaluate pedagogical strategies to approach such problems, with the objective of making the teams more able to deal with the (bio)ethical issues with which they are faced and with constructing comprehensive health care, an essential aspect of a genuine SUS.

Based on these considerations, this article approaches the main (bio)ethical problems identified by the FHS workers in the city of Viçosa, a medium sized municipality in Minas Gerais.

Methodology

Characterizing the area of the study

This study was conducted in the Viçosa, a municipality with an area of 299.39 km² of territory. Geographically, it belongs to the micro-region of Viçosa and the mesoregion of the Zona da Mata in Minas Gerais, made up of 142 municipalities, with approximately three million inhabitants. The population of Viçosa is 72,200 inhabitants – 93.2% living in the urban zone and 6.8% in the rural zone (IBGE, 2010) –, with a demographic density of 241.2 inhab./km². The city's primary health care network has three health care units, of which 12 form part of the FHS, with a total of 11,286 families registered.

Research participants: workers from the fifteen FHS teams in the municipality of Viçosa (MG) who agreed to complete the questionnaire.

Study design

This study falls within the field of social research, using methodology and instruments from qualitative research, due to the characteristics of the object being investigated. The intention was to capture the dynamic and complex reality of the (bio)ethical prob-

lems within the FHS in its historical-social fulfillment (Minayo, 1994). Thus, this study is organized around an outline of the main (bio)ethical problems identified by members of the FHS teams, through a semi-structured questionnaire with both open and closed questions.

The questionnaire - applied between March and July 2012 - contains 25 questions divided into three main sections: (1) general characteristics on the ESF professionals' training and length of time on the job; (2) (bio)ethical problems the team faces; and (3) knowledge of (bio)ethical concepts. The "(bio)ethical problems the team faces" section contains open questions in which the professionals are to describe (bio)ethical situations they have experienced within the FHS unit, the consequences, the way in which the team approached the issue(s) and what the solution, if any, was. The third and last section of the questionnaire - "knowledge of ethical and (bio)ethical concepts" -, contains questions on knowledge of these concepts. In this article, priority will be given to the first two domains, the last reserved to be covered in a separate publication.

The teams were approached within their FHS units - always by the same researcher - to inform them about the proposal of the study, formalize the invitation to take part and to clarify the objectives. Once the professional had consented to take part, the semi-structured questionnaire was applied to those who wished to participate. The researcher's role was to interfere as little as possible, merely providing guidance and encouraging each participant to provide more detailed responses.

Ethical aspects of the research

The project was approved by the Ethics Committee for Research with Human Beings of the Universidade Federal de Viçosa. In order to conduct the study, all participants were required to sign an Informed Consent Form, which emphasized the risks and benefits of the investigation, as well as explaining the guaranteed anonymity of those who responded to the questionnaire. The protocol therefore adheres to the terms of Resolution 196/96 - and posterior, including Resolution 466/2012, currently in force - from the National Health Council regulating research involving human beings.

Data analysis

The responses were evaluated using the content analysis technique, more specifically, thematic analysis (Bardin, 2009), understood as “set of techniques for analyzing communications, aiming to obtain indicators (quantitative or otherwise) that enable inferences to be made concerning the conditions in which these messages were produced/received (inferred variables) through systematic and objective description of the messages’ contents” (Bardin, 2009, p. 32), as it is appropriate to qualitative investigation in the health care area. After a detailed reading of the responses, there were three stages: pre-analysis; exploring the material; and processing the results, inference and interpretation (Minayo, 2007; Bardin, 2009). The data were further quantified using the Epi Info™ program version 3.5.2.

Results and discussion

The results will be presented by questionnaire section, so as to facilitate visualization of the data obtained and of the related discussion.

Section I - General characteristics of the participants

There were 73 FHS professionals (from a total of 138 workers from the municipal PHC, in other words, $73/138 = 52.9\%$), distributed as shown in Table 1, who responded to the questionnaire lasting 30 to 35 minutes. The majority of these were female ($n = 62$). To guarantee anonymity, each questionnaire was given a code, containing a number associated with an acronym, so that any reference to it was made to the corresponding code.

Table 1 shows that the majority of participants belong to the CHW group (47; rel. freq. = 64.4%) and that 60 (rel. freq. = 82.2%) responded that their level of schooling was average, while 13 (rel. freq. = 17.8%) had finished higher education (having completed or being in the process of doing a specialization). This is significant as the perspective of those professionals with an average level of education, especially the CHWs, regarding (bio)ethical problems in the FHS is prevalent in the group studied. It seems clear that the fact that the CHWs live and work in the same geographical space implies a different view of

their own practice and the problems occurring in it (Binda et al., 2013). However, this context reflects the reality, as the FHS teams usually contain 75.0% of professionals with average levels of education - i.e. between six and eight CHWs and a nursing technician, doctor and nurse (Guimarães et al., 2013).

Table 1 - Distribution of the number and proportion (%) of FHS professionals according to profession, Viçosa, MG, 2012

| Profession | Absolute frequency | Relative frequency (rel. freq.) (%) |
|-------------------------|--------------------|-------------------------------------|
| Community Health Worker | 47 | 64.4 |
| Dental Assistant | 2 | 2.7 |
| Dentist | 2 | 2.7 |
| Nurse | 7 | 9.6 |
| Doctor | 2 | 2.7 |
| Other | 4 | 5.5 |
| Nursing Technician | 9 | 12.3 |
| Total | 73 | 100.0 |

The length of time working - in the PHC alone - is shown in Table 2, with two participants failing to respond to this question.

Table 2 - Distribution of the number and proportion (%) of FHS professionals working in primary care according to length of time there, Viçosa, MG, 2012

| Total time working in Family Health (in years) | Absolute Frequency | Relative Frequency (rel. freq.) (%) |
|--|--------------------|-------------------------------------|
| 0-1 | 25 | 35.2 |
| 1-2 | 4 | 5.6 |
| 2-5 | 34 | 47.9 |
| 6-10 | 4 | 5.6 |
| 11-15 | 4 | 5.6 |
| Total | 71 | 100.0 |

The data show that few professionals remain working in the FHS for a considerable time, corroborating what previous studies have described in the literature, highlighting how professionals do not remain working in PHC (Cotta et al., 2006; Junqueira

et al., 2009, 2010). Among the significant causes that explain this finding is the “precariousness” of the work and dissatisfaction with it, stemming from problems related to feeling professionally undervalued; wage policy; instability in the employment relationship - often organized as providing indirect services to the municipal health department (Binda; Bianco; Sousa, 2013); demotivation with working conditions; lack of opportunities for professional growth; interpersonal relationships within the FHS unit; selection and recruitment and lack of adequate infrastructure in the FHS units among others (Medeiros et al., 2010; Junqueira et al., 2009, 2010; Cotta et al., 2006). Another disadvantageous aspect concerns the appearance of inefficient ways of managing the FHS, such as outsourcing to state foundations or social organizations (SO) (Cotta et al., 2006). With regards CHWs - the majority of participants - it should be noted that many workers are only active in the FHS on a temporary basis, while they await opportunities in the labor market

for the positions for which they have trained. In this context, the investigation by Mota and David (2010), in Rio de Janeiro, showed that CHWs are increasingly aiming to improve their level of schooling, at both a technical - administration, construction, nursing, aesthetics, computer, industrial mechanics, radiology or work safety technician - and a higher education level - business administration, architecture, biotechnology, accounting, law, physical education, nursing, geography, environmental management, the Arts, logistics, mathematics, nutrition, education, oil and gas, psychology, advertising, social services, data processing technology, tourism or veterinary studies (Mota; David, 2010).

Section II - Aspects related to the main (bio)ethical problems identified by team members

Based on the analysis of responses related to (bio) ethical issues, it was possible to categorize five types of problems concerning situations experienced in FHS units (Table 3).

Table 3 - Distribution of the number and proportion (%) of FHS professionals according to the main categories of (bio)ethical problems reported, Viçosa, MG, 2012

| (Bio)ethical Problems | Absolute frequency | Relative frequency (rel. freq.) (%) |
|--|--------------------|-------------------------------------|
| No response | 14 | 19.2 |
| No experience of ethical problems in the unit | 26 | 35.6 |
| Related with inequality of access | 4 | 5.5 |
| Related with the teaching-working-community relation | 1 | 1.4 |
| Related with secrecy and confidentiality | 14 | 19.2 |
| Related with conflict between team and service users | 10 | 13.7 |
| Related with conflict between team members | 4 | 5.5 |
| Total | 73 | 100.0 |

A significant number of the participants (n = 40; rel. freq. = 53.8%) reported that they had not experienced (bio)ethical problems (n = 26; freq. rel. = 35.6%) or did not respond to the question (n = 14; rel. freq. = 19.2%). Of those who did not respond, four were nursing technicians, one was a nurse and nine were CHWs. It can also be seen from Table 3, that 33 professionals (rel. freq. = 45.2%) mentioned (bio) ethical conflicts when asked to identify or describe situations of this type that they had experienced in FHS units.

In the group that responded to the question in the affirmative, it can be seen that many responses demonstrate genuine obstacles to identifying situations related to (bio)ethical problems, there being a certain amount of confusion with problems concerning the team’s processes of planning and organizing work:

[...] Lack of communication between team members, punctuality (TE13).

Discussing problems in front of a patient (TE33).

Lack of communication between staff (TSB27).

Such findings are linked, by different authors, to the significant difficulties health professionals have recognizing (bio)ethical issues in situations in their own work practices (Motta, 2012; Zoboli; Fortes, 2004) as well as the their imbalance between acquiring technical competence and moral competence (Feitosa et al., 2013). Moreover, the above mentioned observation is exacerbated by the composition of the group studied - largely made up of CHWs -, workers for whom (bio)ethical concepts are not usually included in the training process and who, to date, do not have their own code of ethics (Vidal et al., 2013).

It should be noted that the difficulty in identifying - or a certain amount of confusion regarding - (bio)ethical issues related to their own knowhow, has also been noted in a study conducted with primary care doctors and nurses in São Paulo (Zoboli; Fortes, 2004). In Zoboli and Fortes (2004), it was proposed that meetings with service users in the PHC units be more frequent and in situations with less or no urgency - for example, when compared to the reality in emergency rooms or intensive care units -, in which (bio)ethical problems present themselves in a more subtle way, less noticeable to FHS professionals (Motta, 2012; Zoboli; Fortes, 2004; Zoboli; Soares, 2012).

The problems identified were organized into five categories - (bio)ethical problems related to inequality in access to health care services; related to the teaching-work-community relationship; to secrecy and confidentiality; to conflict between the team and service users' and to conflicts between members of the team - which will be discussed in the topics to follow. This will be followed by some brief notes on approaches to (bio)ethical problems in the FHS and their consequences.

(Bio)ethical problems related to inequality in access to health care services

As can be seen in table 3, four professionals (rel. freq. = 5.5%) reported (bio)ethical problems concerning users' difficulty accessing family health care unit services, as shown in the following extracts:

[...] Users' requests for procedures not appropriate to the unit [...]; waiting time for specialist consultations (AA70).

Disrespect towards employees due to waiting times for specialist consultation (E63).

[...] There was a problem in making the appointment; the individual became irritated [...]. (ACS65).

Access to health care services can be evaluated from the point of view of SUS principles, from the perspective of comprehensiveness and, particularly, the principle of equality (Siqueira-Batista; Schramm, 2005). The latter - one of the foundations of the current debate on right to health - can be articulated, as indicated by various authors, as the (bio)ethical principle of justice (Beauchamp; Childress, 2002), the original formulation of which can be sought in Aristotle:

If the persons are not equal, they will not have equal shares; this is when quarrels and complaints arise (as when equals possess or are allotted unequal shares, **or persons not equal, equal shares**) (Aristotle, 1985, step 1131a, 21-26, our emphasis).

The identification made by the four professionals, therefore, falls perfectly within the modern (bio)ethical - and legal - debate, especially when we consider the constitutional provision that guarantees all Brazilians access to health and the best possible conditions to maintain and recover it. In the reality of the PHC scene, numerous difficulties in the manifestation of these precepts can be observed (Diniz, 2011), with significant implications in terms of inequality and potential health problems (Cotta et al., 2007):

[...] inequalities, even in health care given and not only in health care coverage, may also be significant for social justice and health equality [...]. Let us suppose that individuals A and B have exactly the same health predispositions, including a predisposition to a particularly painful illness. But A is very rich and is able to cure or completely suppress the illness with expensive medical treatment,

while B, who is poor, cannot afford to pay for such treatment and thus suffers greatly. This is a clear health inequality. [...] the resources used to cure rich A could have been used to provide relief to both [...]. (Sen, 2002, p. 304).

The hypothetical situation presented by Amartya Sen has been detected in a variety of contemporary research (Costa, 2012; Trad; Castellanos; Guimarães, 2012). Dealing with the problem (bio)ethically means recognizing the situation of vulnerability - and/or suffering - that illness provokes, which should find an organized health system capable of providing an approach to adequately deal with threats to users' wellbeing, using the health care unit and home visits in order to do this (Jungues, 2007). Thus, the basic role of the FHS for equality of health care access should be discussed within the team - as a (bio)ethical and political issue -, seeking experiences in the literature that support activities within the ambit of health care management (Carneiro Júnior; Jesus; Crevelim, 2010), to make PHC a still more effective gateway to the SUS.

(Bio)ethical problems related to the teaching-work-community relationship

Of the participants, only one (rel. freq. = 1.4%) highlighted the sphere of the teaching-work-community relationship as an important element from a (bio) ethical point of view. This datum is noteworthy in a context in which a large part of the health care units in the municipality of Viçosa have received medical students from the Universidade Federal de Viçosa - as well as students of nursing and nutrition - since March 2010.⁴

Based on the large number of references and studies already published, in concordance with what is recommended in the National Curricular Directives (NCD) for degree courses in the health care area, it can be seen just how necessary teaching is - especially for professionals who will work in primary care, as it is at this stage that up to 80%

of health problems should be resolved - it takes on a guise of social practice, organized around the proposal of instilling knowhow in which producing/constructing knowledge, academic training and providing services are adapted to health care service users (Cézar et al., 2010). In this context, it stands out that the pedagogical processes of training health care professionals should also prioritize (bio)ethical debate, as highlighted, for example, in the NCD of Degrees in Medicine (Brasil, 2014):

Art. 5º in Health Care, the student will be trained to always consider the following dimensions: biological diversity, subjectivity, ethno-racial dimensions, gender, sexual orientation, socio-economic, political, environmental, cultural, ethical and other aspects that make up the spectrum of human diversity which singularizes each person or social group, in order to deliver:

[...]

VI - professional ethics based on the principles of Ethics and Bioethics, taking into account that the responsibility for health care does not end with the technical act (Brasil, 2014, p. 1-2).

This perspective - which also exists in the NCDs of other courses in the area of health care - reappears in the "Guidelines for Teaching in Primary Health Care in Medicine Degrees"⁵ prepared during the years of 2009 and 2010 (Demarzo et al., 2012). Indeed, investing in educating future health care professionals in PHC space-time is justified as a necessary - although insufficient - condition for developing comprehensive and contextualized clinical practice centered on people and on communities, making interdisciplinarity and articulation between technique, politics and (bio)ethics possible. The proposal is that the students are placed in a longitudinal way that continues throughout the degree, in a spiral model of increasing complexity and, preferable, with activities within PHC during all periods of the course, favoring dialogical and

⁴ From that time, March 2010, the first medical degree began operations in the UFV (Federal University of Viçosa), including participating in actions developed in the Viçosa FHS.

⁵ Document drawn up in conjunction with the "Brazilian Association for Medical Education (ABEM) and the Brazilian Society for Family and Community Medicine (SBMFC).

active teaching-learning methodologies, integrating theory and practice, discussing and enabling reflection on professional practice (Gomes et al., 2012), working in small groups in a variety of scenarios and activities (Demarzo et al., 2012; Gomes et al., 2012).

However, a distancing between the sectors of education and practice within PHC can be perceived and confirmed in the context of the FHS (Gomes et al., 2012; Gomes; Rego, 2013; Junqueira et al., 2009) as can a lack of training for professionals to work according to PHC principles. Some considerations concerning this negative perception of the family health care units can be explained due to the reduced attention the team is able to give the student, originating in their being overworked, this itself explained - among other reasons - by the large number of families assigned to the team, an element that makes working in the FHS more precarious (Junqueira et al., 2010).

Based on these conjectures, it is noteworthy that a small number of professionals - only one - was able to perceive issues related to teaching-work-community tensions, which probably occur without being identified, perhaps due to reasons similar to those mentioned above on the “invisibility” of (bio) ethical problems within PHC/FHS.

(Bio)ethical problems concerning secrecy and confidentiality

Lack of professional secrecy is a concern regarding the confidentiality of information service users of their families provide to professionals and was the main (bio)ethical problem reported by 14 professionals (rel. freq. 19.2%), as can be seen in the extracts below:

Professional secrecy is a question of ethics. There was an incident here in the unit when a member of staff discussed the patient's situation with someone from the community (E38).

Although some agents are part of the system, some information should be passed on to the doctor and/or nurse responsible. So, I understand if sometimes confidentiality is forgotten here, or put to one side (ACS11).

Patients reading the medical notes of other patients and spreading what is written there because a member of staff let them read it. Members of staff discussing patients with other patients (ACS34). Members of staff commenting on the health or personal problems of a patient/service user to other service users (TE66).

This was the group of (bio)ethical issues most commonly mentioned by the participants in this research. In this context, it becomes important to distinguish between the terms “confidentiality” and “secrecy” given the proximity of their accepted meanings, although they clearly do not deal with perfectly coinciding ideas. In effect, “confidentiality” deals with protecting the information given directly from patient to health care professional, guaranteeing the confidentiality of these data. “Secrecy” deals with protecting elements belonging to the patient, such as test results or even contact with the contents of their own medical notes, obtained indirectly by the health care professional, without their assent (Francisconi; Goldim, 1998).

Dealing with secrecy and confidentiality is an aspect that should permeate day-to-day work of the FFHS teams, given the difficulty of protecting users' data - both in health care provided in the unit and in that provided at home⁶ - defining to what extent the private information on individuals and families - as well as facts observed by the professionals, especially the CHWs - should be shared within the ambit of the team.

As is well-known, the information to which the FHS team has access does not deal exclusively with the users' health conditions (Zoboli; Fortes, 2004; Saliba et al., 2011), but also with many other aspects of their way of life. Divulging such information without due consent, therefore, may lead to extremely disagreeable even discriminatory, situations for those involved. The fact that “service users do not consider CHWs entering their residence as an invasion of privacy and that this professional is often seen merely as a facilitator to accessing health care services” (Seoane; Fortes, 2009, p. 42) considerably increases the responsibilities laid on this professional - and

6 Information from: BRAZIL. Ministry of Health. Department of Primary Care. Family Health Strategy. Available at: <http://dab.saude.gov.br/portaldab/ape_esf.php>. Accessed: 17 Dec. 2012.

on all team members - in handling the information to which they have access (Seoane; Fortes, 2007). The situation becomes still more complicated when dealing with situations of domestic violence, especially when those with greater vulnerability, children, the elderly and women, are involved (Angelo et al., 2013; Ramos; Silva, 2011; Wanderbroocke; Moré, 2012).

The data obtained reinforce the idea that conversations on the topics mentioned - secrecy and confidentiality - should form part of the daily routine in the FHS team, worked on in training, perhaps as part of ongoing education (Gomes et al., 2013).

(Bio)ethical problems related to conflict between team member and service users

The (bio)ethical perspective of the conflicts between the FHS team and service users was mentioned by 10 (rel. freq. = 13.7%) of professionals who filled out the questionnaire. Some of the comments below refer to these conflicts, mainly between CHWs and members of the community:

Patients interpret situations in their own way; if we give higher priority to emergencies, those in greater need, they don't understand... selfish (ACS64).

Each person interprets each situation in their own way, if we give preference to those in greater difficulties, others don't understand this (ACS69).

The CHWs are essential members of the FHS team, considered key figures in implementing policies aimed at reorienting the SUS health care model (Bornstein; Stotz, 2008). Although their tasks are well defined - as described in the "National Primary Health care Policy" (Brasil, 2012) - studies with teams in Araçatuba-SP, Cajuri-MG, Campinas-SP and Teresópolis-RJ, have also indicated that CHWs encounter difficulties in completing these tasks, with repercussions on the activities developed for PHC users (Gomes et al., 2009; Guimarães et al., 2013; Nascimento; Correa, 2008) and in conflict with service users and within the team itself.

Some of the main issues related to CHW practice include (Deleuze, 1992; Gomes et al., 2009; Foucault, 1977; Saliba et al., 2011; Siqueira-Batista et al., 2013): (1) the - often significant - intervention

of these workers in people's lives reproducing, even without their knowledge, processes of data capture within the communities, similar to conformations formed in the wake of the societies of control (as formulated by Foucault and Deleuze); (2) difficulty or impossibility of home visits to all registered families, affecting making appointments and caring for their health; (3) the attitude of some CHWs, facilitating access to the primary health care unit for those close to them; (4) low CHW salaries; (5) lack of previous training; (6) overwork in the health care units and these workers being undervalued; (7) lack of receptivity on the part of certain members of the community; and (8) relationships with other team members, creating a self-perceived lack of acceptance from other FHS team members.

The elements mentioned concerning the CHWs, especially those referring to interaction with the community, are similar to the reality faced by other professionals in the FHS/PHC. It is therefore worth returning to the commentary by Ayala and Oliveira (2007) on working in health care:

In our opinion, three conditions are relevant to the essential forms for fully developing health care work: first, the development of health activity must have the real needs of the community as an assumption; second, **regulation of health work processes must take place through exchanges between workers and the community**; finally, the expansion and rational allocation of available human and material resources combatting scarcity. (Ayala; Oliveira, 2007, p. 240, our emphasis).

Adopting health education strategies - in articulation with popular education (Santorum; Cestari, 2011; Stotz, 2005) - may assist users' understanding of the roles ESF team members should play, thus minimizing tension between these professionals and the community.

(Bio)ethical problems related to conflicts between team members

Of all participants, four, total de (rel. freq. 5.5%) highlighted tensions between team members as significant (bio)ethical problems, of which the following comments stand out:

Lack of respect, lack of communication (ACS60).

Problems with the previous doctor, what she discussed during consultations with patients, without anyone from the team present, placing some CHWs in embarrassing situations (ACS60).

Lack of communication within the team [...] (TE13).

Fights, arguments, lack of interaction, even between health care professionals (ACS14).

Lack of communication within the team [...] (TE13).

The extracts - which express lack of communication and team spirit, of respect, of communication and collaboration between staff - can be understood in light of difficulties in outlining the roles and functions of each FHS member and the respective fields in which they operate, due to the incorporation of new professionals and to innovations in care proposals (Matumoto; Mishima; Pinto, 2001; Zoboli, 2009).

Indeed, recent investigations into working in FHS teams have revealed a lack of collective responsibility; a poor degree of interaction between the professional categories; maintaining representations of hierarchy between professionals; fragmentation of the work process; and professionals conducting activities that are juxtaposed and isolated within their “nuclei of competence” (Ayala; Oliveira, 2007; Franco; Bueno; Merhy, 1999; Silva; Trad, 2005).

According to the study by Martins et al. (2012) with PHC workers, in Pelotas-RS, in order to solve conflicts within the multi-professional team - bearing in mind forming bonds -, the team needed to be malleable, receptive and able to adapt to the continual changes that occur in health care services. In this process, one must not lose sight that individuals are different, with different values, points of view and individual and collective beliefs that must be respected and considered in an atmosphere of dialogue and commitment on the part of the whole group. It is believed that the existence of commitment to work provides the opening and the contact needed to establish close, confident relationships (Martins

et al., 2012). In this context, permanent health education may, even with all the difficulties associated with managing conflicts. Be the best approach to this significant type of (bio)ethical issue.

Approaches to (bio)ethical problems in the FHS and their consequences

With regard to the handling of the conflicts mentioned in the questionnaire, 17 participants (rel. freq. = 23.3%) reported that dialogue was the solution adopted by those involved; ten (rel. freq. = 13.7%) responded that no approach was made to the problem; 37 participants (rel. req. = 50.7%) did not respond; five (rel. freq. = 6.8%) stated that the issues were resolved through the affectivity of those involved; only four (rel. freq. = 5.5%) stated that it was necessary to refer the matter to administrative bodies of the FHS coordination to resolve the issue.

When asked whether it was necessary to resort to a bibliographical reference (scientific article, professional code of ethics, text or other) or to a consultant to assist in resolving the (bio)ethical issues encountered, only four professionals (rel. freq. = 5.5%) stated that a bibliographical source was consulted; 32 (rel. freq. = 43.8%) responded that there was no kind of consultation; and 37 (rel. freq. = 50.7%) did not respond.

The main consequence of (bio)ethical problems and conflicts mentioned by the participants are outlined in Table 4.

It can be seen that the worst affected sphere in the context of the (bio)ethical issues identified were the bonds between users and team members, an element that articulated the previous discussion, in the section dealing with “(Bio)ethical problems related to conflicts between team and users”.

The data obtained can be understood in the light of possible gaps in (bio)ethical concepts, theories and methods - perhaps due to training that did not prioritize such aspects - and to any difficulties in finding good information on the topic in the documents available in hard copy or electronically. Returning to the previous comment on the training process undergone by health care professionals, this time focusing on the NCD for Nursing Degrees, as an example, the following aspects stand out:

Table 4 - Distribution of number and proportion (%) of FHS professionals according to the main consequences of the (bio)ethical problems experienced, Viçosa, MG, 2012

| Consequences of the (bio)ethical problems | Frequency | Relative frequency (rel. freq.) (%) |
|---|-----------|-------------------------------------|
| Blank | 37 | 50.7 |
| Did not respond | 10 | 13.7 |
| Negative for the health care worker / professional / team | 7 | 9.6 |
| Negative for the user | 5 | 6.8 |
| Negative for the bonds between team and users | 14 | 19.2 |
| Total | 73 | 100.0 |

“Art. 4. Nursing education aims to provide the professional with the knowledge required to exercise the following powers and general skills: (...) Practitioners should perform their services to the highest quality standards and principles of ethics / bioethics, given that responsibility for health care does not end with the technical act, but with the resolution of the health problem, both individually and collectively (...)” (Brasil, 2001, p. 1-2).

Art. 5º. Nursing education aims to provide the professional with the knowledge required to exercise the following abilities and skills: [...] XXIII - manage the work process in nursing with the principles of Ethics and Bioethics, and resolution both individually and collectively in all professional areas of activity [...] (Brasil, 2001, p. 2-3)

The elements mentioned in articles 4º and 5º represent aspects that should be included in the training of all nurses and, by extension, any health care professional. When there are gaps in these domains, the consequences can be decisions made without any theoretical basis, with all the harmful consequences- as shown in Table 4 - implied by such practice (Rego; Gomes; Siqueira-Batista, 2008).

Final considerations

The FHS represents and innovative and structuring strategy for primary health care in Brazil - and for the SUS itself -, to the extent that it contributes to overcoming the fragmented - and reductionist - view of the human being, adopting a comprehensive

conception of the individual dimension - including the family, social and environmental dimensions -, even enabling users to better understand the disease-health process. Such complexity has allowed (bio)ethical issues to emerge - as can be seen in this investigation, which is in consonance with earlier work (Zoboli; Fortes, 2004; Motta, 2012) -, that are not immediately analyzable with references commonly used to approach (bio)ethical problems described in other levels of health care such as, for example, those permeating hospitals.

One noteworthy aspect of the data obtained concerns the lack of identification of issues relating to two domains of modern (bio)ethics (Motta et al., 2012): aspects related to environmental issue and the inter-relationship between health/environment, significant determinants in what makes the population fall ill (Siqueira-Batista et al., 2009; Guimarães et al., 2013); and the elements related to inter-sectoriality, directly affecting health care processes within the SUS ambit, such as education, housing, transport, work, public safety, social security, sport, leisure and their correlations with the health of community members (Santos et al., 2011). Moreover, classic (bio) ethical topics, such as those affecting the beginning and end of life (Rego; Palácios; Siqueira-Batista, 2009), were not mentioned either.

Identifying and adequately approaching (bio) ethical controversies in the FHS remains incipient, as can be seen in this research and in others, making it a topic that has been little explored. From this perspective, possibilities for research on three different fronts open up:

1. the urgent need to seek **new theoretical references** to approach situations with (bio)ethical implications in the FHS, as those used to assess conflicts in clinical practice – for example, the “principalism” (Beauchamp; Childress, 2002) – appears insufficient to propose solutions, given PHC characteristics (Zoboli, 2009), especially the complex composition between clinical concepts, theories and methods and those of public health;
2. the – perhaps – urgent need to urge the definitive inclusion of (bio)ethics in the training of **all professionals operating within the FHS** (Gomes et al., 2013; Zoboli; Soares, 2012; Vidal et al., 2014), considering the modern (bio)ethical debate and **new references** better directed towards PHC problems; and
3. developing methods to assist (bio)ethical decision making in the FHS – with the perspective of creating support tools (Siqueira-Batista et al., 2014) –, which will depend on a more systematic study of the aspects involved in the decision making process, probably elements of neurobiology, the cognitive sciences and computational neuroscience.

These briefly outlined frontiers may contribute – it is hoped – to improving work within the FHS/PHC ambit, making health care activities still more effective at what is perhaps the main purpose of health care professionals: **helping men and women live happier lives.**

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Authors' contributions

Siqueira-Batista, Gomes, Motta and Vidal conceived the study design; Lopes, Rennó and Miyadahira collected and categorized the data, which were analyzed by Siqueira-Batista, Gomes, Motta and Vidal. Siqueira-Batista, Gomes, Motta and Vidal edited the first version of the article, the final version of which received contributions from Cotta.

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