Validation of the inventory of ethical problems for oral health

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Abstract

This is a methodological research to validate the Inventory of Ethical Problems in Primary Health Care for Oral Health using the Delphi technique, searching for a consensus among 23 dental surgeons. A comparative analysis between the reference instrument and the Inventory for Oral Health was requested, questioning their compatibility and adequacy, including ethical problems specific to the studied area. The professionals proposed rewriting and altering several items. A second round was conducted to seek consensus on issues not exhausted in the previous stage. The Delphi technique was essential to obtain more understandable and adequate items, enhancing the use of the inventory by oral health workers and public health managers, the ethical reflection on the problems experienced, and the construction of collective deliberation processes.
Keywords: Ethics. Bioethics. Primary health care. Oral health. Validation study.

Resumo

Validação de inventário de problemas éticos para a saúde bucal

Trata-se de pesquisa metodológica para validar o Inventário de Problemas Éticos na Atenção Primária à Saúde para a Saúde Bucal por meio da técnica Delphi, buscando consenso entre 23 cirurgiões-dentistas. Solicitou-se análise comparativa entre os itens do inventário de referência e do inventário para saúde bucal, questionando sua compatibilidade e adequação, incluindo problemas éticos específicos da área pesquisada. Os especialistas propuseram reescrever e alterar diversos itens. Houve segunda rodada para buscar consenso nas questões não esgotadas na etapa anterior. A técnica Delphi mostrou-se essencial para obter enunciados mais compreensíveis e adequados, potencializando o emprego do inventário pelos trabalhadores e gestores da saúde bucal, a reflexão ético-política sobre os problemas vividos e a construção de processos coletivos de deliberação.
Palavras-chave: Ética. Bioética. Atenção primária à saúde. Saúde bucal. Estudo de validação.

Resumen

Validación del inventario de problemas éticos para la salud bucal

Se trata de una investigación metodológica para validar el Inventario de Problemas Éticos en Atención Primaria de Salud para la Salud Bucal mediante la técnica Delphi, buscando el consenso entre 23 odontólogos. Se solicitó un análisis comparativo entre los puntos del inventario de referencia y el inventario de salud bucal, cuestionando su compatibilidad y adecuación, incluidos los problemas éticos propios del área investigada. Los expertos propusieron reescribir y cambiar varios elementos. En la segunda ronda, se ha buscado un consenso en temas no agotados en la etapa anterior. La técnica Delphi resultó fundamental para obtener enunciados más comprensibles y adecuados, potenciando el uso del inventario por parte de los gestores y trabajadores de salud bucal, la reflexión ético-política sobre los problemas vividos y la construcción de procesos colectivos de deliberación.
Palabras clave: Ética. Bioética. Atención primaria de salud. Salud bucal. Estudio de validación.

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Approval CEP-UFSC CAAE 60739716.1.0000.0121

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The authors declare no conflict of interest.

According to Rovere [1], since the Declaration of Alma-Ata, primary health care (PHC) has become a pillar to guarantee health as a fundamental human right, based on values such as quality of life, solidarity, equity, democracy, citizenship, and participation. Following these principles, the creation of the Brazilian Unified Health System (SUS), at the pinnacle of the country's redemocratization, sought to modify the hospital-centered biomedical standard, aiming to build a model of universal access and comprehensive care.

Unlike other postwar universal systems, however, the Brazilian system emerged when the welfare state was already in crisis. Neoliberal austerity policies hindered its consolidation, due to underfunding and fragmentation generated by privatist and mercantilist interests. At the late 1990s, the Family Health Program, later transformed into the Family Health Strategy (ESF), was developed to strengthen PHC, reorganize work processes, invest in non-material technologies, humanize care to qualify assistance and propose an expanded clinic, in addition to individualized curative treatment [2,3].

In this sense, social bioethics converges with the sanitary and public health movement to build an epistemological and practical framework, with important advances in the construction of Brazilian bioethical knowledge. In clinical bioethics, the challenge is to consolidate bioethics committees [4]; in PHC, the task is to expose and solve "naturalized" ethical problems due to their relation with organizational and structural issues.

Thus, we sought to develop the Inventory of Ethical Problems in Primary Health Care (IEP-PHC), to identify everyday conflicts in health practices. This process contributed to the emergence of amplified clinical bioethics [5], a reference that highlights the fact that, unlike tertiary care, ethical problems in PHC are not linked to emergency situations and biomedical technologies, but to invisible situations in health *praxis*. Therefore, the approach points to the lack of perception and ethical deliberation about these problems, although the structure of services is an important factor [6,7].

In Brazil, ethical deliberation [8,9] for decision making in the face of moral conflicts has been underused in highly complex care, due to the low number of bioethics committees. In PHC, deliberation usually happens with social control, in participative spaces such as health councils, with discussions involving political questions, distanced from the ethical perspective.

The debate on the co-management of health staffs that use Freire's pedagogical method depends on the commitment of workers and managers. But is the ethical dimension of health problems included in this participatory context? Is it present in PHC discussion spaces? Could the deliberative method be incorporated into the management methods already in use? Would we need to build other spaces for ethical deliberation or would it be enough to provide adequate support for professionals?

Considering these issues, an instrument that considers different PHC contexts would be an important tool to delimit ethical problems and qualify health practices. Oral health, limited to the mouth, with all its epistemological and practical meanings, can be a unique field to identify such problems, reason why the topic was chosen for this study. Using a survey of ethical problems with oral health professionals in the metropolitan region of southern Brazil [10], followed by a stage of equivalence of items, semantics and content of these specific issues regarding the IEP-PHC by a committee of judges, an inventory focused on oral health (IEP-PHC-OH) was created [10,11]. This article presents the validation of this new inventory to reflect and deliberate on ethical and political issues.

Method

Validation seeks to evaluate the reliability of the observations, interpretations and generalizations developed with the research, including the stages to establish the face, content and psychometric verification. Face validation consists in applying the adapted instrument to a sample and to the gold standard inventory. The process, which can be conducted by a committee of experts, is justified when there is a need for a new scale. Internal or content corroboration refers to the judgment on the inventory by different professionals, who analyze the content and relevance of the objectives to be measured [12,13].

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In our research, analyzes of face and content equivalence were developed using the modified Delphi method [14], which examines and discusses the expert's assessment on a specific topic to reach consensus and develop the final version. Based on the mythical Oracle of Delphi, the technique is structured to systematically collect judgments about certain problems, process information, and then establish a general agreement. Its basic principles are: 1) interactivity, by successive rounds of consultations for participants to review their opinions; 2) feedback, in which experts receive evaluations from all participants before rounds to contrast them with their own criteria and offer their judgment again; 3) anonymity of individual responses, and 4) consensus building – general group agreement based on the statistical processing of differences and coincidences between individual assessments and their modifications [15].

Working with 10 to 15 experts is recommended for selecting participants, since a larger number brings few benefits compared to the increased complexity [15]. However, the convenience sample of this study comprised 23 experts, selected from the cities included in the research (Florianópolis, Palhoça, São José and Biguaçu, all in the state of Santa Catarina, Brazil). As the quality of the validation depends mainly on the professionals chosen, we included dental surgeons with work experience in PHC and graduate programs in related areas – residency in family health (4); specialization followed or not by residency (8); master's degree (4); PhD degree (6); graduate, but vast experience in PHC (1). These professionals had relevant knowledge and experience, as well as motivation to participate [14].

As the inventory development stage reached an expressive amount of 36 items, in the validation we subdivided them into two groups, with their respective structured questionnaires, as not to overload the experts. Group 1, composed of 12 experts, was responsible for comparing the 21 items of the reference IEP-PHC with the equivalent items of the IEP-PHC-OH, testing whether the new inventory item was prepared according to the original instrument and whether it was compatible with the reality of ethical oral health problems, with clear language and correct terminology.

Group 2, with 11 experts, evaluated 15 specific oral health ethical problems, without equivalents in the reference IEP-PHC, testing whether the item was compatible with the reality of oral health ethical problems, with clear language and correct terminology. In case of disagreement, they were asked to rewrite the problem to improve understanding, providing comments or explanations.

The experts were invited by phone or in person to participate in the research and, after acceptance, were randomly organized into the two groups and received the questionnaire between July 2018 and April 2019, via e-mail and individually. In the first round, the instrument was accompanied by an explanatory note that included the objectives of the technique and the study, guidelines for responses, and an informed consent form. Then, the responses were analyzed. Based on the changes proposed, several items were rewritten. Answers that did not reach a minimum consensus of 51% [6,7,15] were taken to the second round.

Results

The application of the Delphi method resulted in two rounds of validation, in which items were rewritten according to the experts' suggestions. Items that showed less than 51% disagreement [7] were disregarded for the second round and, as none of the items exceeded those 51% in the second round, a third round was not necessary.

In the first round of the Delphi method, Group 1 compared the items of the reference IEP-PHC with the equivalent items of the proposed IEP-PHC-OH. In the question "is the item compatible with the reality of ethical problems in oral health, yes or no?," we had no consensus only in three items (8, 27 and 38) that were sent to the second round. Group 2 analyzed the other items of the proposed IEP-PHC-OH, with only five items (7, 10, 12, 23 and 27) lacking consensus and being sent to the second round. Charts 1 and 2 show the validation made by Groups 1 and 2, respectively. The complete version of the IEP-PHC-OH can be seen in the Appendix.

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http://dx.doi.org/10.1590/1983-80422020284437

Table 1. Items of the Inventory of Ethical Problems in Primary Health Care for Oral Health certified by the Delphi method

<table>
<tr><th>Reference IEP-PHC item</th><th>IEP-PHC-OH
Writing after 1st round</th><th colspan="2">IEP-PHC-OH
Writing after 2nd round</th></tr>
<tr><td>1. Difficulty in establishing the limits of the professional-user relationship.</td><td colspan="3">1. Difficulty in establishing the limits of the professional-user relationship.</td></tr>
<tr><td>2. Prejudgment of service users by the teams.</td><td rowspan="2">2. Oral health professionals or UBS workers pre-judge and disrespect users and family members based on prejudice and stigmas.</td><td colspan="2" rowspan="2">2. Disrespect for users or family members by ESB professionals or UBS workers, based on prejudice and stigmas.</td></tr>
<tr><td>3. The professional disrespects the user.</td></tr>
<tr><td>4. Inadequate clinical indications.</td><td>4. Inadequate clinical indications.</td><td colspan="2">4. Inadequate clinical indications of treatments or procedures by oral health professionals.</td></tr>
<tr><td>5. Prescription of a medicine that the user cannot afford.</td><td>5. The professionals prescribe specialized treatments or procedures that the user cannot afford, when these treatments/ procedures are not offered by SUS.</td><td colspan="2">5. Prescription of treatment or indication of procedure that the user cannot afford.</td></tr>
<tr><td>7. The user asks the doctor and nurse for the procedures they want.</td><td>7. The user asks the dentist for the procedures they want.</td><td colspan="2">7. User ask the dentist for the procedures they want, following a coercive consumption pattern or traditional invasive cure.</td></tr>
<tr><td>8. How to convince the user to continue the treatment.</td><td>8. Oral health professionals feel powerless to convince the user to continue the treatment, especially without the educational and promotional work strengthened by the team, more specifically the TSB.</td><td>8. How to convince or motivate the user to continue the treatment, especially without the TSB's health promotion clinical work.</td><td>8. Difficulty in convincing or motivating the user to continue the treatment, especially without the TSB's clinical-educational work.</td></tr>
<tr><td>14. Lack of commitment and involvement of some professionals who work in the PSF.</td><td>14. Lack of commitment and involvement of some professionals who work in oral health and EqSF.</td><td colspan="2">14. Lack of commitment and involvement of some ESB professionals related to their duties.</td></tr>
<tr><td>15. EqSF do not collaborate with each other.</td><td>15. ESB and EqSF do not collaborate with each other, have low strategic planning level and few joint actions.</td><td colspan="2">15. EqSF and ESB do not collaborate with each other, resulting in few inter-professional actions.</td></tr>
<tr><td>16. Lack of respect among team members.</td><td rowspan="2">16. There is a lack of respect among the ESB members, especially with regard to valuing the auxiliary service and teamwork.</td><td colspan="2" rowspan="2">16. Lack of respect among the ESB members, especially with regard to valuing the auxiliary service and teamwork.</td></tr>
<tr><td>18. It is difficult to limit the role and responsibilities of each professional.</td></tr>
<tr><td>17. Lack of preparation of professionals to work in the PSF.</td><td>17. Lack of preparation/training (profile) of professionals to work in the PSF.</td><td colspan="2">17. Inadequate training of oral health professionals to perform their duties in PHC.</td></tr>
<tr><td>19. Omission by professionals when the prescription is inadequate or wrong.</td><td>19. Omission by professionals when an improper or wrong clinical procedure is performed.</td><td colspan="2">19. Omission by oral health professionals in face of inadequate clinical procedures or prescriptions.</td></tr>
<tr><td>21. Difficult in preserving privacy due to problems in the physical structure and routine of the USF.</td><td>21. Difficult in preserving privacy due to problems in the physical structure and routine of the USF.</td><td colspan="2">21. Difficult in preserving user's privacy due to problems in the physical structure and routine of the ESB and UBS.</td></tr>
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Table 1. Continuation

Reference IEP-PHC item	IEP-PHC-OH Writing after 1st round	IEP-PHC-OH Writing after 2nd round
22. Lack of support with intersectoral actions to discuss and resolve ethical problems.	22. Oral health and EqSF professionals lack support from intersectoral actions, which depend on the system organization and management, to discuss and resolve ethical problems they encounter in their practice.	22. Lack of institutional support with intersectoral actions to discuss and resolve ethical problems.
23. Lack of transparency of the UBS management in solving problems with the professionals.	23. Lack of transparency of the UBS management in solving problems with the professionals.	23. Lack of transparency of the UBS coordination in solving problems involving professionals.
24. Excess of families assigned to each team.	24. Excess of families assigned to each team of the ESF and ESB.	24. Excess of families assigned to each ESB.
26. Devaluation of referrals made by PSF doctors.	26. Devaluation of referrals made by public service dentists.	26. Devaluation of the quality of care provided by public service dentists by other professionals, especially from the private sector.
27. Difficulties and lack of reference to carry out complementary examinations.	27. There is difficulty related to the referral and counter-referral system for radiographic examinations, in addition to lack of service agility and efficiency.	27. Difficulty in the reference system to carry out complementary examinations, especially radiographic ones.
32. Users who refuse to follow medical instructions or undergo examinations.	32. Users who refuse to follow the indications of preventive oral care actions, without changing their individual health management.	32. Users who do not follow professional guidelines in caring for their own health.
35. USF workers question the medical prescription.	35. ESB professionals question the dentists' conduct.	35. Difficulty in preserve user's privacy due to problems in the physical structure and routine of the ESB and UBS.
38. Lack of structure at the USF to carry out home visits.	38. Home visits are hampered by issues related to commuting, especially the Odontomóvel , reducing the dentist's clinical practice power.	38. Lack of conditions for ESB professionals to carry out home visits.
39. Lack of conditions at the USF for emergency care.	39. UBS does not handle all dental emergency care, besides operational problems.	39. Lack of conditions or installed capacity for the ESB to meet all urgent needs.

PHC: primary health care; EqSF: family health team; ESB: oral health team; ESF: Family Health Strategy; IEP-PHC: Inventory of Ethical Problems in Primary Health Care; IEP-PHC-OH: Inventory of Ethical Problems in Primary Health Care for Oral Health; PSF: Family Health Program; SUS: Unified Health System; TSB: oral health technician; UBS: health center; USF: family health unit

Table 2. Specific items of the Inventory of Ethical Problems in Primary Health Care for Oral Health verified by the Delphi method

Ethical problems in oral health	Writing after 1st round	Writing after 2nd round
2. The reception of users who seek dental care does not follow what is recommended by the ESF.	2. Disagreement between the reception of users in oral health and that recommended by the ESF.	
6. Absence or insufficiency of ASB to develop preventive and clinical activities.	6. Absence or insufficiency of ASB to assist in clinical and collective work.	
7. Difficulty in carrying out preventive actions due to problems in health-education intersectoral relations.	7. Difficulties in carrying out educational-preventive actions due to problems in health-education intersectoral relations.	

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Table 2. Continuation

Ethical problems in oral health	Writing after 1st round	Writing after 2nd round
10. Violence experienced at work.	10. Violence experienced at work involving several actors.	
12. ESB professionals witness discrimination between users.	12. Discrimination of users against other users, related to social stigmas.	12. Discrimination between health system users, related to social stigmas.
13. Oral health professionals understand that users have cognitive problems related to social vulnerability.	13. Some oral healthcare users have cognitive problems related to socioeconomic conditions that generate social vulnerability.	
15. The dental office structure makes teamwork difficult and facilitates auxiliary team's occupational illnesses.	15. Difficulty in developing clinical teamwork and illnesses at work due to problems in the dental office physical structure.	
18. Decrease or lack of UPA emergency dental care.		
20. Precarious working conditions.	20. Precarious working conditions in oral health.	
22. Structural problems about properly allocating professionals to the CEO.	22. Inadequate or insufficient allocation of professionals to the CEO.	
24. Lack of transparency in the waiting list for oral health medium complexity services.		
26. Underestimation and deviation of function from TSB to ASB.		
27. Engagement of professionals in the ESF is related to specific training for the area.	27. Lack of engagement by professionals, related to insufficient training for the ESF.	27. Lack of engagement by professionals, related to insufficient training to work in PHC/ESF.
29. Lack of unity of workers for a greater appreciation of PHC and oral health work.	29. Lack of ESB unity for a greater appreciation of PHC work.	
30. Incomprehension of the dentist's performance beyond curative action and as part of the ESF.	30. Incomprehension of the dentist's performance as part of the ESF and beyond curative action.	

PHC: primary health care; ASB: oral health assistant; CEO: dental specialty center; ESB: Oral health team; ESF: Family Health Strategy; TSB: oral health technician; UPA: emergency care unit

Discussion

As the experts did not have access to all ethical problems listed due to the need to subdivide them into groups, they made suggestions for "new" ethical problems that have already been addressed. In the first round, even the experts who agreed with the proposed formulations commented or proposed improvements in the wording. Some participants did not understand the proposed ethical problem, pointing out that they did not experience such conflict, substantially modifying it. Due to disagreements on or denials of the problems mentioned, differences were observed in each professional' experiences, given the different realities of work in each municipality. However, all notes were considered.

Bearing in mind that the IEP-PHC-OH is being proposed for application in different realities, with different organizational models and work processes, we tried to restrict the ethical problem to its meaning core, without qualifications related to PHC structure, details or justifications. Thus, following the reference IEP-PHC an attempt was made to describe the problem succinctly.

The main challenge for professionals was identifying ethical problems in PHC, in view of the hegemonic conception of ethics, restricted to the deontological scope [16]. It is a limited perception that hinders understanding ethical and political dimensions encompassing a more complex contextual reality. Such complexity seems to require, together with the method of ethical deliberation, a critical hermeneutics capable of thinking of the context and configuration of ethical problems.

As the expanded clinic [5] questions power relations between professionals and users, and in the social dimension of public policies, ethical problems go beyond the walls of health centers and reach the lives of people and families, their

homes and the territory, community and work. They involve health system organization and functioning, in addition to socio-economic and cultural macro-structural processes, transversal to assistance. The complex web of relationships and actions that permeate health work processes with the search for solutions to everyday problems make the ethical dimension inseparable from politics. This complexity hinders identifying ethical conflicts as such and, therefore, subsequent reflection and deliberation.

The expanded clinic, by shifting the centrality of the clinical act to social needs/interests, adds a political reality that refers to specific values, of public, collective and participatory dimension, which consider health professionals and users as subjects and relationships as singular, in a type of ethical-political commitment that seeks integrality [3,5]. In this context, ethics focused on the duties formally prescribed by professional codes limits the debate on morality to contractual relationships between professional and patient, following the biomedical, normative and liberal model.

This deontological ethics incorporates principles of paternalistic ethics, in which good intentions and examples seem sufficient to ensure the ethics of actions and behaviors. This view, which carries legal and corporatist precepts, loses the ability to generate and strengthen networks for the pursuit of professional excellence in social conduct, as well as for making solidarity moral values concrete [8].

Ethical problems must be perceived as challenges that require collective deliberation, going beyond particular solutions to seek contextualized and creative, long-range responses, based on the professionals' commitment [4,6]. In addition, we must face a sub-citizenship [17] socially introjected in the SUS user, which denies rights and quality of care due to their (non) purchasing power. This sub-citizenship makes it difficult to reflect on processes that include socioeconomic and cultural determinants, leading to moral suffering and programmatic vulnerability of professionals [9].

Ethics related to the planning, implementation and evaluation of health policies has a public and protective dimension. It takes shape in the professional body that builds and puts public policies into practice, considering results, consequences and social breadth, that is, the ability to include vulnerable individuals or groups. In this sense, the construct validated in this research, besides serving as a source of information, can open debates that amplify ethical reflection and collective deliberation [4].

We must combine the experiences of bioethics committees' deliberation with the political resolutions of spaces for democratic participation in health. Similarly, co-participative management methods must be incorporated for collective discussions. Facing the criticism of deliberative democracy as a formal, exclusive and impractical conception in contexts of inequality, incorporating ethical deliberation into the participatory practices already existing in SUS would allow overcoming the depoliticized discourse on moral conflicts, reinforcing the participation in moral development processes and humanization. Since to deliberate one must understand and interpret, the dialectical method must give rise to an interdisciplinarity converted into an exchange of ideas, capable of understanding the problem in its context [18].

The path to collective deliberation and a new education for citizenship is hampered by neoliberal ideology, precarious structures and outdated management, which hinder participatory democracy. Similarly, educational systems do not train students to problematize reality; on the contrary, they educate for competitiveness, in an authoritarian way and based on supposed meritocracy, not giving voice or developing the ability to listen to others.

It is education that annuls the subject and prevents the development of communicative skills. This centralized, hierarchical and corporate stance treats citizens as sub-citizens and professionals as sub-professionals. According to Gracia [18], the control of the unconscious and of narcissism, accompanied by reflective capacity, needs to be cultivated, in favor of the capacity for reflection necessary for ethical deliberation. That is why it is essential to exercise self-criticism of one's values and beliefs, facing their argumentative weaknesses.

In the context of SUS and of a bioethics of resistance [19], the need for ethical and political engagement of health professionals in the various levels of power is increasing. In this perspective, the IEP-PHC-OH can help cultivate values such as critical solidarity, political participation, and social entrepreneurship [4]. The construction of an ethos based on daily moral practice fulfills the role of educating a new civility. Collective praxis enhances cooperation, demonstrating the human capacity to transcend and overcome particular interests.

Seeking solutions to problems based on common will, in a praxis that takes responsibility

http://dx.doi.org/10.1590/1983-80422020284437

for the consequences of decisions, reposition the professional as an agent of change and contradict the thesis that moral motivation is reduced to the narrow calculation of personal advantages and benefits [20]. The ideal of collective participation is based on: 1) an ethics permeated by the political (civil society, communities, quality of life and social determinants of the health-disease process), and 2) intellectual commitment assumed as collective responsibility, with confidence in the power of ideas and in the values they carry [21]. It is, therefore, an ethics that becomes political participation based on social justice, human rights, protection of the vulnerable and the patient's needs/interests.

In PHC, the inseparability between assistance and management stands out, since clinical deliberation requires conditions and means to be carried out, which include integration between care activities and strategic planning. In view of the collective health and intersectoral conditions and access to various points in the healthcare network, planning can enhance participation through communicative action. Thus, deliberation depends on strategic actions, and the most important thing is not the product, but the production path, which must see participants as subjects, establish contracts and commitments, and define priorities [22].

Final considerations

After face and content validation using the Delphi method, the final version of the IEP-PHC-OH covered 36 ethical-political problems (Appendix). The process made it easier to understand the statements, substantially qualifying the instrument.

As a methodological limitation, the participation of only dental surgeons stands out, since the group of experts could also count on assistants and technicians who are part of the oral health teams. Even so, it was possible to see the problems analyzed from different angles, in particular the relationships between team and user/community. As a way to overcome this limitation, since the construct aims to be used by the whole team, we sought to describe the problems succinctly, restricting them to their meaning core.

The IEP-PHC-OH is available to be used by workers, teams and managers. Its objective is to qualify services and stimulate ethical reflection, opening new spaces for collective deliberation, in tune with situational strategic planning. Only one more validation of the construct is suggested, based on a study of psychometric approach.

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Participation of the authors

Doris Gomes and Mirelle Finkler designed and planned the study. Doris Gomes collected and analyzed the data and wrote the manuscript. All authors interpreted the data. Elma Zoboli and Mirelle Finkler critically reviewed the article

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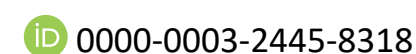 0000-0003-2445-8318
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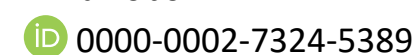 0000-0002-7324-5389
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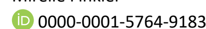
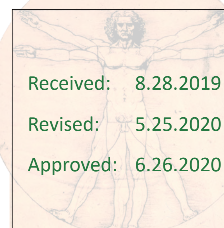
 0000-0001-5764-9183


Received: 8.28.2019
Revised: 5.25.2020
Approved: 6.26.2020

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Appendix

Inventory of Ethical Problems in Primary Health Care for Oral Health (IEP-PHC-OH)
1. Difficulty in convincing or motivating the user to continue the treatment, especially without the TSB's clinical-educational work.
2. Excess of families assigned to each ESB.
3. Lack of conditions or installed capacity for the ESB to meet all urgent needs.
4. Lack of conditions for ESB professionals to carry out home visits.
5. EqSF and ESB do not collaborate with each other, resulting in few inter-professional actions.
6. Disrespect for users or family members by ESB professionals or UBS workers, based on prejudice and stigmas.
7. Prescription of treatment or indication of procedure that the user cannot afford.
8. Lack of commitment and involvement of some ESB professionals related to their duties.
9. Inadequate training of oral health professionals to perform their duties in PHC.
10. Inadequate clinical indications of treatments or procedures by oral health professionals.
11. Omission by oral health professionals in face of inadequate clinical procedures or prescriptions.
12. Devaluation of the quality of care provided by public service dentist by other professionals, especially from the private sector.
13. Difficulty in the reference system to carry out complementary examinations, especially radiographic ones.
14. Lack of respect among the ESB member, especially with regard to valuing the auxiliary service and teamwork.
15. Questioning about the dentists' clinical conduct by other oral health professionals, including auxiliary professionals.
16. Lack of institutional support with intersectoral actions to discuss and resolve ethical problems
17. Difficulty in establishing the limits of the professional-user relationship.
18. The user asks the dentist for the procedures he wants, following a coercive consumption pattern or traditional invasive cure.
19. Difficulty in preserve user's privacy due to problems in the physical structure and routine of the ESB and UBS.
20. Lack of transparency of the UBS coordination in solving problems involving professionals.
21. Users who do not follow professional guidelines in caring for their own health.
22. Disagreement between the reception of users in oral health and that recommended by the ESF.
23. Absence or insufficiency of ASB to assist in clinical and collective work.
24. Difficulties in carrying out educational-preventive actions due to problems in health-education intersectoral relations.
25. Violence experienced at work involving several actors.
26. Discrimination between health system users, related to social stigmas.
27. Some oral health care users have cognitive problems related to socioeconomic conditions that generate social vulnerability.
28. Difficulty in developing clinical teamwork and illnesses at work due to problems in the dental office physical structure.
29. Decrease or lack of UPA emergency dental care.
30. Precarious working conditions in oral health.
31. Inadequate or insufficient allocation of professionals to the CEO.
32. Lack of transparency in the waiting list for oral health medium complexity services.
33. Underestimation and deviation of function from TSB to ASB.
34. Lack of engagement by professionals, related to insufficient training to work in PHC/ESF.
35. Lack of ESB unity for a greater appreciation of PHC work.
36. Incomprehension of the dentist's performance as part of the ESF and beyond curative action.

PHC: primary health care; ASB: oral health assistant; CEO: dental specialty center; ESB: Oral health team; EqSF: Family Health Team; ESF: Family Health Strategy; TSB: oral health technician; UBS: health center; UPA: emergency care unit

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