The view of Intervention Bioethics in Family Health Program (PSF) dentist's work

Evelise Ribeiro Gonçalves
Flávia Regina Souza Ramos
Volnei Garrafa

Resumo O artigo parte de tese de doutorado sobre o trabalho do cirurgião-dentista na estratégia de Saúde da Família, que analisa o cotidiano das atividades dos profissionais da rede municipal com base na percepção dos próprios. Discute-se como seu trabalho expressa o referencial da Bioética de Intervenção, que considera a busca por integralidade, justiça sanitária e inclusão social pressupostos básicos para a efetivação da cidadania. Foram entrevistados um representante da gestão municipal e 17 cirurgiões-dentistas. Foram analisadas as rotinas de acesso ao serviço; os serviços de referência; o estabelecimento de vínculo e a participação popular e controle social. As rotinas de acesso mostraram-se adequadas às linhas de cuidado, mas ainda ineficientes no cumprimento da universalidade. O serviço de referência apresenta falhas; e a participação popular e o controle social ainda não acontecem de forma concreta, podendo haver incentivo à população para participação nos conselhos locais de saúde, espaços para construção da cidadania.

Palavras-chave: Assistência odontológica. Bioética. Programa Saúde da Família.

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The great inequalities and inequities of access to everything that characterizes quality of life, dentistry care included hereto, turn sanitary justice theme the focus of discussion when one intends to apply ethics to ensure human dignity and rights in a collective dimension.

It is worth highlighting the importance of the Unified Health System (SUS) as the most encompassing health public system in the world in number of potential users, as it reaches over 180 million people. SUS presents, by assuming health as a right, large distributive effect, promoting social inclusion[1]. The same can be stated of the Family Health Strategy (ESF), organizing axis of public Basic Health Care of the country, since its assumptions and guidelines search for, in larger scope, effective citizenship of population.

Evelise Ribeiro Gonçalves
Surgeon-dentist at the Municipality Townhouse of Florianopolis, specialist in Collective Health Dentistry, master's degree in Public Health and PhD in Nursing Phylosophy, Federal University of Santa Catarina (UFSC), Florianopolis, Brazil

Flávia Regina Souza Ramos
Nurse, PhD in Nursing Phylosophy and post-doctorate in Education. PhD thesis supervisor and coordinator of Graduate Nursing Program at UFSC, Florianopolis, Brazil

Volnei Garrafa
Full professor and coordinator of Unesco Bioethics Chair at the University of Brasília (UnB), Member of thesis evaluation team, chairperson of the Executive Board of Unesco - Bioethics Network for Latin America and the Caribbean (Redbioetica), Brasilia, Brazil

Insertion of Dentistry in Family Health Strategy (ESF) in Florianopolis/SC took place only in the second semester of 2004, although a process still under construction. In this context, a case study with qualitative approach was undertaken resulting in a PhD thesis about the surgeon-dentist activity in the Municipality oral health teams, based in this professional perception. The current article set forth part of this thesis outcomes and it aims at analyzing daily activities of professionals under the referential view of Intervention Bioethics, whose basic assumptions incorporate the search for integrality, sanitary justice, and social inclusion as indispensable elements of effective citizenship.

Some daily activities and situations of care provided by surgeon-dentists at the Florianopolis oral health teams were analyzed, aiming at checking if they compromised to assure fair and integral care, which configure as element for social inclusion to citizens, identifying, thus, with the referential of Intervention Bioethics. Such activities are: i) routines for citizens' access to dentistry care; ii) reference services for specialized attendance; iii) establishment of bonds with served population; and iv) popular participation and community social control in the service.

Intervention bioethics: a new view for health practice

To speak of Intervention Bioethics implies in rescuing how the *Universal Declaration of Bioethics and Human Rights*[2] homologation took place. It happened at UNESCO 33rd session of the General Conference, in October 19 2005, in Paris, and from then on, international bioethics agenda became definitively politicized.

The struggle for inclusion of social topics followed the Declaration construction process that, with support from Latin American nations, mainly Brazil, was

homologated in October 2005. In addition to customary topics initially contemplated, it discusses sanitary, social, and environmental issues of great interest for the poor countries and/or in development nations[3]. This positioning rescues the meaning attributed by the creator of neologism *bioethics*, Van Rensselaer Potter [4], of an ethics that relates with human life phenomena in its broader sense, by incorporating not only biomedical issues, but mainly environmental ones linked to sustainability of the planet.

This struggle of returning to the discipline origins has taken place since the early 1990s, when the first critics of principlism arouse – a current until then hegemonic in bioethics – and on the pretention of its principles universality[5]. Critics were motivated mostly for its lack of usefulness in analyzing conflicts that would require cultural flexibility and adequacy, as well as facing bioethics macro problems, persisting or daily, experienced by majority of population in countries like Brazil flagged by social exclusion [6].

Thus, worldwide bioethics most recent events are expanding their study and work scope, including in its agenda topics such as: human rights and citizenship; priority in allocating scarce sanitary resources; biodiversity preservation; depletion of planet's natural resources; ecosystem balance; transgenic food; racism and other forms of discrimination, among other topics. Meetings have shown clearly no satisfaction with epistemology followed by the discipline until then, which was restrict to individual problems and conflicts instead to proposing solutions and to intervene in collective socioeconomic and sanitary issues, persisting in majority of peripheral countries [7,8].

Therefore, the necessity to incorporate in bioethics reflection and performing realms contemporary sociopolitical topics became evident, like: social and economic inequities of the world; analysis of sanitary responsibilities; more accurate interpretation of epidemiological situations; establishment of intervention ways to be programmed; environmental issues; training of sanitary personnel and accountability of States toward their citizens[3,7].

It is in this context that Intervention Bioethics builds itself, based in Brazilian and Latin American reality in all of their contrasts and necessities[8,9]. This standpoint incorporates ethical issues imposed by biotechnoscientific development and by asymmetry of the patient-professional relationship, but also situations related to health policies and social inequalities. Reflections under this perspective criticize vertical incorporation of ethical contents from developed countries, trying to contextualize arguments to local topics.

It is in the complex way to analyze inequity countries' reality –supported by social and political feature – that Intervention Bioethics

discusses sanitary justice, social inclusion and citizenship. Corporeality concept is its minimum referential that advocates the idea that the body is the person's materialization and without it, social life does not take place, becoming an indispensable benchmark of ethical intervention to assure the necessary for life of individuals and people. The guiding referential are structured in contemporary human rights matrix, which from the acknowledgement of the collective right to equality, and the right of individuals and groups to equity, incorporates the concept of expanded citizenship by which rights are beyond warranties assured by the State [6].

This new proposal will bring positive and concrete consequences to expand ethical discussions in health, and to favor construction of more accessible sanitary systems. Thus, it will create condition so human societies achieve a fairer quality of life and, within an enlarged scope, it will legitimate intervention bioethics effective action bringing a new glance into health practice, setting reflections over reality based in parameters of equity, justice and social inclusion[7,8,9].

Method

Data collection took place in two stages. Firstly, a questionnaire was submitted to a sample of 40 surgeon-dentists (SD) from the municipal care network, which comprised PSF teams. There was, in July 2008, according to data from Municipal Health Secretariat oral health coordination, a total of 86 SDs in PSF teams. Considering questionnaire responses, the second stage started when 25 SDs were selected (five from each regional health sector – North, South, East, Center and Continent), of which 17 were interviewed, complying to sample saturation criterion. Four major points based the selection criteria of interviewees: i) time elapsed since graduation; ii) graduate training; iii) work period in Florianopolis care network; and iv) type of employment bond. To set a sample from regional with heterogeneous characteristics, that is, encompassing professionals with all described features. Semi structured interviews were guided by own instrument comprising 14 open questions.

It should be emphasized that sampling by saturation is a methodological tool frequently used in qualitative researches in different areas of health sector to interrupt intake of new components, establishing sample final size of the study[10]. This interruption bases in the fact that, in researcher's evaluation, collected data start to repeat and, therefore, is not relevant persisting in data collection. In this work, the first seven interviews indicated an evident accrual of different ideas and perceptions about the meaning of approached topics. Accruals diminished from eighth interview until they were no present anymore at 11th interview. It was decided to make another six interviews to confirm repetitions and in order to totalize four

interviews per regional, except Center regional, participating with just one interview due to refusal of contacted professionals. All interviews were undertaken during July of 2008, and they lasted from 45 minutes to 1 hour and half.

The research was submitted to UFSC Research Ethics Involving Human Beings Committee (CEP), which approved it in December 2007. Free and clarified consent term (TCLE) from all interviewed was requested before questionnaire filling, and interview undertaking and recording, which were recorded in audio tape. In the transcription of material, it was decided to use names of colors as code name in order to preserve identity of the interviewed. To help in analyzing interviews, the software for qualitative data analysis Atlas-TI was used. Interviews were inputted in the software and data pre categorization made with it, as well as the organization of analysis categories, following Bardin's content analysis techniques[11].

Thesis data analysis and discussion, as well as preparation of interviews departed from theoretical referential that contemplated key-concepts of the National Basic Care Policy, particularly the National Oral Health Policy; of Family Health strategy; of Intervention Bioethics and from work process. These key-concepts were organized into an *analytical matrix* and its application to the study was set. It is important to stress that each of thesis resulting articles focused an issue related to ESF surgeon-dentist work, And, therefore, theoretical referentials appear differently in each one of them.

In this article, key-concepts from National Basic Health Care Policy, from the Family Health strategy and from Intervention Bioethics were the most used ones, helping to define and to analyze daily activities and/or situations of oral health teams reported hereto.

Results and discussion

The access to dental care

The first care routine analyzed under this view was access to dental care. A great variety of adopted routines been adapted to each community's need, and with priority care for some groups is seen in interviewees' report. *"...In average, every two weeks I offer twenty openings, patients come at units open hour and I distribute them in the agenda on a first come, first served basis, and I only let them go when I finish their treatment. There is open agenda: pregnant women, elders above sixty years old and children up to ten years old"* (Crimson).

National Oral Health Policy guidelines foresee broadening and qualification of basic care through several actions, including service access expansion by means of oral health transversal insertion in different health integral programs: by lines of care and by condition of life[12]. The objective is to search for equity in health by providing to each citizen

possibilities to access care either through social responsibility or health policies[13].

Setting priority access to babies, student up to ten years old, pregnant women and elders, municipal dental care respects this guideline and World Health Organization (WHO) proposal (OMS)[14], according to which health public policies and systems should try to achieve equity by considering differences in social and sanitary conditions of individuals. To achieve this objective, developed actions are targeted to eliminate or, at least, to reduce to a possible minimum, unequal differences existing among human groups of different social levels[1].

However, it calls attention that concern to give priority of access to vulnerable groups, which is fully justifiable, may turn difficult dental care for *normal* adults – as stated by one of the interviewees–, who are man and non-pregnant women, and adolescents. This population ends up becoming vulnerable, as they do not get priority care: *"The agenda opens once a week, whoever comes gets scheduled until patients finish. Agenda last for one, two months. I provide return visit for elders, pregnant women, and children up to twelve years old. I cannot do the same for adults because otherwise, I will care only for a closed group of people and I will not be able to give opportunity for others. Therefore, I explain this to people, but they think that it is not right. It is not right, but that is the way we do it"*. (Maroon)

Adults, particularly workers, have difficulties to access health unit at conventional timetable for these services. These situations lead to aggravate existing problems, changing them into urgencies and reason for missing work, in addition to consequent dental losses. The ideal would be, as established by the National Oral Health Policy, a way of priority access for workers, in times compatible with their work schedule, mainly because majority of interviewees' report suggests the same reality: a complicated access and without priority for these citizens.

Additionally to the routine to access treatment consultations, unanimity was found regarding emergence care. All reported well established routines for such care and for special care to people who arrive at the unit in pain: *"Emergences we always care for, independently of how many show up: if ten appear in a day, I am going to care, find a way, even if it is just to provide an explanation or a medication"* (Red plum). This particularity of dental care characterizes a respect for the citizen in urgent need, in addition to comply with one of the guiding principles of the National Oral Health Policy regarding absolute priority of access to be given in cases of pain, infection, and suffering[12].

A significant fact reported by interviewees is the high number of missed consultations. According to professionals, these missing occur for two main reasons, both

related to “open agenda” practice. In communities without repressed demand, missed visits characterize, according to professionals, by a certain disdain of people due to easiness to schedule a new visit. In communities with repressed demand, free access provided by open agenda means scheduling consultation for the next week, sometimes months before scheduled day, which leads, frequently, to forgetting or they just do not need care anymore:

“Consultation scheduling was with open agenda, as we wanted to avoid waiting list. I said it was because patients missed consultation exactly because of easiness of scheduling. Then, we changed strategy” (Âmbar).

“Agenda are open. People prefer this way. But during winter, there are too many missing consultations, and I do not know if it is because consultation are scheduled one, two months before, and people forget or if it is because when time comes, they do not need it anymore” (Alizarim).

The referral service

Reference service, in addition to access to care, for specialized treatment was analyzed also. Integrality of dental treatment represented a crucial historical knot of profession, and this situation become more complex within public service scope where the range of integral care totally depends on an effective referral service, which seems still a goal to be achieved.

Public dental care in Brazil restricts almost solely to basic care, and still with a repressed demand. Most recent data show that, within SUS scope, specialized dental services correspond to less than 3.5% of total clinical dental procedures[12]. Low supply of secondary and tertiary care services is evident, compromising, consequently, the establishment of suitable oral health referral and counter referral systems in almost all local health system. Expansion of secondary and tertiary care network did not keep pace, in dental sector, the growth in supply of basic health care services. With expansion of basic care concept and the consequent increase in supply of procedures diversity, investment providing increase in secondary and tertiary care are also necessary to meet the challenge to expand and to qualify the supply of services[12].

Since 2004, with the beginning of the National Oral Health Policy - Smiling Brazil – the Ministry of Health contributed with implementation and/or improvement of specialized dental centers (CEO). CEOs are referral units for basic care oral health teams, always integrated to local-regional planning process, which should offer, according to each region and municipality epidemiological reality, clinical dental procedures complementary to those undertaken in basic care. In these procedures are included, among others: surgical periodontal treatments, endodontic, higher complexity dentistics and surgical procedures

compatible with this level of care.

When questioned about what were their experiences with municipal referral service, many of the interviewed reported that the place they refer their patients is the Dental School clinic at the Federal University of Santa Catarina (UFSC): *"One sends a referral to USFC by means of patient himself. Of course, as it is a teaching unit, there are times when openings existing, and other times when there are not. Nevertheless, as far as endodontics and surgery, we normally referred patients there. Later, they return and schedule an appointment with us"* (Lavender).

Perceptions about Municipal CEO varied. Some acknowledge CEO implementation initiative and they believe that, despite problems, it is possible to improve: *"We are going at low pace, but going. The scheduling system has some faults, but I see as the following: before we had nothing, and now we have something. Now we have endodontics, including molar root canal and treatment; periodontial with enlargement of clinic crown and surgery. Therefore, at least now despite repressed demand, one has an answer to give users"* (Amber).

Others complain that they are not able to access users referred to offered services, mentioning as one major problem the difficulty in scheduling a consultation in CEOs. This leads to each professional to find his own "little ways" and ultimately referring his patients to courses/professionals with whom they have a personal relationship of some sort:
"Actually, it happens with me like that: I am able to refer a patient – I say that it is a clandestine referral – to endodontic studies center. At UFSC, we do not have any contact, but at the centers, we were able to establish a very nice partnership. But we go on providing the Brazilian "little ways", and I think I am not Brazilian as I believe that it had to be formalized" (Rutilus).

Lack of official procedure to be followed by all professionals or, at least, more clarified referral routines, emerges the "double vulnerability" issue. They are vulnerable because the official system is not effective and cannot meet the demand; and they become vulnerable again when specialized care becomes, then, a matter of chance: chance of having in his unit a well-connected professional, who sensitizes with his problems and knows "clandestine" ways to get the needed care.

The bond

The third analyzed routine or situation regarded the establishment of a bond with served population. One realized that, due to the constructing moment of the referral and counter referral service, the bond stated in the National Oral Health Policy was jeopardized. Some of the interviewed presented their perception about the issue: *"I believe that to establish a bond is when we begin to feel responsible for the individual and for the community in health issues and one becomes reference.*

This only happens when one realizes that has conditions to respond to this need. Now, when one is not able to do this caring, there is no bond: demand comes and knocks at the door once, twice, three times and cannot get caring. The service does not work as referral for that need" (Rutilus).

Bond configures as one of the guiding principles of oral health care. Therefore, the term "to establish a bond" with served population means that basic health care units (UBS) are responsible for problem solving within their scope of work, through supply of qualified, effective actions that allow controlling, by user, of the moment of its execution. Bond is the synthesis of humanization of relationship with user and its construction requires definition of responsibilities of each team member for needed tasks for caring in routine or unforeseen citations. Bond is the outcome of sheltering actions and, mostly, for the quality of response (clinical or not) received by user[12].

In this context, one discusses also that establishing a bond passes by the buildup of sanitary awareness and it implies, for managers, professionals and users, awareness of features that conditions and determines a given health status and of existing resources for its promotion and recovery. Some interviewees realize that there is need of greater participation and responsibility at community side:

"I believe that to establish a bond one must take responsibility for one's patient along with him, and it is not one assuming the whole responsibility" (Red plum).

Thus, the stimulus to build up sanitary awareness where integrality is realized as a right to be conquered will permit, with possible participation ways, to develop social control process of actions and oral health services[12]. This idea brings into discussion another concept that supports Intervention Bioethics, which is empowerment. This word becomes better known with Amartya Sen's work, which uses the idea of freedom, often in his works, to discuss empowerment. Sen sees freedom as something intrinsically important for a good social structure. A good society is, under this perception, a freedom society [15].

Thus, the idea of individual's empowerment, who are vulnerable due to historical process and cultural characteristics of societies where he is inserted, pervades the whole social, working as an element capable to potential this society segment performance, deprived of decision power, promoting his inclusion[9]. Along with empowerment, the concept of liberation also corroborates with Intervention Bioethics proposal when it considers that social subjects are eminently political actors whose action may either keep or change reality [6].

Use of these two categories makes reflection to toward political struggle to ensure freedom. Adopting this positioning leads to citizen's struggle for his social inclusion, either in health sector or in other sectors, from the assumption that there are forces that oppress and concrete action must be undertaken to oppose them[9]. Social inclusion corresponds to real people daily action in a dynamic process needs to be constructed and taken into practice in searching the true social justice in health [7].

Thus, stimulus for professionals toward popular participation and social control in activities undertaken by Family Health teams is example of citizenship build up when it fosters people to participate actively in decisions that influence them. Equitable health public policies should not, therefore, remain exclusively in economical considerations, but to search for people's well-being, respecting their differences and giving them opportunity do manifest and to participate in decision-making [16,17,18].

Popular participation and social control

Popular participation and social control, involved in Florianopolis oral health teams, were the last situations to be analyzed. When questioned about if there was stimulus by teams for popular participation in discussion related to health through local councils, reported realities were similar:

Communities without health councils are un-Motivated to participate in this political struggle resource, even with team's stimulus:

"...Our community has this profile; they complain, but do not fight" (Scarlet).

"We did not make it. We tried already to speak to one by one, calling on the phone, placing signs, using dwellers' association, in several forms of dissemination, but it did not work. Thus, the council summarizes in three or four people from the unit, community agents and one or other dweller. It is as if it was a unit meeting" (Grenade).

There were reports about community mobilization in a non-organized and aggressive way against health team, and reflections on the risk to assume as collective interests that may come out as personal, a condition that may not be identified due to insufficient community participation in the few established councils:

"We face a community that comes with the press to argue, yell, and make fuss. We would like them to mobilize really, but due to lack of organization and aggressive manifestation toward the team. I cannot get stimulus to establish here a local health council because there is not dialogue of team with community" (Indigo).

"It is very wary. People are with their own personal interest there, and there is risk of establishing it formally, which is

Not a collective interest. There is such risk" (Rutilus).

Issues that emerge from these report regard both to population and to health professionals: are they prepared to stimulate and to participate in the struggle for individual and collective rights? Will they feel in the condition of emancipated and free subjects to make their own choices in face of means to achieve survival in society? The reality reported by interviewees suggests that the struggle for empowerment, liberation and emancipation [7] of citizens from large portion of communities in the municipality are still to be constructed and, therefore, it is necessary to get organized. This is valid both for health professionals and for this population, generating conditions to promote their social inclusion and participation in decisions related to their health. Some interviewees' report shows the way:

"We are little ants trying to change a reality that is very merciless. We try to develop people's autonomy because this is important. What we want is that these people acknowledge their rights and claim what community needs, looking a bit more toward the collective and not just on the self" (Lavander).

"By attending these meeting, they would participate in discussion of issues connected to community: lack of professional, in general, delays tests, scheduling, parking, theft, waste, dogs in the street, bus stop, everything. Users do not know what a local health council is, which is community's voice, community organized participation. And an organized community is able to get much" (Amber).

Family Health strategy escapes from something that will threaten it always, one believes that by committing toward sanitary citizenship build up: the risk of becoming a paternalist policy. One of the interviewees expresses concern with this risk that, for him, in his community is a reality already: *"One thing that bothers me is that Family Health is turning into a paternalist program, I am afraid because I develop an extremely paternalist activity: we are using rights, rights, and rights.* (...) *But population must be worked upon because actually it also has duties too"* (Indigo).

One believes that search for sanitary justice through Family Health strategy should have its foundations on the respect for citizens' autonomy and in legitimacy of their individualities. This is clear when one accepts that true ethical foundation of the principle of justice is to allow and to help each human being to become truly autonomous, and through his free decisions to improve himself, and, thus, to multiply moral and material wealth of society [19].

Final considerations

The idea pervading concepts that are in the core of Intervention Bioethics is that health is synonym of citizenship. A healthy, schooled individual and inserted in his social context

has greater possibilities to, for example, to compete for a dignified place in the work market and, thus, to improve his survival and that of his family. Human health, therefore, is a concrete instrument of citizenship when it contributes so people become, physical and mentally, better prepared to struggle for a better fate [20]. As it is a concept within social justice scope, which includes freedom and individual and collective rights, citizenship will never be achieved or conquered exclusively with technical or pragmatic measures [20].

Rescuing reflection about Dentistry, one finds that, in as much as profession, it characterizes its practice by an exercise that promotes more inequity than social inclusion. However, it could change into an instrument of citizenship if it were accessible to all that needed it. However, better oral health conditions for the Brazilian population will not be achieved with isolated technical measure, but amidst political advances that society will conquer[19]. Thus, it is clear the importance of health public policies for building up a participative democracy what searches for fairer and more inclusive social ways[20].

Family Health strategy – with insertion of oral health – is a concrete sign of politicizing and progress in the Brazilian sanitary agenda toward search of universality, equity, and respect for human rights. Dental care in Family Health strategy still is a process under construction, initiated just five years ago.

One realizes that major number of professionals inserted in oral health teams show concern, which are translated in their actions and activities, with inclusion of citizens in their communities in municipality's oral health care. Access routines to care are example of this but which, however, still show ineffective regarding universality.

Additionally, municipal referral service for specialized dental care present failures and it needs better organization to comply with its purpose in providing integral dental care to its citizens in timely and universal way. These failures result that bond with community is not always established since it is not able to respond to presented needs, although there is concern by professionals to achieve it.

Finally, perhaps the highest expression of sanitary awareness of a population, which is popular participation and effective control of health actions, still does not happen concretely in researched communities. In order for political advances are configured, it is indispensable health professionals and population engagement to changing proposals, which benefit the collective through a conscious popular participation[21]. Thus, it is emphasized the importance of incentive to people, by professionals and teams, to establish and maintain local health councils.

Daily conquest of health through search for citizen's affirmation and of his rights is a clear expression of ethics as space for political struggle, which will help to build up sanitary awareness of our population[20,22].

Resumen

La visión de la bioética de intervención en el trabajo del odontólogo del Programa de Salud de la Familia

El artículo parte de la tesis de doctorado sobre la labor del cirujano dentista en la estrategia de *Saúde da Familia* (Salud Familiar) donde se examinan las actividades cotidianas de los profesionales de la red a partir de su percepción. Se discute cómo su trabajo diario expresa el referencial de la bioética de intervención, cuyos principios básicos son la búsqueda de la integralidad, la justicia sanitaria y la inclusión social. Fueron entrevistados: un representante del municipio y 17 cirujanos dentistas. Se analizaron las rutinas de acceso al servicio, los servicios de referencia, el establecimiento de vínculo y participación popular y de control social. Las rutinas de acceso demostraron ser adecuadas a las líneas de atención, pero ineficaces en el cumplimiento de la universalidad. El servicio de referencia presenta fallas; y la participación popular y el control social no se realizan de forma concreta, por lo que se debe incentivar a la población hacia la participación en los consejos de salud locales, espacios de lucha política.

Palabras clave: Atención odontológica. Bioética. Programa de salud familiar.

Abstract

The view of intervention bioethics in Family Health Program dentist's work

This article is part of a doctorate thesis about the dentist´s work Family Health strategy, which analyses the activities of public professionals from their point of view. It is discussed how his work expresses the referential of intervention bioethics, which considers the search for integrality, health justice and social inclusion as basic implications to accomplish citizenship. The study interviewed an administrative staff member and 17 dentists. The access routines to service, referral services, establishment of a bond and popular participation and social control

were analyzed. The access routines showed that they were appropriate for lines of care, but still inefficient to achieve universality. The referral service presents deficiencies, and popular participation and social control do not happen concretely, still needing improvement by stimulating people to participate in local health councils, spaces to build citizenship.

Key words: Dental care. Bioethics. Family Health Program.

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Contacts

Evelise Ribeiro Gonçalves – *eveliserg72@hotmail.com*
Flávia Regina Souza Ramos – *flaviar@ccs.ufsc.br* Volnei
Garrafa – *volnei@unb.br*

Evelise Ribeiro Gonçalves – Rua Percy João de Borba, 142. Trindade CEP 88036-200. Florianópolis/SC, Brazil.