Ethical issues and social justice in the Estratégia Saúde da Família

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Abstract

This qualitative study aimed to identify ethical problems from the perspective of the team members of the Estratégia Saúde da Família (Family Health Strategy) in Brazilian state capitals, linking such issues to the theoretical field of social justice. Semi-structured interviews were conducted with 33 members of 4 teams in the cities of Curitiba, Belo Horizonte, Natal and Salvador. The data were subjected to the thematic modality of the content analysis technique, and two main categories emerged. The first involved the main ethical problems in the daily life of the teams identified by the participants, while the second described the functioning that could be identified from the position of the participants with regard to the construction of ethical relations in the field of social justice. It concludes that ethical conflicts in the context of primary health care interfere with the work process and that an approach from the perspective of social justice may allow Estratégia Saúde da Família teams to tackle such issues in their everyday work.

Keywords: Primary health care. Family health strategy. Ethics. Social justice.

Resumo

Problemas éticos e justiça social na Estratégia Saúde da Família

Estudo de abordagem qualitativa objetivou identificar problemas éticos na perspectiva de membros de equipes da Estratégia Saúde da Família de capitais brasileiras, relacionando-os ao campo teórico da justiça social. Foram realizadas entrevistas semiestruturadas com 33 membros de quatro equipes dos municípios de Curitiba, Belo Horizonte, Natal e Salvador. Os dados foram submetidos à técnica de análise de conteúdo em sua modalidade temática e emergiram duas categorias fundamentais. A primeira envolveu os principais problemas éticos identificados pelos participantes no cotidiano das equipes, e a segunda reuniu os funcionamentos que puderam ser identificados a partir do posicionamento dos participantes com relação à construção de relações éticas no campo da justiça social. Conclui-se que os conflitos éticos no âmbito da atenção básica à saúde interferem no processo de trabalho e que sua abordagem pela perspectiva da justiça social pode favorecer seu enfrentamento no cotidiano das equipes da Estratégia Saúde da Família.

Palavras-chave: Atenção primária à saúde. Estratégia Saúde da Família. Ética. Justiça social.

Resumen

Problemas éticos y justicia social en la Estratégia Saúde da Família

Este estudio cualitativo tuvo como objetivo identificar los problemas éticos desde la perspectiva de los miembros de los equipos de la Estratégia Saúde da Família (Estrategia de Salud de la Familia) en las capitales brasileñas, al relacionarlos con el campo teórico de la justicia social. Las entrevistas semiestructuradas se llevaron a cabo con 33 miembros de cuatro equipos de los municipios de Curitiba, Belo Horizonte, Natal y Salvador. Los datos fueron sometidos a la técnica de análisis de contenido en su modalidad temática y emergieron dos categorías fundamentales. La primera involucró los principales problemas éticos identificados por los participantes en la vida diaria de los equipos y la segunda reunió los funcionamientos que pudiesen identificarse a partir de la colocación de los participantes con respecto a la construcción de relaciones éticas en el campo de la justicia social. Se concluyó que los conflictos éticos en el contexto de la atención básica a la salud interfieren con el proceso de trabajo y que su enfoque desde la perspectiva de la justicia social puede favorecer su enfrentamiento en el día a día de los equipos de la Estratégia Saúde da Família.

Palabras clave: Atención primaria de salud. Estrategia de salud familiar. Ética. Justicia social.

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Research

Within the Sistema Único de Saúde – SUS (Unified Health System), the primary healthcare is considered strategic to articulate collective and individual actions towards promotion, protection and recovery of health. In such formulation, primary healthcare has sanitary responsibility for a certain population, attempting to solve most frequent and relevant problems in that territory. The Política Nacional da Atenção Básica - PNAB (National Policy of Primary Healthcare) instructs the decentralization and capillarity of primary healthcare actions, identifying it as preferential gateway of users in the system and orderer of healthcare network to health.

In this regard, the primary healthcare is oriented by principles of universality, accessibility, connection, continuity of care, integrality of care, accountability, humanization, equity and social participation[1]. Thus, it is in such context that ESF has been implemented since 1994 with the purpose of reorganizing the assistance practice and reinforce the fundamental characteristics of primary healthcare. We can mention the focus on family -inserted in its social, economic and cultural context -the constitution of multi professional team, territorialization with addition of clientele, intersectoriality and social control and organization of work centered on surveillance in health.

The ESF teams are formed by, at least, a doctor, nurse, nursing assistant and six agentes comunitários de saúde - ACS (health community agents). Oral health professionals, such as dentist and oral health assistant and/or oral health technician can also be in the team[1]. The reflection about ethical problems in health research and care has been more relevant especially from the 1970s, with the appearance of bioethics. In this regard, it is more emphasized the ethical problems related to limit-situations, such as transplant of organs and tissues, medically assisted reproduction, euthanasia and cloning, in prejudice of everyday moral matters of sanitary practice, especially those faced by health professionals in primary healthcare.

The authors emphasize that work characteristics in primary healthcare cause important ethical problems that, for being less dramatic and visible than those resulting from tertiary or hospital healthcare can often pass unnoticed or being difficult to identify[2-6]. Some particularities of primary healthcare contribute to the existence of such difference. One of them is that interventions suggested at this level of care, upon articulating promotion and protection to health with cure and rehabilitation are broader and involve not only individuals and families, but also communities. Another difference is that at primary healthcare the users are normally in condition to make autonomous decisions about their therapeutic plans.

Then, meetings between professionals and users in primary healthcare are more frequent and in less urgent situations, if compared with those that usually happen, at hospital level -where it is focused the complex decisions related to beginning and end of life. Thus, this study is focused on primary healthcare and approaches the main ethical problems identified by employees of family health strategy of four Brazilian capitals. It is intended to reflect about those problems and the way they are approached in the routine of practices, under theoretical perspective of social justice.

Social justice, operations and health

As analyzed by Sen[7], every conception of justice values equality in a certain space. However, being individuals so different and in so many aspects -social, economic, biological conditions, talents, life plans -it can be questioned what must be equaled so that such justice could exist. In this regard, there are different theories of justice that attempt to answer this matter, having as reference a certain evaluation space. To Rawls, what must be equaled are basic freedoms and primary goods; to Nozick it is the freedoms, to Dworkin it is the resources and to Sen and Nussbaum it is the capability[7].

We adopted to this discussion as conception of social justice the *perspective of operations* suggested by Dias [8]. In such approach, the living organisms are conceived as complex functional systems, with a set of operations that characterize them or constitute their own identities[9,10]. The term "operation" is related to constituting actions or activities of different beings, including the capacity of different degrees of complexity, such as to be nourished and politically participate. Nevertheless, there must be a differentiation of operations of conditions to development and performance of such capabilities.

Thus, so that somebody has the capacity of nourishing himself, he must have access to required foods. Similarly, somebody can have the capability to politically participate but live under an authoritarian government that prevents him from having such capability. Within such approach, justice requires equal promotion of functional integrity of beings, so that they can flourish or express their own nature. It is considered a broad and diverse

set of functional systems, including human beings -autonomous individuals, children, elderly people with serious dementia, individuals depending on medical technologies, etc. -, but also other non-human beings.

In case of human beings, the operations can be grouped in some fundamental spheres -health, education, work, politics, among others -and they must be promoted in all moments of normal existence cycle -birth, childhood, adolescence, adulthood, old age and death. In this set, it is identified both elementary operations (capacity of breathing, locomotion, etc.) and complex ones (capacity of thinking, having affective relationships, etc.).

Within the perspective adopted here, promoting functional integrity of human beings is what characterizes a "decent life". Therefore, a fair society is the one that equally promotes the operations of all individuals. In such context, it is ethical to fight against obstacles that can prevent people from living decently, such as illiteracy, lack of access to health services, impossibility of obtaining a satisfactory income or absence of civil and political freedoms. Thus, under such perspective, the crucial objective of State upon managing public policies must be assuring that all individuals under its custody carry out their operations.

In work by Dias[8], it was proposed[11] an application of *operation perspective* to health field incorporating the concept of vital normativity of Georges Canguilhem[12]. In another work based on such perspective, Ribeiro[13] articulated the discussion of justice with the debate about equity in health. There is a paraphrase below of what was published in such previous works:

- Health is the normative capacity of human beings, operating upon a set of operations of different complexity degrees -as a dynamic and interactive system -that to be developed and carried out require certain material conditions of existence.
- There are operations that are essential requisites to a decent life. Such operations could be acknowledged both as a way to accomplish other operations and something valuable by themselves.
- What is essential can only be determined on an empirical basis, through accurate attention to different voices and particular circumstances lived by different individuals. Both the determination of what will be the essential operation in each case and the level to be reached in each operation will depend on specific nature of each individual. This is for us to include different ways of operation that, under the point of view of constitution of identity of individual himself, must be acknowledged as crucial.
- Every individual must have the right to health and quality of life that provides conditions to development and performance of his essential operations. In this sense, health cannot be considered a synonym of quality of life, but a component of satisfactory notion of quality of life. It is among those operations acknowledged as condition to carry out other operations, such as the capacity to work, for instance, but also valuable in itself.

Although it follows the conception of social justice by Sen[14] and Nussbaum[15], the approach used in this work is different from the authors in two aspects. The first difference is due to the fact that it is adopted as evaluation space -of demands for equality, purposes of social justice and public policies -the focus on operations, differently from Sen, which emphasizes the capability. The capability corresponds to freedom of combining operations that express real opportunities to operate ways of living within available alternatives[14].

Consequently, it is used in this article the most inclusive branch of conception of justice. This is because there is the presupposition that acting in a fair way is not harming and, especially, fostering the operations of all individuals, including those who cannot carry out freedoms, such as children, people with mental disabilities and elderly people with dementias, among others. Therefore, in such approach, freedom is still valued for those who can have it as specific operation.

The second distinction is that it is not intended to determine and relate universal and common operations to all human beings, as it is done in the list of central capabilities proposed by Nussbaum[15]. Thus, it is not defended the unified conception of those operations, as it is understood that the set of relevant operations depends on particular circumstances lived by singular individuals.

Method

The study was developed with qualitative approach due to characteristics of investigated object. It is an investigation included in the field of

social research, with the objective of knowing ethical problems at Family Health Strategy under theoretical perspective of social justice[16]. It was gathered data in four capitals of three Brazilian regions: Curitiba in Southern, Belo Horizonte in Southeastern and Natal and Salvador in Northeastern region. In each city, the local manager assigned a complete team, working in the community for at least one year, to participate in the investigation.

It was interviewed 33 workers, 12 of them were profissionais de nível superior - PNS (upper education professionals) - doctors, nurses and dentist surgeons -, nine técnicos e/ou auxiliares de saúde - TAS (technicians and/or health assistants) – nursing and oral health - and 12 agentes comunitários de saúde - ACS (health community agents). The guide of interview comprised questions divided into two main sections: 1) General characteristics about education and work time of professional at Family Health Strategy; 2) Ethical problems faced by the team. In this last section, the professionals were asked to described situations considered as ethical conflict lived in the unit/community, their consequences and ways the team approached or forwarded the matters.

The research project was approved by Comitê de Ética em Pesquisa com Seres Humanos (Committee of Ethics in Research with Human Beings) of Hospital Universitário Antonio Pedro da Universidade Federal Fluminense (University Hospital Antonio Pedro of Fluminense Federal University). To carry out the study, it was requested a signature of informed and free consent document by participants, emphasizing the risks and benefits of investigation, in addition to make explicit the assurance of secrecy about identity of those who accepted to take part in the interview. The teams were approached by the researchers in their Family Health Strategy units, where the proposal of study was submitted. After the participation invitation was made formal and proper clarifications about the objectives of investigation, it was made the interviews with those interested in participating.

The transcribed answers were assessed from the technique of content analysis, specifically the thematic analysis due to its adequacy to qualitative investigation in the health area. The analysis process followed three stages, as suggested by Minayo[16]. In the first one, it was conducted the initial classification and ordination of data, including the transcription of interviews, floating reading and structuring the map of interviews. After that, it was made a detailed reading of transcriptions, with the purpose of specifying ethical problems in each group of interviewees - PNS, TAS and ACS. Finally, the previous moment was deepened, confronting argumentations by interviewees and theoretical reflections about related ethical problems.

To the analysis, the researchers were inspired in proposition by Rawls[17] submitted in its procedure of ethical justification called reflexive balance, although in a more limited view about the set of beliefs and moral arguments taken into consideration, due to objectives of research[18,19]. In this case, the analysis was characterized by adjustment or mutual support between judgments and moral views of interviewees related to private situations found by the research and adopted conception of social justice.

To understand better the research results, we distinguished in this work moral and ethics. The former is understood as values lived within social experience and the latter is a reflection about moral experience. Thus, partially following Kleinman, *while moral experience is always about practical engagement in a private local world, cultural space that carries political, economic and psychological specificities*[20], the ethical discourse is prepared in terms of trans local values or that can be universalized.

As Kleinman accurately observed, the distinction between moral process and ethical discourse is something crucial. Not only *to see the usefulness of trans local perspective when we are confronted with condemned local practices*[21] - the language of human rights, for instance, has this function -but also because the own local world can provide relevant moral positions and alternatives to ethical discourse. The differentiation by Kleinman can be translated within such investigation as the distinction between moral understood as a first order discourse formed by speeches of interviewees and ethical discourse or ethical of second order where, grounded on adopted theoretical perspective of justice, it analyzed the discourse of research subjects.

Ethical problems at work in family health

It was gathered in such category the main ethical problems related to healthcare at Family Health Strategy, considering the three groups of interviewees. It could be observed that ethical problems highlighted by the interviewees are related both with life conditions of population under its responsibility and the capacity of SUS meeting the

health necessities of those users. The participants report that poverty conditions in the areas covered by Family Health Strategy imply complex problems lived by individuals and families. Such complexity imposes to professionals the challenge of articulating with other sectors and public policies to develop actions that can impact social determinants and foster health.

In such situation, the participants mention the failure of Unified Health System (SUS) produce satisfactory answers to requirements and expectations of dwellers and identify as ethical problem the limit of its operation as mediators of intersectoral actions. Such operation only becomes more efficient in cases when it is related to a local policy. The interviewees emphasize difficulties related to fragmentation of health services of SUS, which interferes with continuity of care and prevents effective flows to solve problems in different attention levels.

Thus, the lack of integration of Family Health Strategy and difficulties to access specialized attention are acknowledged as ethical problems that can become barriers and not facilitators of preferential access to system. In this regard, the difficulty to access medium complexity technologies, especially diagnostic support and medical and dental specialties has been an important restriction factor of care[5,22]. In this context, all teams report the existence of waiting lists and classify it as a "chronical problem" that hinders the solution of health problems and effectiveness of therapeutic projects collectively constructed.

As it is observed by one of ACS: "*Our system has a waiting list, I mean, different 'lists' related to, especially, medium complexity technologies*" (ACS 7). The teams report they find difficulties to monitor those waiting lines to have reference of specialties and, thus, they identify an ethical problem to assure full care, as delays in diagnosis can hinder the effectiveness of treatments. The capitals that invested in regulatory processes define targets and indicators to follow up lines with admissible maximum waiting times. However, there are cases when it is required to broaden the specialized public offer or define ways of hiring private caretakers, where public interest prevails.

The diversity and volume of health problems that require intersectoral interventions put professionals in permanent tension with limits of their work and resources they can employ to foster/protect essential operations of population under their responsibility. It equally contributes to it the pressure of sanitary and medical demands strongly modulated by social and economic conditions of territory. As argued by Furler and Palmer[23], the social inequalities and their effects over health of individuals are the daily reality of health professionals, being also a great ethical challenge to think how professionals can handle inequalities in health.

Such authors identify some common answers[23]: 1) Blame victims for their disadvantages; 2) Do not consider social problems as part of their work; 3) Feel powerless due to magnitude of social strengths operating in user's life. On the other hand, the work process of upper level professionals does not particularly favor the development of actions to foster health and prevent diseases. Those are often postponed due to other activities, especially those limited to physical space of health unit and connected to clinical assistance.

The pressure by spontaneous demand and complex epidemiological profile, which mixes chronical and acute diseases, has been the argument to scarce innovation as medical and dental care and distance of those professionals from broader processes of intersectoral articulation. The work of health team of Family Health Strategy still privileges technologies centered in individual body, especially medicine technologies and those that Foucault calls "technologies of I" or "care of himself"[24]. They operate due to changes in life habits, such as, for instance, stop smoking and drinking, adopting a healthy diet, among others.

Thus, the adoption of perspective of fostering and protecting operations, beyond the set of answers to biologically limited problems is still challenging. The work process in health, according to assessment by interviewees, implies overwork and tension and it can generate personal conflicts within the team. The consequences are identified in the following report: "Some people transform in disagreements, arguments, others 'create diseases', in other words, they bring to the body the pressure of everyday work" (PNS 9).

The PNSs also report conflicts resulting from salary differences and work regime among professionals, which contribute to make the work environment tenser. In this context, one of interviewees asks: "*Who takes care of us?* (...) *Nobody does it* ..." (PNS 9). The assistance and administrative overwork over the nurse was mentioned as reasons of conflicts among categories, especially related to specific nucleus of professional competences[5]. The conflicts in work

teams sometimes also occur due to difficulty in outlining the duties of each member in the context of reorganization of technical and assistance model through Family Health Strategy [5].

It must be understood that the health team involves professional relationships coming from different knowledge and practices and it faces the challenge of an operation where it does not prevail -in management of care -hierarchies among professionals, but an integration of competences. On the other hand, the ACSs emphasize the importance of their work in health team, expression, on the one hand, a personal satisfaction with the professional exercise and, on the other hand, the risks involved in their routine of work in the territory.

The interviewees emphasize the "superimposition" between personal and professional life, as the work becomes a daytime activity, where the ACS is requested by dwellers registered at Family Health Strategy. The ACSs acknowledge that such situation results from the fact that they live in the territory where they work, which facilitates the comprehension that they are always available. The mention as ethical problems situations of harassment and violence in the territory and the fear of catching some transmissible diseases, such as tuberculosis.

Central operations to construct ethical relationships

It was gathered in such category the operations identified from speeches by participants of research. It was started from the theoretical presupposition that the set of relevant operations depend on specific circumstances lived by singular individuals [11]. It was identified three central operations: 1) Capacity of receiving the user in his health necessities; 2) Capacity of managing his own therapeutic project and 3) Capacity of protecting privacy and confidentiality.

About the former, the research subjects highlight that the connection and conversation with users are central components of work at Family Health Strategy. Similarly, the willingness to hear users is considered very important to solve conflicts, even in problematic situations out of professional reach. In a contradictory way, it was possible to identify in speeches of interviewees the characterization of problem users who, within words of participants, as considered "*boring, "impatient", "quarrelsome*" and "*ungrateful*".

According to interviewees, those problematic users complain of provided care and make demands that health professionals cannot always meet, showing an evident degree of deterioration in relationships between professionals and users [25]. The relationship of professionals with this type of user is ambiguous because if, on the one hand, they acknowledge some ground in criticism about the poor services, on the other hand, they consider they must be more understanding and tolerant, valuing the benefits provided by Unified Health System (SUS), despite limitations of health services.

Schramm emphasizes that it is made the inversion of constitutional provision of health as right of citizen and duty of State to the conception of a duty of citizen and right of State [26]. According to such conception, the State has the right to set out conditions to healthcare due to behavior of users, which, on the other hand, have the right to properly behave to deserve the provided services. In reports by ACSs, such perspective can be seen, as such professionals have an important role to mediate conflict situations involving users and health teams.

A health community agent describes such conflicts with battle images, where professionals feel they are "*'shields' in the middle of 'shooting', attempting, as dweller and member of team, defend both sides*" (ACS 6). Kottow [27] emphasizes the importance of a dialogic model in the relationship between health professionals and users/families. In such relationship, the participants are *truthful -they say what consider objectively true; comprehensible -they are concerned with an adequate reception of what was expressed and honest -they say what really think, setting a communication that will be mutually respectful* [28].

Consequently, it is a participative model, where those involved in the decision set out a relationship of trust and cooperation in favorable environment to informed decision. The healthcare professional provides relevant information and the user decides, among proposed alternatives, the one that is more adequate to himself [27]. The second identified operation corresponds to management capacity of the own therapeutic project by users. The research participants are concerned with users who follow orientations proposed by healthcare professionals and claim that such resistance can cause harm to users themselves or third parties.

In such context, it was possible to identify in reports by interviewees the characterization of resistant users, among which are expressed two moral concerns: The first one is related to likeability

of user having or not a certain clinical situation worsened by lack of adherence to orientation, for instance, a certain medicine therapeutics or recommendation of leaving unhealthy habits, like drinking and smoking. Social and cultural conditions, in the professionals' opinion, determine the users' choices. As a TAS exemplifies, "*between buying a toothbrush or food, people choose food as a way of surviving. But some people, even though they have no money, prefer to buy fake jewelry*" (TAS X)

In this case, such comment may suggest the resistance of healthcare professionals in respecting subjects' freedom, particularly of vulnerable people. It can be questioned up to which extent the decisions or no decisions of such individuals can be ignored or recriminated under the claim that their judgment is necessarily influenced by their social status. Would not it be also a type of discrimination to think that paternalistic postures would supposedly protect the vulnerable people from themselves?

The professionals have different behaviors related to degree of freedom granted to users in definition and management of their therapeutic project, as well as in orientations related to lifestyles [3,5]. There can be a conflict in professional practice between user's freedom of choice -with involved benefits and risks -and fostering their wellbeing, especially if professionals adopt coercion rather than persuasion, taking over such paternalistic posture [3,5]. It is emphasized that many clinical decisions, such as a choice about hospital or domicile modality to assist the elderly user have economic repercussions to the family.

As it is argued by Kottow [27], in this case, the user's autonomy can be limited, as the family is also affected by the disease. Furthermore, it must be observed if there are injustices in the family related to distribution of tasks to take care of sick members, with disabilities and elderly ones, as it often occurs, being often in the hands of women [29]. Such burden often limits the range of opportunities to women follow their professional projects, especially when it comes to education and work.

From ethical point of view adopted here, it is the user himself who must assess the type of life he wants to have, including choices about therapeutic project or more or less healthy behaviors he wants to adopt. In such approach, when the user *makes harmful decisions only to his own interests, even though it is different from recommendations he receives, there is no room to paternalistic interference* [30], except if the user is not mentally competent, which would justify such paternalism in certain circumstances. Kottow claims that the fact people are not well educated does not mean they are mentally incompetent or *incapable of understanding, reasoning or valuing* [31].

Franco, Bastos and Alves concluded in a study about doctor-user relationship that the clinical situation of user and his therapeutic plan are usually not discussed, prevailing the focus of mere biological dimension, without encouraging the sanitary conscience and performance of user's freedom. According to assessment by those authors, one of problems is that the technical condition of doctor is considered sufficient to decision making [32] and, therefore, it is not justified to share them with users. Similarly, Schimith and Lima argue that the integrality of assistance is harmed *when it is not considered the user as subject* [33], bearing life plans and his own assessments of what is better to himself.

To the interviewees, the professional's role is "raising awareness" of users of the requirement to adhere to proposed therapeutic projects, employing the "repetition of information" strategy. They emphasize that talking to the user is important to understand his no adhesion to therapeutic project and observe if he is properly informed about his health situation. It is generally supposed that they lack the required knowledge to informed choices, attributing their resistance to "cultural shortage" resulting from poor education.

Generally, when it comes to the therapeutic project, the posture of healthcare professionals is more "pedagogy of knowledge" than "pedagogy of dialogue". In other words, the effort of team is limited to discuss and prepare healthcare plans with the user so that a therapeutic project is defined. Such situations, which are frequent and hard to handle, cause a visible friction to routine of the team, especially due to characteristics of surveillance proposed by the model.

It is observed a real "war" between resistant users and professionals, spokesmen of prescriptions and recommendations to a healthy life, which is a *sanitary imperative* [34] to take care of himself, grounded on a conception of health as duty of everyone and each one, not as the right of citizens. The second concern particularly demonstrated by ACSs is related to damages that can be caused to third parties when the user does not adhere to therapeutic project. For instance, this is the case of user with tuberculosis who, without proposed therapeutics, can transmit the disease to other people. To one of ACS in such situations "*there must be a law obligating people to treat themselves because it is not only their lives at stake"* (ACS 4).

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In case of tuberculosis, one of interviewees remembers the supervised treatment, where an ACS visits the users at medication times "*to know if he is taking the medicine properly*" (ACS 1), having control over the user, so he does not abandon the treatment. Such circumstances bring an ethical problem to the professional, who has to choose between respecting the confidentiality or violate it to protect third parties. Thus, there are contrary and favorable positions to violate the confidentiality, predominating the position that violation is justifiable, as the situation involves prospective damage to third parties.

The third identifies operation corresponds to the capacity of protecting user's privacy and confidentiality. The participants claim that the bond between health teams and families, with regular meetings between professionals and users, creates trust relationships that enable users to talk about rather particular aspects of their lives. The ACSs themselves emphasize that their fundamental duty is instructing users about their health and gather information to be shared with the health team. In such context, although research subjects did not directly mention the problems related to principles of privacy and confidentiality, it could be observed ethical problems about such operation throughout the interviews.

The first ethical problem involves the main places shown to the relationship between professionals and individuals/families: The unit, community and domicile. The structure of some health units does not favor confidentiality and privacy due to precarious spaces, impacting the protection of users' data, either by lack of acoustic insulation or the necessity of sharing spaces in meetings of the team. Similarly, in case of assistance during a domicile visit, although users acknowledge the importance of providing information about their situation, it is common the difficulty to assure privacy, whenever it is required by the individual.

Within such logic, some participants assess the domicile visit as an action that can cross the privacy of individuals/families, although there is a unanimous perception that it is required to know the family dynamics and support health problems. An interviewee wonder: "*Do those people want us in their lives*?" (PNS 9). If the family is the focus of work of Family Health Strategy it is important to reflect about the legitimacy of interfering with the private life of its members. Within the conception of social justice adopted in this article, family is at the same time a place of private nature and space to develop the operations of individuals, and it can consequently be the focus of public policies.

It must be emphasized that the interest in family as social nucleus of sanitary interventions by multi professional teams requires that it is worked with the concept of professional relationship of health/family complementary to the one of healthcare professional/user to approach ethical problems. It is produced loyalty bonds in the family around common interests and relationships of intimacy that enable their members to share joint and informed decision processes about interventions. Nevertheless, family conflicts must be considered, especially those related to fair distribution of domestic duties to take care of sick people[27,29].

Another ethical problem is related to exposure of private information about registered individuals/families. Such information can circulate from conversations among professionals or between professionals and users and even by the flow of documents within a health unit. In this regard, it was identified the moral concern of research subjects about such content, which ended up being shared by the entire team.

Thus, on the one hand, the closer relationship between healthcare professionals and families/communities enabled by Family Health Strategy favors a greater knowledge about dwelling conditions, family relationships and habits of individuals, enabling a more efficient intervention in health problems. Nevertheless, on the other hand, it shows ethical problems related to broadening the access to information that often include intimate aspects of family dynamics[5].

Such situation demonstrates that there is a certain difficulty to set out which information must be shared with the health team, especially by ACS[5]. The users disclose more information to ACSs, either because they have a closer and more often contact with them or they consider they can facilitate their access to health services[6]. In this context, what the ACS must comment with third parties or not and, inversely, what other professionals must inform to ACS or not are concerns observed in the speeches by interviewees.

It is emphasized that ACS may have access to privileged information about, for instance, local movement of drug traffic that, if disclosed, can endanger their own lives. Thus, there is also the important ethical matter related to preservation of privacy of the ACS himself which, regardless of his work, is also a dweller[6].

Final considerations

The replacement of traditional logic to healthcare, centered only in the assistance, by the conception of sanitary responsibility, setting out a connection with individuals, families and communities and follow up more exposed groups to social risks has been a way to organize the basic attention and consolidation of SUS. Within such perspective, Family Health Strategy presupposes a work characterized by the perspective of integration between different professionals in practice that must be connected to the performance of citizenship and assurance of subject's autonomy.

Upon approximating health workers of living territories, Family Health Strategy discloses situations that challenge the teams to make decisions beyond the clinical field in its strict sense, many of them involving bioethics field. Such work process generates both ethical problems common to the team and also singular ones, associated with the performance of each professional segment. It was observed that the situations disclosed in this study are located in multiple interfaces of work routine, but most of them are not object of discussion and development in teams themselves.

It must be considered that multi professional composition broadens the possibilities of intervention about different health problems. Nevertheless, it equally requires investment and valuation of professionals who often start working without being properly trained and are also confronted with infrastructure and precarity problems in work relationships. The professionals must be provided with tools that can encourage reflection and transformation of their own practices. From such presupposition, the articulation between educational institutions and research ones and public services of health is crucial.

Not only because of support to health work, but especially for the perspective of permanent education of professionals who work in health services and implantation of changing processes in education, considering the answer to health necessities of population. In this regard, it is considered that the approach and collective analysis -under the perspective of social justice, ethical problems lived in the routine of teams -must be included in central aspects of processes of education and qualification of health professionals.

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Participation of the authors

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