Problems and bioethical conflicts in the work of a team from *Estratégia Saúde da Família*

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Abstract

The objective of this work is to analyze the genesis and expression of ethical problems and conflicts that emerge during the work of a *Estratégia Saúde da Família* team (Family Health Strategy). This qualitative research considers three stages of operationalisation: ethnography, interview and focus group. The main ethical problem found is the lack of commitment of professionals in relation to other professionals and patients, which, consequently, triggers other ethical problems, such as absenteeism, procrastination and team fragmentation. The origin of these problems is related to the absence of reasonable interpersonal competence, unanswered professional needs, hierarchy and low psychological maturity. Thus, intervention strategies are necessary both in the genesis and in the problems and ethical conflicts in order that teamwork is not established in a pseudo-team at the expense of patient care.

Keywords: Primary health care. Family Health Strategy. Patient care team. Bioethics. Ethics.

Resumo

Problemas e conflitos bioéticos da prática em equipe da Estratégia Saúde da Família

O objetivo deste trabalho é analisar a gênese e expressão de problemas e conflitos éticos que emergem durante o trabalho de uma equipe da Estratégia Saúde da Família. Esta investigação qualitativa considera três etapas de operacionalização: etnografia, entrevista e grupo focal. O principal problema ético encontrado é o descompromisso de profissionais em relação a outros profissionais e paciente, o que, por consequência, desencadeia outros problemas éticos, como absenteísmo, procrastinação e fragmentação da equipe. A origem desses problemas está relacionada à ausência de razoável competência interpessoal, a necessidades profissionais não atendidas, à hierarquia e à baixa maturidade psicológica. Sendo assim, são necessárias estratégias de intervenção tanto na gênese quanto nos problemas e conflitos éticos para que o trabalho em equipe não se estabeleça em pseudoequipe em detrimento do cuidado.

Palavras-chave: Atenção primária à saúde. Estratégia Saúde da Família. Equipe de assistência ao paciente. Bioética. Ética.

Resumen

Problemas y conflictos bioéticos de la práctica en equipo de la Estrategia Salud de la Familia

El objetivo de este estudio es analizar la génesis y la expresión de los problemas y conflictos éticos que surgen durante el trabajo de un equipo de la Estrategia de Salud Familiar. Esta investigación cualitativa contempla tres etapas de operacionalización: etnografía, entrevista y grupo focal. El principal problema ético encontrado es la falta de compromiso de los profesionales en relación con otros profesionales y con el paciente, lo cual, en consecuencia, desencadena otros problemas éticos, tales como el absentismo laboral, la dilación profesional y la fragmentación del equipo. El origen de estos problemas está relacionado con la ausencia de una competencia interpersonal razonable, las necesidades no satisfechas de los profesionales, la jerarquía y la baja madurez psicológica. Por lo tanto, se necesitan estrategias de intervención, tanto en la génesis como en los problemas y conflictos éticos, para que el trabajo en equipo no se establezca en un pseudo-equipo en detrimento del cuidado.

Palabras clave: Atención primaria de salud. Estrategia de Salud Familiar. Grupo de atención al paciente. Bioética. Ética.

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Declaram não haver conflito de interesse

Team is a group of people with a high degree of interdependence and a common goal to be achieved through working together[1]. Teamwork, therefore, is a productive activity carried out by the interaction between people and by the articulation of technologies from different areas of knowledge, being an essential element for care in their respective area of attention to health. Thus, the commitment of each professional is fundamental and all people involved, with their complementary skills, should be considered co-responsible for a purpose[2].

In the Estratégia Saúde da Família - ESF (Family Health Strategy), the idea of organising the work process through interdisciplinary cooperation promotes complementarity between knowledge and actions. It equates the expectation to increase the capacity to solve health problems by offering full actions to the population assigned to a given area[3], in a perspective that involves an ethical commitment of responsibility and bonding.

In this sense, it is up to each ESF team to develop its work process based on the purposes of this strategy in order to achieve the desired goal, i.e., patient care. However, this process can occur in different ways through the intercession of professionals' different ways of acting, in relation to other professionals and the patient, and, in this arrangement, there is a risk of problems and ethical conflicts.

Without wishing to exhaust or restrict any meaning, a bioethical problem is understood as a situation that prevents or hinders care characterised by values such as responsibility, commitment and respect. Bioethical conflict is understood as the breakdown of the relationship between two or more individuals since the formulation of moral judgment on the action that violated values that should have been used for the effectiveness of health care. But this same conflict can operate involving a single person, who is often faced with a situation where the solution may require prioritising one value over another.

Several studies[4-7] classify as ethical problems the difficulty of delimiting the roles and functions of each member of the health team; lack of respect among team members; the lack of fellowship and collaboration among professionals; and disrespect to the confidentiality of user information. Such ethical problems have negative consequences for both professionals and patients, and for the formation of a bond between team and users[7]. They also have the potential to generate ethical conflicts.

In fact, primary health care, from the perspective of the ESF, is a characteristic care space[8] and, therefore, in the same proportion, its ethical problems are also specific and related to the interpersonal relations of health care production. Now, in tertiary health care, dilemmas arise, fundamentally, within the limits of the use of biotechnology which, despite being a poignant issue, is far from the usual practice in the ESF[9].

This way, ethical problems and conflicts are experienced and produced in a particular way in each sphere of health care[6], and thus, ethical issues emerge from singular problems that arise from each instance of health care, in a way that is sensitive and characteristic to their respective technological density. Having this perspective, the objective of this work was to analyse the genesis and the expression of problems and ethical conflicts that arise in the work process of a ESF team.

Method

The main focus of the research was to work with individuals who reflect, from their positioning, *the totality of the multiple dimensions of the object of study*[10]. For that, it was considered in the choice of the multi professional team the accumulation of work experiences between its members and their composition, expressed through (1) the longest period of coexistence between ESF team members and (2) in the presence of a physician, a nurse, a dentist, a dental health care assistant, a nursing technician and, at least two community health agents, among the various ESF teams in the city of Niterói / RJ. The selection was based on information provided by an employee of the Núcleo de Educação Permanente da Fundação Municipal de Saúde (Permanent Education Center of the Municipal Health Foundation.)

Subsequently, in the first contact with the team, it was identified that these professionals worked together for approximately two and a half years and the physician, the nursing technician, the nurse and two community health agents were working together for four years. These seven professionals agreed to participate in the research and signed the informed consent form.

The choice for ethnography is justified by the attempt to have an expanded look at the team's work process. It was sought to observe and collect as much information as possible in order to subsidise the research, building empirical knowledge by approaching

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the participants' reality, their universe of relations, representations, perceptions, opinions, attitudes, the concretisation of their actions, starting from the reality lived and shared with their fellow beings[11].

The ethnography began on February 15, 2016. Team monitoring was performed on Mondays and Tuesdays in the afternoon and on Wednesdays in the morning (when there was greater movement in the unit, according to professionals). Eventually there was a random exchange of these periods by others, totalling 41 periods and approximately 164 observation hours, which is almost seven full days. The last day of follow-up was May 31, 2016.

As the reality of each individual goes beyond a set of material data and observable facts, it is necessary to understand how these facts influence the people involved[12]. Therefore, the second stage of the investigation comprised an interview with each member of the team, using aa semi-structured script. The interviews, which totalled approximately eight hours, were carried out after the ethnography, which allowed to adapt the script to the reality of the team.

After the individual interviews, a focal group with the participants was carried out, which allowed to investigate their relationships and interactions. With the exception of the dentist, who was transferred to another area during the research period, the focus group allowed to compare individual positions in relation to the topics raised in the interviews, as well as to verify the dynamics of the interrelationships regarding the exchange of ideas about the activity professional. The focus group lasted approximately one and a half hours.

We sought to obtain, with the adopted method, qualitative information in depth to reflect on the context in which the participants are immersed, grounding the collective construction of applicable knowledge. The interviews were recorded and the focus group filmed in order to guarantee the reliability of the records. The reports were transcribed literally by the researcher.

In order to preserve their identity, the participants were sequentially and randomly numbered in Arabic numerals from 1 to 7. In addition, Roman numerals were used to distinguish two groups, according to level of education: I for higher level professionals (nurse, doctor and dentist) and II for technical, middle and basic level professionals (nursing technician, dental health care assistant and community health assistant). For the analysis of the material, thematic analysis was used in order to *discover the nuclei of sense of communication, which presence or frequency means something to the analytical object targeted*[13].

Results and discussion

Origin of problems and ethical conflicts in the team

The health unit is composed of four teams that total 24 professionals. Each team consists of a nurse, a nursing technician, two community health agents, a doctor, a dentist and a dental health care assistant hired under the Consolidação das Leis do Trabalho (Consolidation of Labor Laws) regime. The latter two professionals work in two teams.

The team studied is responsible for approximately 2,500 people in the territory and the monthly average of scheduled appointments is 114 for the doctor, 31 for the nurse and 192 for the dentist. The monthly average of patients who did not attend the consultation are, respectively, 25, 9 and 53. The number of missed appointments can be justified by the time between the day of the appointment and the date of the consultation.

In addition to clinical consultations, these professionals carry out home visits and actions to promote health and prevention in the territory at predetermined periods, known as "field schedules". Most of the time, the nurse is also engaged in managerial activities which, together with their other activities, are practices that guide the work according to the characteristics of their training:

"*We manage because, in training, we end up graduating as a manager, as an administrator, but theoretically I am neither manager or manager of the unit, I am a nurse.*"

This professional recognises that in her practice she carries out managerial and administrative activities in the team, due to the characteristics of her training, but she does not formally assume this occupation, although she has limited clinical practice precisely in order to assume the management of the unit. The team recognises the nurse as a democratic leader, someone who listens, conducts the work process and take on problems to solve them:

"She [nurse] is very proactive" (1I);

"*The nurse listens, she ponders, she shows what she wants and you do it or you don't, but you explain why you didn't do what she asked, so she has that feedback*" (2II);

"*I think the nurse is score ten, you talk and she always tries to solve the problem, it's a person who listens to you, you talk to her, if she has to draw attention, she calmly calls your attention, attention that sometimes you do not even take for a sermon, right? Because I think she knows, she knows how to deal with the group ... she wants to solve something? She goes straight to it ... she leads very well indeed, she does the service very well ... she is the foundation of the team* "(5II).

The nurse plays a key role in the cohesion of the group, occupying the role of leader and team member who acts with flexibility and recognition of the other and of the interpersonal situation. According to Moscovici, this ability to deal effectively with others in a manner *appropriate to the needs of each person and to the requirements of each situation* is called "interpersonal competence" and was recognised by professionals during the focus group as a component key to teamwork. Despite the agreement on the importance of interpersonal competence for teamwork and the production of care, some group members do not have reasonable interpersonal competence[15], which impairs the development of the work process and jeopardises the teamwork:

"*There are those [people] who are very complicated, you're going to talk [and] almost make a mess ... there are others that you talk, and go in one ear and out the other, they pretend they're not listening, you have to talk many times the same thing, go after them, ask the same thing (...) then you are a difficult person, and if you insist they start to dislike it* "(5II);

"*There is one person that is harder to deal with a little, because she thinks he is self-sufficient, but then I do not ask anything from that person understood? (...) I do not ask for anything, I say: 'Good morning, good afternoon and good night', only if there is nobody to ask, I ask her, understood? I talk to her, I do not stop talking (...), but then it flows normal, like a broken marriage, you stay there, I stay here, we'll live under the same roof, but it's over, it's more or less that, do you understand?* "(4I).

There is no way to establish commitment with the production of care if there is no interpersonal recognition and perceptual/behavioural flexibility, seeing that without reasonable interpersonal competence of the members of the group, the teamwork does not materialise[15]. In this research, another factor that may contribute to professional disengagement is the lack of satisfaction of the professional's needs, especially the need of safety[16] which is associated in this study to a remuneration that is not always sufficient for decent subsistence[17]. The issue of compensation was pointed out by a senior staff member during an informal conversation at the unit, who referred to the discrepancy between his salary and that of the physician and the recurring complaints of other professionals on low remuneration.

Considering that *all unmet need is a behavioural motivator*[18], we believe that salary inequality between professionals and low salaries are latent factors for the lack of commitment in this model of care, in which the physician usually earns a salary that is much higher than that of other professionals[17,19-22]. Generally, this is justified by the difficulty of find doctors willing to do this specific job, but this can not legitimise the often degrading salaries that are paid to other members of the group.

Differentiated remuneration might attract doctors to the ESF and this, for the most part, does not take into account their general professional training[23]. This framework can contribute to a professional activity to become a means to satisfy personal and selfish interests, thus depriving the professional activity of its social and moral significance[24], what contributes to the lack of effectiveness of the teamwork. The difficulty of hiring a doctor who would stay working long term for the ESF is associated with the reduced number of professionals in the market who are willing to make a career in this model of care, which gives an autonomy and power to this professional that stress the management, because without the doctor there is no ESF "team".

Power circulates as dominant subjectivity in the team[25], structured according to the specific knowledge of each professional. In the case of the physician, the specific knowledge of his or her profession attributes to the doctor technical autonomy and the title of expert in the art of correcting and improving the "social body", keeping it in a permanent state of health. This facilitates isolation and hinders the construction of a subjectivity capable of integrating the desires and interests of different members of the team[27].

"T*his part of the doctor sometimes do what she wants, without listening to us, solve things in her way without listening ... it's not because she's a doctor that things have to be solved the way she wants, we are a team. This brings problems, brings conflicts "(*3II).

This power is concealed as a hierarchy, another factor that compromises the effectiveness of teamwork:

"*He is hierarchical, he [doctor] is above. (...) If he is an agent [community health care agent], you want to step on it, why? One has to be respected as a person, as an individual; independent of having a higher position than the other, has to respect* "(6II).

This phrase places the doctor at the top of the hierarchy, by the power he exerts, and the community health care agent as subordinate subject. College-level professionals also recognise medical authority because of their influence on group members. Thus, as pointed out by other authors[28], the relationships among professionals are defined in hierarchical terms and, as Campos[29] indicates, the hierarchy centred on the physician compromises the concretisation of teamwork. Such organisation of power focuses on the devaluation of the knowledge of other members and on the lack of recognition of the interdependence required for teamwork[30]. This perspective also provokes a ranking of the importance of practices and knowledge, as presented in the speech of a professional with university degree:

"*Sometimes, (...) I could worry about a [small] thing, [but] I'm going to worry about something bigger, more important thing and suddenly let a community health care agent to search for something; instead of looking for, or placing a call, I do something else and she looks for the patient* "(4I).

In fact, there must be division of tasks in teamwork, but this college educated professional presents a distorted vision about the action that requires less complexity and, for this reason, is attributed to the community health care agent, which exercises it not because it is *less important* or *small*, but for being able to do it.

Another factor that may be associated with the lack of commitment is professional maturity, which is people's technical capacity and *willingness to assume responsibility for directing their own behaviour* towards a particular task, that is, *an individual is not mature or immature in a total sense*. Everyone tends to be more or less mature about a task[31].

The technical capacity to perform a certain task is associated with maturity at work, while the disposition for its accomplishment is linked to *psychological maturity*[31]. This study indicated a low psychological maturity, associated, therefore, with the lack of willingness to assume responsibilities for a certain task:

"*You have to be mature, right? And some people have, other people do not. Often [the professional] does not follow the work routine ... because they think it does not have much importance, because they don't give it much value, sometimes it gets in the way a bit "*(7I).

The low psychological maturity of an individual deepens the gap in the group by inducing the loss of the dimension of the importance of the individual's work and of his or her contribution to the accomplishment of teamwork. On the other hand, the professional maturity of the nurse was emphasised as the nurse, although not formally assuming the position of manager, performs this task with excellence for the benefit of the team.

It is important to note that doing a task but in a disarticulated manner with other professionals, and limiting themselves to a certain stage of the health care production process would express a certain lack of commitment, since according to Franco, Bueno and Merhy, *since there is no interaction, there will be no commitment to the result*[32]. In fact, it is not enough for the professional to exercise his attribution without taking responsibility for all stages of the health care. Rather, the professional must commit himself or herself to the user and other professionals in a pact of care[33], sharing responsibility for the production of health care as a whole. If there is no team work, there is no production of care according to the purposes of the ESF.

It should be noted that care is part of any ethics[34] and it is established in the exercise of the commitment of the *self-with-the-other and the self-as- the other*[35], implying an inter-relational care attitude. Each professional knows what must be done, but in many cases, the professional does not undertake the commitment to develop teamwork and produce care. This is exemplified below in an excerpt from the focus group discussion in which mid-level professionals refer indirectly to a professional in the same level and to another one at a higher level, although two participants of the dialogue have also been pointed out in individual interviews as professionals who are not committed to certain tasks:

"*Everyone knows what they have to do; now, if they actually do, it's complicated ...* "(2II)

"*Exactly, that can give that thing of sometimes complain ..." (5II)*

"That!" (2II)

Research

"*So we do not fight, but we disagree and we complain ... we do not fight, but we do not agree with that"* (5II)

"*We get really upset ...*" (3II)

"*Indeed*" (5II).

The affections of each individual are the basis of his or her discernment about something, helping the person to define a particular situation as being moral or not. Thus, for example, indignation and hurt are characteristically moral feelings are part of the reactions to people who don't respect a valid moral norm[36], what is essential for all who find themselves in the situation in which the norm is applicable[37]. When professionals disagree with a certain action, they express a moral judgment, which is the attribution of value, according to their moral feeling, in relation to an act that has consequences that affect the other[24].

Disengagement affects both other professionals and the patient. In this case, the obligation to commit to the team and to the user is not only an institutional norm, external to the individual, but also internal, a *self-obligation that someone recognises in conscience*[3]: "*The team can not think differently. When you think differently ... I know that each one has a thought, each one has a way of working, of acting, but here the goal is juosne: people are coming to get some response, [and] we have to give some response, we have to take care of the patient* "(3II).

What must be done and how it should be done is imposed to the individual, but sometimes only to a certain extent[39]. The way of acting and thinking about health production - influenced by the lack of reasonable interpersonal competence, unmet needs of the professionals, the hierarchy among team members and also by low psychological maturity - stresses and modulates the modus operandi of the team, compromising patient care.

Thus, the bioethical lack of commitment of professionals among themselves and to users compromises not only the moral dimension of teamwork but also the production of care, since it directly affects the resolution of the ESF. This lack of commitment also assumes a political dimension, since the team, as a structure for the production of care, is the materialisation of the public policy that puts into practice and makes possible to effectivate social rights, demonstrating in an efficient way the constitutional principles of the Brazilian health system.

In summary, the absence of reasonable interpersonal competence, the unmet needs of the professionals, the hierarchy that operates by power relations that prevent the expression of the work of the different members of the team and the low psychological maturity are central elements that cause the lack of commitment to other professionals and also to the patient, being characterised as the main bioethical problem.

The reasons for the disagreement hitherto pointed out do not refer exclusively to the work profile in the ESF. In this study, these motives are also manifestations of conflicts of interests and power struggle between staff and between them and the management. Interests can not be annulled nor should they be, but they can be legitimised and managed in a way that will help the constitution of commitment[40]. At the same time, the management of institutional processes based on living labor would make it possible to incorporate all the professionals in the team in these processes and would bring them closer to the managers, to operationalise a collective management that exploits the leading role of the group of workers[41].

In addition to the administration of interests, this co-management would make possible the democratisation of power and, consequently, the reconstruction of subjectivity through the confrontation between those involved and between them and the reality that they experience. The lack of commitment originates other bioethical problems that are expressed in the day to daywork of professionals, such as absenteeism, procrastination and fragmentation. As they are caused by the lack of commitment, they are also related to the absence of reasonable interpersonal competence, unmet needs of professionals, hierarchy and low psychological maturity. These bioethical problems have the potential to act as catalysts for ethical conflicts.

Expression of problems and ethical conflicts in the team

- *Absenteeism*

It refers to the sum of the periods in which professionals are absent from work, *whether due to abscence, delay or some intervening reason*[42]. This number of different factors contributes to increase the complexity of the problem[43]. When absence is not planned, *it disorganises the service, generates dissatisfaction and overload of work for the staff who is present and, consequently, decreases the*

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quality of care provided to the patient[44], even if the absence is due to illness.

When absenteeism becomes an action frowned upon by other professionals, expressing neglect with teamwork and the production of care, it is considered a bioethical problem, a direct consequence of lack of commitment. Absenteeism in the team studied was attributed almost exclusively to a professional, who, when absent, requires the reassignment of patients to other professionals, causing overload, or new scheduling, which generates patient dissatisfaction and complaints addressed to the professionals who are present.

"[4I] *It was meant to be full-time. She attends patients in the morning, [and] in the afternoon, she's supposed to stay at the station, [as] the other professionals stay, regardless of not attending, they have to stay ... She answ in the attends in the morning, [and] in the afternoon we have training, meetings, most of the time she does not stay* "(3II);

"*In a meeting, not staying, not wanting to stay, not finding it necessary to stay, that is ... [4I] ends up leaving, does not give an opinion of what is right or wrong, but does not act either*" (2II).

Another issue raised in the interview was the punctuality of university level professionals. With the recorder turned off, a university level professional complained about the time to arrive at work, questioning why his professional category should arrive at 8 o'clock in the unit if work of attending patients would start patients only after the pre-consultation.

Despite being uncomfortable with punctuality, probably on the part of the management, this issue was not raised directly or indirectly by other professionals as a problem in the team. On the contrary, it seems natural for participants that university level professionals arrive after the start of work as observed in the unit. This is evidenced in the speech of 5II, which refers to the delay of 1I not as a criticism directed to the person, but to demonstrate the intolerance of a patient who did not accept the delay of this professional:

"*We booked him [patient] [at] 8 o'clock. 1I does not arrive at eight o'clock, 1I arrives at eight and a bit, eight fifteen, eight twenty, then the patient: 'Ah, but because I'm scheduled for eight o'clock, and because I do not know what, because I'm going to want to be taken care of, because my schedule was eight '... Then I said,' No, you will be taken care of, you will be taken care of. By the time 1I gets there, sir, you'll be the first, it does not matter if she arrives at nine o'clock, you're going to be the first. " The patient kept complaining, complaining: 'because it is a lack of respect'* "(5II).

The act motivated by the willingness *to respect the other as an autonomous and dignified being* is a priority issue in the work of humanisation [which] is based on strengthening this ethical behaviour[45]. In this sense, punctuality plays an important role in the humanisation of care and building of the bonding, expressing the bioethical commitment of the professional in relation to the vulnerable patient or not.

- *Procrastination*

It is the behaviour of postponing tasks or leaving them for later[46]. Brazilian studies on the subject are scarce[47], especially in relation to ESF workers. Procrastination is related to the behaviour of professionals in relation to the work process, and it has an direct negative effect on the user:

"*What bothers me most about the team is usually this, when the patient wants to solve a problem and the other person is there, you know? It does not solve the problem: 'Oh, no, it will come later'. I even talk, I get irritated ... it's easy to solve the patient's problem, you know? And there are a lot of people here who do this* "(1I).

The patient looks for the service with the expectation of having his or her problem solved. Thus, from the perspective of work in the ESF, the professional should welcome the patient and listen to their demands in a humanised way at least. However, in some cases, even the simplest ones, which could be resolved immediately, the professional who is on a field schedule is not available for service even if there are no external demands, and the professional is idle or in non-attendance tasks in the unit:

"*There was a patient here another day to book [consult], then she [the professional]: 'Ah, my field schedule ...' And I said: 'book him fast.' Then she [the professional] took the schedule, sat down, you understood, right? She made the booking, but said have you seen something like this? My field schedule [and] I'm here booking patients during my field time ' and she kept repeating , you know, as if it were ...* "(1I);

"*I had a patient [waiting to be taken care of] ... [and the professional] was not in office hours ... I'm on a field schedule ...". It has been said several times: 'If you are on schedule, but you are inside the module,*

you are not on the street, you have to work, you will attend the patient' but it does not happen, it does not happen! (...) And this we find a lot (...). Sometimes it's there: 'I'm on field time', but the professional is on the [cell] phone and the [patient] is there watching it. So there has been a lot of discussion here, including in relation to this, because the patient ends up bursting and is holding on, holding on, holding on, there is an hour that he sees as a mockery with him, that he is there all the time and the professional is barely noticing that he's there "(5II).

Thus, in certain situations, there is no humanisation due to the absence of bioethical commitment, which affects the loss of care and the loss of confidence on the part of the patient in relation to the professional, the staff and the ESF itself. Another possible consequence of procrastination is that, when the patient is no longer taken care of, the patient is compelled to seek the emergencies of polyclinics or hospitals, which should not receive this kind of demand for basic care. Still, procrastination occurs not only in the unity, but it also extends to the field:

"*In the [home] visits, we go out to visit, but she [the professional] chooses, she has a list to visit, [and] if we do not stay on top of her, she makes two, three visits; if you have five, sometimes if you let her, she'll only do two or three and the rest will be left for later. You can not!* "(3II).

Care can not be procrastinated, because when the professional works with public health, he or she assumes a bioethical commitment to public policies, to management, to his colleagues, and especially to the users of the system. Procrastination of the professional can also have indirect effects on the user, when a member of the team fails to do some task assigned to him or her and compromises the work of other professionals:

"*The [patient] girl came to make an appointment, but where is the medical record number? 'Ah, it has not been digitised yet,' and where is the SUS (Sistema Único de Saúde- Unified Health System) card? 'Ih, damn, I have not done it yet, there's no time' ... You have the patient's data, you have to do it, what is your job? Register, make the SUS card. Do you have the reference? Take the reference, enter the reference. I consider myself a bit critical with my colleague, I have to go upstairs because I need to and there's no way I can sit down at the computer to give the [SUS card] number. (...) There is a professional just for that. I am not going to say that this creates a conflict for me, this behaviour creates [a conflict] in our day to day* "(6II).

- *Team fragmentation*

Health care production implies the development of specific actions, stemming from the knowledge of each professional, and the way these complementary actions are articulated to offer timely responses to the needs of the user. However, this connection is still fragile, prevailing the confinement of each professional in its specific *nucleus of knowledge and practices*[48]. Teamwork translates into the establishment of connections between different knowledges and practices and is based on *a certain knowledge about the work of the other and on the valuation of the other's contributions to the production of care*[49]. However, this not always happens, as shown below by the team dentist and by 2II:

"*The dentist is something that ... [what] we do, they do not understand our work very well, so, right? There's not much to help with some things ... and we're always chasing after things, right? Even a pregnant woman who asks us to send, we have to write a note: ' send the pregnant woman to odonto', you have to keep insisting so people will remember us*. "

"*It's complicated in relation to the dentist because we do not know exactly how to relate to them. The girls [of dentistry] are closed inside the unit, they stay here only for the patients who come to the unit. They do not go to the streets, they do not have a health education job in the street, only when they are forced to go they go (...) is very: 'nobody told to do' and if they do tell me to do that then I pretend I do not understand, it's like that* "(2II).

As pointed out by other authors, dental professionals are immersed in clinical actions and distant from collective activities of health promotion and prevention[50]. In addition to fragmentation, there is no appreciation of the development of these actions, perhaps due to their training, which, in general, is predominantly aimed at the clinic. It is true that the professional has responsibilities in the clinic, but also the professional has specific schedules for the field work and the development of these actions. This includes dental professionals, who should be encouraged to take on this responsibility.

Silva and Trad point out the *still tenuous connection between the actions developed* by the members of a team, given that, at certain moments,

the interaction between these members is limited to *the transmission and reception of the message, which is not properly articulated*[51]. In this study, we observed little articulation between dentists and all other professionals, because the message exchange is inefficient to interconnect the different practices.

We believe that the explicit programmatic distinction between "oral health staff" and "family health team" further encourages such fragmentation. Dentists complain that they are not included when other practitioners complain that the dentists and the Dental Health Assistants are not included in the team - however, contradictorily, they do not recognise them as members of the family health team. In the context of this work, the fragmentation of the team is associated with the isolation of practices and knowledge due to the lack of commitment of professionals to appropriate and to be jointly responsible for teamwork.

Thus, the bioethical problems found in this study may be triggered by one or more associated factors. Absence of reasonable interpersonal competence and low psychological maturity proved to be important conditions for team fragmentation and professional absenteeism. In addition, fragmentation was also strongly associated with the unmet needs of the professional, and absenteeism was associated to the hierarchy. Procrastination is closely related to any of these factors, isolated or not.

This way, the bioethical problems found in this study contribute to establishing a pseudo-team, which, according to Katzenbach and Smith[2], is a group of people who do not care about collective performance and individual work prevails. Finally, it is worth noting that although the codes of ethics - which define the responsibilities of each profession - deal with good inter professional relationships, in the context of collective and interdisciplinary deliberation, *their uni professional character reduces their usefulness*[52].

Final considerations

The central bioethical problem found in this study was the lack of commitment which originates other bioethical problems, such as fragmentation, absenteeism and procrastination, which require further studies, as well as their bioethical implications in the work process of the EST teams and care in health. The genesis of such problems corresponds to the absence of reasonable interpersonal competence, unmet needs of the professional, hierarchy and low psychological maturity, issues that reflect a power struggle and interests between professionals and between them and the management. In these terms, the proposal of work in the formula of the ESP detaches itself from the bioethical sense of the humanisation of patient care and teamwork.

In order to effectively intervene in the genesis of these bioethical problems, it would be necessary to carry out joint management-team measures that would bring about significant changes in the way professionals act, such as strategies for permanent education, co-management and employee appreciation. This study defends the idea that care can not be produced if all the agents at work are themselves not cared for. In addition, it is important to note the relevance of training that attends to the professional integration required in teamwork.

It is possible that even an intervention in the origin of the problems is not enough to inhibit its occurrence or the emergence of new problems and ethical conflicts, because the process of production of care is always stressed by the way of acting of each professional. In this sense, the bioethical approach has the potential to offer answers to the limitations of the deontological ethics of the professional codes, which do not present subsidies to fully face new challenges[53], such as those that emerge in the work process of an interdisciplinary health team.

In addition, it is important to emphasise that professionals often act in compliance with norms and under the protection of their codes of ethics, which represent effects of normalisation of practice, often to the detriment of the humanisation of the user care and inter professional articulation, although codes recommend a respectful professional relationship. In this case, professionals may mistakenly consider that, by obeying the norms of codes of ethics and satisfying their impositions, they are exempting themselves from ethical obligations[54]. Such a perspective would allow new ethical questions, also related to teamwork.

Faced with the problems and ethical conflicts presented in this study, ESF (Estratégia Saúde da Família - Family Health Strategy) professionals tend to adopt measures that do not alter the practices questioned or even that absolve them of any action that may contribute to the change of this scenario. In this sense, ethical issues must be resolved collectively, and impartial dialogue determines what can and should be done in certain situations[36].

Teamwork is not effective if the origin and the problems and ethical conflicts themselves are not properly addressed. The isolation of assignments inhibits cooperation, and the bioethical implications of the loss of the dimension of the work process reflect both on the means of production and on the care of the user. The loss of this dimension by a single professional affects the team as a unit of production and, therefore, compromises the health care of the user. It is necessary, therefore, to look at the other, not only a look from the professional to the patient, but from management to the professional and from the professional to the other professionals. It is also necessary to recognise that the work is completed in the self and in others and is strengthened by the team.

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Participation of the authors'

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