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Ways of acting in conflict resolution in primary health care

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Abstract

This study examines professionals' ways of acting in the resolution of bioethical conflicts with other professionals in Family Health Strategy teams, based on the Theory of Communicative Action and on Discourse Ethics. For this, a qualitative research was carried out involving observation, interviews and focus group. Faced with a bioethical conflict, some professionals act oriented towards individual success, which allows the conflict to remain latent, thus hindering primary care provision and causing a negative impact on team cohesion. Other professionals, however, use communicative action to seek understandings and agreements aiming at collective success in patient care. Conflicts not resolved between the actors are discussed in team meetings or general meetings, which stimulate team members to engage in communicative action for conflict resolution.

Keywords: Primary health care. Family health strategy. Patient care team. Bioethics. Ethics.

Resumo

Modos de agir para resolução de conflitos na atenção primária

O objetivo deste estudo é analisar modos de agir de profissionais da Estratégia Saúde da Família na resolução de conflitos bioéticos, tomando como fundamento a teoria do agir comunicativo e a ética do discurso. Foi realizada pesquisa qualitativa com uma equipe de saúde da família, com observação, entrevistas e grupo focal. Os resultados mostram que, diante de conflitos, alguns profissionais agem visando o êxito pessoal, o que deixa o conflito sem solução, latente, fragmentando a equipe. Outros, no entanto, buscam o entendimento por meio do agir comunicativo, visando o êxito coletivo, que se traduz no cuidado do paciente. Quando não são resolvidos entre os intervenientes, os conflitos são levados a reuniões que estimulam o diálogo.

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

Resumen

Formas de actuar para la resolución de conflictos en atención primaria

El objetivo de este estudio es analizar los modos de actuar de profesionales para resolución de conflictos bioéticos con otros profesionales de Estrategia de Salud Familiar, teniendo como fundamento la teoría de la acción comunicativa y la ética del discurso. La investigación cualitativa se realizó con un equipo de salud de la familia, con observación, entrevistas y grupo focal. Los resultados muestran que, frente a los conflictos, algunos profesionales actúan hacia el éxito personal, lo que deja el conflicto sin resolver, latente, fragmentando el equipo. Mediante del actuar comunicativo otros profesionales buscan un entendimiento y un acuerdo para el éxito colectivo que se traduce en el cuidado del paciente. Cuando no se resuelven entre los actores, los conflictos se llevan a reuniones que estimulan el diálogo.

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

Research

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Work in the Family Health Strategy (FHS) is structured around an interdisciplinary team, composed of professionals with different practices and technical knowledge, which carry out complementary actions aimed at the same objective: patient care. When this objective is shared among its members, the team is strengthened and becomes effective [1].

Care in the FHS is understood as recognizing the patient's demands and carrying out the necessary actions to meet these demands, through the coordination of the team's practices and knowledge. In this sense, care is materialized not only in the way each professional treats the patient, but also in the relationship between the professionals. In the FHS, therefore, comprehensive care must observe the *ethical imperative that every demand, health need or suffering must be recognized* [2]. This requires a proactive attitude from professionals, who must be ready to respond to the patient, by providing advice or clinical care [3].

Care provision also relies on fundamental objective dimensions, such as the availability of services and supplies and regulatory schemes. However, although essential, these aspects will not be the subject of this study. Our focus here is on the interaction between professionals needed to organize the work process. The care that guides this process should also guide the interprofessional interaction [4].

Acting with disregard for collective goals, aiming only at individual success, compromises this interaction. When this occurs, bioethical problems and conflicts arise and negatively impact on group cohesion [5]. Thus, the way in which professionals act can contribute to the resolution, maintenance or worsening of conflict situations.

Considering this scenario, our study aims to understand, based on descriptive ethics, how professionals act in the face of conflicts [6,7], assessing their ways of acting using ethical theories and the behaviors they indicate to resolve such conflicts [8]. We thus sought to examine the actions of professionals based on their moral convictions, that is, on what they believe to be correct behavior, applying theoretical approaches such as bioethics, a field of applied ethics in which the normative and descriptive dimensions are inseparable [9]. Bioethics contributes to the resolution of problems at the root of conflicts according to an ethical theory *that will serve as standard* [10].

For Habermas [5], conflicts must be resolved by communicative action, which allows individuals to interact with the objective of reaching a compromise and an agreement. Despite differences in personal values, consensus should be sought to underpin the norms that guide group action, in a reciprocal process of convincing, which results from cooperation and transversal dialogue and is not co-opted by a dominant knowledge [3]. Communicative action, therefore, aims at achieving an intersubjectively shared understanding through dialogue, considering collective interests to consensually establish the norms that guide the individual's actions [11]. Thus, the subjects reach an agreement to harmonize their individual interests, resolving interpersonal conflicts in an equitable way, free from coercion and imposition [12].

In communicative action, through speech acts, participants raise claims to validity considering the conditions of action [11]. The speech act has an "actualizing" character, and for this reason the claim to validity can *be criticized, corrected and intersubjectively recognized by means of good reasons* [13]. These speech acts are constatative, regulative and representative. Through them, individuals raise claims to truth, justice, normative rightness, truthfulness or sincerity [11].

A proposition is true – that is, what an individual says is in fact true – when its conditions of existence are fulfilled. A statement is correct in relation to its current regulative context. In this sense, the norm proposed must be legitimate in the individuals' context. And, finally, a statement is sincere when the proposition stated actually coincides with what the person thinks [12]. In discourse ethics, in turn, participants are drawn into negotiations about the validity of statements [11] and must present norms that embody common interests, through an exchange of perspectives between all those involved [14].

Based on the theory of communicative action and discourse ethics, this study aims to examine the ways of acting of an FHS team in the resolution of bioethical conflicts.

Method

A FHS team from Niterói, RJ, participated in this study, selected because it is one of the teams in the city whose composition have remained unchanged for the longest time. The team consists of physician, nurse, dentist, oral health assistant, nursing

Research

technician and two community health agents. All professionals agreed to participate in the study. The criterion of joint work time was established because a greater number of bioethical problems and conflicts, of significant complexity, experienced by the professionals would have become evident.

The health unit to which the team studied belonged has three more teams – all comprised of nurse, nursing technician, two community health agents, physician, dentist and oral health assistant – totaling 24 professionals, for a dentist and an oral health assistant work in two of the teams, establishing a ratio of one oral health team (dentist and oral health assistant) to two family health teams (physician, nurse, nursing technician and community health agent).

The inclusion of only one team from this health unit in the study is justified by the methodological assumption that the members of a group are the product of the same objective conditions, which allows, despite the particularity of the reports, the expression of problems and bioethical conflicts also experienced by other teams [15]. Another reason was to allow researchers immersion in the team so as to collect in-depth qualitative data. To this end, the study followed the stages of non-participant observation, semi-structured interviews and focus group.

The first stage involved getting close to the team by observing the professionals in their work environment, encompassing practical, individual and interactive dimensions. Observations took place on alternate days, totaling about 164 hours. For this stage, an observation script was prepared, and notes on the professionals' ways of acting were made in a field diary.

A difficulty faced during this stage was a certain resistance from some professionals, perceived by the researcher in the distance they maintained of her and by the indifference expressed even in collaboration. Despite the explanations about the research objectives, given individually to each professional, the reason for this resistance may have been the feeling of being evaluated. This caused the majority of the participants, when working at the health unit, to avoid the researcher, spending most of the time in care rooms, hindering the observation of team interactions. On the other hand, home visits were the most favorable moments to establish a relationship of trust, due to the opportunities allowed by the journey through the territory. Prior observation helped to carry out the interviews and the focus group, both because it enabled the questionnaire to be developed based on the team's actual activities, and because it established a bond between the researcher and the professionals.

After the observation period, all the team's professionals were interviewed using a semi-structured script. The aim was to encourage participants to reflect, so that they could verbalize their views and the way in which they usually behave in the face of bioethical conflicts. The interviews, which together totaled approximately eight and a half hours, were conducted and recorded at the health unit itself.

Subsequently, the focus group involved the participation of the entire team, excepting the dentist, who was transferred to another territory at the time the meeting took place. The focus group was recorded in video, which gave the researcher the freedom to fully concentrate on the role of mediator, without worrying about capturing at the moment all the details of the meeting. The focus group lasted about 1 hour and 28 minutes. The atmosphere was relaxed, and the professionals expressed their opinions without showing inhibition with the presence of colleagues and the researcher.

All recordings were literally transcribed by the researcher. The data collected were organized into categories of analysis related to the ways of acting adopted in conflict resolution. These categories were used to interpret the speeches and infer their meanings [16]. To minimize the risk of identification, each participant was assigned a number, from 1 to 7, accompanied by a Roman numeral referring to the level of education: I for professionals with higher education (nurse, physician and dentist) and II for professionals with technical, secondary or primary education (community health agents, oral health assistant and nursing technician).

Results and discussion

In this study, conflicts between professionals are seen as stemming from bioethical problems emerging from work activities. Some professionals, in the face of such conflicts, even though aware of the importance of dialogue for collective success, adopt certain ways of acting that can intensify the conflict or even cause other problems. Professional

1I, for example, declares that she adopts isolation as a norm, "to forget," as she does not like to deal with conflicts: "*Look... I prefer not to chat very much.* (...) *I don't like to deal with any conflict, I'm the kind to isolate myself, then I get upset, then after two, three days, ok, it's gone, I've forgotten.*"

In the face of any conflict, bioethical or otherwise, this was the way of acting most adopted by the professionals – a result that may have been influenced by the observation carried out, because, in potentially conflicting situations, the study participants sought to distance themselves from the researcher. Thus, aspects that could be apprehended by observation could not be examined with due depth, due to the reserve maintained by professionals most of the time.

Participant 5II, on the other hand, adopts the norm of informing the person in the team manager, seeking to exempt himself from the resolution. We can deduce that, because he believes that his actions did not cause the conflict, this professional considers that his colleague, involved in the conflict relationship in the role of "opponent," deserves censure: "*If it's a colleague (...) you turn your back and seek someone to speak to*, [who] *is the nurse in charge: 'it happened like so and so*."

In the two cases above, the professionals aim at what is best for them and thereby reduce the moral conflict to an issue that can be resolved without the other's involvement, in order to control the situation, conditioning the resolution of the problem on the absence of interaction. The consequence of this way of acting is that the conflict remains latent. As no compromise was achieved between the participants, the action at the root of the conflict may occur again. Moreover, those involved may hold a certain resentment, especially in the case of the professional who had his behavior reported to the person in charge of the team.

A third way of acting is pointed out by 7I, who seeks to convince his opponent that he is wrong, that is, he seeks to impose an agreement. In this situation, we may presume a veiled influence on the colleague, who gives up arguing for fear of punishment: "*Wrong or right I try to convince, I try to convince, I use all my points and arguments* (...) *I make the other person give up*" (7I). This way of acting can either make the conflict remain latent or create other disagreements between the participants. Furthermore, this is not a posture expected of health professionals, as it goes against the moral dimension of teamwork and, thus, it can have a negative impact on the team cohesion and hinder care provision.

Participants 2II and 4I prefer to express their opinions according to the other's behavior, depending on the opponent's greater or lesser capacity for dialogue and compromise. Thus, their way of acting is dependent on the way of acting adopted by the other:

"[When I'm] *talking to a person, depending on whom I am talking to, if the person can talk, can understand, I talk* [to them]. *If the person cannot talk, cannot understand, I don't talk.* (...) [I'd] *wear* [myself] *out for nothing. It won't solve anything, so* [it's better to not] *even talk.* (...) *Everything you say will be wrong. She is not, she didn't do it, she didn't speak, it didn't happen*" (4I).

Lastly, 3II and 6II seek to solve the problem through dialogue and compromise: "*It's indeed* [a matter of] *dialogue, if there's no dialogue... It's conversation, I can't impose it, I can't fight over it. Dialogue (...) for us to express our thoughts and reach a single goal*" (3II).

These statements show that some professionals *tend to adopt their own coping strategies, perceived by the other team members as alienation or lack of commitment* [17]. These strategies prevail over communicative action, since conflict resolution through dialogue requires dealing with contradictions, differences and varying expectations. Other barriers that can hinder or prevent the resolution of problems are the lack of time and workload, the lack of motivation to address conflicts and the fear that dealing with conflicts would cause emotional discomfort [18].

After identifying ethical problems, such as procrastination, gossip and absenteeism, and the ways of acting that participants adopt to resolve conflicts, it was possible to verify that when communicative action is not adopted, conflicts remain latent. This attitude does not contribute to successful teamwork, and it is not enough for only some professionals to value dialogue. Bioethical conflicts have a negative impact on team cohesion if there is no coordination between professionals and shared responsibility for patient care.

Responsibility is one of the elements that characterize the provision of care in the FHS, in addition to commitment, comprehensiveness, recognition and listening, which are, to a large extent,

ethical ideals. The concept of teamwork, therefore, must be linked to these FHS ideals, especially with regard to responsibility and commitment to the user.

Changing paradigms in health care services and interpersonal relationships implies changing practices and adopting new ways of acting [19]. Professionals do not choose for their teammates, but need to learn to deal with relational dynamics and interaction processes [20-22]. In fact, the team needs to examine its own way of operating so as to recognize its capabilities, weaknesses and potential for change [23]. A group of professionals only becomes a real team when there is shared responsibility for a common objective, which is care provision – which, in turn, depends on the values embraced in the relationship with the patient and teammates.

When unresolved, the conflict is taken to the general meeting, in which the four teams participate, or to the team meeting, depending on those involved. Weekly, on Wednesday afternoons, the health unit closes for service and there is a meeting with professionals from the four teams. Once every three months, on average, there is a meeting of the studied team members. The long interval between meetings is justified by the lack of time due to the workload. Study participants reported on these meetings:

"Then, if there is a problem, let's suppose, between me and another professional from the other sector [team], *if I don't have much affinity with him, if I don't have much openness, I'll speak at the team meeting, I won't tell him. I'll tell him, but at the team meeting"* (4I).

"It couldn't be [resolved] *just between the two people, since there was no agreement between the two of them, then it was* [addressed] *in the general* [team meeting]" (5II).

"Even to (...) *set an example. We, all of us, have flaws,* [and the meetings serve to] *fix ourselves. Sometimes* [it is] *within the team, sometimes not. It always happens; it's a work process. It's our work process; in general it's our work process. There are conflicts there* [within the team]" (6II).

Problems and conflicts are inherent to teamwork. However, they can hinder the achievement of collective goals or become an opportunity *for growth, if they are dealt with properly* [24]. In general meetings between teams, the professionals seek to achieve a compromise through dialogue, involving all individuals who recognize the resulting agreement as an "example," that is, a norm to guide actions. The same occurs in meetings between members of the same team.

We observed that professionals who generally adopt non-communicative action strategies, in both team and general meetings tend to adopt a communicative action approach. This may occur due to the context, which includes more participants, which leads these professionals to raise claims to validity to justify their own actions, while inhibiting behaviors oriented towards individual success. Therefore, meetings cause the way of acting in conflict resolution to become more homogeneous.

Faced with a conflict caused, for example, by procrastination, the individual who seeks a compromise to establish a valid norm of action must explicitly raise three claims to validity: a claim to truth, that is, he claims that what he says is true ("you are procrastinating"); a normative claim, which is consistent with current norms ("one should not procrastinate"); and a claim to sincerity or truthfulness, which refers to a consistence between what he says and what he really thinks. The listener can: 1) agree with the claims to validity, making an agreement; 2) disagree and question the claims raised by the other; or 3) disagree, but without questioning the claims.

In the first case, a compromise and a consensual norm to guide the actions are established. The conflict between the participants and its root problem are thus resolved, as it is understood that, with the agreement, the individual will stop procrastinating. The listener accepts the truth claim raised (because he recognizes that, in fact, he is procrastinating), the normative claim (one should not procrastinate) and the claim to sincerity (the speaker does not procrastinate).

In the second case, the listener questions the truth or normative claim, and the speaker has to present arguments for the claim raised. According to Habermas [14], in this situation, a transition from communicative action to discourse occurs, since, in questioning, the speaker seeks to establish the legitimacy of the claims to truth and to normative validity raised through argumentation, which is established in an intersubjective exchange to evaluate information and reasons [3]. At this point,

the interlocutors must be willing to meet the requirements of cooperating with each other in the search for reasons acceptable to the others; furthermore, they must be willing to let themselves be affected and motivated in their decisions [25].

The claim to sincerity is not internal to discourse, but refers to the consistency of the individuals' behavior, as it is assumed that there must be coherence between discourse, thought and behavior [11]. Claims to truth, in turn, are challenged or problematized by theoretical discourse, while the normative correction claims refer to practical discourse [26].

In theoretical discourse, one attempts to redefine or corroborate statements about facts [27]. In practical discourse, assertions are assessed in the light of reasons [14], and the validity of norms is questioned according to the social situation of individuals [27]. In this case, participants seek an understanding about a common interest, to achieve an agreement on norms and strike a balance [11]. Therefore, consensus is produced by mutual persuasion, by the awareness that it is in the interest of each and everyone to act in a certain way [11]. This behavior leads to a compromise between the actors, as the norm was collectively substantiated and justified [28].

When claims to validity are questioned, individuals may or may not reach an agreement. In the third case, the individual disagrees but does not question the claims. He silences and hides what he thinks about the matter under discussion, without raising any other claim to truth. In doing that, the listener is *simulating and behaving strategically* [29].

In the below excerpt from the focus group discussion, professionals address another communication problem, common in teamwork, namely, gossip:

"You said you try to resolve [the conflict] [through] *dialogue, but can you reach an agreement?"* (researcher).

"We reach a consensus ... So, each one [knows], *I know that it's wrong to gossip"* (7I).

"It's up to each person to stop doing it" (4I).

"Or not, do you understand?" (7I).

"So there is no such consensus?" (researcher).

"There is. The person will say, "yes, we'll stop doing it," but [for me] *it doesn't guarantee he won't do it, he doesn't give guarantees that he really won't gossip"* (7I).

"I go to 7I saying that it's fine, but sometimes it isn't, so it has to be true" (2II).

In situations of concealed strategic action, at least one of the participants behaves towards individual success, but leaves others to believe that everyone is satisfying the presuppositions of communicative action [12]. This way of acting, according to their own interests, without adopting the collectively established norm, ends up generating other conflicts:

"Our meeting is on Wednesday, then, on Thursday everyone is fine. There was a change. Then, on Friday... [laughs]" (2II).

"Everything is back to normal" (5II).

"Back to normal [laughs]" (6II).

"Then, as it's not solved, it's like a virus spreading, suddenly. (...) I do something that is reprehensible (...): 'hey, if 2II did it, I'll do it,' and it ends up spreading like a virus" (2II).

"There's that stone in the middle of the road that keeps us from moving forward" (2II).

At meetings, individuals seek an understanding to establish a norm for action, but they do not always achieve this goal, as there are individuals who behave towards their own success, to the detriment of collective success. This reveals a lack of commitment and a lack of solidarity with other professionals, to the detriment of patient care. In fact, without following the principles of communicative action, it is impossible to reach an agreement, since discourse ethics, which offers practical discourse to establish a norm, underlies the content of a morality based on equal respect for everybody and on solidarity and commitment [30].

Though not everyone is guided by communicative action, most research participants agree that meetings are important for resolving interprofessional conflicts. These are fundamental occasions to promote communication, cooperation and a sense of commitment and

shared responsibility around common goals [1,31]. In addition to encouraging communicative action in the resolution of moral conflicts, the meetings promote values that facilitate compromise and agreement. These meetings are important for team effectiveness [32], helping to resolve conflicts and promote positive interpersonal relationships [33].

However, with regard to general meetings, which happen on a weekly basis, not all professionals understand that participation is part of their work. Many, for example, take advantage of them to resolve personal issues outside the health unit. Moreover, the fact that the meetings address problems of all four teams, totaling 24 professionals, ends up favoring disorganization. Meetings thus often lose their focus, and their objective is not achieved: *"We sit down, then people start complaining, it's a mess"* (3II); *"Every Wednesday (...) we hold our internal meeting, which is everyone complaining"* (5II).

Meetings should be productive spaces for planning, organizing and evaluating work processes, as well as an opportunity to recognize and resolve conflicts, bioethical or otherwise. Due to the large number of participants, general meetings often do not achieve these goals. Team meetings, on the other hand, seem to work better, *"We need to have more team meetings, so we can talk. (...) We need to have meetings so we can point out the things that sometimes hinder the progress of the team's work. (...) To have this conversation, for us to put forth our thoughts and reach a single goal"* (3II). However, team interaction should not be restricted to meetings, which would hinder a full and efficient work performance [34,35].

Forty-two days after the focus group, in an informal conversation that took place at the health unit, the nurse responsible for the team reported that some participants had been showing greater flexibility in their relationships with other professionals. Showing flexibility, perceptual and behavioral, according to Moscovici, *means trying to see the various aspects and angles of the same situation and acting in a different, non-routine way, experimenting with new behaviors perceived as alternatives for action* [36]. When asked about the reason for the change, the nurse attributed the improvement to the focus group.

This study was not designed as an action research, but the focus group gave professionals an opportunity to talk about problems and conflicts that emerge at work. This dialogue may have led to a self-diagnosis of the ways of acting. The same reflection process should be encouraged in team meetings.

Final considerations

Some ways of acting hinder the conflict resolution and sometimes even cause other problems to emerge, which may have a negative impact on relationships between professionals to the detriment of care provision. Conversely, communicative action, aiming at collective success and the harmonization of individual interests, expands the possibilities of coordinating actions through understanding and common agreement. When collectively established, norms of action begin to guide behaviors in accordance with the common interest. Consequently, it becomes easier to resolve not only conflicts, but also the problems that originated them. For this reason, communicative action should be one of the attributes of family health teams.

Meetings offer a privileged space that encourages communicative action and favors the resolution of problems and conflicts. However, it is not always possible to establish moral norms through dialogue, especially when the professionals act strategically in a concealed manner. Another factor that hinders the resolution of problems and conflicts is the lack of focus of these meetings, and the lack of appreciation for these opportunities for communication, as well as the long interval between meetings in the case of team meetings. Besides missing an opportunity to resolve conflicts, professionals who do not attend meetings also miss an opportunity to recognize themselves as part of the team. This lack of recognition weakens both commitment and solidarity, hindering the achievement of understandings and agreements. To reverse this situation, it is necessary to establish a weekly rotation between general meetings and team meetings, and raise the awareness of professionals about the importance of these meetings, which are part of the work process and must be properly organized and conducted.

Communicative action and discourse ethics seek to universalize behaviors through understandings and the consensual formulation of norms. Given their characteristics, these theoretical approaches can be applied in the practical and everyday situations faced by health teams, especially in conflict resolution. However, reaching intersubjective understanding and agreement through dialogue requires solidarity

and commitment. It is necessary to recognize the importance of the other in the provision of care and to always seek what is better and fairer for the team and for the user of the health care system.

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Research

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