Hermeneutics of the ethical problems perceived by primary health care professionals

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Abstract

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This article interpreted the ethical problems perceived by professionals of Primary Care Health Service in two qualitative researches, conducted in the metropolitan area of Porto Alegre. The data of both researches were collected in eight meetings of focal discussion concerning ethical challenges of practice, with different professionals of the Family Health Strategy of Campo Bom (EFS) and of a primary health care service of Sao Leopoldo. The analysis was also conducted in the perspective of deep hermeneutics, in order to identify ethical problems, with particular attention to the context and discourse of professionals. Ethical problems understood as challenges cannot receive dichotomous answers. Once there are no immediate responses, deliberations concerning different paths and solutions are required, demanding creativity and decisions of extended range and time, with continuous evaluation. The analysis of the professionals' discourses pointed out ethical problems related to demand, processes of work and to the health system.

Key Words: Ethics. Primary health care. Health personnel.

Resumo

O artigo interpreta os problemas éticos percebidos pelos profissionais da atenção primaria em duas pesquisas qualitativas realizadas na região metropolitana de Porto Alegre. Os dados foram coletados em oito reuniões de discussão focal sobre os desafios éticos da prática, tendo como participantes diferentes profissionais da Estratégia Saúde da Família (ESF) de Campo Bom e de uma unidade básica de saúde (UBS) de São Leopoldo. A seguir, foram analisados na perspectiva da hermenêutica de profundidade, para identificar os problemas éticos, com especial atenção ao contexto e ao discurso dos profissionais. Problemas éticos entendidos como desafios não podem ter uma resposta dicotômica e não existem respostas imediatas, pedindo deliberação sobre caminhos possíveis de solução, exigindo criatividade e decisões de longo alcance, com avaliação contínua. As falas dos profissionais apontaram para problemas éticos relativos a demanda, aos processos de trabalho e ao sistema de saúde.

Palavras-chave: Ética. Atenção primaria a saúde. Pessoal de saúde.

Resumen

Hermenéutica de problemas éticos percibidos por profesionales de la atención primaria

El articulo interpreta problemas éticos percibidos por profesionales de la atención primaria en dos investigaciones cualitativas realizadas en la región metropolitana de Porto Alegre. Los datos de las dos investigaciones fueron colectados en ocho reuniones de discusión focal sobre los desafíos éticos de la practica, teniendo como participantes a diferentes profesionales de la Salud de la Familia (ESF) de Campo Bom y de una unidad básica de salud (UBS) de São Leopoldo. Los datos fueron analizados en la perspectiva de la hermenéutica de profundidad para identificar los problemas éticos con atención especial al contexto y al discurso de los profesionales. Problemas éticos entendidos como desafíos no pueden tener una respuesta dicotómica y no existen respuestas inmediatas, pidiendo deliberación sobre los posibles caminos de solución, exigiendo creatividad y decisiones de largo alcance, con evaluación continua. Lo hablado por los profesionales apunto para problemas éticos relativos a la demanda, a los procesos de trabajo y al sistema de salud.

Palabras-clave: Ética. Atención primaria a la salud. Personal de salud.

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Bioethics has examined with great dexterity the ethical problems of the hospital environment, developing theoretical instrumental identified with other principialism traditional bioethical principles: autonomy, beneficence, non maleficence and justice [1].

The same skill was not developed when ethical issues relates to primary care, because you cannot apply the same type of analysis, either because the configuration of the problems is different, or the service is organized from a different rationale.

In 1978, the Conference of Alma-Alta, primary care has become so central focus of health initiatives. A very broad concept including appropriate methods to ensure access for all citizens to health care services entered into by the local reality, considered as the first level of contact with the heath system user [2]. The 1988 Constitution and the implementation of the Single Health System (SUS) promoted the reorganization of the health care dynamics in Brazil, requiring new professional practices and work strategies. In this context, emerging ethical issue related to the logic of work processes organization [3].

Health care hitherto focused on curative hospital practices and targeted only to a small portion of the population, it is the right of all and duty of the State, and action and education and promotion, with a view to improving the quality of life population. This new perspective changes the reality of work and professional demands of a changing attitude toward its achievement. Meanwhile, new ethical issues emerge. Due to the characteristics present in primary care, professionals cannot perceive certain ethical challenges as problems. Everyday situations easier than the reality experienced in hospital, but even so, they involve great complexity of care[3].

This article is based on the analysis of data from two qualitative studies conducted by researchers in Public Health graduate program (PPG) at the University of Vale do Rio dos Sinos (UNISINOS) on the ethical problems of primary care professionals perceived by the Family Health Strategy (FHS) and Campo Bom and a primary health care unit (BHU) in Sao Leopoldo, cities located in the metropolitan area of Porto Alegre, Rio Grande do Sul (RS).

The data were interpreted to codify ethical problems, understood in the perspective of Gracia [4,5] as situations that cannot be reduced to two opposing answers to the dilemma would be more appropriate to a hospital reality, and challenges that allow multiple courses of solution requiring deliberation and consideration to find the best solution that needs to be continually reassessed. Perceived ethical problems and challenges cannot be solved with ready-made recipes, but require constant creativity, because the answer has to be far-reaching, standing apart from the solution of a particular case.

It is, therefore, hermeneutic of a study that aims to interpret the data from the context and the speeches delivered in the discussions focus on the logic of the new primary. To this end, we sought to identify the emergence of ethical problems point out possible differences in their occurrence in SFH services and in a BHU, discussing them from the literature referential.

Methodology

The article is an interpretation of the ethical problems evidenced by the practice of primary care professionals from studies in online research Health vulnerability bioethics PPG Unisinos in Public Health: The perception of professionals on the ethical aspects of the Family Health Strategy (FHS) in the town of Campo Bom (RS) and the workers' discourse of a primary health care unit (BHU) in Sao Leopoldo on humanization of services.

A survey conducted in Campo Bom, between the years 2004 and 2006, aimed to produce knowledge about the relationship between bioethics and public health from the PH, the perception of professionals working in teams. The methodology used was exploratory, qualitative approach. For data collection was done using the focus group technique, a total of eight meetings - an hour and half duration, each it dealt with the ethical aspects present in strategy, the practices of professional relationships that are established in the

workplace and the cultural traditions of the community served. The choice of the municipality gave a nominee of the state board of Health participated in groups of seven teams of professionals working in the city, according to distribution criteria for competence, totaling 12 professionals, thirteen doctors, three nurses, two nursing techniques and four community agents health. The discussions were digitally recorded and later transcribed.

Continuing the previous study, the second survey was conducted in Sao Leopoldo, between the years 2007 to 2009, and aimed to capture the speech, on humanization, a BHU employee and produce knowledge for the construction of a bioethics of health public. The methodology was exploratory, qualitative approach.

The technique for collecting data was the same as the previous study; the themes addressed in each focus group were SUS-Humanize strategies [6] and the right to health, the humanization of work processes, relationships, practices and as the axis of ethics of health services. Each point has two focal discussion sessions facilitated by dynamic totalized eight meetings of one hour and a half. The universe was intentionally set according to criteria of competence, a total of 10 professionals: a doctor, two nurses, three nursing technicians, a dentist, an assistant concierge, a manager in charge of the warehouse and the tally recorded and later transcribed.

The number of meetings of both studies was previously defined from proposed topics for discussion in order to understand the situation and context that ethical problems are evidenced in primary care. The statements appear such as D for doctors and N for nurses, nursing technicians to T, BHU for community health workers and administrative agents for AD.

Armed with data from both surveys was possible to compare their results to see whether there were differences between the ethical practice of an FHS teams and a BHU without FHS

To make this interpretive reading proceeded to the analysis based on the perspective of Thompson's [7] depth hermeneutic, which interprets the data from the facility of the context and the discourses constructed in the discussion focus and critically discusses the theoretical framework, so as to reach to a deeper level that goes beyond the obvious meanings.

The depth hermeneutics consists of three phases: 1) member-historical analysis, in which the researcher seeks to reconstruct the social situations of the socio-historical time and space that surrounds the studied phenomena, in order to know how to build shapes, symbolic meanings, and their peculiarities, 2) formal or discursive analysis, referring to the objects and expressions in the speeches and relationships set in symbolic and complexes forms that have an articulated structure, such as text, lines, images, dynamic actions, and practices, and 3) interpretation and reinterpretation, which refers to understanding the social world and the construction of knowledge that are potentially critical emancipator sense [7].

The phase of socio-historical analysis seeks to learn the context in which data were obtained. The health unit in Campo Bom works under the FHS rationale, which operates from an interdisciplinary team responsible for a territory ascribed. The work process is characterized by meeting the demand and scheduled staff meetings occur weekly. Once a month, there is a meeting integrating all health teams from the city. The health unit of Sao Leopoldo centers its work processes in spontaneous demand, because it is structured from the FHS perspective - in this context, team meetings is not evidenced, and work is characterized by a individualized rationale.

The second phase of hermeneutic analysis works from the perspective of formal or discursive analysis for which they may use different methodologies to reach the interpretive categories of analysis. This study chose to use the content proposed by Bardin [8], which considers three major steps: 1) pre-analysis; 2) operating material and treatment results;

3) inference and interpretation. The first phase consists in the organization and systematization. The second searches for coding and listing as function of previously established criteria , Finally, it is the categorization of the findings according to similarities and differences observed in the analysis, enabling and opening the way for a deepened interpretation, because it does not remain as in one pure description, but explicitly implied meanings that depend on the context and the ways to understand this reality.

Both surveys were submitted to the Research Ethics Committee of Unisinos, in accordance with Resolution 196/96 from the National Health Council (CNS).

Results and discussion

The main ethical problems that emerged from the primary data from both surveys were coded for content analysis in the following categories: *demand, work processes and the health system*. This tripartite categorization came to the same subdivision of Zoboli and Fortes [9] study on the same subject; he found ethical problems in the relationship between themselves and the professionals in the list of users and professionals with each other and the relationship of users and professionals with the Health system. Although the mentioned ethical issues are not always the same, the demand category summarizes the ethical problems of relations between users and professionals, the work process, ethical issues in relations among professionals and, finally, the relations of both with the health system.

Regarding the first category demand - that showed that the relationship between professionals and users may be stronger in primary care. Due to the characteristics of work (labor), the demand tends to increase as users' unawareness in seeking health services for many different reasons, turns it an ethical challenge to meet these needs.

A first ethical challenge of demand, appointed by both the BHU and by FHS professionals is to understand the person's individuality in face of growing demand and the consequent crowding of health services in all instances of the system. According to one professional's speech, there are difficulties in designing the individual in its completeness and uniqueness, elicited by the demand for services that should be prioritized daily:

"These people have a mental disorder, a deficiency. The proposal is good, I think the team would have a little more will to do something for these people because they want someone to listen, someone to appreciate, but often demand does put that aside to respond to protocol "(E of FHS).

The ethical problem arises in the conflict between individuality and from the person protocols defined by the system. The speech shows that due to the requirements of the system, he loses the ability to provide a humanized, as an ethical issue highlighted in the professional-user relationship. Thus, the user needs to be interpreted in their demands from their living conditions, affecting a collective and cooperative multi-professional practice [10].

In contrast to the need for closer funded human relations, there was an ethical problem in the FHS professionals Identified for the Difficult to Understand the new demand generated by establishing a relationship with users: "on the other hand, we must be careful about this bond that is created, because I think most of my colleagues here have had problems in this regard. They have the phone number of the unit. Not every user knows the limits "(E of FHS). The changes by experienced health services closer to users and, with this, changed the relations between the different actors Involved in health care.

This new context, marked by the prominence of users, generated new work reality and the fact that professionals perceive these situations as ethical problems that may represent the necessity to work this new health configuration through permanent education projects, for example, making them to change their view and recognizing users not as a nuisance, but as a bearer of rights, life choices and, also, as the social

agent for their own changes [11].

The demand arises from the perception of a health problem that thrives for (instigates) the search of service for its possible solution. However, demand is not always the expression of a need, either by ignorance of the people than by what they truly need, or by lack of information about the solution to their problems, or even the lack of supply of desired services [12].

Often health professionals identify the needs of the user simply as search for access to medical technology to solve his problem, but when these needs are received and interpreted, the yearning for care and Autonomy emerges [12]. Therefore, professionals need to develop a relationship marked by relations of symmetry and self accountability, discouraging the development of relations of dependence.

The effective demand occurs in daily life of Involved actors, the result of the inter-relationship of existing needs, the projects of happiness of the users and the paradigm of care culturally designed by them. In this context, the symbolic move professionals mutually implicated in this relationship, although contingent by the technical and economic resources provided by the system in its health policy. The demand is established socially, because it depends on the context in which these needs are being built. It is verified, also, shortages related to daily needs, requiring opening and redemption of values and bonds enabling new relationships That enable new and new systems of care and attention that safeguard the integrity of human life [11,12].

It is important to emphasize the ethical dimension of demand, since attempting to the subjective singularities in the collective is to prioritize a look at the production and promotion of integral health, challenging the practitioner to interpret the needs with which it faces in practice. To this end, the existing demand must be met in the perspective of the subject's uniqueness, not submitting such expectations to protocols standardization.

This attention to the singularity leads to accountability for their situation, discouraging dependency. Thus, objectify will be the realization of humanization, the resolution and the fulfillment primary care user.

The second category addresses ethics issues related to work processes. The logic of working developed in primary care is different from the hospital and emergency, raising other ethical problems. The team must work together in multi-professional practice. The objectives are built from and achieved for extended terms, requiring a distinct profile of professionals who know how to track users.

The first ethical challenge of the work processes evidenced by the professionals of existence is existence of little dialogue and correct understanding between FHS working team members, because teamwork is guiding the success of work processes - while this is still an open question to be developed at BHU. This finding appears in the words of the BHU manager*: "The Day that we will be able to communicate, we will be team. But while we can´t solve the problem from start to finish, we're not a team"* (AD of BHU).

Health work should be characterized by addressing the needs of users, and so the team must be concerned to establish a relationship of cooperation and exchange of knowledge, based on dialogue and required listening. Health problems have become ever more complex, requiring from professional intersectoral action with team spirit and community support for their resolution. Therefore, it is essential to develop a *culture of living labor* [13], which has Its main focus not so much in the end product of the service, which can be an examination or a prescription, but in dialogue relationship established between the user and the professional. This relationship needs effective in conjunction with the capacity of democratic and participatory management of collective actions is only possible through co-management, in which all professionals and users, feel included in their needs and responsible for the final results [14].

Another ethical challenge is evidenced as

particularly difficult in establishing the role of community health agents (CHA). These FHS professionals have a liaison function between the community and the health team, supporting individuals and families, identifying risk situations, carrying out guidance, disease prevention and health education. Should the ACS allow communication and bonding between health services and the community, considering the local singularities, enabling better qualifications of services from the needs and potentialities of the population [15]. However, next quote suggests that perhaps the team's professionals do not understand all the peculiarities of the agents' role:

"I agree with Cristiane when she says that the agents have to be better prepared. They even faced with situations that they do not know how to solve, even things of people's suffering, not only that, but something they do not know. Then come back to the team, usually the nurse (...) If they had a much improved training and deepened continued education they could solve. Would be some alternative "(E of FHS) .

The ACS has a tendency to identify more with the team, assuming progressively model in solving biomedical health needs, ultimately overvalue technical issues, leaving aside the issues and socio-cultural community. Thus, it becomes a router tasks back and forth, subjecting the technical aspect, because their cultural knowledge is not valued, hampering the excellent design of functions [15,16].

Finally, the ethical challenge of the lack profile of professionals to work in the dynamics of SHS refers to the training process, a this problem more present in the FHS employees' speech to configure as a new work proposal: "*Our own colleagues in the health area do not understand the SFH. They still do not have the idea of a differentiated service, other than a simple post where they do not even have to look at the doctor's face, simply prescribe examinations. If we want the population to have this type of vision, we have to start first by all professionals, even at the college level up* "(E of FHS).

Studies point to the need to reorder the professional formation according to the context of changes in health care, promoted by the Health Reform, which led to the creation and implementation of SUS [17-19]. Most health education Institutions still graduate students based on the biomedical model guidelines, with a fragmented view of the health-disease process, guiding more curative than preventive actions. The challenges of working in health demonstrate the need to establish strategies that aim for the formation of critical, reflective and creative subjects, capable to cope with ever more complex health problems, involving social, environmental and cultural issues [20].

If the primary focus of attention is to welcome, interpret and respond to the everyday health needs, which are complex, determined by the socio cultural and psychological conditioning, work processes must be configured to try to solve this demand. If therapy to tackle the disease in a hospital setting is to abide defined healing protocols, the clinic required in primary care need to be more attentive to the manifestations of subjectivity because the multivariate therapeutic itineraries need to be agreed with the user, happen in your daily and long terms, which largely depend on their autonomy. Campos [21] calls this the expanded clinic or subject's clinic.

This greater attention to user subjectivity in clinical care requires a change in the very logic of the work processes in health, for the professional subjectivity also must be taken into account in setting the dynamics of activities. This observation points to another important concept to understand this phenomenon: the difference between dead labor and living labor, Proposed by Merhy [13] - when the carpenter makes a chair and customer purchase it, the job dies in the product sold. The work is mediated by the product, not by the relationship. The live work, by contrast, is defined by the established relationship.

Thus, the relationship, rather than the procedures and instruments should be the basis of

living work in healthcare, which cannot be exhausted in the product. The way work is organized, for example, the logic customized, transforms the living into dead labor. Focus on the relation means not ignore technology, but knowing how to combine the live work, according to Merhy, the hard technologies (devices), light / hard (knowledge) and light (care) [22].

Emerging needs in health are important issues for the assistance, as they guide the organization of services, establishing actions and interventions to achieve goals and objectives to minimize, adjust and prevent health problems. The configuration of the health system is a response to the needs built by the social imaginary, expressed in constantly changing demands and dynamism. The systemic organization of health services to respond to demand by work processes constitutes the third ethical challenge.

The health system was designed to address the health needs as a user's right and duty of the state, which requires new organizational logic and new management paradigms. This practice establishes unprecedented mindset, raising unique ethical challenges, the paradigmatic change topics. Although with a different logic, such challenges appear in both FHS and in BHU, which considering the difficulties relevant to the system are the same.

The Ministry of Health recommends specific programs of prevention and treatment of injuries most common to health. However, the communities need programs that meet their own needs, which sometimes do not identify with the officially prescribed. Therefore, the system has to be aware of the specific context, expanding knowledge about the real needs, the characteristics of the community served and the local health complexity [23]. This fact appears in the speech of one technician:

"There is not any group and no one knows how to handle common problems of Campo Bom, obesity, stress, back pain, caused by the shoe factory environment. We should be prepared for these things and stop to focus only on diabetes and hypertension " (T of FHS).

Users easily link the poor quality of SHS, the fruit produced by the imaginary social media, creating hype about the ills of public service. This is a social imaginary ethical challenge for the system. The media affects the perception of users on the system to produce more news about the SUS deviations than on the successes and possible changes in the social setting of health [24].

This distortion clearly appears in the following speech by the manager, referring to the user's complaint: "One lady came and said: they lost my exams, minimum. Then I said: No, madam, we do not lose anything here. And she replied: (...) well, that is the SUS, anyway" (AD BHU). The ethical problem appears between the established, represented by the social imaginary of the old health model, disseminated by the media, and the instituted, represented by the new proposal, focused more on promotion and health education [25].

The lack of stability and constant changes of team members hinder the establishment of close and enduring relationship with the user. In this study, FHS professionals reported this problem: "*What people complain much is that (of) when they are getting used to the doctor or nurse, they leave. It would be good always stay with the same team, but it does not work, it does not remain* "(T of FHS).

Studies suggest that some of the elements essential to establish bonds with the health team refer to the professional's respect and commitment to the community as well as the undertaking of public competition selection, which contributes to the permanence of the professional on the team, avoiding, thus, the turnover [26].

The Municipalities face problems related to budget, affecting personnel management and leading to bureaucratic assistance. In an attempt to solve these problems, management refers to outsourcing of services. This phenomenon leads to the constant exchange of professional, who do not work under the accountability point of view or are committed with the FHS rationale. If the scope is the user and his family's integral care and monitoring, professionals need time

to establish connection, necessary for achieving such goals. The outsourcing of services is a problem for the ethic system, as It focuses directly on the work processes [27, 28].

Another ethical problem is Interference from local politicians in the functioning of health services to benefit their constituents. They are concerned only by electoral interests, showing a lack of effective political accountability by Improving services - which is clear in the BHU physician's speech, as follows: *"Eve of the election day, you will see that will have pressure, that the councilors saying: ah, but I'm going to call so and so "(*M of BHU).

The problem points to the need for the health council is, in fact, the social control and reference for enforcement of health services, not politicians who transgress the rules of system to benefit themselves. This behavior misinforms citizenship, because it does not encourages the participation, but godfathering and patronage. This way of "solving" problems, based on "little ways" ethical uses the subterfuges of the power of influence and disrespects (major Influence that) compliance with regulations that apply to everyone. This situation discourages commitment to responsible citizenship in an environment of accountability and transparent administrative policy [29].

Another ethical problem of the system is lack of concern for professionals' mental health, as concerns with the quantitative results and accountability are a priority. It is not difficult to find professionals tired and dissatisfied with the working conditions, which creates even more anxiety and worn out and causes a hazard to the user and professional - occurrence evidenced in the dialogue between a nurse and a technician, complaining about the situation: *"Today I am tired, I'm not willing to work, can´t stand. " And I said, "But you'll have to work-hard ... You will be here until 7 am*" (E of BHU).

Faced with this situation, the defense strategies are absenteeism, the jokes, harassment and psychological demonstrations of insensitivity towards human suffering.

Therefore, there is a need to develop strategies for coping with institutional stress among professionals[30].

Final considerations

The ethical problems point to important issues Identified that interferes with established relationships in the workplace, among professionals and with users or with the health system itself. Such problems may affect the dynamics of work on health needs.

The FHS has specific operations characteristics, grounded in teamwork and in support of ascribed families, differently of the BHU that serves spontaneous demand of the neighborhood. Thus, the conflicts shown are peculiar to each model of care. In the FHS stand out conflicts connected with the teamwork and the excess bond. At the BHU (WFH), the perceived conflicts are related to communication difficulties and correct understanding between professionals and users, since there is not the proximity and continuing assistance allowing their integration. However, we notice the existence of similar conflicts in both models of care with regard to ethical problems related to the health system.

With this awareness of the ethical problems of primary care is possible to reach the last stage of the hermeneutics analysis (again of the), which is the reinterpretation [8], whose objective is to wake the professionals' critical sense and emancipating potential, and when they understand the meanings and the context of their care practices. The article seeks to provide primary care professionals the opportunity to critically understand their practices from the ethical problems present in the reality of work. With that, they might position themselves against the outcome of their consultations, reviewing the solvability of excellent contributing practices and to change and transformation processes and health services.

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