Construction and validation of the instrument "Inventory of ethical problems in primary health care"

José Roque Junges [1], Elma Lourdes Campos Pavone Zoboli [2], Marcos Paschoal Patussi [3], Rafaela Schaefer [4], Carlise Rigon Della Nora [5]

Abstract

Identifying ethical conflicts contributes to improve healthcare quality. This study aimed to evaluate content validity and verify internal consistency of the Inventory of Ethical Problems in Primary Health Care. The instrument – a close and structured questionnaire – is a result of decades of researches on bioethics in primary health care. The article focuses on the last stage of validation. At the beginning of this stage the instrument had 41 items. It was applied to 237 professionals of 12 primary care centers at Grupo Hospitalar Conceição (Porto Alegre/RS). After the exploratory factor analysis, it resulted in six dimensions with high degree of reliability and consistency (KMO = 0.831, Bartlett p < 0.001; alpha 0.876), which explained 61.4 % of variance. At the end, the validated version of the instrument had 6 factors and 24 items. The instrument may contribute to researches in bioethics through the development of studies to recognize the most common ethical problems in primary care and to explore the influence of different contexts on ethical problems.
Key words: Validation studies. Ethics. Bioethics. Primary health care. Problem solving.

Resumo

Construção e validação do instrumento "Inventário de problemas éticos na atenção primária em saúde

Identificar conflitos éticos contribui para melhorar a qualidade da assistência. O estudo objetivou verificar a validade de construto e consistência interna do "Inventário de problemas éticos na atenção primária em saúde". O instrumento, questionário estruturado e fechado, é fruto de uma década de pesquisas sobre bioética na atenção básica. O artigo enfoca a última etapa da validação. No início dessa fase, o instrumento continha 41 itens. Foi aplicado a 237 profissionais de 12 unidades de saúde do Grupo Hospitalar Conceição (Porto Alegre/RS). Após análise fatorial exploratória dos escores, obtiveram-se seis dimensões centrais com elevado grau de confiabilidade e consistência (KMO=0,831; Bartlett p<0,001; α geral 0,876), explicando 61,4% da variância. Ao final, o instrumento validado ficou com seis fatores e 24 itens. O instrumento poderá contribuir para pesquisas em bioética, com estudos quantitativos em grandes amostras, bem como propiciar o reconhecimento dos problemas éticos mais comuns na atenção básica.
Palavras-chave: Estudos de validação. Ética. Bioética. Atenção primária à saúde. Resolução de problemas.

Resumen

La construcción y validación del "Inventario de problemas éticos en la atención primaria de la salud"

Identificar los conflictos éticos contribuye para mejorar la calidad de la atención. Este estudio tuvo como objetivo evaluar la validez de constructo y la consistencia interna del Inventario de Problemas Éticos en la Atención Primaria de la Salud. El instrumento, un cuestionario estructurado y cerrado, es resultado de una década de investigaciones sobre bioética en la atención primaria. El artículo enfoca la última etapa de validación. En el inicio de esta etapa, el instrumento contenía 41 elementos. Se lo ha aplicado a 237 profesionales de 12 centros de salud del Grupo Hospitalar Conceição (Porto Alegre/RS). Tras el análisis factorial exploratorio de las puntuaciones, se encontró seis dimensiones centrales con alto grado de fiabilidad y consistencia (KMO = 0,831, Bartlett p < 0,001, alpha 0,876), explicando el 61,4 % de la varianza. La versión validada del instrumento quedó con 6 factores y 24 ítems. El instrumento contribuirá para las investigaciones en bioética, pues posibilita estudios cuantitativos en grandes muestras para llevar a reconocerse los problemas éticos más frecuentes en atención primaria.
Palabras-clave: Estudios de validación. Ética. Bioética. Atención primaria de salud. Solución de problemas.

1. **Doutor** roquejunges@hotmail.com – Unisinos, São Leopoldo/RS, Brasil 2. **Livre docente** elma@usp.br – Universidade de São Paulo, São Paulo/SP, Brasil 3. **Doutor** mppatussi@unisinos.br – Unisinos, São Leopoldo/RS, Brasil 4. **Doutoranda** rafaelaschaefer@hotmail.com – Universidade Católica Portuguesa, Porto, Portugal 5. **Doutoranda** carliserdn@yahoo.com.br – Universidade Católica Portuguesa, Porto, Portugal.

The author(s) declare(s) that there is no conflict of interest

Artigos de pesquisa

Investigations on the ethical challenges in health care services can lead practitioners to reflect, discuss and evaluate ethical attitudes in health practices [1]. Ethical problems are challenges that require resolution by the best solution. Comprehended as challenges, they cannot be solved by means of ready-made recipes, but require constant creativity, for long-range answers, beyond the solution of a particular case [2]. The Unified Health System (SUS), the Family Health Strategy (FHS) is reorganizing the Primary Health Care Cente (PHC) through the adoption of the principles of longitudinality and completeness. This reinforces the need for ethical commitments of the teams, who have to exercise new practice marked by humanization, care and citizenship [1].

In this perspective, since 2000 we have been studing the topic of ethics in PHC. The first study, between 2000 and 2003, has developed a qualitative research with nurses and doctors of the family health teams in São Paulo, objecting to recognize a profile of ethical issues in this new form of organization of PHC in SUS. As a result, we obtained a list of 41 problems [1] who originated the first version of the Inventory of ethical problems in primary care (IEP-PHC).

Between 2004 and 2005, it has developed a second study to recognize if problems highlighted in the first recur in the experience of other family health teams and if there would still be something to add. The study showed that the first version of IEP-PHC was easy to understand and fill out, containing a list of ethical problems in PHC practice sufficiently wide, not being necessary to include new examples [3].

From 2005 to 2009, in São Paulo, another two qualitative studies have investigated the ethically significant situations experienced by nurses and doctors in PHC services not reorganized by the FHS. One of these studies investigated the traditional basic health units (BHU) and the other focused on the school health centers [4]. The results proved the scope of the list of problems that formed the first version of the IEP-PHC. A third study validated this same period the sensitivity of the instrument. For this stage of validation, a study was developed with experts in the area of ethics and bioethics. The instrument was sensitive, allowing you to capture the variation of vision in the group that was applied: PHC professionals and experts in ethics and bioethics [5].

With these studies, it was seen that the first version of IEP-PHC showed itself comprehensive, sensitive, very understandable and easy to apply. In continuing the validation, it was necessary to assess the construct of the instrument. To validate the clar-ity, readability and reliability of the construct it was developed between 2006 and 2008, a methodological study [6]. The validation of clarity and reliability was given by a panel of experts on family health, with the use of Delphi technique.

Each item of IEP-PHC had its description described according to the situation narrated by respondents of the study, whose results led to the list of problems in the inventory. For each item of the IEP-PHC was asked the experts of the panel to assess the congruence between the statement of the ethical problem and the description of the situation that spawned it. There was room for experts to suggest new writting for the statement, if appropriate. The cutoff point of congruence was 80%, being maintained the writing with an equal or greater than it [6].

To validate the readability we used the Index of Ease Reading Flesch-Kincaid (ILFK), available in Windows Microsoft Word. The final wording of the statements of ethical problems arising from consulting the expert panel was set to one compatible with an approximate the seventh year of schooling (old 6th grade) elementary school (reading fairly easy) ease of reading. The writing fitted for each item has been reviewed by a Portuguese teacher to verify the adequacy and correctness of writing. With this methodological study closed in 2008, the second version of the IEP-PHC [6].

Until this second version of the IEP-PHC to be validated in the qualitative aspect. Its scale for the record of the occurrence of ethical problems was nominal and not numerical. From 2009, using the second version of IEP-PHC, began the validation through quantitative techniques, to enable the incorporation of a Likert scale on the instrument. This would make it possible its use in quantitative studies with larger samples. The research objective was to determine the construct validity and internal consistency of the IEP-PHC. This article describes the results of the last research validation IEP-PHC.

Method

Cross-sectional study conducted in Rio Grande do Sul, with professionals from 12 health units of the Conceição Hospital Group (GHC), a federal public institution under the Ministry of Health, reference in service of the Unified Health System (SUS). The Group has a team of 7,913 professionals and covers four hospitals (Conception, Crainça Conceição, Cristo Redentor and Fêmina), 12 health posts in the Department of Community Health, three psychosocial

care centers (Caps) and the Center for Technology and Education Health Research, the CHG School. It is nationally recognized as the largest public hospital in southern Brazil, with 100% service from SUS [7].

Field work began in July 2011 with a pilot study conducted at the Conceição Health Unit, which included about 60 professionals. The purpose was to know the reality *in loco* to organize the fieldwork and also to observe the comprehensibility of the instrument by practitioners within its completion time, once it had only been used in studies in São Paulo.

Data collection occurred between August and December 2011, taking advantage of the weekly team meetings. Professionals were invited to participate voluntarily, forming a convenience sample. After the clarification of research and freedom of participation, all attending the meeting received the IEP-PHC, with instructions for its completion. At the end, gathered up all distributed instruments, wheter filled out or not. As there was no identification of the respondents' anonymity, it was also preserved also anonymity of who refused to participate, since the withdrawal of the blank instrument was not done in the field.

The sample included 237 professionals. For the procedure of exploratory factor analysis, stricter authors as Dassa [8], maintain that the ideal sample size is at least ten subjects per inventory item or a total of at least 250 subjects. Other authors, such as Pestana and Gageiro [9], propose at least five subjects per question in inventory with over 15 items, considering a minimum of 100 subjects. Given this, we consider the sample enough for this present study for the proposed analyzes.

The IEP-PHC version submitted to quantitative validation contained the 41 items of the qualitative second version, with ethical problems in three relational levels of health care: user-professional, family health teams and health system [1]. In each item respondents could express their view on the topic on a scale that ranged from zero to four. The zero meant that the respondent did not consider ethical problem the situation set out in item. Otherwise, hw would have to point out how often met the problem in his work in PHC: never (1); rarely (2); often (3); always (4).

It also had been recorded-some characteristics of respondents: socioeconomic, especially education; demographic (gender, color or race, and marital status); factors related to the work process (profession, training time, working time in PHC, and working time in the unit of current health).

The EpiData version 3.1 was used for data entry and the sotware Statistical Package for Social Sciences (SPSS) version 12.0 for analysis. Aiming to evaluate the adequacy of the data to a factor analysis, we used the Kaiser-Meyer-Olkin (KMO) test. To validate the construct, it was made use of principal component analysis and varimax rotation. For that, we followed the steps proposed by Hair JF, Anderson RE, Tatham RL and Black WC [10]: formulating the problem; construction of the correlation matrix; determining the method of factor analysis; determining the number of factors; rotation of factors; interpretation of factors; calculation of loading factors or choice of proxies, and determining the adjustment of the model.

To find the best solution in terms of numbers of factors, were used as criteria: eigenvalue greater than or equal to 1, minimum of three items per factor, and consistency with the theory that justified the construction of the instrument in all studies: the deliberative bioethics Diego Gracia. The criteria for removing items were the increase of *alpha* after removal of the item; item with several factors at the same time, and the removal of the item whose content was not consistent with the construct. To assess the internal consistency of the total scale and its subscale used the Cronbach's *alpha* [11].

The study was approved by the Ethics Committee in Research of the Conceição Hospital and all participants signed an informed consent.

Results

Among other health professionals in family health teams, the sample included 237 medical professionals (14%), community health workers (11%), assistants and / or nurse technicians (10%) and nurses (9%). Prevailing females (79%), 82% considered themselves white, 50% were single and 60% were aged between 21 and 40 years.

Data analysis considered the responses of 237 professionals participating. In order to assess the overall structure of the data, the analysis using SPSS openly was run, that is, without first defining the amount of factors with varimax rotation. The result of this analysis indicated the existence of 10 different factors, where KMO = 0.847 and Bartlett p <0.001 index. The variance explained in this solution was 63.5% and the overall *alpha* 0.921. These measurements indicated that the results were satisfactory, that is, showed the suitability of the data for initiating the exploratory model of factorial analysis.

After verifying the adequacy of the data for the sequence analysis of the items that were taken at the same time, there were two or more factors albeit with low communality. Withdrew, one by one, six items, which increased the variance to 64.4%.

After the removal of these items, the analysis generated nine factors. Three factors had only two items, which is not recommended in validation, according to authors such as Tabachnick and Fidell [11]. Therefore, it was decided to remove six items. Thus, the explanation of the variance decreased to 59.6%. Is was not expected this behavior of the variance with the removal of the items, but despite this, due to the need to eliminate factors that contained only two items, we opted for the withdrawal.

When analyzing the theoretical consistency, three items found ethical problems whose statements did not make sense in the factors allocated. It also was opted for withdrawal. Thus, there was obtained 61.4% explanation of variance model with six factors and 24 items. The KMO index was 0.831, Bartlett p <0.001 and the general *alpha* of 0.876 (Table 1). This arrangement of items and factors was considered the best solution for analysis, as important combined statistical results and grouped the ethical issues appropriately the theoretical point of view [11].

The factors can be taken as categories of analysis or even areas of evaluation of IEP-PHC. They grouped the ethical problems in the PHC by frequency and by its characteristics, those that happen most and what kind they are, based on publications in primary care [12]: 1) Management of primary care; 2) longitudinality; 3) Practice teams; 4) professional profile; 5) Privacy in primary health care and; 6) Professional secrecy (Table 1 - Appendix).

The domain 'management of primary care' contains six items, with Cronbach's *alpha* equal to 0.854. Groups ethical problems related to: lack of conditions for emergency care; lack of conditions for conducting home visits; deficiencies of the rear service for removal of patients; difficulties in the reference and counter system; return and confidentiality of the results of laboratory tests and; excess families ascribed to each team at FHS. This domain IEP-PHC brings the question of the aspects directly related to the organization and operation of services as a source of ethical problems for health professionals in the FHS.

The factor 'longitudinality' contains four items that deal with issues related to: continued treatment; refusal to follow medical advice; prescription drug that the user will not have money to buy; and

difficulty in practice to fulfill the responsibilities of each professional team. This domain includes the PEI-PHC ethical problems arising from prolonged relationship established between the professional and the user. The Cronbach *alpha* for this factor was 0.70.

On the factor 'practice teams' are four items that express ethical problems arising from fragmentation of team work and the difficulty of exerting interdisciplinary practice. This domain deals with: lack of respect among team members; lack of collaboration of a team with the other; professionals who do not have to work in the FHS profile and; professionals who work with lack of commitment and involvement. The Cronbach *alpha* for this factor was 0.76.

Three items form the factor 'professional profile', with Cronbach's *alpha* of 0.72. Are ethical issues related to attitudinal professional profile on PHC, reorganized or not by the FHS: pretrial users and their families; disrespectful and inappropriate prescriptions.

The fifth factor, 'privacy in primary health care', comprises three items that bring specific aspects of this ethical issue in the context of PHC, where households and the community are extensions of the office. The factor had a Cronbach's *alpha* of 0.70.

The factor 'professional secrecy' had Cronbach's *alpha* of 0.64 and grouped four items related to ethical issues in health information of users and sharing these among professionals, patients and families.

There is internal consistency of the resulting data analysis, with Cronbach *alpha* indices ranging from 13.14 desirable (α = 0.85) to acceptable (α = 0.64).

Discussion

As a result of over a decade of research exploring the interface of bioethics and primary care, it succeeded to build and validate an instrument for inventorying ethical problems in primary health care. The application of IEP-PHC allows an 'epidemiology' [15] of ethical problems in the view of health professionals working in primary care. But, surpasses the accounting because it can provide the mediation of reflection on ethical issues for the improvement of health services.

The results of this study validated the IEP-PHC because they showed that the instrument has internal consistency and homogeneity, consistency with

the items in each factor and the whole [16]. The total explained variance was acceptable. Only 38.6% of the variance remained unexplored [11]. Besides the satisfactory statistical measures, there was an important theoretical coherence of the factors obtained from analysis, according to the reviewed literature [12,17].

The factor with the greatest percentage of variance explained was 'management in primary care', because, regardless of the number of factors retained, this always grouped as the first. This probably stems from the importance of this issue for the PHC, especially in SUS, in which it has been suggesting that this level of attention is the gateway of the system and, at the same time, coordinator of care in different points of the health care network. Ethical problems related to the size of the PHC management are directly related to ethics in the management of health services, leaving patent the difficulty of separating the ethics of health care ethics in health administration [18].

Several studies have reported the existence of problems related to the management of SUS [19-21]. Increasingly health services require municipalities good performance management capacity, there are turning to positive change in health indicators of the population. With this becomes important the figure of the manager and its political-management decisions in the effectiveness and efficiency of the NHS. Professionals from the FHS teams and managers should guide their practice the principle of ethical responsibility [22].

The longitudinality care is the second factor of the PHC-IEP and can be understood as a central and unique characteristic of primary care. To Starfield [23], longitudinality refers to the monitoring of the patient, over time, by general practitioner or healthcare team, in multiple episodes of illness and promotion of care and rehabilitation. For this continuity of care are essential to the existence and recognition of a regular source of primary care, the establishment of lasting therapeutic bond between patients and healthcare professionals of the local team and informational continuity [24]. Amog these points are concentrated also, the main ethical problems related to longitudinality.

The third factor, 'practice teams' corroborates studies that showed deficiencies in collective responsibility on teamwork in the FHS, because professionals fragment isolated performances in what should be a collectively knowledge built [25]. To achieve the objectives of the FHS is necessary to the effective teamwork, with everyone working towards the same goal. Health teams, each professional exercises his

profession in the midst of a collective work, the final result depends on the contribution of different areas of knowledge to assistance [12].

The 'professional profile' fourth factor, meets the evidence from studies of managers and workers of SUS, the different spheres of government, by showing that the same way that the performance and the management of human resources, staff training profoundly affects the quality of services and the degree of user satisfaction [26,27]. The public sector has trouble hiring professionals with suitable profile that is intended and expected to PHC. In worker training process, despite recent efforts to change, especially with the expansion of hours of internship in family health, the gap persists in relation to the demands and needs of the NHS, with difficulties in the integration of clinical knowledge and health collective [12].

The factor 'privacy' reveals characteristics of PHC, because the house of users becomes the extension of the office. The relationship ceases to be individual (doctor-patient) to become collective (team of health-family), enriching the discussion of a topic essential to bioethics, the privacy of autonomous persons, with specific and peculiar problems of this level of attention. Privacy is a derivative principle of autonomy and embraces intimacy, privacy and honor of the people. In multiprofessional teamwork, exchange of information is fundamental to good quality assistance. However, the information to the team members will be limited to those needed to carry out each of their activities on behalf of the user [28].

The sixth factor, 'professional secrecy', arises the issue of secrecy is not necessarily linked to direct contact between informer and listener. Depending on the service users and families, information can be obtained by one or more persons and confidentiality should be preserved, as concerns a user right [29]. Brazilian study conducted by Fortes Spinetti and [30], found that community workers health are concerned with the ethical principle of privacy and the need to maintain confidentiality as an ethical obligation of health professionals.

It should be noted that the last two factors keep similarities between them, as the terms *'confidentiality'* and *'privacy'* are confused and ethical problems described in both domains intertwine in assistance and may be interpreted differently by professionals - so maybe have presented the lowest levels of Cronbach's *alpha* (0.70 and 0.64, respectively).

In fact, the SUS proposal of teamwork for primary care, especially with the Family Health Strate-

Artigos de pesquisa

http://dx.doi.org/10.1590/1983-80422014222012

Rev. bioét. (Impr.). 2014; 22 (2): 305-13   **309**

gy, brings ethical questions about the confidentiality and privacy that require depth reflections to get the answers that respect the dignity and autonomy of users of the services. However, perhaps the confusion manifested in the analysis of these items on the instrument is reflective of users and professionals are still stunned by the reach provided by the FHS, where professional teams and penetrate the privacy of homes, in the intimacy of family dynamics.

The study of Seoane and Forts [31] show differences in the opinions of users about the information about your health and family life that pass the community health agent. Some cogitate to limit the information, not trusting the agent even items related to their illness. However, there are users who claim to share everything that concerns your health, aware that the information will be brought to the team. Although perpetuate themselves in everyday primary care practice situations of disregard for confidentiality, health teams consider the preservation of confidentiality and privacy of users is key to offering a quality service and humanized [32].

The amazement of everyone involved in this proposed collective work is reflected in the training of future professionals. Medical students recognize that the confidentiality of information in their learning experience in primary care is essential point in the development of professional confidentiality which shall be observed as doctors, but recognize it difficult to define the situations in which it is necessary to share information and when they should be kept secret [33] It is clear that the exchange of information between user and professional depends directly on the climate of trust that permeates the clinical relationship and the host user in service [34].

A study with HIV women in a region of São Paulo, showed that they reveal their condition to family health team only after establishing a bond and trust with the professionals. Instead, when they feel fear and insecurity due to the attitude of some professionals or trust that confidentiality will be maintained on their condition, do not reveal their diagnosis to the primary care team [35]. The bond, trust and acceptance in respect of services and professionals with users and families are key elements for thought and conduct of ethical issues about confidentiality and privacy.

Final considerations

The IEP-PHC is a unique and innovative tool for the proposal to develop research in bioethics in order to deepen the reflection on the ethical challenges in everyday professional practice of health services. It is unknown so far, the existence of similar instruments validated to measure the same construct. So, the IEP-PHC is an important tool in improving health care. It will facilitate the realization of extensive studies with large samples, which, in turn, will contribute to following the validation of the instrument itself. The application of the same instrument validated in different locations facilitates comparison of findings, in compliance with the issues of cultural adaptation.

The applicability of the IEP-PHC proved possible in different circumstances and workplace primary care and is a good resource for researchers, practitioners and managers to obtain information on the profile of ethical problems in the view of the service teams, guiding the work of ethics committees, bioethics committees and continuing education programs to local realities.

The IEP-PHC is an instrument designed with a construct emanating from the reality of SUS and validated through qualitative and quantitative research that laid hands on the instrumental discourse analysis, content analysis, psychometrics, statistics. Theoretically, it anchores itself in the deliberative bioethics of Diego Gracia. After this latest research validation IEP-PHC, with which we come to a third version of the instrument, we conclude that it enables: draw reliable profiles of the ethical issues in the PHC; trigger reflection of teams and professionals to reformulate personal attitudes and work processes.

With the PHC-IEP open up new paths for research in bioethics interface with primary health care. The relevance of the instrument is to enable studies with representative samples of populations professionals to verify the capability of generalization of the problems listed in the IEP-PHC. Furthermore, the use of a validated instrument in different regions, ie, its application in studies with multiple sites for data collection, allow comparison of results to check for the influence of cultural factors, local, social, organization of services primary care in experienced and ethical problems identified by the teams, being able to assess the interference of these factors, if so.

Such studies may also indicate whether there are significant local and regional differences in the ethical problems of primary care profile. With this, we do not defend the mere description of the ethical problems, but systematic recognition of the situation, with the generation of evidence, to direct

actions to transform the practice of primary care in order to make it more ethical, humane and citizen. Finding the weak points in the ethical sense, the performance of primary care teams, you can address the ongoing formation for the most relevant topics and issues in each and frequent reality.

References

1. Zoboli ELCP. Bioética e atenção básica: um estudo de ética descritiva com enfermeiros e médicos do Programa Saúde da Família. [tese]. São Paulo: USP; 2003.
2. Gracia D. Ethical case deliberation and decision making. Med Health Care Philos. 2003;6(3):227-33.
3. Silva LT, Zoboli ELCP, Borges ALV. Bioética e atenção básica: um estudo exploratório dos problemas éticos vividos por enfermeiros e médicos no PSF. Cogitare Enferm. 2006;11(2):133-42.
4. Zoboli ELCP Relación clínica y problemas éticos en atención primaria, São Paulo, Brasil. Aten Prim. 2010;42(8):406-1.
5. Silva LT, Zoboli ELCP. Problemas éticos na atenção primária: a visão de especialistas e profissionais. Revista Brasileira de Bioética. 2007;3(1):27-39.
6. Silva LT. Construção e validação de um instrumento para mensuração de ocorrência de problema ético na atenção básica. [dissertação]. São Paulo: USP; 2008.
7. Grupo Hospitalar Conceição. Atenção à saúde. [Internet]. (acesso 24 jun. 2012). Disponível: http://www.ghc.com.br/default.asp?idMenu=atencao_saude
8. Dassa C. Analyse multidimensionnelle exploratoire et confirmative. Montreal: Université Montréal; 1999.
9. Pestana MH, Gageiro JG. Análise de dados para ciências sociais: a complementaridade do SPSS. 3ª ed. Lisboa: Silabo; 2003.
10. Anderson RE, Tatham RL, Black B. Multivariate data analysis. In: Hair JF, colaborador. 5th ed. New Jersey: Prentice Hall; 1998.
11. Tabachinick BG, Fidell LS. Using multivariate statistics. 4th ed. San Francisco: Allyn and Bacon; 2001.
12. Brasil. Conselho Nacional de Secretários de Saúde. Atenção primária e promoção da saúde. Brasília: Conass; 2011.
13. Cronbach LJ. Coefficient alpha and the internal structure of tests. Psychometrika. 1951;16(3):297-334.
14. Cronbach LJ, Meehl P. Construct validity in psychological tests. Psychological Bulletin. 1955;52(4):281-302.
15. Fetters MD, Brody H. The epidemiology of bioethics. J Clin Ethics. 1999;10(2):107-15.
16. Pasquali L. Psicometria: teoria dos testes na psicologia e educação. Petrópolis: Vozes; 2003.
17. Brasil. Portaria nº 2.488, de 21 de outubro de 2011. Aprova a política nacional de atenção básica, estabelecendo a revisão das diretrizes e normas para organização da atenção básica, para a estratégia de saúde da família (ESF) e o programa de agentes comunitários de saúde (PACS). Brasília; 2011.
18. Silva JA, Dalmaso ASW. Agente comunitário de saúde: o ser, o saber, o fazer. Rio de Janeiro: Fiocruz; 2002. p. 240.
19. Serra CG, Rodrigues PHA. Avaliação da referência e contrarreferência no programa saúde da família na região metropolitana do Rio de Janeiro (RJ, Brasil). Ciênc. & Saúde Col. 2010;15(3):3.579-86.
20. Mendes EV. A atenção primária à saúde no SUS. Fortaleza: Escola de Saúde Pública do Ceará; 2002.
21. Paim JS, Teixeira CF. Configuração institucional e gestão do Sistema Único de Saúde: problemas e desafios. Ciênc. & Saúde Col. 2007;12(Supp):1.819-29.
22. Amorim AG, Souza ECF. Problemas éticos vivenciados por dentistas: dialogando com a bioética para ampliar o olhar sobre o cotidiano da prática profissional. Ciênc. & Saúde Col. 2010;15(3):869-78.
23. Starfield B. Atenção primária: equilíbrio entre necessidades de saúde, serviços e tecnologia. Brasília: Unesco; 2002.
24. Haggerty JL, Reid RJ, Freeman GK, Starfield BH, Adair CE, McKendry R. Continuity of care: a multidisciplinary review. BMJ. 2003;327(7.425):1219-21. DOI: http://dx.doi.org/10.1136/bmj.327.7425.1219
25. Pedrosa JIS, Teles JBM. Consenso e diferenças em equipes do programa de saúde da família. Rev. Saúde Pública. 2001;35(3):303-11.
26. Nogueira R. Avaliação de tendências e prioridades sobre recursos humanos de saúde. Brasília: Opas; 2002. (Rede Observatório de Recursos Humanos de Saúde).

http://dx.doi.org/10.1590/1983-80422014222012

Rev. bioét. (Impr.). 2014; 22 (2): 305-13   311

27. Cotta RMM, Morales MSV, Gonzáles AL, Ricos JAD, Cotta Filho JS. Obstáculos e desafios da saúde pública no Brasil. Rev Hospital Clínicas de Porto Alegre. 2002;22(1):25-32.

28. Fortes PAC, Martins CL. A ética, a humanização e a saúde da família. Rev. Bras. Enferm. 2000;53(n. esp):31-3.

29. Francisconi CF, Goldim JR. Aspectos bioéticos da confidencialidade e privacidade. In: Costa SIF, Oselka G, Garrafa V, coordenadores. Iniciação à bioética. Brasília: Conselho Federal de Medicina; 1998. p. 269-84.

30. Fortes CAP, Spinetti RS. O agente comunitário de saúde e a privacidade das informações dos usuários. Cad. Saúde Pública. 2004;20(5):1.328-33.

31. Seoane AF, Fortes PAC. A percepção do usuário do programa saúde da família sobre a privacidade e a confidencialidade de suas informações. Saúde Soc. 2009;18(1):42-9.

32. Bellenzani R, Mendes RF. Sigilo na atenção em DST/Aids: do consultório aos processos organizacionais. Polis e Psique. 2011;1(3):140-65.

33. Ferreira RC, Silva RF, Zanolli MB, Varga CRR. Relações éticas na atenção básica em saúde: a vivência dos estudantes de medicina. Ciênc. Saúde Coletiva. 2009;14 (1 suppl): 1.533-40.

34. Teixeira RR. O acolhimento num serviço de saúde entendido como uma rede de conversações. In: Pinheiro R, Mattos RA, organizadores. Construção da integralidade: cotidiano, saberes e práticas em saúde. Rio de Janeiro: Abrasco; 2003. p. 89-111.

35. Ferreira FC, Nichiata LYI. Mulheres vivendo com Aids e os profissionais do programa saúde da família: revelando o diagnóstico. Rev. Esc. Enferm. USP. 2008;42(3):483-9.

Participation of authors

José Roque Junges: coordinator of the study in Porto Alegre, who built the coordenador do estudo em Porto Alegre, who built the final validation phase of the IPE-PHC. Elma Lourdes Campos Pavone Zoboli: developed the original study that identified the ethical problems that make up the IPE-PHC and guided the searches that compose the previous steps to validate the instrument. Marcos Pascoal Patussi: researcher responsible for the quantitative arm of the study of Porto Alegre, for final validation and internal consistency. Rafaela Schaefer and Carlise Rigon Della Nora: conducted the field work, structuring databases and data analysis. All authors contributed equally to the development and final revision of the article.

Artigos de pesquisa
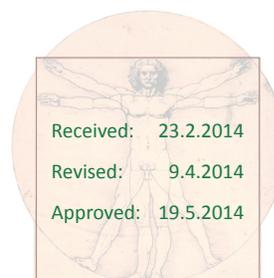
Appendix

Table 1. Factors, items, reliability indices of the factors and factor loadings of items.

Items	h²	Factor loadings					
		1	2	3	4	5	6
Fator 1. Gestão da atenção primária (α=0,85)							
40 The PHC has no condition for emergency procedures	0,567	0,804					
39 The PHC does not offer family health teams conditions for homecare	0,581	0,791					
41 There is no backup on the remotion service, in the PHC	0,479	0,766					
37 There are difficulties in the system of reference and counterreference for complementar exams	0,555	0,700					
38 There are difficulties regarding the return and trustness of laboratorial exams	0,566	0,680					
33 There is na excess of families for each team of PHC	0,557	0,671					
Fator 2. Longitudinalidade (α=0,70)							
8 Professionals feel impotent to convince the user to continue the treatment	0,454		0,755				
17 Users refuse to follow medical prescriptions or to undergo exams	0,466		0,683				
25 It is difficult to define in practice, the role and responsibilities of each professional FHS	0,538		0,626				
5 Professionals prescribe medications that the user will not have money to buy	0,468		0,563		0,382		
Fator 3. Prática das equipes (α=0,76)							
23 There is a lack of respect among members of the FHS team	0,390			0,768			
22 The family health teams do not collaborate with each other	0,563	0,324		0,678			
24 Healthcare staff do not have profile to work at FHS	0,632	0,349		0,626			
21 The professionals of the FHS act with lack of commitment and involvement	0,394			0,539			
Fator 4. Perfil profissional (α=0,72)							
4 The professionals make inappropriate or wrong prescriptions	0,366				0,778		
2 The team at FHS prejudges users and family based on prejudices and stigmas	0,214				0,694		
3 The professional treats you with disrespect	0,281			0,412	0,668		
Fator 5. Privacidade (α=0,70)							
12 The CHA tells his countrymen information obtained in their work about users and families	0,415					0,826	
10 The CHA says about the intimacy of the family and the couple with the healthcare team	0,307				0,324	0,764	
13 The professional account information on the health of a family member that he meets for the other members of this family	0,370					0,593	
Fator 6. Sigilo (α=0,64)							
27 Users ask a member of the family health team that other members will not have access to any information related to your health	0,333						0,834
30 Users ask a member of the health team that other family members do not have access to any information related to your health, even in situations in which family participation in care is necessary	0,404						0,601
20 The professional account information on the health of a family member that he meets for the other members of this family, when it can not manage self-care and is exposed to risk	0,434		0,322				0,581
16 Minors seeking BHC and ask the staff tests, medications or other procedures without authorization and / or knowledge of parents	0,374		0,354			0,319	0,528
Alpha		0,85	0,70	0,76	0,72	0,70	0,64
% variance		16,02	9,75	9,72	9,03	8,67	8,20
% cumulative		16,02	25,77	35,50	44,54	53,21	61,42

Artigos de pesquisa