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(Bio)Ethics and Primary Health Care: preliminary study on Family Clinics in the city of Rio de Janeiro, Brazil

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Abstract *The Family Health Strategy (FHS) started out as the Family Health Program (FHP) in 1994, and has since has been re-thought and re-worked in Brazil as the primary rationale for reorganizing Primary Healthcare (PHC). Transforming the hegemonic PHC into FHS has resulted in many changes in how healthcare is provided, which have impacted different areas. For example, matters of (bio)ethics must still be elucidated. Within this context, this investigation is characterized as an exploratory study focused on mapping the main (bio)ethical problems identified by PHC workers in the city of Rio de Janeiro. For this reason, we used a questionnaire and asked Family Clinic (FC) healthcare professionals to answer it. The answers were submitted to content analysis as proposed by Bardin. PHC in the context of Family Clinics has unique elements in terms of the (bio)ethical relationships established in this level of healthcare. It is extremely necessary that new theoretical references be proposed, and that education/training measures to address such issues be developed.*

Key words *Family Health Strategy, Integrated care, Primary healthcare, Bioethics*

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Introduction

Primary Healthcare (PHC) was defined by the World Health Organization (WHO, 1978)[1] during the *1st International Conference on Primary Healthcare* held in Alma Ata, in what was then the Soviet Union. Primary healthcare is essential healthcare based on practical, scientifically sound and socially acceptable methods and technology, and made universally accessible to individuals and families in the community[2].

International debates about PHC resonated in Brazil, resulting in the creationof the Family Health Program (FHP) in 1994, which proposed to change the former concept of healthcare professional activity from being primarily curative to a practice centered on integrated care, where the individual is thought of as a member of a family unit and a socioeconomic and cultural community[3].

This model of PHC became even broader in 2004, when the FHP (Family Health Program) was expanded into the Family Health Strategy (FHS)[4]. In 2006, Directive GM 648 created the *National Basic Care Policy* (PNAB), which was reformulated and confirmed in 2011 in GM Directive 2,488, consolidating FHS as the primary strategy for reorganizing primary healthcare in Brazil[5].

Starting in 2009, PHC coverage in Rio de Janeiro expanded a great deal, with the implementation of Family Health Teams[6]. This expansion happened both in terms of new family clinics (FC) that opened up as part of the FHS, and also basic care clinics working under the traditional model of Municipal Healthcare Centers (MHC)[7]. In 2009, about 3.3% of the Rio de Janeiro population was covered by the FHS; four years later, with 806 FHS teams, 40.22% of the population was covered[8].

While highly desirable, expanded coverage faces a number of hurdles, in particular a mismatch between the population's need for healthcare and the training of healthcare professionals in general[9,10]. In fact, we have found that the profile of those trained by the universities is inadequate for the work performed by the Unified Healthcare System (SUS), looking at healthcare as a social product, nor is the training suitable for those who should provide integrated and equitable care[11]. In effect, one of the questions linked to the process whereby healthcare professionals are trained – which has been found to be a problem in terms of PHC/FHS work –, is the issue of (bio) ethics[12,13]. Traditionally, (bio)ethics has focused primarily on a deontological approach[14], concentrating on questions related to tertiary care in the hospital environment. As a result, the (bio)ethical problems of PHC/FHS tend to be invisible to healthcare professionals[12,13,15,16], as shown by the rather limited number of articles on this theme published in recent years.

With these preliminary considerations in mind, the aim of this article is to describe the main (bio)ethical problems found by the professionals that make up the city of Rio de Janeiro PHC/FHS. The selection is related to the recent expansion of primary healthcarecoverage in recent years, with the FC (family clinics) as part of the current challenge to expand and deepen the reach of the FHS in all of the country's metropolitan regions.

Methods

This is an exploratory study of the main (bio) ethical problems identified by PHC workers in the city of Rio de Janeiro, based on the answers to a questionnaire used in previous studies[12,13,16.]

Study area - City of Rio de Janeiro

The city of Rio de Janeiro is part of a metropolitan area located in the state of the same name. The estimated population in 2013 was 6,429,923 inhabitants[17]. The Unified Health System (SUS) divides the city into ten Planning Areas (PAs). The system has 194 healthcare units, 187 staffed by FHS teams, totaling 893 teams providing care for 2,869,795 users[18].

Here we point out that this increase is not only due to the addition of units that had been under the old management model, but also due to new units opened in the city. Between 2008 and 2013, 71 new family clinics were opened[19].

This study was performed at nine family clinics, one in each PA. PA 2.2 has no family clinic so it was left out of the study.

Study participants

Healthcare workers of different professional categories in nine selected FCs in the city of Rio deJaneiro participated in the study. All were asked to answer a questionnaire, which they did unassisted. The inclusion criterion was professionals employed at the FC, and the exclusion criterion was refusal to participate in the survey.

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Data collection procedures

One team researcher went to each of the selected FCs to apply the questionnaire. The units were selected by random drawing – one FC per PA. Healthcare unit managers were approached and we explained the purpose behind the work. We then handed out the questionnaires to the FC employees, explaining the importance of the survey and of providing free and informed consent to participate in the study. In some cases, the FC manager asked that the investigator return on another day to collect the questionnaires so as not to interfere in the work and give the professionals more flexibility to answer the questionnaires.

Analytical procedures

We analyzed the answers to the questionnaires regarding (i) the overall characteristics of the survey participants, and (ii) the (bio)ethical problems faced by the team. Their awareness and appreciation of the concepts of ethics and (bio) ethics will be the topic of another paper. Finally, we outlined the main (bio)ethical problems identified by the members of FC investigated.

Data was analyzed for content, using systematic and objective methods to describe the content of the messages - the indicators of knowledge of the conditions for production/reception (inferred variables) in the messages[20]. Answers to the questionnaire were categorized based on an initial floating reading (pre-analysis), exploration of the material, and processing the results and interpretation[21]. In addition to the qualitative analyses, we ran a second analysis where participant responses to the questionnaire were processed using Wordle™, to create "word clouds" from the answers.

Ethical aspects

The investigation underlying this article was approved by the Federal University of Viçosa Ethics Committee for Research Involving Human Beings (REC), and by the Rio de Janeiro, RJ City Department of Health REC. Professional participation was formalized by signing a Free and Informed Consent Form (FICF).

Results and discussion

Description of the study population

The first nine questions in the questionnaire provided information about the participants (152 professionals in total). Respondents were predominantly female (83.6%). In terms of age, half (50.0%) were aged 31 to 50, 24.9% between 18 and 30 and 15.1% were over 51 years of age. Most of the participants claimed to be white (30.3%), followed by brown (26.3%) and black (184%). 25% declined to state their ethnicity.

Among the stated occupations, we found a preponderance of Community Health Agents (CHA) (44,70%), which is aligned with the Ministry of Health guidelines, recommending that there be more CHAs than other types of professionals in any team[22], followed by Nursing Technicians (15.8%), Nurses (9.2%) and Physicians (8.6%). Other professionals made up 21.7% of the participants. Regarding the question on how long they have been doing work directly related to FHS (Table 1), we found a most of the answers to fall between a few months to less than two years (46.1%), with a large percentage (54%) of the professionals working for the same PHC for less than two years.

Table 1. How long participants have been involved in FHS.

Time working in FHS	Absolute frequency	Relative frequency (%)	Time at same FHS	Absolute frequency	Relative frequency (%)
0 - <1 year	31	20.4	0 - <1 year	43	28.3
≥ 1-<2 years	39	25.7	≥ 1-<2 years	39	25.7
≥ 2 - <5 years	55	36.2	≥ 2 - <5 years	51	33.6
≥ 5 - <10 years	11	7.2	≥ 5 - <10 years	2	1.3
≥ 10 - 15 years	16	10.5	≥ 10 - 15 years	9	5.9
Does not know	0	0	Does not know	8	5.2
Total	152	100.0	Total	152	100.0

Source: survey data.

These findings may be due to two possible situations: (1) the respondent only recently passed the civil servant exam, or (2) the respondent is working under a temporary employment agreement. The latter is not a desirable situation, and could suggest a high turnover, with professionals not remaining long at the PHC/FHS, weakening its efforts, often part of a market rationale typical of the late capitalism[23], and a disconnect between the team and the population it serves, which is one of the main requirements for such teams under a rationale of family healthcare[13,24,25].

Bioethical problems identified and solutions proposed by survey participants

This section analyzes the answers to questions 10 through 14 of the questionnaire:

Question 10 - In which situations you experienced at the unit do you feel there were ethical and/or (bio)ethical problems?

Question 11 - How did the team address these problems?

Question 12 - Did you have to resort to the literature (text, article, code of ethics, etc) or to a consultant to help resolve these issues?

Question 14 - Were the problems resolved? What was the solution?

Question 14 - In your view, what were the main consequences of the ethical and (bio)ethical problems mentioned?

One third (33.6%) did not answer this section of the questionnaire, and 27 professionals (17.8%) answered that they had not experienced any (bio)ethical problems. Seventy-four participants (48.7%) claimed to have witnessed and/or experienced this type of problem, grouped according to the involvement of (1) *teams and families/users*, (2) *team members*, (3) *team members and management*, and (4) *issues of professional embarrassment and/or confidentiality* (Table 2).

The category *Problems involving the team/family/user* accounted for 37.6% of the survey answers, and is related to a set of situations experienced in the day-to-day operation of PHCC/FHS and the inter-relations between the workers and those the team serves - users and their families:

... We occasionally witness family conflicts when we make house calls...

The lack of humanity among some team members in welcoming users was also mentioned:

... rudeor uncaring service on the part of agents when patients walk into the unit. This can result in situations that are embarrassing to the patient...

Table 2. Categories of (bio)ethical issues identified by FC professionals.

Bioethical issues	Absolute frequency	Relative frequency (%)
Issues involving teams/ families/users	38	37.6
Issues involving team members	16	15.8
Issues involving team/ management	11	10.9
Issues involving professional confidentiality	09	8.9
Did not experience (bio) ethical issues	27	26.7
Total	101	100

Source: survey data.

Among the guidelines of the *National Humanization Policy* is the concept of an expanded clinic, where professionals are committed to users and the community, and all players are accountable and involved in the health production process[26]. This concept is deeply linked to the problem of continuity[27,28]. According to Mattos[29], continuity leads to an inter-subjective practice between subject and healthcare professionals, based on dialog and shelter. Within this scope, creating a link, which according to Cunha & Giovanella[30] is essential, assumes a good relationship between the healthcare professionals and the users of the SUS, sending us back to the field of (bio)ethics[12,31] and matters of power relationships and interdependence between those involved. Another issue that often came up was disrespect for the professionals on the part of system users, often due to their discontent with the service provided or the difficulty they had actually getting service.

... patents argue with employees and call them names in front of other employees just because of a certificate...

The interaction between individuals and healthcare services is related to the system's ability to meet their needs and expectations, providing them with access to healthcare. Making this operational means considering the current relationship between individuals and the system in a context of needs and responses that are oftentimes limited[32]. This outlook agrees with Donabedian's[33] definition of access as the fit between

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healthcare resources and the needs of the population in their search for health.

Regarding the category *Problems involving team members*, obstacles were reported regarding lack of companionship, respect and collaboration, as well as difficulties clearly assigning roles and functions for each team member. Below are a few highlights to demonstrate this:

...professionals interfering in the conduct of colleagues...

...a 17 year old came in for a dT shot out of the calendar, but I was required to give the patient the vaccine because the doctor was a manager. He said we couldn't turn away the teenager without the vaccine...

These situations cause tension in the daily lives of PHC/FHS teams, and compromise the continuity of user/family/community care. Thus a change in labor relationships is required, eliminating the spurious power relationships between professions that are evident in healthcare services, transforming these practices and creating harmonious relationships and teamwork[13]. Gonçalves et al.[34] investigated academic training, motivation and the work process for PHC physicians, finding that these professionals are team leaders, which results in over-load and increased strain – both emotional and physical –, sometimes due to conflicting relationships with other healthcare workers in the same ESF, due to the demand for accountability for the activities performed. This gives rise to "a new way of looking at system users, working colleagues and one-self as a healthcare professional"[35].

In terms of *Problems involving the team/management,* the issues reported involved different situations, some of which are exemplified below:

... the CAP mistreating professionals...

...some employers that fail to provide worker rights...

There is a relationship between the work performed by the healthcare team and unit management, where management is responsible for coordinating and for setting guidelines and targets, and also for providing material inputs, infrastructure and other conditions required for team to do its job. We also point out its responsibility for intra-sector integration, which also has a direct impact on the work performed by the teams. One must understand that management takes place in a conflict-laden political space, as is characteristics of the *ethos*[36,37], and permeated by contradictions and challenges[38]

If we are to take a more human look at management functions, it is essential that day-to-day tasks contributed to overcome fragmented healthcare, de-personalized care and the excessive rigor of authoritarian management that limit the horizon of healthcare work[39].

Regarding *Problems involving professional confidentiality*, the following types of situations were reported:

... In terms of ethical situation, I would mention colleagues who arrive late or just don't come in, making the unit's work more complicated, or commenting on patient clinical situations in public locations...

This extrapolates the relationships between users and the PHC/FHS team, with important consequences for the community. Confidentiality between healthcare professional and patient is essential, and a component of the ethics of the relationship between healthcare professionals and system users[40]: (i) *privacy* - the control the individual has over who has access to his/her information, manifest in the choice of whether or not to reveal personal information[40] – and (ii) *confidentiality* - understood as a situation where a confessor shares information such that only he or she can authorize this "confession" to be revealed[40,41]. Both conditions are inherent to providing healthcare. When users provide personal information to healthcare professionals, or when items are found during physical examination or lab tests, discretion, loyalty and confidentiality are essential, beyond a mere deontological approach[42,43], constituting actual ethical imperatives.

The (bio)ethical problems found by FC professionals were, in decreasing order (n=68 respondents) (1) dialog with the team (n = 27; rel. freq. = 39.7%), (2) dialog with management (n = 14; rel. freq. = 20.6%) e (3) dialog with users (n = 22; rel. freq. = 32.3%); five participants (rel. freq. = 7.4%) said there was no solution for the (bio) ethical problem.

The category *dialog with the team* is *expressed in the following transcription:*

... The solution is to try and explain that we must follow the correct procedure so as not to get in anyone's way and not harm the flow of work...

Communication among FHS members is extremely important to ensure the quality and continuity of care for SUS users, and to strengthen teamwork[44]. When this communication is non-existent or inadequate, problems emerge such as setting limits for professional fields of action, and questions regarding the performance of clinical activities[15].

The category *dialog with the manager* highlights management's need to be aware of the re-

quirements to build a more equitable and human healthcare system, that fulfills the requirements of integrated care and citizenship according to the principles of the SUS and the FHS proposal. The following sections is an example of this:

...management called all of the professionals to talk about improving relationships and flows in the unit...

To change management and care practices, Ceccim[45] believes it is essential to establish a dialog with the concepts and current teamwork activity, problematizing them.

The category *dialog with users* highlights the importance of active, qualified and resolutive listening based on the rationale of shelter, is an important factor to guide service and suitable referrals, leading to increased/better resolution of the problems faced:

...with instructions users feel they understand...

In healthcare, there are always at least two people involved: the user and the professional. There must be a dialog between them that includes emotion, points of view, beliefs and values, rather than just information about the signs and signals of disease and test results, although these are clearly essential as well. Thus, Bioethics may be a tool that enables PHC/FHS healthcare professionals to be more than mere problem solvers, becoming interlocutors seeking cooperative dialog with the users, where everyone learns and can arrive at the magnitude of the reality of which they are a part of[13]. These dialogs are an element of mediation with users who are at the center of the healthcare system.

Listening and guidance makes users feel satisfied and increases resolution when they demand healthcare. Still in this field, good user service and relationship with the community are valued as they explain the routines and procedures to the users, as well as the service flows and limitations[46].

The consequences of the (bio)ethical problems found by FC professionals are summarized in Table 3.

The difficulty found by the professionals under the category *breach of respect between user and team* have to do with respect for ethical and therapeutic limits, as shown below:

...employees are discredited and other people use the same attitudes and threats to get what they want...

Dialogic communication as part of shelter is the basis for creating a respectful relationship among those involved in healthcare, thus constituting the basis for creating a link between PHC teams and users[13]. Thus this is a key element of the work performed by PHC professionals[47], explaining its relevance as a consequence of the (bio)ethical problems identified. In effect, the link between the family healthcare team and the user is an essential tool that ensures links of trust and co-responsibility for the work of professionals on behalf of users[48].

Table 3. Consequences of the (bio)ethical problems listed.

Consequences	Absolute frequency	Relative frequency (%)
Lack of respect between users and teams	28	43.7
Breach in confidence	14	21.9
Relationship problems between team professionals	22	34.4
Total	64	100.0

Source: survey data.

The category *relationship problems within the team professionals* can be seen from the following:

... the lack of team unity interferes in the proper flow of the working process...

FHS is a privileged forum to try out knowledge of practices involving multi-professional and inter-disciplinary healthcare, training professionals for this new model of care. If the relationships between the professionals involved are fragile or unstable, individual work will be privileged over the collective effort, leading to fragmented knowledge[48].

The category *breach of trust* can be clearly seen from the following:

...exposes patients, only wants to talk about matters related to them...

Breach of trust goes against one of the fundamental aspects of healthcare work, and can contributed to destroying the link between the team and the system users. Paul Ramsey[49] argues that the fundamental ethical question in health research and care is the following: *What is the meaning of loyalty between human beings*? It is possible to recognize that loyalty - understood here as the articulation of the trust between individuals - is an essential aspect of ethical conduct, stressing the obligation to be true, reliable and loyal in all healthcare related professional conduct[50].

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Analysis of the frequency of the words in questions ten, eleven and fourteen

An analysis of the frequency with which certain words were used in the survey answers was completed using Wordle™, and is shown in Figure 1.

Analyzing the questions revealed the following words used most frequently:

— *Question 10*: "Team", "Patient", "Professionals", "Work", "Service" and "Unit";

— *Question 11*: "Team,", "Patient", "Problem", "Meeting" and "Service":

— *Question 14*: "Absence", "Work" "Team", "Professional", "Patient", "Problem", "Bioethics" and "Users".

Questions 12 and 13 did not generate word clouds, as the answers were generally more concise, and the answers less suited to problematization and questioning.

Once we had the word clouds, we were able to make conjectures on the core role of the terms "patient" and "team" - which were present in the answers to the three questions analyzed by survey participants -, signally an understanding that addressing the (bio)ethical questions that emerge in the day-to-day lives of PHC/FHS will depend on the close articulation of the two poles – users and teams –, which is fully in agreement with the hypotheses of family care, and certainly with the theory/practice of Bioethics.

As the last comment for this section, was that participant failure to answer certain questions was considered relevant. In fact, more than 50.0% of the responses failed to answer questions regarding (1) addressing (bio)ethical issues and (2) the consequences of (bio)ethical problems. This despite a guarantee of confidentiality regarding the responses to survey questions. This may be the result of (i) limited (bio)ethical problems found by the professionals answering the survey in the work performed by PHC/FHS, which previous studies also found[16,37], or (ii) the discomfort that remembering (bio)ethical problems might induce when answering the questionnaire.

Final Considerations

Surveys to identify (bio)ethical problems in Primary Healthcare are, unfortunately, still infrequent in the literature. Thus, the present article attempts to contribute to explain some of the aspects of this field of study, and standards out for its novel approach – situations in family clinics that are unique in their organization and operation. In fact, the Rio model shows significant differences compared to conventional FHS.

Despite the peculiarities of FC, the results of this study are similar to those found in other similar studies in Brazil, as shown in this article. In effect, in this field of action - PHC/FHS

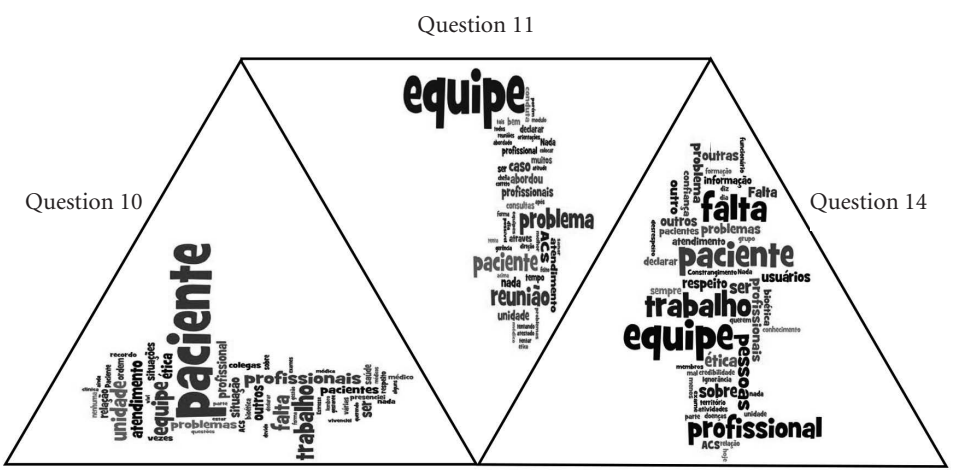

Figure 1. Frequency of word use by those answering the survey.

Source: survey data.

- demonstrate unique (bio)ethical questions (not immediately addressable with the ethical references used for problems described in hospital situations). These must be overcome by a collective construction involving all stakeholders - users, families, communities, teams and management. Ultimately this will depend on proposing new theoretical (bio)ethics tool, or at least a new way of using the tools available, and especially building powerful areas of permanent education and training, which will help problematize and train process players, minimizing the lack of knowledge and failure to question day-to-day (bio) ethical conflicts. These are the current challenges.

Collaborations

KBF Simas, AAZ Costa, AP Gomes and R Siqueira-Batista were involved in the concept, methodology and final draft of the article. PP Simões and CG Pereira were responsible for bibliographical research and helped write the final draft.

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where it reads:
Rodrigo Siqueira-Batista [1,2,4]

it should read:
Rodrigo Siqueira-Batista [2,3,4]