interface
comunicação, saúde, educação
https://www.interface.org.br
eISSN 1807-5762

Articles

From ethical confrontation to suffering: what did the Covid-19 pandemic teach us about the work process in oral health

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Del enfrentamiento ético al sufrimiento: lo que la pandemia de Covid-19 enseñó sobre el proceso de trabajo en la salud bucal (resumen: p. 17)

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This multicentric qualitative study aimed to understand how difficulties in the work process were perceived and felt by oral health workers (including dentists, technicians, and assistants) in ethical and mental health terms during the Covid-19 pandemic. A discursive textual analysis was conducted analyzing responses from 2560 workers to three open-ended questions in a websurvey from August to October 2020 in the Brazilian Southern region. The main difficulties in the work process included understanding the interruption of elective appointments and prioritizing emergencies, accessing services, and implementing biosafety protocols. These difficulties became the basis for several ethical problems, including uncertainties in case prioritization, increased risks, and heterogeneous professional conduct. The suffering of the workers was explicit, including anguish due to public demands, fear of the pandemic situation, work exhaustion, and managerial neglect.

Keywords: Oral health. Health services. Health professionals. Ethics. Covid-19.

Warmling CM, Finkler M, Palma LZ, Pires FS, Fornazari RCS, Silva-Junior MF, Baldani MH. From ethical confrontation to suffering: what did the Covid-19 pandemic teach us about the work process in oral health. Interface (Botucatu). 2024; 28: e240316 https://doi.org/10.1590/interface.240316

Introduction

Oral health care is one of the areas encompassed in the inventory of responsibilities of the Brazilian National Health System (SUS). In 2004, the National Oral Health Policy (PNSB) was instituted and recently enacted as an Ordinary Law, ensuring that the State has a duty to promote universal access to oral health services and respect for the principles of health ethics[1].

The health crisis caused by the Covid-19 pandemic has reduced dental care globally and increased costs as a result of the recommended requirements[2-5]. Inequalities in access to oral health care for vulnerable populations have increased in Brazil[6,7]. There has been a decrease in specialized dental consultations and an increase in emergency care in the SUS[8,9]. The spread of SARS-CoV-2 throughout the country was massive and severely impacted the population, revealing social injustices and reinforcing the assumption that efforts to promote equity must include the defense of oral health[10,11].

In August 2020, the World Health Organization (WHO) published global recommendations for the public and private sectors responsible for oral health actions. Preventive activities should continue to be a priority, but carried out through remote consultations or social networks, but non-urgent routine care such as examinations, cleanings and cosmetic treatments should be postponed until community transmission rates are reduced. On the other hand, urgent interventions to manage severe pain should be ensured[12].

The Brazilian Ministry of Health recommended guidelines for the operation of outpatient oral health services through Technical Note (TN) No. 04 of the National Health Surveillance Agency, published on March 31, 2020. The TN restricted dental care to emergencies, emphasized care with anamnesis, waiting room, Personal Protective Equipment (PPE) and generation of aerosols[13], and was updated eleven times by March 2023[14].

It should be noted that consensus on the definition of essential or urgent care has been difficult in dentistry[5]. The suspension and resumption of dental care were problematic decisions to be made by health system managers[7], also bearing in mind their responsibilities, especially as public service providers, in having to balance both individual needs and the epidemiological risk situation[15].

As the virus spread, the pandemic revealed historical negligence, both at national and international levels, including the devaluation of work and workers[16,17]. In this dramatic context, professional qualification has been strengthened as a key action for the continuity of health care. Despite dealing with obvious situations of devaluation, oral health workers were considered fundamental to maintaining people's well-being[18].

However, some of the challenges presented to dental practice in coping with the pandemic were later transformed into opportunities for reorganizing oral health care. Issues related to risks, screening, protocols, adaptability, tele-odontology, among others, became priority agendas as part of the actions to deal with the crisis, becoming possibilities for innovations or restructuring services[18]. In this sense, in a challenging scenario, it is necessary to take advantage of the lessons learned as a result

of the crisis to rethink care models, the scope of practice, what constitutes essential care, ethical issues involving dental practice and even defending the importance of the continued provision of oral health services[7,19].

With the aim of joining forces to respond to the problems posed by the spread of the pandemic, the Southern Region Collaborative Oral Health Research Network (RedeSBC Sul) was set up, with the participation of institutions from the three southern states: Public Universities State University of Ponta Grossa (UEPG), Federal University of Paraná (UFPR), Federal University of Rio Grande do Sul (UFRGS) and Federal University of Santa Catarina (UFSC), Regional Dental Councils (CRO), Oral Health Coordinators of the State Health Departments and the Brazilian Dental Association[20]. RedeSBC Sul carried out a wide-ranging multicenter research project with the overall aim of analyzing the biosafety measures used in dentistry to combat Covid-19 and evaluating the practices of workers in the production of oral health[21]. Understanding that qualitative approaches to the topic of oral health are necessary in the face of contemporary global complexities[22], particularly in this case, those imposed by the pandemic, this component of the research carried out by RedeSBC Sul was developed and will be presented in this article with the aim of understanding how difficulties in the work process were perceived and felt by workers, sometimes generating ethical and mental health problems - in order to reflect on innovations in the oral health work process that the pandemic has revealed to be necessary.

Methods

The qualitative data analyzed was produced through a websurvey, with a structured questionnaire of complementary closed and open questions.

A total of 2,560 oral health workers took part in the study: 1,941 dental surgeons (DS), 401 oral health assistants (OHA) and 218 oral health technicians (OHT), with active registration with the Dentists Regional Councils of the states of Rio Grande do Sul, Santa Catarina and Paraná and who were working at the time of the study in direct contact with patients, in both the public and private sectors.

Between August 10 and October 7, 2020, the online form hosted on the Google Forms® platform was made available to participants. The invitation with the link to participate in the study was sent three times to the e-mail addresses of the professionals registered with the Councils, 15 and 45 days apart from the first invitation. Information about the survey was also disseminated via social networks and conference calls.

Table 1 shows the characterization of the study participants, according to data from Block 1 of the online questionnaire. 44.5% had more than 10 years of training, 59% had a specialization degree (61% of them with an emphasis on clinical dentistry) and 69.9% reported having been absent from work during the pandemic.

Table 1 Sociodemographic and work characteristics of participants, August-October 2020.

Characteristics	n	%
Gender (n = 2558)		
Feminine	2,005	78.4
Masculine	553	21.6
Age (years) (n = 2560)		
18-24	134	5.2
25-39	1,231	48.1
40-59	1,105	43.2
≥60	90	3.5
Place of residence (n = 2560)		
Parana	1,127	44.0
Santa Catarina	790	30.9
Rio Grande do Sul	643	25.1
Occupation (n = 2560)		
Dentists	1,941	75.8
Oral health Technicians	401	15.7
Oral health Auxiliaries	218	8.5
Area of work (n = 2560)		
Public	1,350	52.7
Private	966	37.7
Other	244	9.5

Source: Data from research

The structured online questionnaire had a total of 50 questions organized into three blocks. Block 1: sociodemographic, educational, work and health profile. Block 2: surveillance and biosafety measures to control Covid-19 recommended by the Ministry of Health's Technical Note GVIMS/GGTES/ANVISA n. 04/2020[11]. Block 3: Professional practice, management, education and teamwork. Of the total number of questions, 47 were closed, three questions (numbers 29, 30 and 48) were open-ended, non-mandatory and the subject of analysis in this study (Frame 1).

Frame 1. Total number of participants who answered each question in relation to the total study population.

Open questions	Participants
Question 29. During the Covid-19 pandemic, what difficulty(ies) have you encountered working as an oral health professional?	2006 (78.45%)
Question 30. What ethical problem(s) or dilemma(s) have you faced as an oral health professional during the Covid-19 pandemic?	1742 (68.04%)
Question 48. Issues of emotional and mental suffering have been widely reported during the pandemic. For this reason, it is important for us to know how you feel and how your emotional condition affects your work. Please speak freely about this.	1932 (75.46%)

Source: Data from research

Discursive textual analysis was performed, aiming to move between content and discursive analysis[23-25] in order to understand the participants' answers to the open questions. The analytical processes were carried out as follows: (1) unitarization or separation into units of meaning: the NVivo® software was used to count the frequency of words present in the texts of the answers to the three questions; (2) the most frequent units were grouped around similar meanings, generating sets of categorical units; (3) returning to the software, we went back to the individual texts of each answer, looking for the participants' "speeches/answers" with references to the most frequent words; 4) the analysis of the speeches highlighted with references to categories generated analytical and interpretative texts. The whole process was produced in dialogue with the empirical and theoretical experience of the researchers.

The research project was cleared by the Research Ethics Committees (CEP) of the educational institutions involved: UEPG (CAAE: 31720920.5.1001.0105), UFPR, (CAAE: 31720920.5.3001.0102), UFSC (CAAE: 31720920.5.2001.0121) and UFRGS (CAAE: 31720920.5.2002.5530). Participants were given access to the Informed Consent Form (ICF) via the online form, with information on how long it would take to complete, and confidentiality and privacy of the information were ensured. Access to the questionnaire was only made available to professionals who agreed to the ICF and agreed to take part in the study.

Results

Frame 2 shows the frequency of the most significant words present in the texts of the answers to the three open questions, which were then grouped around similar meanings, generating three sets of initial categorical units, namely: Feelings, Work and Biosafety.

Frame 2. Frequency of words in the texts of the three open answers organized by categorical units of analysis

Feelings	**Frequency**
Fear/awareness/worry/apprehension	1.146
Anxiety/suffering/anxiety/panic	575
Emotional/mental/psychological	360
Family/children	264
Insecurity	218
Tranquility/calm	199
Tiredness/weariness/stress/depression/sadness	174
Tension/pressure/overload/demands	146
Sleep/insomnia	26
Work	**Frequency**
Patient/user/person/client	1685
Service/action	1398

Work	978
Care	343
Scheduling/access/demand/management	278
Elective	266
Procedures	259
Biosafety	**Frequency**
Covid 19/virus/coronavirus/pandemic	941
PPE/equipment	633
Contamination/transmission/spread/infection	799
Risk	402
Biosafety/hygiene/cleaning/sepsis/sterilization	331
Quarantine/isolation/distancing/spacing/suspension/removal	300
Mask	272
Aerosol	115
Apron/white coat/gloves/goggles	84
Face Shield	71

Source: Data from research

Frame 3 presents in a systematized fashion, the categories resulting from the interpretative analysis of the corpus of data, based on the difficulties experienced by the workers (subcategories identified with #1), the ethical problems faced (subcategories identified with #2), as well as the subjective repercussions in terms of feelings and mental health (subcategories identified with #3). Some of the most representative statements from each subcategory are also presented in order to illustrate the raw data, in which each participant is referred to by a different number. It is worth noting that although they are interrelated, the difficulties experienced may or may not generate ethical problems, and that these may or may not generate suffering. It was therefore decided to analyze the data while maintaining the possibility of understanding the results based on their origin in the questionnaire.

Frame 3. Categories, subcategories and example statements derived from the analysis of the participants' answers to the study's three open questions (about difficulties at work, ethical problems and mental health)

Categories	Subcategories*	Examples of answers
Access, suspension of elective care, and emergency prioritization	Understanding the suspension of elective care and prioritization of emergencies (1)	My difficulty is dealing with patients who don't understand what urgent and emergency cases are and want to carry out elective treatment anyway. And sometimes we're judged by them who think we don't want to provide care (R. 27).
	Distance between health units and people's homes (1)	The lack of understanding on the part of the population, which does not accept the discontinuation of elective care, the displacement of patients for care far from their reference units. The lack of physical structure and the lack of haste on the part of the service in adapting these structures to resume care (R. 2146).
	feeling of powerlessness (2)	The biggest dilemma is the feeling of putting out a fire, the desire to get back to treating all the individual's needs and not just that day's complaint. I feel that the pandemic has brought back a bit of that SUS of the INSS, which treats little, just "wipes ice" so that in a little while, when it returns to "normal", it can extract those teeth that are now not being treated (R. 182).
	Prioritization of cases and definition of urgency (2)	When at that moment it's not an emergency, but, from clinical experience, the urgency will become real in a few days. Should I put myself or other members of the team at risk? (R. 110).
	Misunderstanding and prejudice (2)	A dental appointment without a procedure, for many professionals and patients, means that we have done nothing. Unconcealed demands for fewer clinical procedures (R. 188)". "Discrimination from society for working; lack of awareness on the part of patients; unethical propaganda that we are vectors of Covid-19 (R. 59).
	Worsening conditions or complexity of treatment (2)	Not carrying out certain procedures so as not to expose myself or patients to risk and to deal with the possibility of worsening oral health problems, unrelated to the pandemic (R. 33).
	Conflict over whether or not to provide elective care (2)	Not seeing patients who don't qualify as urgent, according to the recommendations, and knowing that they may present an emergency until the end of the pandemic because I'm not treating the non-urgent case at the moment (R. 184).
	Public demands (3)	[...] the mental strain of hearing from some patients that the dentist doesn't want to work [...] (R. 80).
	Fear of the pandemic situation (3)	The uncertainty of information about Covid-19, together with the slowness of the dental service in times of pandemic, generates great anxiety. Especially about the future and when we will return to a possible "normal" or new normal... (R. 277).

Biosafety protocols and standards	Definition of biosafety protocols (1)	I believe that the greatest difficulty is the uncertainty of correctly conducting evidence-based care, due to the large amount of information (sometimes contradictory) and the unreliability of the sources (or the difficulty of finding the source and having sufficient knowledge to interpret whether the research or source is reliable) (R. 38).
	Implementation of biosafety protocols (1)	The biggest difficulty is that you try to impose safety protocols based on evidence, and colleagues and/or your boss don't care. This was the main reason I was off work for 42 days, but due to the financial situation, it was necessary to return to work and deal with these practices taking all due care at least in the individual sphere, since the collective is in chaos, which is to be expected as a reflection of the current political leadership in Brazil (R. 98).
	Careless professionals or not following regulations (2)	Some professionals making serious mistakes in relation to the protocols, some professionals on the team who don't take care of themselves or think this pandemic is a joke (R. 47).
	Increased risks (2)	Continuing to treat patients in the Covid-19 risk group (elderly people over 60) (R. 396).
	Heterogeneous conduct (2)	My main dilemma is that I have taken care of biosafety in every way and I hear that this is not necessary because other dentists are not doing it. I know of several colleagues who don't even use N95s, nor do they take time apart. They are working normally without any concern. I feel like reporting them... (R. 383).
	Exhaustion from work (3)	[...] the exhausting work of changing protective barriers, sanitizing and disinfecting the office between appointments; the discomfort in using the new PPE (the N95 mask has already ulcerated my nose) [....] (R. 80).
Contamination	Care of contaminated patients (1)	Seeing patients with respiratory symptoms, they don't stay at home, they come for care and the clinics force the CD to see them (R. 96).
	Time between treatments (1)	The waiting time for each patient to be seen. To avoid possible contamination (R. 07).
	Patients who lie (2)	Patients who omit having symptoms or contact with positive people, the asymptomatic and the lack of knowledge about the virus, where everything is still inconclusive (R. 701).
	Careless patients (2)	The lack of respect that the population has for us health professionals, often knowing that they are testing positive, they come to the clinic for a consultation in all sectors and then say that they are positive, so we are insecure (R. 333).
	Spread and cross-contamination (2)	Insecurity of being contaminated and passing it on (R. 524).
	Fear of contamination (3)	I feel afraid of contamination and I've already been away from work for 10 days due to anxiety symptoms (R. 753).
	Post-care behavior (3)	Fear of passing the disease on to my family, especially those in the risk group (R. 698).
	Apprehension about their own health (3)	Due to my risk condition, I became more anxious and worried, thinking about my family and my own health, and the concern to make the work environment the best it can be, so that patients and colleagues also have confidence in me, and that the Municipality can also count on my work in health (R. 250).

Work management	Human resources (1)	Adapting to the new routines: not being able to do the procedures that generate aerosol, doing them manually generates a lot more time, physical wear and tear and doesn't look as good; working without an ASB because she has been off work since the beginning of the pandemic because she belongs to the risk group (the manager hasn't replaced her with another professional); [. ...] not having any kind of guidance from the municipal management on how we should proceed (there is only one dentist colleague passing on the guidelines from the SES - Oral Health technical area) (R. 80).
	Maintaining quality of care (1)	Being able to provide good care without both parties being dissatisfied (R. 15).
	Physical structure (1)	Lack of physical structure in the dental office (very cramped and poorly ventilated, makeshift furniture, compressor that doesn't work properly and no vacuum pump), inadequate cleaning and garbage collection in the office (some days the cleaning lady doesn't clean the floor and doesn't collect the garbage), difficulty in getting more high- and low-rotation pens in adequate quantities to be able to treat all patients with sterilized pens, difficulty in getting enough isolation materials for all treatments, technical difficulty on the part of the assistant in how to treat safely without contaminating everything around during treatment and in dressing/dressing (R. 75).
	Collaboration and teamwork (1)	Dealing with multi-professionalism (R. 27).
	Availability of material and structure for biosafety (1)	Lack of absolute isolation material, having to reuse PPE (lab coats), providing elective and emergency care, the lack of PPE is one of the main difficulties I've encountered, as well as a poorly ventilated and small care room, making the disinfection process difficult. There is also a lack of training for general service professionals in cleaning the room between urgent and emergency care. Lack of PPE for urgent and emergency care (R. 61).
	Cost, lack or inadequate use of PPE (2)	Having to provide care with the same PPE because the suppliers don't produce or deliver it, thus having to reuse some PPE for a longer period of time, which creates a feeling of insecurity (R. 415).
	Negligence or inadequate action by management towards workers (2)	Disregard for the oral health professional, who is often ignored as a health professional (R. 139).
	Conduct of the national government (2)	Disagreement with the guidelines provided by governments, especially the Federal Government, which are often at odds with scientific evidence (R. 724).
	Colleagues' neglect of patients (2)	The laziness of some professionals who treat patients with disregard (R. 345).
	Workers not informing on contaminated patients (2)	The nursing team doesn't inform us of the names of users infected with Covid-19, so we often end up seeing or having contact with people who should be isolated and aren't (R. 407).
	Misunderstandings or disagreements within the team (2)	Pressure from other employees, from other categories not understanding the dental service and comparing it to medical consultations (R. 237).
	Sufferings associated with the organization of work and the context of the pandemic (3)	Anxiety, insomnia, frequent panic attacks, bouts of crying, not wanting to get out of bed to work (R.,178)." "It's more accurate to say that my work affects my emotional condition, because not being able to continue with the appointments has left me fragile. When I'm able to take care of a patient in a resolutive way, I'm fine. The fact that there is no vaccine or medicine for Covid-19 has made us very afraid to see patients at the unit. Professionals wear PPE and, in theory, know how to protect themselves, but the patients who come to us may not have the necessary information or understand it (R. 300).

Source: Data from research

Discussion

The main results of the study show that, for the participating workers, providing oral health care during the pandemic involved decisions that brought together conflicting social interests, moral values, public health and economic issues, as McGough and Simon[7] also found. An analysis of the discourses produced in the open-ended responses of workers in both public and private services, when referring to the issues of reorganizing access to oral health services, suspending elective procedures and decisions on essential or emergency care, showed how the difficulties of understanding the suspension of care generated stressful clashes.

The quantitative component of this same survey reaffirmed the difficulties described in the open questions and analyzed here, regarding the exclusivity of essential care, since only 37.5% of the participating workers said they had suspended elective care, as well as the characterization of this care, since only a little more than half of the workers (56.8%) said that urgent care was based on pre-established clinical protocols[21].

Concurring with the data from the quantitative analysis carried out in the same study[21], the qualitative analysis showed that, even after the official suspension, the population continued to seek elective care, not understanding or underestimating the risks they were running and to which they would expose workers. This behavior of maintaining an apparent normality was also observed by Szwarcwald et al.[26] in the survey that investigated behaviors and changes in the lifestyles and health conditions of Brazilians during the pandemic. In the United Kingdom, clinical, legal and economic issues were raised regarding the refusal of necessary but non-urgent clinical care, highlighting the expected worsening of oral diseases and the substantial financial repercussions for dental practices[2], as indicated by the participants in this study.

Not all oral health procedures are essential, and not all essential procedures are urgent as well[5,7]. This equation, which was already difficult in the context prior to the pandemic, was even more difficult to manage during the pandemic, not least because what is not urgent at a given moment may soon become so. The way in which oral health services were reorganized to deal with the pandemic led to the need to rethink the very concept of what is essential in care and the models of care[5,7]. At the time, postponing treatment was seen as an ethical necessity for the greater good of society, both to control the spread of Covid-19 and to avoid wasting scarce PPE. However, with a pandemic outcome looming and the damage resulting from indefinite postponement, the problems arising from suspending elective care have increased[27].

It is important to highlight how the study understands and uses what it calls ethical problems. It is not necessarily referring to studies in the field of deontological ethics - which evaluates and rules on professional attitudes and actions using pre-established parameters. What is wanted is a problematization of the ethics of power, as something that forms and constitutes the subject himself in his condition and trajectory. "The context is not external to the problem: it conditions the form that the problem will take"[28] (p. 16). In this sense, the subject's ethical deliberation would be related to a critical operation that seeks to understand existence itself[28]. This was the meaning of the study, considering that the constitution of ethical

problems in oral health care is naturalized in the common, everyday relationships and circumstances of health care.

The results showed that the atypical situation of the pandemic accentuated previously existing ethical problems, as well as introduced new ones. Among them are those related to making decisions about providing care or ensuring one's own safety, or balancing the professional commitment to provide the necessary professional care with the responsibility for the livelihood and health of one's family. When considering not providing care, thinking about the consequences for patients and colleagues was also an ethical issue that generated conflict, among others. As a health professional, there is a social expectation to maintain urgent health care, even in the face of a greater than usual risk to your own safety, health or life[3].

The institutional apparatus and structure of health services do not provide support for workers in situations of ethical problems, neither in the legal nor institutional spheres, nor in the construction of spaces aimed at their perception, analysis and solution, in such a way that they end up causing subjective precariousness for the worker, as also observed in the results of the study by Gomes and Finkler[29]. Thus, the ethical problems triggered in the context in question increased the workers' sense of powerlessness, characterizing moral distress.

The answers dealt intensely with the subjective context, with the question of the limits experienced in the process of implementing protocols and conduct appropriate to the health realities demanded by the pandemic. There were alternating difficulties in defining work processes and heterogeneous professional decisions, since all decision-making is based not only on facts, but also on the moral judgments we make and our individual and collective duties. All this sharpened the picture of the serious crisis that was emerging, the exhaustion and suffering.

Workers were also challenged to face the epidemic of disinformation - the infodemic. This scenario of unpredictability generated by the pandemic has produced worries and insecurity, which in several cases, in addition to affecting well-being, has damaged health, as evidenced by reports of seeking mental health care. The pandemic has made the importance of popularizing recommendations to control and protect workers' health more visible[16], a fact that has been amplified in daily life during and after the pandemic.

Fear emerged forcefully in the speeches (1,146 quotes - Frame 2) and in different contexts. It was related to the possibility of contamination and uncertainties about living and working in the period before the vaccines arrived, and apprehension about changes at work. Oral health teams, due to the nature of their practice with aerosols and constant contact with saliva, were immediately considered to be a professional category at high risk of contamination by SARS-CoV-2. Later, when comparing data on confirmed cases among dental professionals with population rates in the country, a different reality was found, with a cumulative incidence not so high, around 5% higher among these workers[30].

Although many of the challenges faced could have been minimized with improving the effective ways of controlling infections, collaborative work, the availability of PPE and the use of tele-odontology[31], the results showed that there was suffering due to the fact that they were active workers during the initial

pandemic period. Service management contexts emerged in which political and economic aspects were not favorable and affected the coordination of services, producing inconsistencies in the information available. Decisions had to be made even in situations of uncertainty, which required the analysis of possible courses of action with an important ethical component. Caram et al.[32] corroborate these results, stating that working on the front line was seen by health workers as an experience of moral distress, which occurs when workers perceive problems in their work but are unable to act according to their conscience.

Final considerations

The main hurdles included understanding the suspension of elective care and the prioritization of emergencies; access to services; the definition, implementation and guidance on biosafety protocols; the care of potentially contaminated patients; the interval in care; the availability of workers; supplies and infrastructure; as well as collaboration in teamwork.

Each of these hurdles was the basis on which some ethical problems were reported: feeling powerless; uncertainty in prioritizing cases; experiencing misunderstanding and prejudice; worsening illnesses or the complexity of treatments; conflicts over whether or not to carry out elective care; dealing with increased risks; with heterogeneous professional conduct; with colleagues who didn't follow the rules or take the necessary precautions; who didn't inform people who were infected; or who acted with disregard for users; dealing with patients who lied or omitted facts and with patients who didn't take care of themselves; the risk of the spread and cross-contamination of the disease; and the disregard of local and federal management.

Likewise, each of the difficulties reported was correlated with issues that affected the well-being or even the mental health of the workers, with many explicit mentions of falling ill as a result of being a health professional during the pandemic. There was anguish derived from the population's demands for care; exhaustion at work; fear of the general situation of the pandemic, contamination during care, illness and contamination of family members; as well as suffering associated with the necessary reorganization of work.

Despite the losses and damage caused by the pandemic, it was possible to realize the opportunities to learn from it. Particularly in relation to the scope of this study, it is an ethical imperative that oral health itself recognizes the difficulties experienced, objectively and subjectively, in the work process during the pandemic period and, based on them, re-establishes routines and protocols, especially those related to access to services, prioritization of care and biosafety regulations, thinking about the care that is due not only to patients, but also to health workers.

It is worth pointing out limitations related both to the sample of participants defined by convenience and the limitation to the southern region, but especially the choice to analyze the data independently of characterizations, such as public or private services, or technical or higher-level workers. We opted for a global analysis of the three open-ended questions because it allowed us to delve deeper into the

quantitative component already published. Another point that strengthens the study is the high response rates to the open questions, even though they were not compulsory, which shows that the participants felt encouraged to talk about the topics covered.

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Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

Conflict of interest

The authors have no conflict of interest to declare.

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Associated editor
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Félix Héctor Rigoli Caceres

Submitted on
04/03/24
Approved on
06/20/24

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Este estudo qualitativo multicêntrico objetivou compreender como as dificuldades no processo de trabalho foram percebidas e sentidas por trabalhadores de saúde bucal (cirurgiões-dentistas, técnicos e auxiliares) em termos éticos e de saúde mental no enfrentamento da pandemia de Covid-19. Realizou-se a análise textual discursiva das respostas de 2560 trabalhadores a três questões abertas de um *websurvey,* entre agosto e outubro de 2020, na região sul do Brasil. As principais dificuldades do processo de trabalho foram: compreensão sobre suspensão dos atendimentos eletivos e priorização de urgências; acesso aos serviços; e implementação de protocolos de biossegurança. As dificuldades tornaram-se base para alguns problemas éticos: incertezas na priorização de casos, riscos aumentados e condutas profissionais heterogêneas. O sofrimento dos trabalhadores foi explícito: angústia por cobranças da população, medo pela situação da pandemia, situação de exaustão no trabalho e descaso da gestão.

Palavras-chave: Saúde bucal. Serviços de saúde. Profissionais da saúde. Ética. Covid-19.

El objetivo de este estudio cualitativo multicéntrico fue comprender cómo las dificultades en el proceso de trabajo fueron percibidas y sentidas por trabajadores de salud bucal (cirujanos-dentistas, técnicos y auxiliares) en términos éticos y de salud mental en el enfrentamiento de la pandemia de Covid-19. Se realizó el análisis textual discursivo de las respuestas de 2560 trabajadores a tres preguntas abiertas de un *websurvey*, entre agosto-octubre de 2020, en la región Sur de Brasil. Las principales dificultades del proceso de trabajo fueron: comprensión sobre la suspensión de las atenciones efectivas y priorización de urgencias, acceso a los servicios e implementación de protocolos de bioseguridad. Las dificultades pasaron a ser la base para algunos problemas éticos: incertidumbres en la priorización de casos, riesgos aumentados y conductas profesionales heterogéneas. El sufrimiento de los trabajadores fue explícito: angustia por exigencias de la población, miedo por la situación de la pandemia, situación de agotamiento en el trabajo y falta de atención de la gestión.

Palabras clave: Salud bucal. Servicios de salud. Profesionales de la salud. Ética. Covid-19.