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Original Article

Moral sensitivity in the practice of Family Health Strategy professionals*

Sensibilidade moral na prática de profissionais da Estratégia Saúde da Família

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ABSTRACT

Objective: to understand the development of moral sensitivity in the practice of Family Health Strategy professionals. **Methods**: a unique case study, of qualitative approach, conducted with thirty-five professionals from the family health teams. Data collection occurred through interviews guided by semi-structured script and observation. The data was analyzed through Thematic Content Analysis. **Results:** the analysis revealed that factors related to work organization, interpersonal relationships and personal values influence the development of the moral sensitivity of professionals in family health teams. **Conclusion:** the development of the moral sensitivity of Family Health Strategy professionals is influenced by enabling and hindering factors that present themselves in daily work.

Descriptors: Ethics; Morale; Professional Practice; Family Health Strategy; Patient Care Team.

RESUMO

Objetivo: compreender o desenvolvimento da sensibilidade moral na prática de profissionais da Estratégia Saúde da Família. **Métodos**: estudo de caso único, de abordagem qualitativa, realizado com trinta e cinco profissionais das equipes de saúde da família. A coleta de dados ocorreu por meio de entrevistas guiadas por roteiro semiestruturado e observação. Os dados foram analisados por meio de Análise de Conteúdo Temática. **Resultados:** a análise revelou que os fatores relacionados à organização do trabalho, às relações interpessoais e aos valores pessoais influenciam o desenvolvimento da sensibilidade moral de profissionais das equipes de saúde da família. **Conclusão:** o desenvolvimento da sensibilidade moral de profissionais da Estratégia Saúde da Família é influenciado por fatores potencializadores e dificultadores que se apresentam no cotidiano de trabalho.

Descritores: Ética; Moral; Prática Profissional; Estratégia Saúde da Família; Equipe de Assistência ao Paciente.

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Introduction

The health practice is considered a moral action and its goal is to ensure the welfare of people who need assistance[1]. The health practice is considered a moral action and its goal is to ensure the welfare of people who need assistance[2]. Internal assets give meaning to the practice, benefiting all those involved with credibility and social legitimacy.

In the field of health, it is understood that the internal good of the practice is related to the good of the patient[3]. In this sense, the practice goes beyond the dimension of technical-operational analysis and derives from the direct application of biotechnological knowledge by involving moral aspects. Therefore, in order to respond to the social purpose of the practice and interconnect its technical and ethical elements, it is necessary that the professionals combine the technical competence, in the daily work, the principles and moral-ethical values, in an interface of co-responsibility and welcoming[4]. This reality demands from health professionals the development of moral sensitivity, an attribute capable of enabling them to recognize moral issues when they arise in practice[5], and allow the search for matching solutions.

Perceived as a prerequisite for ethical performance, moral sensitivity is defined as a complex phenomenon and considered as a personal attribute within interpersonal relationships, which encompasses the entire context related to the conflict and the particularities of the subjects. Therefore, moral sensitivity is the primary condition for the recognition, interpretation and management of ethical demands that arise in practice[6], offering subsidies for moral deliberation, understood as the consideration to solve the ethical problem identified, seeking courses of action that are prudent, responsible and possible in view of the context in which the problem presents itself[7].

Moral sensitivity has a multifactorial influence and is directly related to relational orientation, the professional dimension and ethical education[6,8]. Understanding these factors in health practice is essential for establishing ethical behaviors and developing moral sensitivity in health contexts[6]. International and national literature has sought to describe moral sensitivity in the context of ethical problems mainly with a quantitative and objective approach, through the Moral Sensitivity Questionnaire, especially of nurses[6,8] in the hospital environment[8]. However, there is still little research on how it operates in daily practice. This reality points out gaps in knowledge, especially in spaces beyond the hospital, especially those related to the Family Health Strategy, which is today considered the preferred access door for users of public health services, where there are no studies pertinent to the moral sensitivity of the family health team.

In this approach, in this investigation, we looked at the moral sensibility in the practice of professionals who make up the multi-professional team of the Family Health Strategy. The choice is linked to the understanding that ethical problems, in this assistance locus, manifest themselves in a more subtle way, as common situations of everyday life, potentiating its complexity[6] and demanding, from the multi-professional health team, moral sensitivity for its recognition and deliberation. Faced with this, one wonders: How does moral sensitivity develop in the practice of Family Health Strategy professionals?

They become essential, considering that professional practice is ethically dependent and that the development of moral sensitivity is a significant requirement for ethical actions in daily life, investigations that deepen the subject, favoring the care of excellence.

Through the above, it aimed to understand the development of moral sensitivity in the practice of Family Health Strategy professionals.

Methods

This is a unique case study, with qualitative approach, carried out in family health units of a medium-sized city located 76 km from Belo Horizonte, Minas Gerais, Brazil.

The methodological choice for the integrated single case study refers to the search for the understanding of moral sensibility in the practice of Family Health Strategy professionals, considered as a complex, contemporary and social phenomenon in a real context where the researcher has very little control over events[9]. The research was developed in family health units, allowing all to be analyzed in their singularities and together. The case of this study is the practice of professionals of the family health teams.

Participants in the research were Doctors, Nurses, Nursing Technicians and Community Health Agents who make up the minimum team of the Family Health Strategy. At the time of data collection, the municipality that constituted the scenario of the study had 43 family health teams registered in the Basic Care information system and distributed among the five municipal administrative regions. As a criterion for the inclusion of the teams in the study, it was adopted the condition of being with the complete professional staff. Thus, of the 43 teams registered, 32 counted with all the professionals of the minimum team.

Also, the research included professionals with at least six months of work in the team, since the development of moral sensitivity occurs through the experiences of the professional in the work environment in order to know the dynamics of organization, the operation of the service and the establishment of greater proximity to the community. Professionals on vacation or on medical leave during data collection were excluded from the sample. When considering these eligibility criteria, 19 family health teams met the requirements for data collection. From then on, a random selection by administrative region was made to select the order of participation of the teams.

In line with the qualitative research, the number of participants was not indicated a priori and data collection was finalized when data saturation occurred for each professional category. It means that the information started to be recurrent, always valuing the significant contents for the study[10]. Thus, the interviews were conducted in ten family health units, with nine nurses, nine nursing technicians, seven doctors and ten Community Health Agents, making up 35 professionals.

The data collection took place between January and July 2019 through interviews recorded and guided by a semi-structured script prepared by the study coordinator. The semi-structured script consisted of questions that sought to characterize the participants in relation to gender, age, time of training, time of performance in the Family Health Strategy and specialization in the area and elucidate the ethical aspects involved in the practice of Family Health Strategy professionals. The interviews were previously scheduled and carried out individually, in a reserved environment, in the health units where the professionals were crowded, with an average duration of 28 minutes. Professionals were offered the opportunity to hear and validate the interviews after they were finalized.

In accordance with the triangulation of data, which gives the accuracy of the case study method and robustness in the description of findings[10], Non-participating observations, which took place before and after the previously scheduled interviews, were also carried out by the researchers in places such as: reception; Nursing and Medicine consultation room; basic care room and home visits, recording them in a field journal. The observations were consented by the professionals and allowed the researchers to identify converging lines of investigation.

The data was manually transcribed in full and subsequently submitted to Content Analysis, which consists of a set of techniques that allow the researcher to relate and check meanings between the linguistic and psychological or sociological structures[11]. The qualitative data analysis software atlas.ti 8 was used as a technological support for the analysis of the interviews, favoring the process of data organization, which allowed the researchers an overview of the findings during the analytical process[12].

From the data analysis, two analytical categories emerged that signaled the development of moral sensitivity in the practice of Family Health Strategy

professionals: Moral sensitivity in the practice of Family Health Strategy professionals: difficult factors and moral sensitivity in the practice of Family Health Strategy professionals: enabling factors. For a better understanding of the findings, the categories cited were joined in a single more comprehensive: Factors involved in developing moral sensitivity in the practice of Family Health Strategy professionals.

The research was approved by the due instances of the municipality through the Letter of Institutional Consent and the Committee of Ethics in Research of the Federal University of Minas Gerais (Opinion No. 2,285,857/2017). In accordance with Resolution No. 466/2012 of the National Health Council, the participants signed the Term of Free and Informed Consent, expressing their agreement to participate in the research, as well as their science in the face of possible risks, benefits or inconveniences. To ensure anonymity, it was chosen to identify the statements with the initial categories: (N) Nurse; (NT) Nursing Technician; (D) Doctor and (CHA) Community Health Agent, followed by the numbers established for each interview. For the presentation of the observation notes, the initials ON were used.

Results

Among the participants, 34 (97.1%) were female. The age ranged from 22 to 59 years, and the average was 34.4 years. The average time of training varied between seven years and seven months for nurses, 14 years and seven months for nursing technicians and five years and three months for doctors. The professional performance in the current Family Health Strategy had an average time of seven years and five months for Community Health Agents, three years and one month for nurses, three years and six months for Nursing technicians and two years and two months for doctors. Of the nurses and doctors, 12 (75.0%) had a specialization in Family Health. From the data analysis, the analytical category presented emerged.

Factors involved in the development of moral sensitivity in the practice of Family Health Strategy professionals

The participants revealed low regard for ethical issues in daily practice. It is important to highlight the need of one of the participants - N7 to rescue conceptual aspects of ethics to establish associations with their practice: *An ethical question is very difficult to answer because it has a lot of things. I need first to understand what it is, not that I don't know, but I need to remember and understand what ethics is all about, and then I start to identify where it's not happening. Now, at this moment of your question, I am not managing to relate the concept with the practice of what has been happening* (N7).

The difficulty in identifying an issue as being of an ethical nature was also mentioned by the Community Health Agent 10, revealing that the professionals experience, in their practice, various ethical problems, although they are not recognized as such: *Ethics, I would say* [time to think]*! I don't know if it covers ethics. It would be even this disrespect to the patient, wouldn't it? Difficulty to talk* (CHA 10).

The results show that moral sensitivity is an individual attribute, which is why the same ethical issue can be perceived and felt differently by team members, culminating in different deliberations regarding the ethical problem. A situation recorded in the field diary converges with the reports of the participants: *Male patient, 45 years old, goes to the reception carrying medical referral that said: heavy drinker patient seeks me wishing hospitalization to abandon the addiction. I go to Social Services. The receptionist reads the referral and guides the patient to the Social Assistance Reference Center. However, the nurse notices the movement and invites the patient to go to her office, where she heard her story and immediately got in touch by phone with the mental health sector of the city, promptly scheduling an appointment with the psychologist and the social worker to give therapeutic follow-up* (ON).

The testimonies signal that the practice is directly related to the care of the patient and, from this point of view, can be negatively influenced by the excess of administrative activities that distance the professional from direct assistance, associated with the

absence of support personnel and the scarcity of institutional and financial resources: *...Overload of administrative services, we could have an assistant in the team to help. There is also the situation that the city halls are going through, financial. I understand that we, nurses, have this training for management, but we need an assistant because the clerk also wants to do his job and the agents have to go to the street to meet, register and report all the families they have. So, as much as we delegate, I still need to do most of them and I end up not doing the assistance* (N7).

Moral sensitivity is harmed since the limitation of the time dedicated to the patient, enhancing the bond and considered necessary by the professional, imposes situations that do not match the desired ethical practice: *Sometimes, we break the protocol in some badly done service because of the time. Because there is a lot of bureaucracy for the Unified Health System, so, all this makes us not have much time to identify the needs and dedicate to the patient* (D3).

Other factors were also identified as hindering the development of moral sensitivity by the team members, especially those that promote non-conformity to the guiding principles of primary care, highlighting the excessive spontaneous demand and the predominance of actions of a curative nature. These issues are allied to the deficient structural conditions in the units that, in association, impact on the desired practice and that actually executed: *The demand is very big, the physical structure of the unit very bad. And it still has a vision of the hospital centric population. On the issue of prevention, the population still has great difficulty in understanding. The population still wants a lot of medication, and a lot of medicine* (N6). *Here, it is a little different, we do not do Family Health Strategy. The population is very big, we can't do prevention, we attend more spontaneous demand than scheduled, we don't do anything of prevention, nothing of Family Health Strategy, only curativist* (D1).

Although the testimonies emphasize the barriers to the development of moral sensitivity in the practice of the family health team, it was possible to identify the factors that enhance their development.

For participants N1, N9 and D5, the ethical problems present in practice require the development of values and principles, such as empathy, humility, trust, respect and dialogue, for their perception and attempt to resolve: *To deal with problems, I always put myself in the patient's place, I try to be humble because sometimes the patient may think that the nurse is the owner of knowledge. And I am not! There are many things that the patient helps me, teaches me. I learn from him* (N1). *For me, it is much more important to have a healthy relationship with my patient, especially in primary care, because this is the main starting point for us to implement our planning and health actions in his life and get confidence! This link needs to exist and the basis of this is my value, the respect. For me to achieve this, the main attitude I have to have is to talk to the patient, to be true to him, not to deceive, not to roll up the patient or the team* (N9). *I always hope that the patient will be at ease with me, that he won't feel ashamed to be in front of a doctor. I treat the patient with the greatest possible humility, with affection, respect and medical ethics so that he treats me well too. Thus, I believe that our relationship will be able to help you solve your problems* (D5).

The feelings of belonging built in practice and the mobilization of emotions when dealing with users strengthen bonds, allowing the professional to become aware of the needs of the team and the population assisted: *Here, I learned that we live more with the patients, in their house, a very deep coexistence. Sometimes we feel together the pain of the patient, their daily need. So, here, I have cried, I have laughed, I have suffered a lot with the patients' stories* (N2).

The participants emphasized the importance of interpersonal relationships, whether among the professionals of the team itself or other teams that make up the network of care or even between professionals and users. The relationship allows each member of the team or the user himself to expose his point of view on a given situation, fostering new perceptions that mobilize sensitivity and moral deliberation: *In my personal practice, I consider a lot of respect to people, their opinions and wishes. Through respect, absolutely all dimensions of the human being are contemplated. I can, with mutual respect, treat the patient, the patient can relate to me, and this relationship is very important for the planning of care, rehabilitation of the patient, treatment, in short, for an adequate assistance* (N7). *The importance of interpersonal relationship was observed during a matriculation meeting, in which health agents, nurses and physicians discussed specific cases of patients, paying attention to their singularities and, through collective listening, tracing strategies of problem solving* (ON).

Discussion

It was considered, as a limitation of the study, the accomplishment in a single municipality, whose organizational form of Primary Health Care is specific. Therefore, the results cannot be generalized. Thus, it is suggested that new research be developed in order to broaden the understanding about the development of moral sensitivity in the practice of Family Health Strategy professionals. However, the knowledge acquired with this unprecedented research generates contributions for professionals and for the management of Primary Health Care services by instigating the search for the construction of work environments that value the practice of the family health team, thus contributing to the awareness of the ethical content that permeates the daily routine of health, enabling the development of its moral sensitivity.

Family health team professionals routinely experience ethical problems in their practice[13-14]. Such problems are important challenges in professional daily life, as they are sources of conflicts of values and duties, allowing different courses of action for their solution. In order to face these situations, professionals need, initially, to recognize them as problematic, interpret them and seek, through ethical reasoning, the best course of action. Thus, moral sensitivity is the first and fundamental step for ethical professional practice[1].

The findings of this study pointed out potential and difficult factors for the development of moral sensitivity of professionals in the family health teams. The understanding of these factors is important to optimize the stimulus to the development of moral sensitivity and to the elaboration of strategies that minimize the occurrence of situations that negatively influence their development[15-16].

The results of this research corroborate the literature by revealing that barriers affect the moral sensitivity of professionals[15]. It is understood that the problems that occur most frequently in the daily life of family health teams are subtle, pragmatic, non-dramatic and focus on the subjective production of care[6]. Thus, with low moral sensitivity, professionals may not be able to attribute relevance to the ethical problems of their practice and may not act adequately according to the needs of individuals, families and communities, object of action of this health care point[1,6].

However, it is worth pointing out that moral sensitivity can be developed by the subject both through his or her experiences of socialization, which mobilize ethical conceptions, and through the systematic study of ethics, which can explain the difference in the perception of ethical problems and deliberations by each professional. Still in this respect, ethical education is considered to be a determinant for the development of the moral sensibility of professionals[6]. Professionals who receive training in ethics, both theoretical and practical, develop greater moral sensitivity.

It is important to reflect that the factors pointed out by this study, as obstacles to the development of moral sensitivity, encourage the execution of mechanistic and impersonal actions, configuring a work environment marked by divergences of values, uncertainties in the recognition of ethical issues and decision making that are not sustained in the deliberative process. The findings of this research are corroborated by research that sought to understand the practice of nurses of the Family Health Strategy of *Quilombola* communities, showing that the aforementioned factors weakened the effectiveness of professional practice, distancing the nurses from integral care and centered on the individual/family[16].

However, the practice of the family health team has as its object the human health, the good of the patient. Therefore, the development of the capacity to be morally sensitive is a premise for the identification of ethical and moral issues that involve the care process and preserve the rights and interests of patients[17]. Based on this line of reasoning, the findings of this study revealed that, regardless of the factors that hinder the development of moral sensitivity of Family Health Strategy professionals, they use virtues to deliberate,

in an ethical manner, in favor of patients.

In this way, the objective of improving the health and well-being of patients, with a person-centered approach, is shared by the professionals of the family health teams, configuring the professional action[3] and overcoming ethical problems in an attempt to prevent them from becoming obstacles to health care and stimulating the professional to develop as a moral agent.

The results revealed that virtuous values, principles and behaviors are able to enhance the development of moral sensitivity. It is understood that these factors are related to the way professionals deal with the work routine and the desire to do what is best for the user, which enables the professional's sense of belonging and the establishment of a bond between the parties involved[17]. In this sense, values are assumed as a central point for moral development, perceived as the process of valuing acts, behaviors and characteristics of each professional, such as the ability to identify and reflect on moral aspects and deliberate on them[18].

The practice of the family health team is developed under the prism of the assistance model that foresees integral responsibility for the attention to the health needs of the entire population. Such model presupposes assistance focused on the individual, in his/her entirety, considering him/her as part of collectives and in their family and socio-cultural relations[19]. Thus, values such as empathy, dialogue and respect guide the provision of health care and shape practices, enabling the prevention of possible ethical conflicts through effective communication between users and the team[8].

With regard to personal attitudes that have a positive impact on the professional's action, it is suggested that satisfaction and self-confidence in relation to work have favorable impacts for the development of moral sensitivity. Having an optimistic vision about their skills and competencies at work raises the level of moral sensibility[20].

It was also identified in this study that interpersonal relationships are associated with the development of moral sensitivity, which corroborates the research that characterized the profile and described the moral sensitivity of Primary Health Care nurses, showing that the dimension of greatest influence on moral sensitivity was that of interpersonal orientation. This reality signaled that the participants developed their practice focused on building a relationship of trust and patient-centered, seeking to find ways to meet their individual needs[6].

In this sense, the importance of interpersonal relationships and mutual respect is emphasized for the formation and the continuity of moral sensitivity[20]. A reciprocal understanding between professionals and users will ensure that the decisions and actions of the team are valued by the user, family and society, enabling an assistance based on moral deliberations[7], shared among those involved, who seek prudent and responsible solutions to the ethical problems identified in practice.

Conclusion

The results of this study revealed that the development of the moral sensitivity of professionals in family health teams suffers interference from enabling and hindering factors that present themselves in daily work and those experiences can be established at the interface of interpersonal relationships, personal values and work organization.

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Collaborations

Ferraz CMLC and Brito MJM contributed with the conception and design, the analysis and interpretation of the data, the writing of the article, the relevant critical review of the intellectual content and the approval of the final version to be published. Vilela GS and Moreira DA contributed with the analysis and interpretation of the data, the writing of the article and the relevant critical review of the intellectual content and the approval of the final version to be published.

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