(Bio)ethics and primary health care: Dental surgeons' perspectives

(Bio)ética e atenção primária à saúde: Perspectivas dos cirurgiões dentistas

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ABSTRACT
Objective: The aim of this study was to describe (1) the main (bio)ethical problems identified by dentists working in Primary Health Care (PHC) of the Viçosa-MG Health Microregion, (2) the conduct adopted by them in front of these questions and (3) the knowledge of these professionals about ethics and bioethics. Methods: This is a quantitative-qualitative study with questionnaire application to 48 dentists. A descriptive analysis of quantitative data and content analysis of Lawrence Bardin was performed. Results: Thirty-eight participants identified (bio)ethical problems, which were categorized into related problems: to PHC team members; management; to the team and users; and the breach of confidentiality. Of the total, 46% of the participants said that there was a solution to these questions and 79% answered that they did not know any concept of ethics and bioethics. Conclusion: The results of this study corroborate the need for permanent education directed to professionals, so that they recognize and deliberate on (bio)ethical problems.

Keywords: Bioethics, Odontologists, Primary Health Care.

RESUMO
Objetivo: O objetivo do presente estudo foi a descrição (1) dos principais problemas (bio)éticos identificados pelos cirurgiões-dentistas que atuam na Atenção Primária à Saúde (PHC) da Microrregião de Saúde de Viçosa-MG, (2) da conduta adotada por estes frente às referidas questões e (3) do conhecimento destes profissionais sobre ética e bioética. Métodos: Trata-se de um estudo quanti-qualitativo com aplicação de questionário a 48 odontólogos. Realizou-se análise descritiva dos dados quantitativos e análise de conteúdo de Lawrence Bardin. Resultados: Trinta e oito participantes identificaram problemas (bio)éticos, os quais foram categorizados em questões relacionadas aos membros da equipe da PHC; à gestão; à equipe e aos usuários; e à quebra de sigilo. Do total, 46% dos participantes disseram ter havido solução para tais questões e 79% responderam não conhecer nenhum conceito de ética e de bioética. Conclusão: Os resultados deste estudo corroboram para a necessidade da educação permanente dirigida aos profissionais, para que estes reconheçam e deliberarem sobre os problemas (bio)éticos.

Keywords: Bioethics, Odontologists, Primary Health Care.

1 INTRODUCTION

From the promulgation of the Federal Constitution of 1988, the Unified Health System (SUS) was established in Brazil – which has as its principles universality, equity and integrality – producing a reorganization of the dynamics of health care[1], with a firmly articulated character to the references of distributive justice, by assuming health as the right of all and duty of the State[2]. In this context, Primary Health Care (PHC) was configured as the user's preferred gateway to the SUS, with individual and collective actions aimed at health promotion, disease prevention, treatment and rehabilitation[3]. For the realization of this new practice, it is necessary to transform the actors involved[4], and

in this context, higher education institutions must commit themselves to the ethical-professional training of students and the bioethical dimension of health care[5].

The teaching of ethics in undergraduate health courses has been based mainly on the deontological perspective, often directed to the mere transmission of established rules, such as rights and duties, present in the code of professional ethics, disregarding the subjectivities and complexity of the process of building bonds necessary for health care[6]. In fact, one of the issues that emerge from the professional training process is the lack of preparation for the approach of ethical issues in the daily work in PHC[4]. Thus, it is essential that, during professional training, themes that empower future professionals to perceive, anticipate, minimize and resolve conflicts – including those of ethical nature – that occur in their work environment are contemplated[7,8].

Ethics, in the present sphere of the training of health professionals, is articulated bioethics, a discipline that constitutes a field of knowledge applied to situations of conflicts, making possible the construction of a rational – and reasonable – choice in the face of ethical issues that occur routinely in daily professional life[9]. Among the bioethical currents, principialism – considered the first to be structured, and chosen as a reference for the discussion of the (bio)ethical[1] problems listed in this article – is based on four equally important principles: respect for autonomy, beneficence, non-maleficence and justice, which are useful to guide decision-making[9].

The ethical problems that occur in PHC are due to daily concerns – common circumstances of practice in health care – and not from dilemmatic situations. Such peculiarity can lead to difficulty in identifying them. However, these problems are of no less importance, as they are broad and complex[4], and are configured by subjectivity and

[1] * According to Siqueira-Batista (2020), the spelling "*(bio)ethics has been employed in recent years by some authors*" (p. 262), in order to overcome impasses related to the relations between ethics and bioethics. For an assessment of this issue, it is suggested to consult the text (Siqueira-Batista, 2020)[7].

the sociocultural context of users and professionals. In fact, a purely deontological ethics cannot be applied in the sphere of PHC, which concerns only duties, because it requires a hermeneutic that reflects the very facticity of the context in which ethical problems occur[1].

In dentistry, as well as in other health fields, ethical problems often occur, involving different aspects[10]. However, the few studies related to the subject, found in the literature, have reported that dentists present an often-limited view of ethical problems, associating them only with situations of deontological order, which leads them to a distorted understanding of the reality of their environment, especially when considering the space-time of PHC[10,11,12].

Based on these considerations, the aim of this article is to describe the main (bio)ethical problems identified by dentists (CD) working in PHC of the Viçosa Health Microregion, MG, comparing them with previous studies on the same theme and discussing them, in the light of principialist bioethics.

2 METHODS

This article is part of the analysis of the results of a project entitled: *Bioethics and Primary Health Care: perspectives of dentists working in the municipalities that make up the Health Microregion of Viçosa, MG*. Due to the amount of information obtained – given to the studied locality[13], the length of the questionnaire and the analyses undertaken[14] – the research results were divided into two publications. In this, it will be contemplated, in addition to the characterization of the population studied, the analyses of the questions related to (1) the (bio)ethical problems experienced by dentists, (2) the approaches, solutions and consequences of these questions, and (3) the knowledge of the concepts and the understanding of these professionals about ethics and bioethics.[12,15].

This investigation is characterized as a quantitative-qualitative study, located in the field of social research, and was carried out through the application of a questionnaire containing closed and open questions, already used in previous investigations[12,15].

The field of research comprised the Viçosa Health Microregion, located in the Zona da Mata region, in southeastern Minas Gerais. The microregion consists of 9 municipalities: Araponga, Cajuri, Canaã, Paula Cândido, Pedra do Anta, Porto Firme, São Miguel do Anta, Teixeiras and Viçosa. The total population of the microregion, in 2017, was 138,211 people, and PHC coverage in the modality of the Family Health Strategy (FHS) was 88.6% (122,448 inhabitants), with 44 teams implanted, with Viçosa being the

only municipality that did not have coverage of 100.0% of the FHS (coverage of 79.8%)[13]. In the municipalities of the microregion, 32 Oral Health Teams (OHT) were implanted, 20 in modality I [composed of 1 CD and 1 Oral Health Assistant (OHA)], and 12 in modality 2 [composed of 1 CD, 1 OHA and 1 Oral Health Technician (OHT)]. In addition to dentists working in the OHT implanted in the FHS, there were still 21 dentists who worked in PHC in conventional health units13 and who were also included in the research.

After the approval of the Municipal Health Secretary of each municipality to apply the questionnaire, a previous contact was made with each professional, to schedule the date, time and place of preference of the interviewee, so that it would not impair the progress of the service in the Basic Health Unit (BHU). All dentists who performed activities within the scope of PHC in cities in the microregion were invited to participate in the study, except those who were on medical leave or acting exclusively in prevention actions during the period of data collection.

Descriptive analysis (absolute and relative frequency) of the general characteristics of the research participants was carried out. For qualitative questions, Lawrence Bardin's[14] content analysis technique was used, which proposes a sequence for data analysis based on the following steps: pre-analysis, exploration of the material and treatment of the results, inference and interpretation. The answers to questions about the understanding of ethics and bioethics were appreciated.

The investigation that gave rise to this article was approved by the Ethics Committee on Research involving Human Beings, federal university of Viçosa (CEP/UFV), under nº 2.205.321/CAAE: 69789917.4.0000.5153. The participation of each dentist was voluntary and linked to the express approval of the participant, through the signing of the Free and Informed Consent Form (TCLE), according to Resolution 466/2012. Participants were assured of confidentiality and confidentiality in the collection of information, and anonymity in the presentation of the results. Each questionnaire was identified with the CD code – referring to a dentist - followed by increasing numbering.

3 RESULTS AND DISCUSSION

3.1 CHARACTERIZATION OF THE POPULATION STUDIED

Only two dentists – of the 53 who worked in the PHC of the Health Microregion of Viçosa, MG – met the exclusion criteria. Of the 51 remaining professionals, 48 (94.1%) accepted to participate in the study. The age of the participants ranged from 23 to 70, with

average and standard deviation of 40.7±12.6 years old. There was a predominance of females – 35 participants (72.9%) –, and approximately 71.0% of the professionals had already undergone a graduate degree, with specialization (lato sensu) being the most cited (52.1%). Most respondents (62.5%) had a time of profession equal to or greater than 12 years, and, in relation to the time of service in PHC, there was a predominance of professionals who worked in this area for six years or more (Table 1).

This data is contrary to those found in other studies on the same theme, with professionals from various categories, working in PHC, in the municipalities of Rio de Janeiro, RJ[15] and Viçosa, MG[12], where the time of work of the interviewees in PHC was predominantly less than five years.

Table 1. Time of profession and work in Primary Health Care (PHC).

Time of profession	N	%	Total working time at PHC	N	%
< 1 year	4	8.3%	< 1 year	7	14.6%
1-5	11	22.9%	1-5	11	22.9%
6-11	3	6.2%	6-11	9	18.7%
12-20	13	27.1%	12-20	14	29.8%
21 or older	17	35.4%	21 or more	7	14.6%

Source: Search data.

The fact that most dentists working in PHC in this microregion have a time of public service of six years or more – with a predominance in the 12 to 20 age group – is a positive point, due to the greater possibility of creating the bond with patients and with the team. The bond is one of the guiding principles of health care actions[16], and it takes time to establish this relationship[17].

3.2 (BIO)ETHICAL PROBLEMS IDENTIFIED BY PARTICIPANTS

When asked about situations experienced in PHC, which they considered to be (bio)ethical problems, ten interviewees (20.8%) said that they had never experienced any such problem, or that they did not remember. The remainder, 38 participants (79.2%), reported one or more (bio)ethical problems experienced, totaling 61 problems of this nature, which were divided into four categories: (1) (bio)ethical problems related to PHC team members, (2) (bio)ethical problems related to management, (3) (bio)ethical problems involving the team and users, and (4) (bio)ethical problems related to breach of professional confidentiality.

Table 2. Categorization of (bio)ethical problems identified by dentists of Primary Health Care in the Health Microregion of Viçosa - MG, 2017.

Categories	(bio)ethical problems cited	N	%
Related to PHC team members 24 quotes – 39.3%	Inappropriate comments about the life of other people (gossip)	7	11.5%
	Difficulty in delimiting the specificities of each professional	4	6.6%
	Violation of privacy of colleagues	4	6.6%
	Image denigrated by colleagues	3	4.9%
	Bullying	3	4.9%
	Medical record fraud	1	1.6%
	Non-compliance with hourly shift	1	1.6%
	Theft	1	1.6%
Related to management 16 quotes – 26.2%	Political interference at work	5	8.2%
	Abuse of authority/persecution by managers	4	6.6%
	Lack of working conditions	3	4.9%
	Lack of preparation of managers to deal with conflict situations	2	3.3%
	Admission of professionals without training	2	3.3%
Involving staff and users 9 quotes – 14.8%	Predilection/privileges	4	6.6%
	Disrespect and disregard for the patient	3	4.9%
	Average conversations about patients	1	1.6%
	Refusal to care for HIV+ patients	1	1.6%
Related to breach of professional secrecy 12 quotes – 19.7%	Breach of professional secrecy	12	19.7%

Source: Search data.

The difficulty of recognizing the (bio)ethical problems – as exemplified in the following speech: "*I do not remember, it happens a lot, but most of the time it goes unnoticed*" [CD18] – had already been identified by Zoboli and Fortes[4] in a study conducted with nurses and doctors of the Family Health Program (FHP) of the city of São Paulo, SP.

The (bio)ethical problems emerge from the context in which professionals are inserted and differ depending on the scenario of health services, and, as in family health units, such issues present themselves in a more subtle way, they may go unnoticed[4], or not be recognized as ethical problems by professionals[17].

The category **(bio)ethical problems related to PHC team members** represented 39.3% (24/61) of the interviewees' reports (Table 2).

The health teams configure a network of relationships formed by professionals who have different knowledge and develop practices[18], which makes these conflicts as expected teams[4], and producers of tensions in the daily life of PHC teams, compromising the integrality of care[15]. The participant's speech, then, represents the complexity of the relationship between the professionals: "*The head nurse of the FHP wanted me to do jobs*

that do not agree with my work. When I questioned her, she yelled at me in front of the team, and I also felt the same right... and today we don't talk anymore" [CD10].

This disparity of power in the hierarchy, about orders, was also reported in a study on the same theme conducted with professionals from two teams of the FHS of Salvador, BA; this time, for the authors of this study, this behavior brings "*uncertainties regarding the fluidity and effectiveness of the work of the team members*"[19]. For the success of PHC, comprehensive and resolutive care is necessary, and this requires communication and cooperation among professionals[19], so that the hierarchy among team members does not prevail, but the integration of competencies and cooperation in activities[20].

Another ethical problem mentioned was the difficulty of delimiting the functions of each team member and the interference in the work of the colleague, as exemplified: "*some agents consider themselves able to diagnose the patient, which leads the patient to question us during the consultation why what is being treated, since it does not match what the agent* [Community Health Agent] *said*" [CD05], and *"situations among colleagues in all sectors, where health professionals in the BHU end up 'intruding' too much outside their area because they think they know the user outside the environment"* [CD16].

For Zoboli and Fortes[4], the characteristic of linking and accountability of PHC/FHS with users in their area "*brings new nuances to an old problem: the establishment of the limits of the relationship with the user*" (p. 1692). In the speech of [CD16] an intrusion justified by the knowledge of patients outside the workplace is identified, thus not respecting the technical limitation of each area, which can be harmful to the patient himself, because it generates distrust regarding the conduct of other professionals. To resolve conflicts in this order, professionals need to define their attributions and competencies jointly, with dialogue and respect for differences[4].

There was also a report of defamation among co-workers: "*I suffered bullying by a colleague (dentist) who spoke to the population that I did not work, who was not going to BHU...*" [CD34]. The defamation of one team member on the other may be the result only of the bad relationship between co-workers, and not having any technical and legal basis that justifies it, being thus unfair, since if the patient already arrives with a pre-established idea about the professional, his judgment on the proposal and the conduct of treatment will be compromised. The formation of the bond between the health team and the user is indispensable for ensuring co-responsibility at work between professionals and users[21].

The complexity of relationships is also evidenced in the disrespect of the privacy of colleagues, as exemplified below: *"recording of conversation of dentists, by employees"* [CD36]. The disrespect for privacy – in this case specifically among colleagues – hurts the principle of respect for the autonomy of the individual, by neglecting the desire of the colleague not to be exposed, and of non-maleficence, for the damage that this exposure can cause.

Regarding the category **(bio)ethical problems related to management**, there were 16 (26.2%) reports (Table 2).

In directing the health care process, the municipal manager has a fundamental role, and his decisions must be governed responsibly, as they affect both individuals and the community[10]. The inability of some managers to manage conflict situations was identified as a (bio)ethical problem, as exemplified: *"We can cite relationships of the health manager/secretary, in which when informed of problems among employees, he exposed the report to co-workers, causing discomfort in the work environment"* [CD19]. This lack of preparation of managers can also be evidenced in the form of abuse of authority, which was also described in a previous study[15], and can be exemplified by the following statement: *"The manager proposed, or almost imposed, the professional to step down from his or her position, once he was hired"* [CD20]. The precariousness of the employment relationship can put the server in a situation of submission, taking away the autonomy of deciding whether to perform the other function.

The interference of politicians in the operation of the service was also considered a (bio)ethical problem: *"Tickets from authorities, making sure that the queue was not respected"* [CD41]. This interference, already evidenced in a previous study[17], directly hurts the principle of justice for that patient who is waiting in line to start a treatment, since, putting others in front of them, it makes their access even more difficult. With this conduct, politicians disrespect the current norms and take advantage of health services for their own benefit, for voter interests[17].

The lack of adequate working conditions, as exemplified – *"Professional being forced to wash hands with washing powder, wiping hands with toilet paper"* [CD41] – was also perceived as a problem of (bio)ethical order. The code of dental ethics reserves the professional the right to refuse to practice the profession, in the public or private sphere, where working conditions are not dignified, safe and healthy[22]. The lack of adequate working conditions, also found in other studies[10,17], represents a serious (bio)ethical problem for directly hurting the principle of beneficence and non-

maleficence, since the best possible treatment cannot be guaranteed, and without any possibility of damage, if there is no adequate working condition.

The inadequacy of the workplace for the purpose for which it is intended also compromises the confidentiality and privacy of users[19] and can be exemplified in the statement: "*inadequate custody of medical/dental records*" [CD47]. In this case, the inadequacy refers to the difficulty of maintaining the confidentiality of the information contained in the users' medical records, due to the lack of an adequate place to store them. In this sense, the right to privacy can be conceptualized, in a more comprehensive way, as limited access to users' information[19]. The owner of the right over the medical record is the user himself, and he should be able to define who has the right to have access to such documentation[23]. In this sphere, there is already a study in which patients expressed a desire to restrict access to their information by professionals who were not directly linked to their care[24].

Regarding the **(bio)ethical problems involving the team and users** were identified 09 (14.8%) reports (Table 2).

Disrespect for patients seems to be a common problem and has been cited by PHC professionals in previous studies on this theme4,15,19, and can be exemplified in the following statements: "*Patients complained about poor care and the professional answered that in public health it was like this, but if he went to the private practice the care would be differentiated*" [CD22].

Patients who depend on public health services find barriers and delay so far for scheduling appointments, which already puts them in a position of disadvantage compared to users who can pay for a particular treatment, configuring an injustice in access to health and hurting the principle of non-maleficence, since due to damage caused to patients, one can also understand the action of frustrating them or causing obstacles to their interests[9].

Another situation, also reported in the research, was the predilection for relatives and "acquaintances", as exemplified in the report: "*the CHA patronize relatives and friends, giving them privileges in care at the BHU*" [CD47]. PHC, even because of its configuration of care in delimited areas and with team members living in the coverage area, is subject to this type of situation, which hurts the principle of justice, by not giving the same opportunities of right to access services for all residents of the area served[25].

The discrimination of patients in the public service was also recognized as a (bio)ethical problem, according to the citation: "*refusal to care for patients with infectious diseases*" [CD33]. The discrimination of the human being, in any case, or on any pretext, constitutes an ethical infraction[22], and hindering their access to health services is a determinant of injustices in this area[9], opposing the principle of universal access to health services offered by the SUS. In fact, dehumanization infringed on stigmatized people is attentive to human dignity and inferiorizes it to others, increasing their vulnerability[26]. For Naidoo[27], the principles of protection, justice and responsibility should be embraced by each professional within their practice, to facilitate access to dental care for the most vulnerable users.

Finally, contrary to previous studies[4,10,19] – which highlighted as a (bio)ethical problem the difficulty of referring patients to specialists from different health areas – there was, in this research, no reference by professionals to this problem, even though there was no dental specialty center working in the studied health microregion at the time of data collection. This problem is mainly related to the lack of comprehensive care[10], which still represents a critical node for dentistry, especially in the public service[16], because it lead patients to choose – due to lack of option – the only available treatment[28] i.e., tooth extraction. Tooth loss is still naturally seen in dental practice[10], and perhaps this is the reason for the invisibility of this problem by the interviewees.

The category involving **(bio)ethical problems related to professional secrecy** represented 19.7% of the questions described (12/61) and was as asked in a separate category due to this expressive number of citations, exemplified below: "*Particularities that should be kept about the health and/or intimate life of patients and employees of the unit be disclosed openly and freely...*" [CD02] *and* "*Professional talking to people outside the work environment about some illness of a patient*" [CD17].

In PHC, especially when referring to the FHS, the sharing of information regarding patients is fundamental for the responsibility of the entire team for its follow-up. This new logic of care brings with it the need to rethink a way of dealing ethically with secrecy[23,29]. In these terms, the lack of guarantee of confidentiality and respect for the confidentiality of information has already been identified as a (bio)ethical problem in the literature[4,12,15,19,20,30], an issue that directly affects the principle of respect for autonomy, *"threatening the relationship of trust between professional and patient"*[19], which may extrapolate the user/health team relationship, producing consequences throughout the community[15].

3.3 TYPES OF APPROACH TO (BIO)ETHICAL PROBLEMS

When asked about how the (bio)ethical problems described were addressed, 26 participants reported: meeting with the team, triggering administrative and/or political instances for the referral of the issue, adoption of penalties (e.g., warnings), verbal condemnation of attitudes and guidance to employees, among other types of approach. It is worth mentioning that 14 dentists reported that there was no approach to the problem, seven participants did not answer the question and one did not remember the type of approach used.

The team meeting was the main approach cited for solving (bio)ethical problems (40.0%), as exemplified: "*during the team meetings I exposed the problem and talked about it...*" [CD05]. Communication between professionals was also identified by another author as the preferred approach to deal with these issues[15]. It should be noted that meetings between team members are extremely important to ensure continuity of care and to strengthen teamwork[31]. However, sometimes the problem presents itself in a proportion that requires the intervention of managers, as a report below: "*the dentist and oral health coordination were gathered to clarify the size of the problem and the punishment, even criminal, that could happen to the professional*" [CD12].

However, a major problem occurs when the inability to deal with such issues is also present in management, as exemplified in the following reports: "*addressed further increasing undue conversations*" [CD37]; and "*...I went to talk to* [...] *who was coordinator of the FHP at the time, and he answered me with ignorance and said that I had to comply with the orders given...*" [CD34]. In the latter case, the vertical actions of the management represent a disrespect to the autonomy of the server[19].

The response of one interviewee drew attention, because he showed discredit with the resolution of (bio)ethical problems, perhaps caused by the disappointments experienced during his professional life: "*I believe that this* '*ethical*' *problem already originates from management to employees, in general, hindering the solution to this problem*" [CD16]. Thus, the conformation of the health system can be a factor that generates (bio)ethical problems, as well as influencing its perception, analysis and solution[4]. It should be considered that the (bio)ethical challenges should not have an immediate, uncritical, dichotomous and prompt response, as they require reflection on their possible solutions[17], and since such questions are modulated "*in their generation and solution by working conditions, it would be recommended to implement strategies to support the conduct of such situations*" (p. 1697)[4].

When asked about the need to use some bibliographic reference or to some consultant to assist them in solving the (bio)ethical problems raised, only four participants (8.3%) responded positively to the question. It is noteworthy that when asked if there was a solution to the problems experienced, 22 participants (45.8%) reported that there was some type of solution, 18 participants (37.5%) answered that there was no solution, and 8 (16.7%) did not answer the question.

Decision-making on (bio)ethical problems can be a difficult task for health professionals[9,32,33], which confirms the need to review all existing alternatives to adequately substantiate the decision-making process – and the reasons for them – developing consistent, reasonable, impartial and non-contradictory arguments to achieve a solution that is the best possible for all those involved in the conflict. There are several ways to solve a (bio)ethical problem, which requires the interpretation of the context in which they occur and the deliberation on its consequences[34]. In this sense, when asked about the consequences of the (bio)ethical problems experienced, 10 interviewees did not remember the outcome or did not answer the question. The other 38 participants recorded 58 consequences for the (bio)ethical problems identified, categorized and summarized in Table 3.

Table 3. Consequences of listed (bio)ethical problem.

Consequences		N	%
For team professionals	Embarrassment/demotivation/frustration/outrage	12	20.7%
	Impaired work environment	11	19.0%
	Disreaved the professional/Defamation of the team	5	8.6%
	Physical and/or mental wear	3	5.2%
	Distance between co-workers	5	5.2%
	Dismissal/punishment of those involved	2	3.4%
	Ethical and judicial proceedings	2	3.4%
	Not achieving goals/ Loss of financial resources	2	3.4%
	Physical threat	1	1.8%
In relation to the user	Patient exposure	6	10.4%
	Disrespect/conflict as patient	4	6.9%
	Patient dissatisfaction	3	5.2%
	Patient no longer returned to BHU	2	3.4%
	Treatment not completed	2	3.4%

Source: Search data.

All actions are influenced by the environment in which they are inserted. In fact, an action depends not only on who executed it, but on the conditions of the environment where it happens[35]. For Valadão, Lins and Carvalho[19], a professional is not the same after interacting with another, because the action of one provokes reaction in the other, and thus *"it is essential to produce the professional skills of an individual, so that the professional competence of another can be developed*" (p. 739)[19].

The rupture of the team's ties, exemplified below – "*the greatest consequence is the exclusion of the dentist in the team*" [CD40] and "*no one intervened, and today we do not speak anymore*" [CD10] – had already been reported in a previous study[19]. This situation favors the fragmentation of knowledge since it privileges individual work over the collective[36]. Thus, a disharmony work environment compromises actions and will unpredictably cause harm to patients[37] – as exemplified in the following statement: "*lack of communication among health professionals generates losses for patients*" [CD10] – because the resolution of users' needs depends on the exchange of knowledge, dialogue and a relationship of cooperation between team professionals[17]. An equally disastrous consequence is the breakdown of the relationship of trust between professionals and users, which can contribute to the rupture of the bond created between them[15], bringing consequences that are difficult to reverse, as exemplified below: "*patient was embarrassed and upset. He never came back to BHU*" [CD14].

Another issue raised in this research, and already evidenced by Junges and collaborators[17], was the lack of concern for the mental health of professionals and the insensitivity to their suffering, as exemplified: "*...I've been so stalking and I'm sick because of it... the main consequence for me was my emotional strain...*" [CD34]. In this case, since beneficence is understood as acting in favor of the other[9], the lack of inadequate approach and/or approach of a conflicting situation directly hurts this principle. Thus, work processes should be thought of based on the principles of humanization, which value the subjectivity of users and professionals[1].

When the following statement was presented to the research participants: "**All health professionals should have their work based on the principles of ethics and bioethics. Comment.**", the majority – 42 (87.5%) participants – answered clearly that they agreed with the statement, which shows that there is an awareness in the professionals about the importance of such an attitude. When they were asked if they were aware of any concept of ethics and bioethics, 10 (20.8%) participants stated that they knew these concepts, but nine of these 10 did not present the concepts consistently. It is worth noting that 38 participants (79.2%) reported not knowing any concept of ethics and bioethics or did not answer the question.

When asked about what they understood about ethics and bioethics, only three participants did not answer the question, and seven answered that they did not remember the themes. The other 38 participants answered the questions. In general, ethics can be conceptualized as the science of conduct[38]. It comprises the study of good or bad, correct

or incorrect, fair or unfair, appropriate or inappropriate, and establishes a reflection on human action, differentiating itself from morals and law by not establishing rules[39]. Bioethics can be conceptualized as ethics applied[7] to health and research issues with human beings, and addresses new problems in a contemporary way, stimulating new levels of discussion and reflection, through a systematic, rigorous and coherent analysis of the facts, which make it possible to find adequate solutions to the various (bio)ethical problems[40].

4 FINAL NOTES

The present study allowed the identification of different (bio)ethical issues by dentists working in PHC of the Viçosa Health Microregion, MG, which were categorized into four groups: (bio)ethical problems related to (1) PHC team members, (2) management, (3) relationships between team and users, and (4) break professional confidentiality.

It was also evidenced the little preparation of professionals to deal with these issues, which caused harmful consequences for the team and patients. Moreover, the invisibility of (bio)ethical problems by a significant portion of the interviewees, their ignorance about concepts of ethics and bioethics, and the aforementioned consequences of the lower preparation of these professionals to deal with issues of this order, reinforces the importance of this study – and others on this theme – and corroborates the need for a deconstruction of the hegemonic model of education, and the curricular matrices of undergraduate dentistry courses, with the inclusion of a (bio)ethical dimension applied to a reflexive practice. It also reinforces the need for the implementation of a permanent education program for professionals working in PHC, to enable them to recognize and deliberate correctly on the (bio)ethical problems that will eventually happen.

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