

Virtue ethics in family health team's practice

A ética da virtude na prática da equipe de saúde da família

La ética de las virtudes en la práctica del equipo de salud de la familia

Cecília Maria Lima Cardoso Ferraz¹  <https://orcid.org/0000-0001-6897-3798>Carolina da Silva Caram¹  <https://orcid.org/0000-0001-6219-3301>Maria José Menezes Brito¹  <https://orcid.org/0000-0001-9183-1982>

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Corresponding author

Cecilia Maria Lima Cardoso Ferraz
E-mail: cecilia.lima@unifemmm.edu.br

Associate Editor (Peer review process):

Paula Hino
(<https://orcid.org/0000-0002-1408-196X>)
Escola Paulista de Enfermagem, Universidade Federal de São Paulo, São Paulo, SP, Brazil

Abstract

Objective: To understand Family Health team's practice from the perspective of virtue ethics.

Methods: A single case study of a qualitative approach, conducted between January and July 2019 in Family Health Strategies in a municipality in the countryside of Minas Gerais. Participants were physicians, nurses, nursing technicians and community health workers, totaling 35 professionals from Family Health Strategy teams. Data were collected through interviews and observation and analyzed through content analysis, with the help of atlas.ti software.

Results: Family Health team's practice is developed by care centered on users, in the search to meet their objective and subjective needs. However, there are obstacles that pass through the interface between legality/bureaucracy (bureaucratic ethos) regarding compliance with standards recommended for service organization and operation and professional ethos related to professionals' commitment to people.

Conclusion: Family Health team's practice from the perspective of virtue ethics allows us to recognize that professional and patient are moral agents who are guided by values and virtues in the search for the internal good of their lives and practice.

Resumo

Objetivo: Compreender a prática da equipe de saúde da família sob o prisma da ética da virtude.

Métodos: Estudo de caso único de abordagem qualitativa, realizado entre janeiro e julho de 2019, em Estratégias de Saúde da Família, de um município do interior de Minas Gerais. Os participantes foram médicos, enfermeiros, técnicos de enfermagem e agentes comunitários de saúde, totalizando 35 profissionais das equipes da Estratégia Saúde da Família. Os dados foram coletados por meio de entrevistas e observação e, analisados por meio da análise de conteúdo, com auxílio do software Atlas.ti.

Resultados: A prática da equipe de saúde da família se desenvolve pelo cuidado centrado nos usuários, na busca de atender suas necessidades objetivas e subjetivas. Contudo, existem obstáculos que transitam na interface entre a legalidade/burocracia (*ethos* burocrático) referente ao atendimento de normas preconizadas para organização e funcionamento do serviço e o *ethos* profissional relacionado ao compromisso dos profissionais com as pessoas.

Conclusão: A prática da equipe de saúde da família na ótica da ética da virtude permite reconhecer que profissional e paciente são agentes morais que se orientam por valores e virtudes na busca pelo bem interno de suas vidas e prática.

¹School of Nursing, Universidade Federal de Minas Gerais, Belo Horizonte, MG, Brazil.

Conflicts of interest: nothing to declare.

Resumen

Objetivo: Comprender la práctica del equipo de salud de la familia bajo la perspectiva de la ética de las virtudes.

Métodos: Estudio de caso único de enfoque cualitativo, realizado entre enero y julio de 2019, en Estrategia Salud de la Familia de un municipio del interior de Minas Gerais. Los participantes fueron médicos, enfermeros, técnicos de enfermería y agentes comunitarios de salud, que sumaron un total de 35 profesionales de los equipos de Estrategia Salud de la Familia. Los datos fueron recopilados mediante entrevistas y observación y analizados mediante el análisis de contenido, con ayuda del software Atlas.ti.

Resultados: La práctica del equipo de salud de la familia se desarrolla mediante el cuidado centrado en los usuarios, buscando satisfacer sus necesidades objetivas y subjetivas. Sin embargo, existen obstáculos que transitan la interfaz entre la legalidad/burocracia (*ethos* burocrático), relacionado con el cumplimiento de normas recomendadas para la organización y el funcionamiento del servicio, y el *ethos* profesional, relacionado con el compromiso de los profesionales con las personas.

Conclusión: La práctica del equipo de salud de la familia bajo la perspectiva de la ética de las virtudes permite reconocer que profesional y paciente son agentes morales que se guían por valores y virtudes en la búsqueda del bien interno de su vida y práctica.

Introduction

Family Health Strategy (FHS) emerges as the organizing basis for the reorientation of Primary Health Care (PHC), configuring health work through understanding the multiple demands of individuals, families and communities that live and organize themselves in different contexts.⁽¹⁾ FHS develops in the expanded aspect of comprehensive health care, effectively focused on the person/family and guided by interdisciplinary work in a multidisciplinary team.⁽²⁾

In the context of FHS, the Family Health team (FHT) is constituted, which is historically composed of nurses, physicians, nursing technicians and community health workers (CHW). The joint work of this team has specific characteristics and is intended for its own purpose, configuring the concept of practice from the perspective of virtue ethics.

Practice, from this perspective, constitutes a set of activities structured by social arrangements and centered on objectives that are their own (internal good), given by their history and tradition.⁽³⁾ The internal good of health practice can be considered as the “good of patients”, concretized in individuals’ search for the achievement of standards of excellence in practice.⁽⁴⁾ Under this logic, understanding FHT’s practice means transcending its conception of a set of technical-operative skills for the connotation of a qualified performance of a variety of tasks, centered on the direct application of biotechnological knowledge.⁽⁵⁾

Practice is configured by the legality of ethics (bureaucratic ethos) and by the ethics of profession

(professional ethos). Professional ethos, although not abandoning deontology (bureaucratic ethos), aspires to excellence with the focus on people, whose benefit gives meaning to practice.⁽⁴⁾ Considering the complexity of the relationships in FHT and that of the moral plurality of users and workers, it is insufficient to resort only to codes of professional ethics to carry out practice, since they point to externally established rules, i.e., only for what is correct or not to do.⁽⁶⁾

In this perspective, it is considered that deontological ethics does not cover all the singularities required in FHT’s practice, making it necessary to broaden the view to another ethical approach in this context. That is, looking at the subjective aspects involved that contribute to achieving the purpose of practice, namely the comprehensive care centered on person/family.^(2,7)

Although FHT is a way to operationalize PHC and transform reality, it still has weaknesses related to articulation with other health network services, inadequate working conditions, highly bureaucratic environment, insufficient work overload and autonomy and recognition^(8,9) which leads FHT professionals, in many situations, to distance themselves from person-centered care and, because they are unable to exercise their practice, they promote its mischaracterization and invisibility.

Moreover, FHT’s practice needs to be understood as a unit, whose events related to it only materialize in the whole and, its internal good, shared by the team members. However, it becomes a challenge to constitute practice as a unit in FHT, since, because it is composed of different professional categories,

each of them also has its specific internal assets that configure its professional practice. Therefore, the goods of practice can be understood from individual point of view of each professional category or from the point of view of multidisciplinary practice.

Therefore, it is perceived the need for FHT professionals to mobilize competencies to resignify their practices, becoming individuals capable of leading the actions manifested in the production of care, unveiling the invitation to virtue ethics. For MacIntyre, virtue is “an acquired human quality whose possession and exercise tend to allow the reach of goods that are internal to practices and whose lack effectively prevents them from reaching such goods”.⁽³⁾ Thus, virtues are characteristics of a moral agent incorporated into the world of values that guide practice in the search for excellence.⁽⁴⁾

Considering that virtue ethics supports reflections on the development of FHT's practice and that literature does not make such articulation, the fundamental question of this study arises: How does FHT's practice take place from the perspective of virtue ethics?

The present study aimed to understand FHT's practice from the perspective of virtue ethics.

Methods

This study is qualitative, outlined by the integrated single case study method, conducted in family health units, in a medium-sized city in Minas Gerais, Brazil. The qualitative approach seeks to understand the meaning that the subjects attribute to their actions, in their time and space, proposing to visualize human experiences in their sociocultural dimension, valuing the facts and meanings of their diverse contexts.⁽¹⁰⁾

The case study refers to the object of this research that seeks to understand FHT's practice, being considered a social, complex, and contemporary phenomenon in a real context, where the researcher has very little control over events.⁽¹¹⁾

The research participants were professionals who make up the basic team of FHS, being: physicians, nurses, nursing technicians and community health

workers. The municipality has five administrative regions and 43 FHT teams, thus a random draw was performed by administrative region to elect the participating teams.

To compose the study population, professionals with at least six months of experience in the team were included in the study, a period considered necessary for them to experience the work environment, relationships and activities that make up their practice. Professionals who were on sick leave or vacation during the data collection period were excluded from the study.

It should be noted that the number of participants was not indicated a priori and data collection was interrupted when data saturation occurred for each professional category, i.e., when the information, after the analysis, presented the scope of participants, valuing the significant contents for the study.⁽¹⁰⁾ Thus, the interviews were conducted with 09 nurses, 09 nursing technicians, 07 physicians and 10 CHW, totaling 35 professionals.

Data collection occurred between January and July 2019, through two sources of evidence: guided interviews by semi-structured script and non-participant observation. The interviews were previously scheduled and conducted individually, in a reserved environment in the health units where professionals were crowded, were recorded and lasted an average of 28 minutes. The questions that guide the interviews addressed the meaning of work in FHS; the report of professional practice and the values that guide it in the context of FHS. Observations were made throughout the data collection period, at times before or after the interviews, at the reception, in the medical and nursing offices, in the basic care room and in home visits. The observations were recorded and identified as observation notes (ON).

Thematic content analysis was used for data analysis, following the three chronological centers proposed by Bardin, with the help of Atlas.ti 8. The qualitative data analysis software was used as an operational instrument for analysis of all interviews, favoring the process of organizing the data, allowing the researchers an overview of the findings during the analytical process.⁽¹²⁾

Regarding the chronological poles, the first moment occurred with the pre-analysis phase, in which a thorough and exhaustive material reading was performed, which was later inserted into the program, which contributed to data visualization and organization. The second moment was the data exploration phase, in which the use of a software facilitated the material management for code creation and categorization, culminating in the creation of families that gave rise to the study categories. The last stage was inference and interpretation, in which the raw data began to have meaning through data inference, interpretation and discussions with literature and with virtue ethics theoretical framework.⁽¹³⁾

The study complied with Resolution 466/2012 of the Brazilian National Health Council (*Conselho Nacional de Saúde*), had the approval of appropriate organizations of the municipality, through Institutional Consent Letter and Institutional Review Board (IRB), under Opinion 2,285,857. Participants signed the Informed Consent Form, expressing their agreement to participate in the research as well as their science in the face of possible risks, benefits or discomfort. To ensure anonymity, we chose to identify the statements with the initial categories; (N) nurse, (NT) nursing technician, (P) physician, and (CHW) Community Health Worker, followed by the numbers established for each interview.

Results

The results revealed that FHT's practice develops from the perspective of a health care centered on meeting the objective and subjective needs of a person/user, in their life context. Moreover, they showed that the organization of work sometimes poses a risk to the development of a practice with excellence.

N6, P3 and NT3 express in their statements that the centrality of the activities they perform is the person/user, demonstrating the search for the internal good of FHT's practice.

Family Health Strategy attracts me because it allows me to take care of people in a continuous way. (N6)

I try to provide a dignified, humanized care to people who are often unable to go to a large center to have quality health care. So, it means helping others with the humanization of health. (P3)

There are patients who come here every day, they have nothing, they just want to talk, sometimes they just want to see me. I also put myself on patients' shoes, I never think of myself, professional, patients first. Then I feel valued because they like to talk to me and, they leave satisfied due to service. (NT3)

In this sense, D6 and D4 reveal that the population-centered practice requires understanding of its real needs, which are subjective and extrapolate the standardized clinical complaints in ministerial protocols (bureaucratic ethos), expressing professional ethos.

We can help many people, not only in health. I think the family physician interferes a lot in patients' lives. Sometimes patients do not need the physicians, but need to be heard more. I think, as a family physician, I can do much more than just a consultation, only patients' illness at that time. I take care of people! (P6)

I take care of much people, but I learned to seat and to have a relation more than listening with my patient. I let them talk about their needs. Not all related to health, some psychological, emotional, family. I identify that most people are not normally sick. (P4)

FHT's practice was also described by participants M7, E3, NT2 and CHW3 through the technical activities they perform, revealing mainly the procedural elements congruent with bureaucratic ethos provided as the scope of their attributions as FHT members.

Consultation, childcare, prenatal care, home visit, attending demand, urgency, sometimes I help other units when they are without a physician, only. (P7)

My practice here is to perform nursing consultations, i also help in all nursing procedures, welcoming. My practice is both administrative and welfare. I do prenatal consultation, cytology, breast evaluation, childcare. So it's a full practice. (N3)

My professional practice is to measure pressure, glycemia, perform dressings, remove stitches, make home visits to bedridden, assist the physician, the nurse care. (NT2)

I make home visits, at least one per month for each family, I store my records folder, the records of patients' medical records, classifying who is hypertensive and who is diabetic, who is mental health, I stratify the family's risk as well. (CHW3)

As noted in the previous statements, participants define that the centrality of practice is in person/user. However, P2, N9 and NT1 report that the organization of work in FHt presents itself as an obstacle to the achievement of the internal good of FHt's practice. These obstacles are related to the absence of adequate inputs for users' needs and the predominance of a bureaucratic administrative character experienced by the health team in FHS' daily work, which define how professionals organize their actions in the context of practice.

It is stipulated about 20 minutes for each service, but I think this time should be longer, because the user, to have a complete treatment, requires anamnesis, for example. It is important to let patients say what he has and it spends time, if you do not have that time, will not be able to do the treatment and full diagnosis, and the follow-up as a whole, in the best way. (P2)

We have a huge demand for administrative service. Unfortunately, we nurses, and I think most of us think so, we are too limited to play our care role. Our dream was to have an employee who cared exclusively for this administrative part, to schedule tests for patients and schedule prenatal and preventive consultations to achieve goals for example, so that we could be more patient-oriented. (N9)

Currently, I am unable to work. I'm still here because I like it, I do what I like. But I can't work, give decent and respectful care to patients. I'm calling all units to borrow a team, syringe, dipyrone medication, because the child who's out there waiting, he's got 39 fever. (NT1)

In addition to the statements, during observation made by the researcher, it was evidenced the cancellation of a schedule of six childcare consultations to replace it with another of cytopathological examinations of the cervix, so that the unit would meet the goal of this care for that month (ON). This action reveals that work organization does not focus only on the needs of persons/users as centrality, but the bureaucratic requirement of goals and indicators, being, therefore, an obstacle to achieving the internal good of practice by FHt.

Another obstacle to carrying out practice was mentioned by N7, which refers to conflicts arising from interpersonal relationships that hinder the construction of a unit in FHS.

I also experience difficulties in relationships that, sometimes, because we work with people, meet people, each with their personality and their goals, which are sometimes not the same, generates conflicts. As the technical manager of the team, I have to take some postures that contradict our co-worker. (N7)

Regarding the report of N7, the researcher identified situations of conflict between the deliberation intended by the nurse and that intended by the physician in relation to the renewal of prescription-controlled medication for an elderly lady in the area of coverage. The physician did not want to hear the justification of renewal of prescription at that time, claiming that this was not the day to perform this activity. While the nurse had already talked to the user and identified that she had undergone hospitalization and therefore did not renewed the prescription before, running out of medications for continuity of treatment (ON).

On the other hand, N1 and NT1 report good experience in sharing work with other team profes-

sionals in the search for the best care to be offered to the user, evidencing the search for the internal good of practice.

I had a patient who used our service a lot. She came here daily. She was accompanied and medicated by our physician. However, he always came to our unit with some complaint. So, the physician and I decided to make a home visit to understand what was happening, since from the point of view of clinical care we no longer had what to do. We activated CHW and performed the home visit. In her home, we identified that the medication was being taken incorrectly. As she took many medicines, we all set out, between morning, afternoon, and night, and again we guide her on the right way to do it. We agreed with CHW to make weekly visits to her, to check how treatment was. That way, we take care of her more closely and still find out how she lives, what she feeds. (N1)

We once accompanied a patient who already had an open wound two years ago. Our teamwork, thank God, has enabled us to close her wound. The physician on our team was also very good, had a very good partnership, he gave us the freedom to talk, discuss the case. He had the humility to admit that he understood nothing of dressing, and asked us for suggestions. This is very gratifying! It gives us reason to believe that teamwork can make a difference. (NT1)

Another prominent aspect of FHt's practice was mentioned by N5, CHW1, N6 and NT1, which refers to the importance of values such as dignity, ethics, empathy, sensitivity, trust, comprehensiveness of care, bond, affection, knowledge, as beacons to perform person- and user-centered care practice in the context of FHt.

Speaking of ethics, we have to have sensitivity to understand patients. So, comprehensiveness, ethics, knowing whether to put one's shoes on the other, having empathy, all this is important in our profession, especially here in FHt, because we deal more time with patients, we know their reality. (N5)

People trust us a lot, they tell things, they open up! In this way, we create a very great bond with families, they entrust their lives to us. We enter their house, we know everything from there. (CHW1)

I try to go on the side of comprehensiveness, look at the human being in a comprehensive way, as much as I can, and never fragment, because mainly in FHS we have to try to look in a more complex way, right? Even, because when we are closer here, we create bonds and have a number of factors that we can see better and meet in a more complete way. (N13)

My main values are, first, the knowledge I acquired in the medical course and the attention and affection that I have in attending patients. I have affection and attention for patients, I try to solve the health problems in daily care, including I spend more time, which usually delays in the time of my consultations, because sometimes patients have much more social complaints than biological. (P2)

It is noticed that professionals, even in the face of obstacles in FHt's daily work, seek to perform practice with excellence and centered on people/users. In this sense, CHW3 expresses the importance of primary search for practice and its values due to the rewards it can provide, such as money.

Work with ethics. I put myself on patients' shoes, and this is very important! There are people who work just for money. I think the person has to work for the sake of what he does, he has to choose a right profession, because if not, if he chooses only for money, it is very bad. (CHW3)

The present study revealed that, FHt professionals, although experiencing obstacles to the effectiveness of their practice, seek to develop it directed to the objective and subjective needs of individuals/families, i.e., a practice centered on people/users. They also report the importance of team practice and values as foundations for care centered on the person/user, in the context of FHS.

Discussion

By practice we understand the work in health structured by social arrangements and, centered on objectives that are internal to them.⁽³⁾ Moreover, practice is also understood by the application of knowledge in concrete situations, which brings with it a determined end that responds to a society project in which health-disease-care conceptions are permeated.⁽⁷⁾ Considering FHt as a practice means that, through professional practice, nurses, physicians, nursing technicians and community health workers seek the realization of comprehensive care centered on the person/family as the internal good.

From the perspective of professionals, the understanding of population's health needs should be based beyond the clinical demands standardized by protocols and intervention in biological bodies. It is emphasized that the internal good of FHt needs to broaden the perspective of the biological and technical model, to understand the instituting nature of the singular arrangements that structure the functioning of FHTs, capable of influencing the ways of being, living and producing care in this context of the health care network.

In this aspect, this study dialogues with other studies that sought to understand how work is configured in FHts, focusing on the potentiality of the subjective dimension of the mode of production in health, integrating the world of values, feelings and ethical and cultural aspects.^(7,9) Subjectivity related to care in the context of FHt relationships, "is marked by a constant deconstruction and construction of existential territories, according to certain criteria that are given by knowledge, but also and fundamentally following the sensitive dimension of perception of life, and of itself, in the flow of continuous intensities between subjects who act in the construction of social reality".⁽⁷⁾

For this, FHt needs to expand its creative and imaginative capacity, as well as its human sensitivity and understanding of health and social issues in order to incorporate reflections and actions on new themes and problems and express its capacity to deal with the complexity inherent to the person and/or the community.^(4,14) The expressions of FHt's prac-

tice, centered on the care of people/family, show the focus on professional ethos, whose approach to activities is in people.⁽⁴⁾

From the perspective of virtue ethics, it is important to clarify that, in order to achieve the internal good of practice, professionals need to incorporate, in daily work, the virtues understood as the excellence of the character⁽³⁾ and, identified as a necessary ingredient for the meeting of health professionals with users.⁽¹⁵⁾ Professional virtue is the disposition or characteristic that allows the moral agent to act for good, pursuing the goal of a specific activity. The virtuoso in a profession is therefore one who in the search for *telos* of practice aspires to be the best and most competent possible.⁽³⁾

From this perspective, the results pointed out that FHt professionals impel values to their actions as important virtues in practice. Thus, values such as respect, justice, care, empathy, humility, responsibility and comprehensiveness appeared as a guide of the ethical moral elements of FHt's practice, enhancing the reach of the internal good.

A study that sought to identify the values that guide nursing as a social practice correspond sup- plements with the findings of this research by revealing that for good care, it is necessary to look at the comprehensiveness of health care. This situation demands that professionals understand the social context through empathy, the promotion of a space of dialogical interaction between users, community and team and the identification of people's health needs and expectations, based on qualified listening.⁽⁷⁾ It is then inferred that comprehensiveness is delineated as a fundamental principle of health care and that reverberates in practice as a virtue, i.e., implies commitment to a care resulting from a practice constructed socially between professionals and users, directed to the objective and subjective needs of people in their social context, seized and transformed into actions by FHt, in line with the internal good of practice.

The establishment of bonding and trust are remarkable virtues in the relationships between team and users and, was externalised in this research, by the bonds of affection and attention that strengthen and strengthen relationships, making them fruitful

for mutual cooperation between community people and FHT professionals in the production of health.

Authors have pointed out that among the potentialities of FHT's work, those related to light technologies, such as bonding and welcoming, demonstrate great effectiveness for horizontalized practices marked by mutual commitment, responsibility and intimacy, favoring care and interpersonal affinity.^(7,16) Also point out that such strategies are strengthening empathy and the relationship of trust between the health professional and the user, assisting in the construction of user autonomy.^(16,17)

However, participants revealed circumstances in which care centered on individual/family was unsuccessful due to the excess of administrative and procedural demands with consequent work overload. In the same direction, a study conducted with FHT nurses reveals that practice is weakened due to high demand for care and overload of non-private services of nurses, distancing professionals from continuous and intimate contact with patients, revealing the non-realization of the idealized and considered correct practice.⁽¹⁸⁾

Aspects related to the organization and management of FHTs were also mentioned as obstacles to the implementation of team practice. Precarious working conditions, work overload, time limit for patient care and interpersonal relationships redirect professional work to the focus of current norms and, to achieve the imposed goals, evidencing bureaucratic ethos.

In this regard, it is worth mentioning that the technical and administrative activities of work management and organization also compose what is characterized as a practice for FHT, being part of bureaucratic ethos of practice.⁽⁴⁾ What cannot happen is prioritizing the realization of bureaucratic ethos to the detriment of professional ethos, which would hinder the search for the internal good and would mischaracterize FHT's practice.⁽³⁾ Study that showed the recurrence of weaknesses in FHT organization and relationships demonstrated that the participating professionals faced daily situations that contradicted their ethical precepts of comprehensive and continuous care to people, which allowed experiences of moral distress.⁽⁸⁾

Therefore, FHT, in its practice, needs to combine scientific knowledge, technical skills and legal norms of professions with interpersonal relationships, which, in turn, must be permeated by values that guide the search for person-centered care. It is understood, therefore, that FHT's practice should be configured in the coexistence of legality (bureaucratic ethos) and ethics (professional ethos).⁽⁴⁾ Thus, the virtuous practice of FHT should promote empathic listening, emotional sensitivity and recognition of the uniqueness of each user, combined with knowledge, scientific evidence, and technical skills.

Therefore, it is suggested that moments for listening and discussions about the difficulties faced for the implementation of practices be created in health units, allowing space for emotions, moral values and feelings to be expressed, especially in order to promote actions that allow the reduction of obstacles to ethical practice. Furthermore, it is recommended to reorient the training processes of professionals, with emphasis on the presentation and valorization of virtue ethics as a potentiating component of professionals' moral development, with a view to improving FHT's practice.

As limitations, it is pointed out that FHT's practice was explored in a city in the countryside of Minas Gerais, suggesting that new investigations be developed to explore other spaces, and the scarce literature using virtue ethics as an epistemological basis, especially in the context of FHT. It is emphasized, however, that, since ethics is intrinsic to professionals' practice in FHT, the results of this investigation can be applied, supporting reflections about the construction of professional practices that envision individual-centered care centered considered as the scope of performing health.

Conclusion

The internal good of FHT's practice was explained by the constant search of professionals to centralize their actions on users and seek to meet their needs. However, they encounter obstacles to achieving it due to excessive bureaucracy, failures in the organization of services, excessive demands, and the

pressure of time. FHT, through virtues, performs its practice with the expansion of the gaze in the direction of understanding the singularity of each subject and the comprehensive perception of attention to its objective and subjective demands.

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Collaborations

Ferraz CMLC, Caram CS and Brito MJM collaborated with the project design, data collection, data analysis and interpretation, writing of the article, relevant critical review of intellectual content and final approval of the version to be published.

References

- Mendonça MH, Matta GC, Gondim R, Giovanella L, organizadores. Atenção Primária à Saúde: conceitos, práticas e pesquisa. *Saúde Debate*. 2018;42(11):452-6. [resenha por Carlos dos Santos Silva].
- Brasil. Ministério da Saúde. Portaria Nº 2.436, de 21 de Setembro de 2017. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes para a organização da Atenção Básica, no âmbito do Sistema Único de Saúde (SUS) [Internet]. Brasília (DF): Ministério da Saúde; 2017 [citado 2020 Jun 30]. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt2436_22_09_2017.html
- MacIntyre A. *After virtue: a study in moral theory*. 3rd ed. New York: Bloomsbury; 2013.
- Cortina A. *Cidadãos do mundo: para uma teoria da cidadania*. São Paulo: Loyola; 2005.
- Zoboli EL, Schweitzer MC. Nursing values as social practice: a qualitative meta-synthesis. *Rev Lat Am Enfermagem*. 2013;21(3):695-703.
- Ferraz CM, Vilela GS, Moreira DA, Brito MJ. Moral sensitivity in the practice of Family Health Strategy professionals. *Rev Rene*. 2021;22:e60281.
- Santos DS, Mishima SM, Merhy EE. Processo de trabalho na Estratégia de Saúde da Família: potencialidades da subjetividade do cuidado para reconfiguração do modelo de atenção. *Cien Saude Coletiva*. 2018;23(3):861-70.
- Cardoso CM, Pereira MO, Moreira DA, Tibães HB, Ramos FR, Brito MJ. Moral distress in family health strategy: experiences expressed by daily life. *Rev Esc Enferm USP*. 2016;50(Spe):89-95.
- Costa IP, Moreira DA, Brito MJ. Meanings of work: articulation with mechanisms of risk and protection for resilience. *Texto Contexto Enferm*. 2020;29:e20190085.
- Minayo MC. Amostragem e saturação em pesquisa qualitativa: consensos e controvérsias. *Rev Pesq Qualitativa*. 2017;5(7):1-12.
- Yin RK. *Estudo de caso planejamento e métodos*. 5a ed. Porto Alegre: Bookman; 2015.
- Brito MJ, Caram CS, Montenegro LC, Rezende LC, Rennó HM, Ramos FR. Potentialities of Atlas.ti for data analysis in qualitative research in nursing. In: Costa AP, Reis LP, Sousa FN, Lamas AM. *Computer supported qualitative research*. Switzerland: Springer International Publishing Switzerland; 2016. p. 75-84.
- Bardin L. *Análise de conteúdo*. São Paulo: Edições 70; 2016.
- Gomes D, Zoboli EL, Finkler M. Problemas éticos na saúde bucal no contexto da Atenção Primária à Saúde. *Physis Rev Saúde Coletiva*. 2019;29(2):e290208.
- Scott PA. Nursing and ethical dimension of practice. In: Scott P, editor. *Key concepts and issues in nursing ethics*. Deutschland: Springer; 2017. p. 1-13.
- Santos RO, Romano VF, Engstrom EM. Vínculo longitudinal na Saúde da Família: construção fundamentada no modelo de atenção, práticas interpessoais e organização dos serviços. *Physis Rev Saúde Coletiva*. 2018;28(2):e280206.
- Bain LE. Revisiting the need for virtue in medical practice: a reflection upon the teaching of Edmund Pellegrino. *Philos Ethics Humanit Med*. 2018;13(1):4.
- Rezende LC, Caram CS, Caçador BS, Brito MJ. Nurses' practice in quilombola communities: an interface between cultural and political competence. *Rev Bras Enferm*. 2020;73(5):e20190433.