

# Singularities work of a rehabilitation center under the perspective of the healthcare team

*Experiências da equipe de centro de reabilitação - o real do trabalho como questão ética*

*Experiencias de un equipo de salud en un centro de rehabilitación - la realidad del trabajo como cuestión ética*

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## ABSTRACT

**Objective:** The primary objective of this research was to identify the working experiences of health professionals at a physical rehabilitation center, and from there, to discuss the central ethical/bioethical issues that permeate the care for physically disabled persons. **Methods:** This is an exploratory-descriptive study of a qualitative nature and unique case research type, with the participation of 16 professionals from the multidisciplinary team of the rehabilitation center. **Results:** It was possible to identify situations associated to a labor organization, user accessibility, communication difficulty among professionals and managers, troubles to perform the prescribed work and achieved one. **Conclusion:** Moreover, the professionals do not recognize nor identify situations or ethical problems on the healthcare practice. There are no spaces or opportunities for ethical discussions and reflections on behalf of the team, which expresses the need for ethical skills development.

**Keywords:** Disabled Persons; Rehabilitation Centers; Patient Care Team; Working Conditions; Ethics, Professional.

## RESUMO

**Objetivo:** O grande objetivo deste estudo foi identificar as experiências de trabalho de profissionais da saúde de um centro de reabilitação física e, a partir disso, discutir as principais questões éticas/bioéticas que permeiam o cuidado ao deficiente. **Métodos:** Estudo exploratório-descritivo do tipo estudo de caso único, de natureza qualitativa, com participação de 16 profissionais da equipe multiprofissional do centro de reabilitação. **Resultados:** Foram identificadas situações relacionadas à organização do trabalho, acessibilidade do usuário, dificuldade de comunicação entre profissionais e chefia, dificuldade de implementação do trabalho prescrito e o realizado. **Conclusão:** Além disso, os profissionais não reconhecem ou identificam situações ou problemas éticos na prática assistencial, inexistindo espaços ou oportunidades de discussões e reflexões éticas por parte da equipe, o que expressa a necessidade do desenvolvimento de competências éticas.

**Palavras-chave:** Pessoas com deficiência; Centros de reabilitação; Equipe de assistência ao paciente; Condições de trabalho; Ética profissional.

## RESUMEN

**Objetivo:** Identificar las experiencias de trabajo de profesionales de salud de un centro de rehabilitación física y, a partir de esta observación, discutir las principales cuestiones éticas y bioéticas que permean los cuidados con personas con discapacidades. **Métodos:** Investigación exploratoria-descriptiva del tipo estudio de caso único, de naturaleza cualitativa, con participación de 16 profesionales del equipo multidisciplinar de un centro de rehabilitación. **Resultados:** Fueron identificadas situaciones relacionadas a la organización del trabajo, accesibilidad del usuario, dificultad de comunicación entre los profesionales y la jefatura, dificultad de implementación del trabajo prescrito y de lo realizado efectivamente. **Conclusión:** Los profesionales no reconocen o identifican las situaciones o problemas éticos en la práctica asistencial, no existiendo espacios u oportunidades para discusiones y reflexiones éticas por parte del equipo, lo que expresa la demanda por el desarrollo de las competencias éticas.

**Palabras clave:** Personas con discapacidad; Centros de Rehabilitación; Grupo de Atención al Paciente; Condiciones de Trabajo; Ética Profesional.

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## INTRODUCTION

Disability became part of the human condition, being that this is a broad term that covers various forms of disability; and almost everyone will have some type of temporary or permanent disability at some point in their lives<sup>1</sup>.

Studies describe health actions the person with a disability must be provided at various levels, ranging from Basic to specialist services, such as Rehabilitation Centers, always striving for comprehensive care for the health of this individual<sup>2</sup>. Healthcare to these persons are intended to rehabilitate the disabled person in their functional capacity and human performance, while protecting health and preventing diseases that determine the onset of disabilities through health promotion actions<sup>3</sup>.

The specialized site for the rehabilitation of persons with disabilities is the Rehabilitation Center (RC) which is organized by Ordinance MS/GM Nº 818/of 05/06/2001, where it is determined the creation of the State Networks of medical assistance to persons with disabilities and the composition of the multidisciplinary team responsible for such care<sup>3</sup>. Teams are formed by professional nurses, doctors, physiotherapists, occupational therapists, speech therapists, psychologists, social workers, and nutritionists, which perform individual review and also the planning of the rehabilitation process<sup>4</sup>.

This study presents a part of a research that focused not on disability itself, but the professionals who work directly with physical disabilities in a specific institutional setting - A rehabilitation center.

The work in the studied institution is developed by a multidisciplinary<sup>4</sup> professional manner, developing activities in five distinct areas: adult neuro and musculoskeletal rehabilitation; treatment of spasticity and dystonia with botulinum toxin application; pediatric rehabilitation; cardiopulmonary rehabilitation and orthotics program, prostheses and auxiliary means of locomotion - OPMAL.

The study had the objective of discussing the major ethical/bioethical issues that permeate the care to the disabled from the workers' experience of the healthcare team a referral center for physical rehabilitation. Moreover, it sought to identify the intensity and frequency of stress of the participants in the performance of daily activities in the service.

This study is aimed at the interface between professional experience and ethical problems that may be related to work in this type of service and next to disabled users. This theme is justified by the importance of recognizing the difficulties and ethical demands in this work, where problems and circumstances require professionals to judgment and moral deliberation, as well as protective actions of the rights of these individuals and promoters of quality of care.

## THEORETIC REFERENTIAL

In their practice of healthcare workers are faced with numerous obstacles which are characterized as aspects that hinder the application of a particular care. In the experience of social processes, and in environments where they share knowledge and actions, the subjects involved issuing opinions, ideas, and changes and organize their conceptions of the world, identifying values that mobilize a process of deconstruction and reconstruction of knowledge on the subject and society. Critical propositions about health work imposes a change of look about the practices and the values involved, starting by identifying obstacles to a dignified and human care, in which all participants are responsible for devising and implementing effective strategies for effective, determined, and humanized quality care<sup>5</sup>.

Once recognized the ethical dimension of professional practices, the concept of humanization shown as an important basis and applicable in various departments and fields of nursing practice. Professionals are articulated this concept to multidisciplinary practice and customer relations, valuing all the protagonists of the care process, including subjective issues, moral, ethical and relational, that align to the principles of the national policy of Humanization<sup>6</sup>. It is up to the professional review and rethink their practices, abilities and limitations, get theories, and associate the ethical issues involved in ensuring patients' rights, to make humanized and quality care<sup>7</sup>.

In the adopted perspective, as important as the focus on ethics is the focus on experience, so that the reflection on the ethical dimension of seized experiences gave up not merely by events or ethical problems but also by how these workers talk about what is the work and how to perform it, the difficulties they experience and the values and skills that mobilize them. To support such an analysis concepts were used on healthcare work, especially the relationship between the prescribed work and actual work, i.e., the dialectics between the face discursive, regulated and institutionalized labor and its singular and subjective face, which escapes control and rule<sup>8,9</sup>. In addition, the discussion of the empirical results was supported in bioethics propositions related to vulnerability of poor and accessibility thereof; and some principles of the National Policy of Humanization (NPH), as extended clinic, reception, co-management and participatory management<sup>10</sup>.

## METHOD

This is descriptive exploratory study of type single case study, qualitative in nature, being a study developed in a physical rehabilitation reference center in the State of Santa Catarina, of public character, belonging to the State health Secretariat (SHS).

The study was carried out with 16 professionals from a multidisciplinary team: 03 nurses, 03 physiotherapists, 03 physicians, 01 physical education teacher, 01 nutritionist, 01 psychologist, 01 occupational therapist, 01 social worker and 02 nursing technicians, being that these the most quantitative multidisciplinary team professionals of the studied site. As an exclusion criterion we used; professionals that worked at the site for less than 06 (six months) or were on work leave. The gathering occurred on the clock, but scheduled as the availability of same without jeopardizing care to users. The period was April and may of 2013, through a semi-structured interview.

For the organization of qualitative data the ATLAS-Ti 7.0 software was used. Data analysis was carried out through the transcription of interviews, where similar snippets were grouped reflecting the main ideas identified in the research.

The proposed master's thesis integrated the macro project (funded by PRONEX Edict), "The health care of the handicapped in Santa Catarina: reality and challenges. The study was approved by the Ethics Committee of the Federal University of Santa Catarina, respecting the recommendations of Resolution Nº 466/12 of the National Healthcare Council (NHS).

## RESULTS

The professional respondent profiles are characterized by a predominance of females; aged 29-57 years; time of work in physical rehabilitation from 08 months to 20 years; and 06 exclusively dedicated professionals and 08 keeping other ties; all joined by public tender and were trained, mostly in public institutions.

The results are summarized in two main categories, interrelated and that, while not similarly highlighted the workers' demonstrations, receive similar importance in this study. Initially they are presented distinctly, as "the real work" and "as real as the real work said," to be articulated in the analysis process.

### The actual work

When talking about their work experiences it is common for workers to speak not only about what they do, but as they do, or under what conditions. An important element of the labor organization as regards working conditions recognized by directly influence the care provided and the very subjective relationship of the worker with their activity. When the professionals were asked about the working conditions, reported several negative aspects, mainly related to:

- a) Physical structure as it is old and in need of reform; They have improvised rooms for service and even being a reference institution for disability, the structure does not have adaptation in doorways or furniture.

*The structure here is bad, even the door for a quadriplegic... Does not open. It has been said,*

*it was scored, accessibility for a "quadriplegic", "paraplegic" and wheelchairs it is not good inside (P2)*

- b) Lack of basic materials and equipment for daily activities with users and lack of maintenance in the few that have equipment.

*The ultrasound machine has to be checked to see if that the sound ultrasound wave is good or bad and its calibration should be performed frequently, but it is not (P1).*

- c) Lack of human resources due to non-replacement of retired or transferred workers; combined with lack of resources appears in the work overload reported by professionals who remain in the institution and the lack of professional enhancement.

*The issue of human resources it is well short of our need, in every industry here in rehab. We are all the time having to transfer the employee from now on, for example, we have a nurse there in medical bills, and we have a nursing technician here on paper, when it could have administrative personnel (P5).*

When asked about the difficulties they face in carrying out activities, issues were identified relating to:

- a) Working conditions such as structural difficulties, lack of equipment and consumables, lack of human resources and exams and have been described above.
- b) Lack of support from managers in the development of activities, as well as the excess monitoring activities carried out by professionals;

*The body is very small, but nevertheless has plenty of supervision with professionals; there is a lot of supervision being that no one is a child, everyone is an adult and knows their duties (P2).*

- c) Difficulty of communication between team members; lack of case discussion/study groups regarding the pathologies treated in the institution and lack of commitment of some professional colleagues;

*I think some relationships could be better, but then public service has a stability issue, so I think people have to learn to live with those people and not so much about change (P13).*

*I think they could refine the administrative and technical communication, I think this is a great point of power, trying to act and establish a better alignment (P8).*

- d) difficulty in providing high of user service and empower the family in caring for this user, retro nurturing lack of family support;

*Our major challenge in rehabilitation is to bring the family around, because the patient alone can't, that that's very clear, if the rehabilitation is not worked along with the primary caregiver, the family that is, I cannot rehabilitate the patient (P5).*

- e) and Difficulty in training) admission of new employees, in which they don't feel as qualified professionals;

*I think I'm going to become repetitive, but I told the planning, to set goals, make a prediction that should not include only the operational part more managerial assistance and health education; things that we can do a little example, forecasting of some professionals with contest, I had to make a forecast additional training, we can't! (P7).*

- f) Difficulty in organizing the scheduling of consultations and the large bureaucratic demands;

*It is the large volume of administrative activities [...] as an institution we should organize it better. We fill out paper too much; we could have an administrative organization for this paper flow and service information (P13).*

- g) Difficulty in providing transport for users to be able to come to the CR;

*As most patients depend on transport, therefore, I think our biggest problem is SUS. Today for example we had two patients scheduled for curative and we know you need and that did not come because we know that the public ambulance did not bring them, there is a problem since the ambulance could not come (P14).*

- h) It is difficult to disclose to other health services the real role of the CR and the activities developed by the institution.

*The question of rehabilitation is very related to lack of knowledge of health professionals, except the physiotherapists, with regard to what they are rehabilitating. If there was this knowledge and to come from vocational training we had in another situation today (P7).*

### As real as the "real saying" the work

A dimension less visible and spoken, but no less real, refers to what produces while subjective experience of everyday work, expressed in different forms, among which are highlighted.

The perception of working conditions and refers to identification by participants of the stress they feel to perform

daily activities on the job. When asked to indicate the intensity of this stress, considering a gradation of 1-5 (1: Very weak; 2: Weak; 3: Moderate; 4: Strong; 5: Very strong) a large part of professionals flagged the perception of stress intensity 3 and 4 (moderate and strong), totaling 11 responses. They emphasized that the activity is not always stressful, but even in individual cases require management. Only one professional answered option 5 and the same was returning from a leave of absence for health treatment.

Yet, on the same scale were requested to respond to often feel stress to perform daily activities in service (being 1: ever; 2: rarely; 3: sometimes; 4: often; 5: always). Six respondents chose option 3, and options 2 and 4 were chosen by three professionals each. The reason was the same alleged earlier, even if it seems contradictory that frequency as "sometimes" and "often" (9 replies) may be characterized as "specific situations". What turned out to be common in the two issues was difficult to relate objectively being situations, generally termed as "on time", or relate them to many of the conditions before described, as if they were relatively expected effects in the work they develop.

An interesting result is that the participants, when questioned about ethical issues, do not recognize or remember the occurrence of any ethical situation they have experienced within the service. There have been reports relating to fill forms and bureaucratic reports that were cited by reducing the time of customer service, causing nuisance to the professional.

*Ethical dilemmas, look I do not remember recently having had a big ethical dilemma, I do not remember at least here in (P3).*

*Look the only question that bothers me a lot that form-filling issue. So an effective 40 minutes could be quietly to 45 minutes, or so instead of 40 minutes depending on the patient, 35 minutes (P1).*

## DISCUSSION

### The actual work as object of ethical reflection

When they sought to identify the main ethical issues present in the poor care practice from the experiences of professionals, I was expected to find reports of situations experienced and related to the poor condition of vulnerability, lack of accessibility or else the lack of user autonomy in decision making<sup>11</sup>. Contrary to what was expected, negative reports related to predominated working conditions experienced by professionals.

Far from being empty, the silence on the subject is very significant and can be the focus of analysis, especially from concepts and assumptions mediators. Here we launched hand the concept of prescribed and real work, of some principles of PNH who become reference for this type of service/care and elements for a discussion on bioethics.

For this discussion, it is understood that the prescribed work is based on the definition of tasks (formal and informal) that operationalize a division of labor, determine the rules and dictates the qualitative and quantitative production goals. Real work involves the subject's activity<sup>8</sup>. Identify the activity means identifying the actual work. The institutional requirements must be accompanied by conditions to be effective and if there is insufficient or inadequate manner, the means may hinder the achievement of activities or even stop it<sup>9</sup>.

Considering the need to organize the health care handicapped, Ordinance No. 818 regulated the deficient care services based on the principles of universality and comprehensiveness of health actions<sup>9</sup>. Services can be regionalized and, in the absence of these, must be deployed to a State reference service in physical medicine and rehabilitation, with appropriate physical facilities, materials available and multidisciplinary team specializing in the care of these users, both in outpatient activities and for monitoring and dispensation of orthoses, prostheses and auxiliary means of locomotion. From this general order, a prescribed work is constituted, that is, a way to structure the institution is based on formal rules outlined in the ordinance and in order to standardize assistance to the physically disabled.

The actual work does not conform or is driven by the aforementioned. The service is public and State reference character, and there is no record of another institution that performs the same type of assistance. The referrals for entry to the institution are conducted through the Municipal Health Department, but as the demand of people seeking the service is great, there is waiting list for admission. The physical structure is old, in need of structural reforms and adaptations including for receiving the public that is serviced on site. Despite having a large installation, the amount of rooms is insufficient for the professionals who are faced with problems of different order, resulting from a fragile structure with basic supply of materials and equipment, but without periodic and/or preventive maintenance.

Regarding the team, this presents multidisciplinary composition, maintain a discourse of collective and interdisciplinary care, but most of the observed activities elapse of individualized and team meetings or brief case discussions to sectors of referrals are characterized as a collective moment. The team includes minimally all professionals who are described in the Ordinance, but requires completion due to retirements and departures of employees, which causes overload in professionals who continue performing the functions at the institution. In addition, the team mostly, except for medical physiatrist and physical therapist, has no training/expertise in the field of physical rehabilitation and learning to develop the practice. The service also has an orthotics sector, prostheses and auxiliary means of locomotion, which partially covers the activities, suggested in the lobby, getting weakened in monitoring the prosthetized users in fact the institution is bound by the physiatrist or laboratory that confectioned the prosthesis.

The discrepancy highlighted over here on the prescribed and real work leads us to reflect on the numerous barriers faced by professionals and how the guidelines, which are advocated by the Government, end up getting linked to its own bureaucracy. This contradictory relationship is reflected in the making of the professionals, who know or believe to know what the right thing to put into practice is, but for many situations can't perform the action in a manner prescribed or desired.

However, it is recognized that the ways of working reinvented the dynamics of services is adapted to the extent possible, be resistance to a prescribed or even arrangements built more or less agreement involved, do not always mean harm to the result achieved or break with established values. Often they represent alternatives to safeguard values, promoting certain principles and logic to the detriment of others, or produce the least possible damage.

The "activity", or actual work, translate the work done and this should be thought of as a dialectic between say and do, the general and the singular, the micro and the macro, the local and the global, the goal and the symbolic<sup>8</sup>. Thus, the work cannot be predicted.

In addition to the issues related to working conditions, others were identified in the daily activities of the professionals. Regarding service flow, it was observed difficulty scheduling generating duplicity times and dissatisfaction of the professionals in the high demand of filling out forms during care. The difficulties may be related to professional work overload causing mental wear and inattention, as well as the relocation of staff due to the need of the institution, often to perform functions for which they were hired.

In the case of some principles of PHN, not limited to new requirements to guide what to do and how to do it, as they are usually taken and regulatory policies, but refer the valuation of forms of creation and co-management which should emerge from the analysis that the workers themselves performing the care. As an example, it could be argued user access to the CR, which goes through a screening process for admission to the institution, and there is a hosting service for receiving them. The host is an important instrument suggested by the PHN which differs from triage theory as in the practice. Screening there selection of who will be admitted, including qualified listening, care, and if necessary, the responsible referral<sup>10</sup>.

With respect to filling out forms, professionals should have a specific time to perform such activity, understanding the importance of data and using their results and indicators to qualify and make the care planning. The PHN assumes that most of the time the employee submits to work to realize the interests of the institutions and this model omits the process of creating professional, making work a place of repetition, series production, realization of what was thought by someone else<sup>10</sup>. For this, it is suggested the production and construction of responsibilities shared form, resulting in the production of health improvement, since the will to participate and develop will be magnified, reaffirming ethical assumptions on healthcare.

Whereas public health services still have a few spaces for discussion and sharing of experiences, the fight for better working conditions is an ethical exercise<sup>10</sup>. It is noteworthy that not always what is prescribed is the ideal, therefore it is important that in the staff is attentive and conducting the evaluation of the assistance in the service, identifying the conduct that is being implemented is the most suitable.

The relationship between prescribed and real work can be seized important ethical issues related to the accessibility of the user, the prioritization and flow of daily activities of the professionals, the communication between staff, to relatives, to high and to the relationship of professionals with each other and with the leadership; all situation highlighted by interfering in health care practice and require the decision of the professionals.

In relation to health care, every citizen must have a health-care network, composed of a set of organized health services and equipment in a particular geographic territory, with basic health services/family health strategy next to homes; these pleadings for the care services according to the user's health needs<sup>10</sup>. In this case, the barriers identified were related to assistance network set up problems because users of inner lack of close care referral services to households without a guarantee of comprehensive care.

With respect to assistance provided there are reports of difficulty in communication among professionals, with few opportunities to exchange knowledge, limited to meetings and ad hoc situations and not contemplating continuing education. Although not noticing a relationship of support and solidarity among peers, were also not identified manifestations of conflict or friction between the relevant professionals.

The current health policies propose multidisciplinary actions guided by the expanded clinic, where professionals meet the user taking into account different attitudes and feelings. In addition, they seek help in other sectors (inter-sectoral), recognize the limitations of knowledge and technologies employed in the service, seeking other knowledge and support and assuming an ethical commitment in the activity that they are developing<sup>10</sup>.

Again, an important gap between prescribed and real, fragile team relationships. The members believe perform an interdisciplinary work, but this is limited to specific group activities. Most actions are individualized, without knowledge or complementarily of team interaction, especially between different sectors. PHN devices would apply to the various problems identified. The expanded clinic, for example, would promote the relations, once the team discusses the cases met by placing in watch mode analysis. Also the implementation of co-management and participatory management could lead to discussion, analysis, Division of responsibilities and consensus, producing greater inclusion of professionals in the development of new roles and tasks, as well as sharing power, conflicts and responsibilities.

It reinforces the idea that teamwork is fundamental in physical rehabilitation with the goal of making the user the most functional possible<sup>11</sup>. A weakened team relationship can influence indirectly other evident difficulty, which is the empowerment of the family by the user care and the outpatient discharge process. In the real work, professionals report that the adherence of the family is important, but in practice only perform orientation activities for them and in specific situations. This draws attention to the fact the high of a user being discussed as a group since the activities carried out with it are individual, as well as planning and evaluation; and that reason can be one of the factors causing insecurity to the professional when providing the discharge. The prescribed activity reinforces the importance of having the family as a partner in rehabilitation because they will continue the care at home, as a supporter in the recovery and maintenance of the handicapped at the household level.

Matters relating to the coordination of work emerged through lack of support in development activities, excessive monitoring and lack of training for employees. On the job prescribed, it is expected that the leadership supports the activities, stimulating open and linear dialog with peers, valuing professionals in care practice, these features present in the co-management or participatory management. It is expected that the leadership is a partner, empowering and guiding new employees and keeping training for employees already working in the institution. It is believed that the quality of care and satisfaction of workers will depend on the conduct of managers in facilitating dialog, strengthening the creative interaction between professionals and health services, in addition to considering the collective management as a key criterion for the promotion of health and prevention of illness<sup>10</sup>. However there is still not enough experiments reported or of services expanded provision of health that work on the logic of collective spaces enabling discussion and sharing of experiences.

All the issues described somehow generate stress and restlessness in CR professionals and, not being object of study; it has not been possible to identify their specific causes. The perception of stress itself goes against a subjective evaluation, once the confrontation of potentially stressful situations depends on the perception and analysis of the individual regarding the overload caused by a stressor<sup>12</sup>, thus, questions the effectiveness of professionals to make a subjective analysis of the activities that are developed within the service.

The care provided to people with physical disabilities refers to various ethical situations, as well as the experiences of these people point not yet overcome problems such as prejudice, vulnerability and disenfranchisement, despite the public policies that ensure the inclusion of these subjects. Ethics is evidenced in the attitudes and individual decisions, including the Act of profession; influencing the rights front positioning and recognized vulnerabilities or ethical problems present in the daily life of the

services. Everyday conflicts experienced by nurses demanding moral deliberation and these are based on speeches legitimized by the profession for arguments, evidence and values<sup>13</sup>.

Even in the face of all the difficulties already discussed and professionals to experience on a daily basis, they do not understand the ethical content of their experiences. This can be seen as a problem within the institution, as in so many others, it signals that the professionals are not experiencing the sensitivity to acknowledge and the competence to deal with ethical problems, blending the everyday technical issues and demand for moral deliberation.

Moral sensitivity plays an important role in the decision-making process of the professionals and is required for the identification of fundamental ethical dilemmas, favoring the assessment of appropriate values seeking alternative solutions. This relates to the decision process that is brought into the study by Zoboli and Smith as the self-education process, almost self-analysis, which aims to underpin the transformation of professional practice through change of attitude. Thus, it extends to understanding the experiences and experiences, creating favorable environment for changes of professionals, responsible commitment to moral and technical excellence of their practice and care<sup>13</sup>.

When the professional can't perform this exercise, may indicate a significant gap in the ability of perception and questioning, under the ethical point of view, issues normally reduced to a technical or managerial dimension in health services. Still it is believed that the collective discussion is the best way, and can be used as a strategy to stimulate reflection and identify institutional problems and the professionals themselves. When professionals base their actions on recognized as ethical values in health and nursing, they seem to be more protected in their decisions, which can help themselves and the patients<sup>14</sup>. Thus, decisions based on ethical reflection provide added safety to health professionals.

Possibilities of change in the quality of care and power relationships present at work in health are related to forms of resistance and moral deliberation that face institutional and relational conditions that cause moral suffering and loss of autonomy, as well as the strategies of advocacy for the patient by the nurse<sup>15,16</sup>.

When working with health professionals demands require making decisions with responsibility and respect for others, including the team that shares the same work environment<sup>17</sup>. The absence of ethical discussion is already suggestive of the challenge of overcoming the Division and isolation of ethics in relation to reasoning and clinical trial assistance. Technical competence is not divorced from the ethical competence and this requires a new kind of commitment and sensitivity, which still seems to be neglected in training and work processes, especially when the professional performance, as in the case of the rehabilitation team, turns to people with specific vulnerabilities.

In function of the work being performed in a complex site, featured as the only assistance service specifies within the State, it is believed that all actions of the professionals, be they social, guidance or technical, are liable to questioning and ethical reflections and that non-reflection about these practices can influence the result of the work done by these professionals in daily practice. Still, there is that the prescribed work and the actual work can be important tools to aid in the understanding and discussion of ethical problems and bioethical issues in health care.

## FINAL CONSIDERATIONS

With this work we were able to demonstrate within a service aimed at users with specific demands and high social vulnerability the absence of discussions and ethical reflections. It was evident among the studied professionals, the need to develop sensitivity and ethical competence to articulate clinical, managerial and moral deliberation decision, even when they are able to point out different situations and limits weighing on the work they do.

Far from indicating limits or personal guilt must recognize the effects of training processes that have not valued the same way technical skills and ethics; as well as services that were not able to commit to continuing education or the execution of public policies that restore ethics as the foundation of practices. There is a major challenge towards the identification and recognition of situations/ethical problems by professionals and it is believed that the problems will only be seen after stimulating dialogue about professional practice, as in promoters of co-management devices and enhancement of the workers.

Still, the exercise to reflect on the work prescribed and the actual developed in the institution was interesting because it allowed the perception that various difficulties are verbalized adjustments, however, for that to happen, the teams must start with the change of attitude and relationship between the members themselves.

The importance of studying bioethical issues in healthcare services yet distanced from the everyday work emphasizes that this theme should pervade the practice and decision-making of all healthcare professionals in order to ensure good care practice.

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