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Barriers and facilitators to the implementation of an ethical environment in a traumatology service

Barreiras e facilitadores para construção de um ambiente ético em um serviço de traumatologia

Barreras y facilitadores para la construcción de un entorno ético en un servicio de traumatología

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ABSTRACT

Objective: Identify the main barriers and facilitators to multi-professional practice to promote an ethical environment in a traumatology service. **Method**: this exploratory-descriptive study with a qualitative approach addressed ten professionals from the multidisciplinary team of a traumatology service at a University Hospital located in southern Brazil. Three doctors, three resident doctors, two nurses, and two nursing technicians participated in the study. Data were collected from September to October 2019 through a Focus Group and analyzed through Discursive Textual Analysis. **Results**: Two main categories emerged: barriers and facilitators to building an ethical environment in a traumatology service. **Conclusion and implications for practic**e: The main barriers hindering the construction of an ethical workplace environment included the presence of different employment contracts, restricted physical space, and bureaucracy, while facilitators included existing protocols and effective communication, which have the potential to promote an ethical workplace environment to fulfill the service's goals, i.e., the humanization of care and patient safety.

Keywords: Ethics; Traumatology; Nursing; Physicians; Ethical Environment; Health.

RESUMO

Objetivo: identificar as principais barreiras e facilitadores do trabalho multiprofissional, com vistas à construção de um ambiente ético em um serviço de traumatologia. **Método:** estudo exploratório-descritivo com abordagem qualitativa realizado com dez profissionais de uma equipe multiprofissional de uma unidade de traumatologia de um Hospital Universitário localizado no Sul do Brasil. Participaram três médicos, três médicos residentes, dois enfermeiros e dois técnicos em enfermagem. A coleta de dados ocorreu no período de setembro a outubro de 2019, por meio de Grupo Focal e foram submetidos à Análise Textual Discursiva. **Resultados:** os dados permitiram a construção de duas categorias principais: as barreiras e os facilitadores encontrados para construção de um ambiente ético em um serviço de traumatologia. **Conclusão e implicações para a prática:** como principais barreiras para a construção de um ambiente ético de trabalho foram identificadas a presença de diferentes vínculos empregatícios, a limitação de espaço físico e a burocracia e como facilitadores, foram destacados a presença de protocolos e comunicação efetiva que juntos podem resultar em uma direção para a construção de um ambiente ético de trabalho, de modo a ir ao encontro com a meta do serviço, no qual se constitui na humanização da assistência e a segurança do paciente.

Palavras-chave: Ética; Traumatologia; Enfermagem; Médicos; Ambiente Ético; Saúde.

RESUMEN

Objetivo: Identificar las principales barreras y facilitadores del trabajo multiprofesional, con miras a la construcción de un ambiente ético en un servicio de traumatología. **Método:** estudio exploratorio-descriptivo con abordaje cualitativo, realizado con 10 profesionales de un equipo multidisciplinario de una unidad de traumatología en un Hospital Universitario ubicado en el sur de Brasil. Participaron tres médicos, tres médicos residentes, dos enfermeras y dos técnicos de enfermería. La recolección de datos se llevó a cabo de septiembre a octubre de 2019, a través del Focus Group, sometidos al Análisis Textual Discursivo. **Resultados:** Los datos permitieron la construcción de dos categorías principales: barreras y facilitadores encontrados para la construcción de un ambiente ético en un servicio de traumatología. **Conclusión e implicaciones para la práctica:** Las principales barreras para la construcción de un ambiente de trabajo ético fueron la presencia de diferentes vínculos laborales, la limitación del espacio físico y la burocracia. Como facilitadores, se destacaron la presencia de protocolos y una comunicación efectiva, que en conjunto pueden resultar en un rumbo para la construcción de un ambiente de trabajo ético, a fin de cumplir con el objetivo del servicio, que constituye la humanización del cuidado y la seguridad del paciente.

Palabras clave: Ética; Traumatología; Enfermería; Médicos; Ambiente ético; Salud.

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INTRODUCTION

The word "ethics" originates from the Greek word "*ethos*" and is understood as integrity, custom, habit, or way of being, comprising behaviors that indicate a culture or group of workers holding values. It is a social tool that guides human behavior, including values, principles and standards[1]. It is indispensable for life in society and is the basis for promoting ethical workplace environments.

From this perspective, work relationships, especially in the health field, are subject to ethical conflicts given the frequency of interpersonal relationships and the workers' ethical responsibility with the care provided to patients[2]. Thus, building an ethical workplace environment is a significant challenge for health institutions, considering that an ineffective management of ethical conflicts leads to precarious working conditions, power games, dissatisfaction, decreased quality of care delivery, and increased costs for institutions[3].

The ethical environment of any organization can be defined as how the institution deals with ethical issues or concerns to determine how one should deal with ethical problems. Thus, an ethical environment can be seen as the organizational climate, including aspects related to the institution's culture and its impact on the workers' practices and procedures, along with organizational policies[4]. Therefore, an inadequate workplace environment from an ethical perspective, in which ethical behavior is not discussed, encouraged, or supported by the institution, can result in more frequent and intense moral and ethical problems, negatively affecting the workers' ethical decision-making and, consequently, leading to moral distress[5].

Several studies report that ethical workplace environments are associated with job satisfaction, increased feeling of professional competence, satisfaction with the quality of care, improved skills to deal with differences at work, and increased efficiency at work[4,5].

The practice of health professionals within hospital settings is permeated by a complex and interdependent work process, which requires the integration of the actions of different professionals in favor of the care provided to clinical patients, thus, resulting in collaborative work. Therefore, assessing the functional and ethical relationships among those involved is essential to identify difficulties and weaknesses, thriving for excellence at all levels of care within the traumatology service, and promoting an ethical environment for health practice[6].

The construction of a robust ethical environment promotes cohesion and harmony among professionals and more effective and quality care practices. Thus, there is a need for multidisciplinary teams to work efficiently and harmoniously to integrate their knowledge, ease difficulties and tensions arising from professional practice, and improve efficiency and competence when providing care[7]. Additionally, professional and personal ethics applied in hospital settings improves the relationship among colleagues, favors the unit's performance, decreases conflicts, and positively interferes in the workplace environment and worker's health[4].

Considering that the main barriers and facilitators imposed to multi-professional work are seldom investigated and intending to promote an ethical workplace environment in a traumatology service, this study's objective is to identify the main barriers and facilitators to multi-professional work toward the construction of an ethical environment, by supporting and strengthening more harmonious and healthy workplace environments, contributing to patient safety and occupational health[7]. Therefore, this study aims to identify the main barriers and facilitators to multi-professional work to promote an ethical workplace environment in a traumatology service.

METHODS

This qualitative, exploratory, and descriptive study addressed ten health professionals from the trauma unit of a University Hospital located in southern Brazil. This study was conducted in a traumatology service because this unit is composed of many workers who need to join efforts to assist the population in general. Because multi-professional relationships take place in this unit, ethical conflicts may occur and impact practice development, possibly compromising patient safety.

The focus group technique was used to collect data. This technique encourages the participants to interact and share their experiences regarding a common subject, enabling discussions and reflections. In this sense, a focus group is a qualitative research technique that promotes communication among participants, producing data. Thus, it is considered a method that promotes interaction, in which participants are encouraged to dialogue and exchange knowledge[8]. Three meetings were held from September to October 2019, lasting up to one and a half hours. A moderator coordinated the meetings accompanied by an observer (the primary researcher and a student from the research group).

Three doctors, three resident doctors, two nurses, and two nursing technicians working in the traumatology unit of a University Hospital located in southern Brazil participated in the study. Guiding criteria were used to gather the group, considering that six to 15 is the ideal number of participants to meet the study's objective. Additionally, the selection of participants should be intentional or planned, and the participants' characteristics should be homogenous[9]. In this case, the participants' common characteristic was working in the same unit, so that ten professionals were selected.

The inclusion criteria were: being a physician, a resident, a nursing technician, or a nurse working in the traumatology unit for at least six months. The exclusion criteria were professionals who did not regularly work at the unit, considering their inclusion could affect the study's results. All the participants signed free and informed consent forms.

The following question was asked in the first meeting: What are the ethical conflicts physicians and nurses experience in their practice at the traumatology service? Each participant was asked to describe a problem situation experienced within the unit and report the solution adopted. Afterward, everyone read their responses, which the group discussed, along with potential solutions for the problems presented.

In the second meeting, the participants received a diagram synthesizing all the situations reported, and each participant was asked to list three factors that impeded and three factors that facilitated the establishment of an ethical work environment. The group also discussed these factors.

In the last meeting, the discussion was intended to propose ways to deal with the main ethical problems presented in the first meeting and list the main barriers and facilitators. In the end, the discussion focused on a multi-disciplinary partnership to establish an ethical environment in the traumatology unit.

Data analysis was based on the discursive textual analysis. The objective was to produce a new understanding of the phenomenon and reports through a self-organized process in which understanding about a given phenomenon is obtained through three sequential phases: unitarization, categorization, and communication[10]. In the unitarization stage, the interviews are read in detail until the participants' statements are deconstructed. The goal is to elaborate a broader meaning and perceive different meanings emerging from the interviews; that is, the reports were disorganized into units gathered by common ideas to facilitate a new understanding[10].

In the second stage— categorization, the initially deconstructed reports were gathered and led to the grouping of new phrases with similar meanings. This step was conducted from an inductive and intuitive perspective, in which the categories emerged from the text by comparing and organizing similar elements and finally, after obtained deep knowledge regarding the theme[10].

In the third stage— communication, we sought to describe and interpret the common meanings of what was produced throughout the study and make it understandable. These three stages enabled reaching a fourth and final stage, the self-organized process. This last stage enabled creating and recreating a new understanding that emerged from deconstructing the reports throughout the process[10].

In order to ensure the study's credibility and internal validity, the transcripts of each focus group's reports were corrected and verified by the participants, which enabled verifying the study results' accuracy and reliability. To ensure reliability, the focus groups' reports were recorded, and detailed notes were taken to keep data organized and enable its recovery and review.

Theoretical triangulation was also used to obtain an analysis from different perspectives, i.e., one professional from the medical field and one from the nursing field interpreted the same set of information: two researchers, a physician, and a nurse, independently analyzed and compared the results. Regarding the study's external validity, one member of the research group, not participating in this study, critically reviewed data to validate the results.

This study complied with the ethical guidelines established by Resolution 466/12 that regulates research involving human subjects. The Institutional Review Board approved the project (Opinion report 175/2019, CAAE: 15723419.3.0000.5324). The reports are identified by the letter "P" followed by the number corresponding to the order in which interviews were held to preserve the participants' identities.

RESULTS

The barriers imposed to the promotion of ethical workplace environments are factors that undermine or impede ethical environments from being created, such as not discussing ethical problems existing within the organization. The facilitators, on the other hand, are factors that help to create an ethical environment, such as the institution providing incentives, encouragement, and discussing ethical issues with professionals[4,5].

Two categories emerged from data analysis: barriers to the construction of an ethical environment in the multi-professional traumatology service and facilitators to the construction of an ethical environment in the multi-professional traumatology service, which resulted in the factors presented in Table 1.

Table 1. Subthemes based on emerging themes. Rio Grande, Rio Grande do Sul, Brazil.

Themes	Subthemes
Barriers to the construction of an ethical environment	Conflicts concerning different employment contracts
	Lack of protocols
	Limited physical infrastructure
	Bureaucracy
	Lack of communication
Facilitators to the construction of an ethical environment	Periodical meetings
	Multi-disciplinary rounds
	Protocols
	Training programs
	Continuous education
	Effective communication

Source: Study's data

Barriers to the construction of an ethical environment in the multi-disciplinary traumatology service

This category shows that the workers recognize the existence of barriers impeding the construction of an ethical workplace environment. In this sense, they note that the main barriers impeding the establishment of ethical work environments, quality service, and patient safety include conflicts concerning the different employment contracts, lack of protocols, limited physical infrastructure, bureaucracy, and lack of communication.

The workers report that ethical conflicts arise from different employment contracts. The university hospital was integrated to the *Empresa Brasileira de Serviços Hospitalares* (EBSERH) [Brazilian Hospital Services Company]. Under its administration and management, a new employment contract, *Regime Jurídico Único* [Single Labor Regime], different from the former one linked to the *Consolidação das Leis do Trabalho (CLT)* [Brazilian labor law], was created to more rapidly hiring employees. These newly hired workers started working together with old employees, and even though they performed the same functions, they received different remunerations, worked under different work schedules, and had different career plans and benefits. These discrepancies generated conflicts, affecting the integration and relationship among the team members.

> […] currently, I guess that the main barrier is here in the hospital, the different employment contracts, legal regime, I suppose that this is one of the biggest problems, at least it's a very apparent problem, ethical issues, the management that is not prepared to establish priorities, I guess that somehow we should unify both contracts, or at least, rights and duties, equal professional relations [...] (P 6).

> […] this is confusing, and the interpersonal relations, because sometimes the personnel at the unit, between shifts, among us… there is an issue with the university's and the EBSERH's contract, the university and the EBSERH. It is so frustrating, that's what we see every day; it seems no one is speaking the same language […] (P 8).

Additionally, the workers report that a lack of protocols is another negative trait of the service, affecting from the mere prescription of medications to the most complicated decisions concerning the treatment of patients, pre- and post-operative orientation, and even what exams should be required. Therefore, a lack of protocols leads to significant divergences in the behavior of workers within the same sector, compromising patient safety.

> [...] I think that what causes conflicts is a lack of protocols. One says the patient is supposed to sit. Another says the patient cannot sit; instead, the patient has to lie down. So, everyone says different things, and what are patients supposed to think? […] (P 5).

Concerning the development of ethical multi-disciplinary environments, the participants note that the university hospital's physical structure became a problem, and the high demand of patients is a factor determining the service's quality, care delivery, and patient safety.

> […] a way to optimize the service a bit, perhaps is try adapting it to our context, improving the hospital's structure, the service itself, starting with the unit, inputs for the unit, the number of elective surgeries, emergencies, number of beds, there are many cities that we end up […] (P 9).

> […] so, currently, we have a hospital that is a reference for many cities, you know? There are 14 preceptors nobody mentioned. There's the traumatology service, highly complex, so I guess you have to start there… by having a structure. If you don't want it, it's like… putting the cart in front of the horse. They hired a lot of people, but how are these people supposed to work? There's no way, no structure, no tools. I guess that most conflicts start with this demand, you know? The hospital ends up regulating public health and having to deal with it, and it is actually a university hospital […] (P 1).

Health workers report that bureaucracy is a barrier impeding the construction of ethical environments, highlighting that it prevents the service from reaching high problem-solving capacity, agility, and effectiveness. That is, bureaucracy has the potential to harm health practice and patients.

> […] I believe and also agree with my colleagues here, that bureaucracy comes first… the patient has fallen in the scale of importance, the priority is papers, someone's authorization, and the patient becomes less and less important, the patient who was supposed to be up there [high in priority], ended up down here, so there are many conflicts […] (P 2).

> […] The bureaucracy issue comes before equality and equity. They want to treat the patients equally, not inclusively. The thing is that everyone has a different need, so we have a certain number of beds available and a certain number of male beds available; while the surgical unit sometimes has beds available, you could reallocate the patients, but they don't allow it because there are two males and two females, so sometimes people are not thinking about the patients […] (P 10).

Finally, the participants highlighted that a lack of effective communication impedes the construction of ethical workplaces and quality service. The health workers consider that this lack of communication at all levels (interpersonal, professional, with the institution and patients) affect harmonious relations, care practice, stating that information is vital to understand a patient's problems and support the staff's decision-making.

Health workers report that lack of communication or miscommunication causes conflicts among multi-disciplinary workers in the traumatology service and is also a factor that negatively interferes with the quality of health care and patient safety. Hence, the workers report that lack of time, work overload, and bureaucracy lead to ineffective communication within the service.

> […] sometimes, it seems that people are not speaking the same language, because the patients… like I get there and say "good morning" and then I tell the plan for the morning, only that each of you residents, seem to speak another language […] (P 3).
>
> […] because sometimes, one says it has to be this way, but another doesn't't agree and goes there, and the patient becomes confused so that she won't believe me. I know that she has to do this and that, so I say "madam, you have to sit, you have to do this and that" I provide orientation, but how is she supposed to trust me if my colleague told her that she could get up […] (P 9).

Facilitators to the construction of an ethical environment in the multi-disciplinary traumatology service

In this category, health workers recognize that various factors favor the work and the development of an ethical environment in the traumatology service, highlighting that periodical meetings, multi-disciplinary rounds, protocols, training programs, continuous education, and effective communication are practices essential to construct an ethical workplace environment.

Health workers emphasize the importance of regular meetings because these meetings allow them to discuss different opinions and points of view, contributing to the quality and humanization of the care provided to patients. These meetings should also be part of the service's dynamics because they improve team performance, resulting in better healthcare quality.

They also highlight that workers' plurality, with their different professional and personal backgrounds, favors strategies intended to foster ethical environments.

> […] I don't know how to get it, but an idea would be that whenever there is a meeting, nursing workers, physicians, residents, students, I don't know… should discuss or talk about cases, so they'd participate, train people in these sectors […] (P 8).
>
> […] I'd say that we should interact more, between the medical and nursing staff, and I guess there should be regular meetings to discuss the service, you know, more frequent meetings and the protocols, which would be very interesting to facilitate the service […] (P 6).

From this perspective, health workers identify that multi-disciplinary rounds are essential to qualify the service and get the team closer to ensure patient safety. The workers report that failures in teamwork and miscommunication result in medical errors, adverse events, and low quality of care.

> [...] having the physician's presence in the unit is vital; we should have this interaction with the physicians more frequently, having the physician available, you know. I guess that making the rounds, they'd do rounds once a week, the nurses would participate, I guess it is essential, we'd get ready to join the rounds, we'd have to have basic information that is necessary for the service because we knew that there would be a round, and would have data prepared, and we would give our opinions […] (P 8).
>
> [...] we should really work from a multi-disciplinary perspective because we have this kind of service, we have students, graduate students, physicians and nurses, and nursing undergraduates, and they are not circulating, are not interacting […] (P 2).

Health workers report that the use of clear and feasible protocols facilitates teamwork and the development of an ethical environment in the traumatology service, as these contribute to efficient healthcare, improving patient safety by decreasing errors and adverse events. Although the participants report that some workers are still reluctant to use protocols because they believe protocols restrict professional autonomy.

> [...] as facilitators, I think that protocols, you know… evidence-based protocols. I guess that it'd be interesting to integrate training activities, integrating the teams, you know?…and better distribute the delivery of care. Better distribute the tasks […] (P 8).

Health workers suggest that training programs and continuing education provided by the institution would favor the construction of an ethical workplace environment These would improve and update the knowledge of workers, and consequently, improve the quality of the service provided to patients.

> [...] I guess that the greater the knowledge of the entire team, the better the workplace and the better the care provided to patients […] (P 5).
>
> [...] the service, the institution should equally provide training and continuing education programs at all levels so we would provide better care and it would even encourage personal and professional growth […] (P 1).

Finally, effective communication was highlighted as a factor that facilitates the establishment of ethical workplaces as it encourages patient safety, decreasing errors in the work process, and improving integration among teams. However, the

workers note that many factors hinder communication, such as lack of time, different ages, and peculiarities of each individual within the team.

> […] So, it's not like that, I guess they should talk among each other, and everyone should know about the patients, because at the end of the week there will be another worker, and she or he needs to know about all the patients, and in an emergency, I have to call the one on duty […] (P 4).
>
> […] lack of communication, I think that most things, having unfriendly conversations. We can work most things out by talking, you know? Today, it's challenging to have a conversation, to reach a consensus about a given subject (P7).

DISCUSSION

The establishment of ethical workplaces within health services has gained attention in hospital management, though there are still much resistance and impediments to change, especially in the public sector due to its inherent characteristics, resulting in many barriers to harmonious and healthy relationships among workers as this is a context with many factors favoring competitiveness[10,11].

The presence of barriers such as different employment contracts, the lack of protocols, restricted physical structures, bureaucracy, and lack of communication were recurrently discussed among the participants. The factors that favor ethical workplace environments include regular meetings, establishing efficient and quickly understood protocols, and effective communication among collaborators, multi-disciplinary rounds, training programs, and continuing education.

Having employees with different employment contracts in a single sector wears out personal and professional relationships within the traumatology service. This fact emerged with the advent of the private company EBSERH, which became responsible for managing Brazilian university hospitals. Therefore, to meet the demand of workers in these institutions, new employees were hired under the CLT, creating a new employment contract, different from the previous one[12].

In the health field, where the environment is already very complex, these differences increase the number of ethical conflicts and aggravate stress due to the differences in how workers hired under different contracts are treated, including different hierarchy standards, workloads, career plans, and salaries. This perception is in line with a study conducted with workers experiencing the same situation in a similar service, where different working hours and salaries among individuals performing the same functions emerged as the leading causes for conflicts and dissatisfaction, in accordance with the complaints and discomfort reported in this study[13].

Regarding the lack of protocols reported by the participants as one of the barriers to ethical work environments, various reports made it apparent how much it interferes in the work, the institution's organization, interpersonal and professional relationships, and the care provided to patients. Protocols are an essential tool in hospital management, considering that protocols standardize consultations, treatments, and diagnoses, organizing and facilitating decision-making[14].

When properly adopted, protocols, together with other strategies, promote effective health care delivery, both in quantitative and qualitative terms, improving patient safety and decreasing the risk of errors and adverse events[14]. In this sense, adopting protocols is essential because they support the organization and management of healthcare delivery by standardizing behaviors and conducts and incorporating it into care practice using available resources. Additionally, protocols ensure the excellence of health services and the safety of patients and workers[15].

Lack of communication was reported as one of the factors hindering the establishment of ethical workplaces. Communication involves interpersonal relations, and problems may occur, with difficulties and restrictions that prevent messages from being correctly decoded when communication fails. Proper communication is vital in the health field because it facilitates interaction among the team members and facilitates managing interpersonal and group conflicts[16,17]. Additionally, effective communication promotes quality and safe care, enabling the staff to transmit and receive clear and correct information[18], contributing to patient safety.

The limitation or lack of physical space is a severe problem in most public hospitals due to the massive demand and difficulties in expanding hospital facilities due to a lack of financial resources and/or structural or legal impediments. Not having an adequate physical structure, such as dealing with disorganization due to a lack of proper structure and insufficient beds to accommodate patients, aggravates daily conflicts among those providing care[15-19]. Uncomfortable physical facilities, with no air conditioning, coupled with disorganization or lack of hygiene, affect workers' morale and harm their production. These conflicts result from the need and obligation to care for a high number of patients while having to deal with a restricted physical structure[19].

Additionally, with the significant changes in healthcare delivery, health institutions started adopting previously unimportant goals such as increased profits, which directly and indirectly change a hospital's general structure. Health institutions take on business contours in an increasingly competitive environment, requiring professional management in this context. In this sense, bureaucracy emerges as part of the process and often goes unnoticed[20]. Bureaucracy is often seen as a negative factor that harms and delays processes that could be rapidly implemented otherwise. It is synonymous with disorganization, slowness, delay, and a factor that harms work processes[21]. This study's participants report that bureaucracy causes many conflicts within the workplace, considerably harming healthcare delivery, which often remains in the background.

However, the participants recognize that the humanization of care and patient safety should be a priority, and despite all the difficulties and barriers hindering the establishment of ethical environments, some factors favor this process. Among these factors,

clinical meetings were one of the two main topics reported due to their extreme importance not only to the functionality of the work but also to include everyone in discussions and decision-making.

Some authors consider that in addition to being an opportunity to establish behaviors that result in higher quality service from an inter-disciplinary perspective, meetings also strengthen other aspects such as interpersonal relationships[22]. Meetings configure a democratic space, free from prejudice and judgment, where the team members' performance is valued, being a critical device for structuring, organizing, and establishing guidelines and decision-making[23]. For this reason, everyone should be equally treated in these meetings regardless of their background or profession, feeling responsible and encouraged to succeed.

Some authors note that meetings should obey at least four criteria: regularity, purpose, delegation of responsibility, and monitoring. Keeping regular meetings is intended to enforce the unit's standards and conduct and identify problems and promote discussions intended to achieve concrete solutions[24].

From this perspective, multi-disciplinary rounds should be implemented to ensure changes, unify teams, and improve care delivery quality and safety. Hence, a multi-disciplinary team's job is a collective work based on reciprocal relationships established among multiple interventions and techniques, an essential tool for delivering comprehensive healthcare to patients. For this reason, the work of the multi-disciplinary team became one of the central precepts of the Brazilian Unified Health System (SUS), especially under the management of university hospitals unified by the EBSERH administration[15,25].

An Australian study shows that even though rounds were initially conceived to educate medical students, currently its adoption is intended to support clinical practice. Additionally, the authors highlight that the communication process within a multi-disciplinary team focuses on the patient with a joint decision-making process[26]. Hence, multi-disciplinary rounds became the pillar of all other changes within an institution because, besides favoring patients from an administrative and technical perspective, multi-disciplinary rounds also contribute to a more ethical and healthy work environment.

Lack of communication or integration among the members of a health team can harm patients, generate inconsistencies in behavior, compromise the care process, and lead to medical errors[27]. From this perspective, the health workers reported that communication is vital in developing organizational processes, ensuring patient safety, and promoting ethical environments[25]. Thus, communication is an essential tool to providing integral and humanized care to patients and should be present at all levels of health care to ensure patient safety[22].

Together with multi-disciplinary rounds and effective communication, other factors are essential for safe practice, including establishing precise protocols to guide care delivery practice and implementation. Even though some people consider protocols to be bureaucratic or an instrument that harms the workers' autonomy[14], this study's participants suggest that the use of protocols is a way to decrease conflicts within the sector.

Protocols are intended to standardize actions, guide practice, and organize work processes, aid decision-making, and prevent errors. Therefore, protocols enable all workers to provide standardized care to patients based on scientific-based evidence, improving the likelihood of success in all procedures, promoting patient safety and an ethical and healthy climate within the team[28].

Having competent multi-disciplinary teams and offering infrastructure and an environment of excellence is vital for promoting health. In this sense, quality management should be seen as a priority, especially in terms of managerial aspects and qualification, promoting improved quality of care delivery in the short and long terms. Hence, training programs and continuing education are essential to foster improvements and promote changes that would be meaningless without teams' competence and aggregated knowledge[22].

FINAL CONSIDERATIONS AND IMPLICATIONS FOR PRACTICE

Barriers and facilitators were identified in the routine of a traumatology service seeking to implement a more ethical workplace. The participants considered that most of the barriers arise within the institution and accrue from the administrative process, such as lack of an appropriate physical structure, a small staff meeting many demands, confusing bureaucracy, and lack of protocols and effective communication. Note that some barriers depend on workers' behavior and commitment and their willingness to acquire knowledge.

Various factors facilitate the establishment of healthy and efficient workplaces, all of which are accessible and possible to be implemented in professional practice. These factors include clinical meetings and multi-disciplinary rounds to promote the interaction and relationship within the teams, establish protocols, a physical structure that is adequate to meet the demand, training programs and continuing education, and the promotion of effective communication at all the care levels. The existing relationships within multi-disciplinary teams often favor the (re) definition of roles. The team should adapt to specific and local demands to perform a work of excellence, establishing ethical, safe, and humanized settings to provide care.

Hence, discussing the context of practice in a conflicting context is a way to encourage new types of knowledge and practice, transforming the context based on individual and collective initiatives. Finally, this study's results are expected to promote an approximation between management and health care and interventions to promote communication through meetings and multi-disciplinary rounds and establish clear protocols to reinforce patient safety and humanization of care through simple and efficacious conduct.

This study's limitations include the fact that this study was conducted with the health workers of a single traumatology facility from a university hospital, which prevents the generalization of results. The reason is that workers may experience ethical conflicts

when their beliefs or values diverge from those concerning clinical or organizational decisions established in their workplaces[6], so that the causes of conflicts may vary among teams and work environments. Hence, further studies are needed to address other professions and contexts within the health field as studies seldom address the factors impeding or facilitating multi-disciplinary work intended to establish ethical workplaces.

AUTHORS' CONTRIBUTIONS

Study design. Rafael Chiesa Avancini. Edison Luiz Devos Barlem. Jamila Geri Tomaschewski Barlem. Caroline Bettanzos Amorim. Laurelize Pereira Rocha. Gabriela do Rosário Paloski.

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Interpretation of results. Rafael Chiesa Avancini. Edison Luiz Devos Barlem. Jamila Geri Tomaschewski Barlem. Caroline Bettanzos Amorim. Laurelize Pereira Rocha. Gabriela do Rosário Paloski.

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REFERENCES

1. Chiavenato I. Gestão de pessoas. 4. ed. Rio de Janeiro: Manole; 2014. p. 1-512.
2. Pishgooie AH, Barkhordari-Sharifabad M, Atashzadeh-Shoorideh F, Falcó-Pegueroles A. Ethical conflict among nurses working in the intensive care units. Nurs Ethics. 2019;26(7-8):2225-38. http://dx.doi.org/10.1177/0969733018796686. PMid:30336767.
3. Alves J, Ribeiro C, Campos S. A inteligência emocional em enfermeiros responsáveis por serviços hospitalares. Rev Enf Ref. 2012 jul 31;III Série(7):33-42. http://dx.doi.org/10.12707/RIII1199.
4. Koskenvuori J, Numminen O, Suhonen R. Ethical climate in nursing environment: a scoping review. Nurs Ethics. 2019;26(2):327-45. http://dx.doi.org/10.1177/0969733017712081. PMid:28659068.
5. Pugh GL. Perceptions of the hospital ethical environment among hospital social workers in the United States. Soc Work Health Care. 2015;54(3):252-68. http://dx.doi.org/10.1080/00981389.2015.1005271. PMid:25760491.
6. Lunardi VL, Lunardi WD Fo, Silveira RS, Silva PA, Mancia JR. Gestão de enfermagem e construção de ambientes éticos. Enferm Foco. 2017;7(3/4):41-5. http://dx.doi.org/10.21675/2357-707X.2016.v7.n3/4.914.
7. Silva JS, Kfuri Jr M, Abagge M, Guimarães JM, Barbosa PRL, Balbachevsky D et al. Como o especialista em Ortopedia e Traumatologia avalia o atendimento ao trauma ortopédico no Brasil. Rev Bras Ortop. 2011;46(suppl 1):9-12. http://dx.doi.org/10.1590/S0102-36162011000700004.
8. Backes DS, Colomé JS, Erdmann RH, Lunardi VL. Grupo focal como técnica de coleta e análise de dados em pesquisas qualitativas. Mundo Saúde. [Internet]. 2011; [citado 2021 jan 26];35(4):438-42. Disponível em: http://bvsms.saude.gov.br/bvs/artigos/grupo_focal_como_tecnica_coleta_analise_dados_pesquisa_qualitativa.pdf
9. Dall'agnol CM, Trench MH. Grupos focais como estratégia metodológica em pesquisa na enfermagem. Rev Gaúcha Enf. [Internet]. 1999; [citado 2021 jan 26];20(1):5-25. Disponível em: https://seer.ufrgs.br/RevistaGauchadeEnfermagem/article/viewFile/4218/2228
10. Moraes R, Galiazzi MC. Análise textual discursiva. 2. ed. Ijuí: Editora Unijuí; 2013.
11. Başoğul C, Özgür G. Role of motional Intelligence in Conflict Management Strategies of Nurses. Asian Nurs Res. 2016;10(3):228-33. http://dx.doi.org/10.1016/j.anr.2016.07.002.
12. Ministério da Educação (BR). Empresa Brasileira de Serviços Hospitalares. Termo de referência. Solução integrada de gestão de pessoas [Internet]. Brasília: EBSERH; 2013. Disponível em: http://www.ebserh.gov.br/sites/default/files/consulta-publica/2019-02/Termo_de_Referencia-SolucaoRH-EBSERHv321.pdf
13. Bernardo MH, Verde FF, Pinzón JG. Vivências de trabalhadores com diferentes vínculos empregatícios em um laboratório público. Cad Psicol Soc Trab. 2013;16(1):119-33. http://dx.doi.org/10.11606/issn.1981-0490.v16i1p119-133.
14. Azevedo CDS, Miranda L, Sá MC, Grabois V, Matta G, Cunha M. Entre protocolos e sujeitos: qualidade do cuidado hospitalar em um serviço de hematologia. Cad Saude Publica. 2018;34(6):00043817. http://dx.doi.org/10.1590/0102-331X00043817. PMid:29952396.
15. Krauzer IM, Dall'Agnoll CM, Gelbcke FL, Lorenzini E, Ferraz L. The construction of assistance protocols in nursing work. Rev Min Enferm. 2018;22:e-1087. http://dx.doi.org/10.5935/1415-2762.20180017.
16. Olino L, Gonçalves AC, Strada JKR, Vieira LB, Machado MLP, Molina KL et al. Comunicação efetiva para a segurança do paciente: nota de transferência e Modified Early Warning Score. Rev Gaúcha Enferm. 2019;40(spe):e20180341. http://dx.doi.org/10.1590/1983-1447.2019.20180341. PMid:31038606.
17. Broca P, Ferreira M. Communication process in the nursing teama based on the dialogue between Berlo and King. Esc Anna Nery. 2015;19(3):467-74. http://dx.doi.org/10.5935/1414-8145.20150062.
18. Nogueira JW, Rodrigues MC. Effective communication in teamwork in health: a challenge for patient safety. Cogitare Enferm. 2015;20:636-40. http://dx.doi.org/10.5380/ce.v20i3.40016.
19. Rosa C, Menezes MA. Avaliação da Influência da Estrutura Física das Unidades de Internação de Clínica Médica e Cirúrgica de um Hospital Público do Município de São Paulo: proposta para o gerenciamento de riscos de queda. Revista de Gestão em Sistemas de Saúde. 2015;4(01):55-70. http://dx.doi.org/10.5585/rgss.v4i1.177.
20. Costa LA, Neves JAB. Bureaucracy and social integration: a study on the Ministry of Health in the management of the National Health System (SUS). Saúde Soc. 2013:22(4):1117-31. https://doi.org/10.1590/sausoc.v22i4.76506.
21. Costa LA, Rocha DF. Burocracia e gestão pública: uma análise do Ministério da Saúde. Cad Bras Ter Ocup. 2018;26(3):632-45. http://dx.doi.org/10.4322/2526-8910.ctoAO1639.
22. Bohrer CD, Marques LGS, Vasconcelos RO, Oliveira JLC, Nicola AL, Kawamoto AM. Comunicação e cultura de segurança do paciente no ambiente hospitalar: visão da equipe multiprofissional. Revista de Enfermagem da UFSM. 2016;6(1):50-60. http://dx.doi.org/10.5902/2179769219260.

23. Grando MK, Dall'agnol CM. Desafios do processo grupal em reuniões de equipe da estratégia saúde da família. Esc Anna Nery. 2010 set;14(3):504-10. http://dx.doi.org/10.1590/S1414-81452010000300011.
24. Gomes AP, Costa JRB, Junqueira TS, Arcuri MB, Siqueira-Batista R. Atenção primária à saúde e formação médica: entre episteme e práxis. Rev Bras Educ Med. 2012;36(4):541-9. http://dx.doi.org/10.1590/S0100-55022012000600014.
25. Broca P, Ferreira M. Processo de comunicação na equipe de enfermagem fundamentado no diálogo entre Berlo e King. Esc Anna Nery. 2015;19:467-74. http://dx.doi.org/10.5935/1414-8145.20150062.
26. Novaretti MZ. Aplicação da análise causa raiz como ferramenta na gestão de segurança hospitalar. Rev Adm UFSM. 2014;7(3):442-52. http://dx.doi.org/10.5902/1983465916272.
27. Guzinski C, Lopes A, Flor J, Migliavaca J, Tortato C, Pai D. Good practices for effective communication: the experience of the interdisciplinary round in orthopedic surgery. Rev Gaúcha Enferm. 2019;40(spe):e20180353. http://dx.doi.org/10.1590/1983-1447.2019.20180353. PMid:31038609.
28. Sales CB, Bernardes A, Gabriel C, Brito M, Moura A, Zanetti A. Standard Operational Protocols in professional nursing practice: use, weaknesses and potentialities. Rev Bras Enferm. 2018;71(1):126-34. http://dx.doi.org/10.1590/0034-7167-2016-0621. PMid:29324954.