The Brazilian Code of Medical Ethics: Ethical and bioethical limits

Francisco José Passos Soares [1], *Helena Eri Shimizu* [2], *Volnei Garrafa* [3]

Abstract

The technological and scientific evolution has imposed challenges on society and especially on medicine. Changes in the doctor-patient relationship and among healthcare professionals require new regulatory formats to such relationships. The current Brazilian Code of Medical Ethics adopts the principialist North American model as a universal ethical framework, based on autonomy that is out of step with the emerging bioethics in Latin America, whose theoretical assumptions on the plurality of moral subjects and multi-inter-transdisciplinarity are oriented to public health and the defense of the most vulnerable. The text reflects on the historical aspects that organize professions and their codes, and on the reasons for the gap in the evolution of bioethics in Brazil and the revision of the code. Equally, the text considers the contemporary challenges to the medical authority, which imposes the extension of the ethical debate to draft more democratic formats of professional codes, considering the *Universal Declaration on Bioethics and Human Rights* as the structural axis.
Keywords: Ethical theory. Codes of ethics. Ethics, medical. Bioethics.

Resumo

Código de Ética Médica brasileiro: limites deontológicos e bioéticos

A evolução tecnocientífica tem imposto desafios à sociedade e, particularmente, à medicina. Mudanças sociais nas relações médico-paciente e entre profissionais da saúde demandam novas formas de regulação dessas relações. O atual Código de Ética Médica adota o modelo principialista norte-americano como referencial ético, universalista, baseado na autonomia, em descompasso com a emergente bioética latino-americana, que tem como pressupostos teóricos a pluralidade dos sujeitos morais e a prática multi, inter e transdisciplinar, orientada para saúde pública e coletiva e defesa dos mais vulnerados. O texto reflete sobre aspectos históricos conformadores das profissões e seus códigos e as razões do descompasso da evolução da bioética no Brasil e da revisão do Código de Ética Médica. Igualmente, reflete sobre os desafios contemporâneos para o poder médico, que impõem ampliação do debate ético para elaboração de formatos mais democráticos dos códigos profissionais, tendo como eixo estruturante a *Declaração Universal sobre Bioética e Direitos Humanos*.
Palavras-chave: Teoria ética. Códigos de ética. Ética médica. Bioética.

Resumen

Código de Ética Médica brasileño: límites deontológicos y bioéticos

La evolución tecnológica y científica le ha impuesto retos a la sociedad y, en particular, a la medicina. Los cambios sociales en la relación médico-paciente y entre los profesionales de la salud requieren nuevos formatos regulatorios para estas relaciones. El actual Código de Ética Médica adopta el modelo norteamericano principialista como marco ético, universalista, basado en la autonomía, fuera de sintonía con la bioética latinoamericana emergente, que tiene como presupuestos teóricos la pluralidad de sujetos morales y las prácticas multi, inter y transdisciplinarias orientadas a la salud pública y colectiva, y a la defensa de los más vulnerables. El texto reflexiona sobre los aspectos históricos configuradores de las profesiones y de sus códigos, sobre las razones de las diferencias en la evolución de la bioética en Brasil y de la revisión del código. Asimismo, reflexiona acerca de los desafíos contemporáneos del poder médico, que imponen la ampliación del debate ético para el desarrollo de formatos más democráticos de los códigos profesionales, basados en *la Declaración Universal sobre Bioética y Derechos Humanos*.
Palabras clave: Teoría ética. Códigos de ética. Ética médica. Bioética.

1. PhD francisco_passos01@hotmail.com – Universidade de Brasília (UnB) **2. Doutora** shimizu@unb.br – UnB **3. PhD** garrafavolnei@gmail.com – UnB, Brasília/DF, Brasil.

Correspondência
Francisco José Passos Soares – Rua Cônego Antônio Firmino de Vasconcelos, 138, apt. 301, Jatiúca CEP 57036-470. Maceió/AL, Brasil.

Declaram não haver conflito de interesse.

The contemporary world is characterized by conflicts generated by the accelerated technological and scientific evolution in the biomedical and communication fields. In addition, globalization, the hegemony of neoliberal capital, and local health and environmental issues with global repercussions have a major impact on human health. At the same time, the affirmation of individual rights, especially those of women and children, is recognized, not without conflict, and in the field of health, the emergence of the patient as a moral subject, no longer subordinated to the authority or paternalism of the physician [1].

In the area of health, distortions related to the inaccessibility of the poorest sectors of the population have been identified both to the benefits of scientific and technological development and to the basic consumer goods essential for a decent life [2].

The Code of Medical Ethics (CEM - Código de Ética Médica) [3], with its traditional deontological nature, having recently been revised, had as its reference the principlist North American bioethics, which is insufficient to respond to the health macro-problems of the peripheral or developing countries [2]. Other formats, however, are possible - for example, those taking into account the pluralist foundations proposed by Latin American authors and academic groups [4]. Latin American bioethics points out the paths of historical pluralism and multi, inter and transdisciplinary approaches for the renewal of the ethical debate, prioritizing the principles of justice and equity in the world of health.

This article proposes a reflection on this possibility. It considers historical aspects that shape the professions and their codes, as well as the reasons for the lack of progress of the CEM review and the evolution of bioethics in Brazil. It also addresses the contemporary challenges to medical power, which require broadening the ethical debate to elaborate more comprehensive and inclusive formats of professional codes.

Professional ethics in health

A profession in the area of health is defined, in the narrowest sense of professional ethics, as a regulatory organization that controls entry into occupational roles. It formally certifies that candidates have acquired the necessary knowledge and expertise to be used morally to benefit patients [5]. Three professional interests conceptually define a profession, according to Testa: the mastery of certain knowledge, the monopoly of the market and the formalization of norms of conduct [6].

The first of these interests refers to the characteristics of professional knowledge, systematized, acquired and sanctioned scientifically in educational institutions. It aims to be complex, unattainable and incomprehensible to laypeople, which may extend to regulatory codes. The second, according to the same author, concerns the delimitation and exclusivity of the labor market; The professionals organize themselves in institutions representing interests to pressure the State. The third element, self-regulation, is considered essential to standardize the conduct of the professionals with their peers, with competitors and with clients, conferring identity, personal commitment, specific interests and general loyalties. Regulated health professions specify and impose obligations that ensure professional competence and reliability, correlated with the rights of others [5].

For Testa, the broader view of professional practice involves considering both science and the professions beyond the field of legal formalities, at the heart of the historical conception of the state as a global continent of social practices. Therefore, it is admitted that the physician fulfills two functions: one concrete, as a result of specific training and concrete work, and the other abstract, social and independent of scientific training, the result of the abstract work, identified with added value, and which develops as a consequence of the social conditions that the State generates for this practice [6].

Testa states that t*he present day transformations of labor place medicine among the professional practices of which the function, not being part of the direct production relations between capital and labor, is in the realm of ideology of the set of classes that comprise the society* [7]. The work on people's bodies places medicine as *one of the elements of the control exerted by the State on the same subjects, complementing the control procedures exerted by the other ideological devices of the State to legitimize its existence* [8]. The success of medicine is associated with the power of the profession to promote patient/client dependence on the knowledge and competence of the physician [9].

This dependence, however, is built ideologically throughout the historical process. To account for the alienation, denial, and self-imposed estrangement of physicians, disidentified with the proletariat, Testa proposes that *the social body formed by the living bodies of the persons in relation is the true object of the medical work* [10]. For the author, *a fundamental error is made when the body of an isolated individual is considered as an object of medical work, since the*

(historical) determinations that give it its unique and irreversible characteristics are lost: life and humanity [11].

While in the deontological codes of the area, including that of physicians, the object of work is the sick body, the healthy body is also the object of health practices, incorporating measures of prevention and health promotion. The redefinition of the object of medical work as the health-disease process proposes to consider this inseparable unity, the social meaning of medicine as a process linked to the lives of people in relation and subject to the transformations of history [2,6].

The role of the codes in the professional practice

The professional code represents a formal statement of the moral role of the members of the profession, also specifying rules of internal etiquette and responsibility [5]. If in the modern social organization a profession does not do without a code of norms guiding professional practice, we also know that morality includes more than obligations. In the occurrence of moral conflicts, it is recognized, in the character traits of the persons who must judge, as much importance as in the obligations expressed in the principles and rules [5].

Considering the application of ethics to the professional exercise in health, it is possible to understand the reason to list certain virtues. In today's globalized, complex and plural world, the most important virtue is the acceptance of the other, according to the environmental, cultural, political and economic context. This implies a conceptual and practical reconfiguration of the concept of virtue as a whole which encompasses justice, solidarity, responsibility and authenticity, to confer political equality and equal economic and social opportunities [12].

Virtues stimulate the individual to act properly by conviction, not by obligation. So, to avoid that vices influence the attitude of the professional, the codes of ethics, with deontological foundations, turn the virtues inherent to the profession into duties. The codes of ethics of professions, therefore, materializes legal requirements to which all professionals must abide without questioning their reasons, otherwise, they will be punished [5]. The code of professional ethics imposes a prescriptive face to the normative ethical theory of ethics.

However, professionals also act according to their individual consciences, corresponding to the moral relativization or simplistic corporativism that can originate in the process of training and, later, more strongly in the exchanges on rules of the deontological code with medical and non-medical colleagues in the daily life of the practice of health care. Other factors may also influence this, such as values inherent to the professed religion and to the general cultural context, nowadays generally expressed in the media.

Obedience to the CEM is therefore relative, and depends on these judicial, often conflicting, exchanges among professionals and with patients or family members. It also depends on the social values expressed by the media, which can provoke affirmation or denial movements, with responses from professional councils ranging from silence to filing with a process or warning, or more severe punishment with definitive loss of the register [13]. In the current historical moment of recognition of the private autonomy of the subjects, the CEM prescribes balance with the private autonomy of the physician [3].

Health professionals in Brazil deal with periodic reviews of their codes and witness reviews of different code systems and laws for other aspects of their personal and professional lives. These revisions were resumed with the process of re-democratization of the country, and became a field of conflicts due to the development of professions, science and technology, and the hegemony of capital in its current neoliberal face that treats life as a financial asset.

Each change in the professional code system must therefore reflect professional corporate maturity to understand the more general changes in the codes of laws that must protect the whole nation. It must also dialogue with knowledge from the humanities so that, on a democratic basis, it guarantees the constitution of the social bond, expanding the rights and the necessary protection of the most vulnerable. However, the deontologization of the set of ethical dilemmas related to the accelerated and market development of technosciences seems exaggerated and is criticized as a decision-making monopoly. The reduction of ethical problems to issues of professional ethics is no longer justified [14].

Social-historical understanding of professional ethics and the code of medical ethics

The prescriptive deontological face still distanced from the patient's rights in the Code of Medical Ethics,

 http://dx.doi.org/10.1590/1983-80422017252184

and even further from the health-disease process, will be better understood by monitoring its socio-historical evolution. Humanity has witnessed different versions of rules, norms and codes regulating the medical profession throughout history dating from the beginning of the Christian era, when the first medical deontological rules arose, maintaining the religious influence in the formulation to this day [15].

Initially in the form of oaths and invocations under the influence of the Hippocratic oath, it was only in the sixteenth century that the Royal College of Physicians of London changed the name of "Penal Code for Physicians" to "Code of Ethics." It was thus distant from the even older Code of Hammurabi, king of Babylon, first to institute a civil and criminal code for all, which even included medical practice [16].

The influence of paternalistic Hippocratic ethics, based on the principle of vertical or imposed beneficence, remained hegemonic until recently, in the management of the body that could only be performed by a qualified person, such as the physician [5,15]. This model survived in Western culture, dominant in social and political relations, when subjects would only obey, without any power of intervention in government and public management.

This lasted until the sixteenth century, when, with the advent of the Protestant Reformation, which challenged the dogmas of the Roman church, differences of values and beliefs were recognized for social life. The principle of tolerance and the concept of freedom of conscience were founded at that time.

In the seventeenth century, basic human rights were elaborated: the right to life, health, freedom, property, which presupposes, in a way, the recognition of autonomy for individuals to manage their lives. The liberal achievements of the French Revolution in 1789, characterized by pluralism and self-government, were not enough to achieve the body's manageability.

That is, medicine was not reached and physicians continued to decide on behalf of patients, maintaining the paternalistic stance until the middle of the twentieth century. This model is called "monarchical" or "vertical" [16].

At the end of the eighteenth century, there was the birth of the clinic particular to modern medicine, based on bedside experience and dependent on the practitioner's searching look on the corpse, now allowed to be explored. In this regard, Foucault says:

It would be necessary to conceive of a medicine sufficiently bound up with the state for it to be able, with the cooperation of the state, to carry out a constant, general, but differentiated policy of assistance; medicine becomes a task for the nation. Menuret in the early days of the French Revolution dreamt of a system of free medical care administered by doctors who would be paid by the government out of the income from former church property. In this way a certain supervision would be exercised over the doctors themselves; abuses would be prevented and quacks forbidden to practice, and, by means of an organized, healthy, rational medicine, home care would prevent the patient's becoming a victim of medicine and avoid exposure to contagion of the patient's family. Good medicine would be given status and legal protection by the state; and it would be the task of the state 'to make sure that a true art of curing does exist'.... Medicine, in all its sovereignty, proclaims its judgment and its knowledge. It becomes centralized [17].

In 1803, Thomas Percival used the expression "medical ethics" in the work "*Medical ethics: a code of institutes and precepts adapted to the professional conduct of physicians and surgeons*". The elaboration of the first code of medical ethics that would influence models still in the present time is attributed to him. This work represented the transition from traditional Hippocratic hegemony to a less doctrinal and more normative ethics. It dealt with the medical conduct in the different professional spaces of the time, the private clinic and the public hospital, the relationship between colleagues and other health professionals, the relationship with the patient and the interrelationship between medicine and law [16].

At the beginning of the twentieth century, the transition to the oligarchic model of shared decision among professionals occurs without the renunciation of the vertical relation with the patient. As a result of factors external to medicine, backed by changes in politics, family, and accelerated scientific and technological advances and behavioral rights claims, the clinic is made more horizontal in the last decades of that century. As a result, the patient was included in decision-making, there was a democratization of health relations, with the active participation of users, overcoming paternalism and opening space for self-management of the bodies. Moral criteria are harmonized with scientific and secular rationality.

At that moment, the code of patients' rights, the informed consent, the rights to choose, to information, to refuse treatment, to health education, to quality of services, etc. are defined. [5,15,16]. At the end of the twentieth century,

bioethics was born, which strongly influenced the elaboration of new codes of ethics throughout the world, which, however, were still limited by the Anglo-Saxon principlist orientation. Although considered as documents of public knowledge, for ethical guidance of professionals, categories and people, there are many aspects that are not foreseen in the codes which demand periodic revisions, with additions and substitutions adaptable to the technical-scientific advances and of customs in each epoch.

This suggests to the professional an ethical commitment based on the code specific to the category and beyond it, in tacit rules built and obeyed in the daily practice of the professional. In this openness to what has not yet been regulated and prescribed, the role of virtues, common sense, theoretical ethical updating, political positioning, and greater openness to dialogue with the patient and his relatives or representatives And with society itself. That is, inclusive, dialogic, dialectical, emancipatory openness that surpasses the paternalistic deontological tradition and dares to challenge the imposed principlist approach [14].

Since the time of Hippocrates, physicians have created codes without examination or acceptance by patients and the public [5,15,16]. Today, rather than the epistemic change, there is a need for political change to an ethic that formulates the rights of non-physicians, especially patients and vulnerable groups and communities. An ethic that broadens their rights to autonomy in the management of their bodies and life-and-death processes, in the defense of the public over the private, and in the consideration of society in general in the revision of future codes [14,18].

Another historical aspect still to be considered is the patient's position as a Kantian subject in the relationship with the physician, the latter being understood, in the current context, as an agent of satisfaction of the health needs of the former [19].

Latin-American bioethics as a reference to expand deontological limits

Since its advent in the twentieth century, bioethics has evolved, acquiring peculiar characteristics in the Western world. It is constituted, in particular, of three distinct systems: the Anglo-Saxon, principlist, pioneer and of strong influence on the other systems; The humanist-European, guided by the rights and duties inherent to the human person; And the Latin American, which prioritizes social issues and considers the foreseeable consequences. While the first two systems, individualistic, have as main axes the ethics of the doctor-patient relationship and the ethics of research, based on the autonomy of social subjects, for Latin American bioethics the dominant axis is public and collective ethics.

Bioethics, especially the Latin American system, incorporates biomedical ethics, but is not limited to it and to the deontological frontiers proper to the relationships between professionals and patients [2,20]. In developed countries, bioethics still presents conceptual and practical limitations, prioritizing discussions for limiting situations arising from scientific and technological development [2]. After its advent in the 1970s and its diffusion in the 1980s, bioethics underwent a critical review stage comprised between the following decade and the first years of the twenty-first century.

There are visible socio-cultural distinctions in the movements for the recognition of political rights of blacks, women, homosexuals, indigenous people and other groups, as well as the ethical confrontation of basic social and health issues such as social exclusion and equity. The most current stage of conceptual expansion occurred with the approval of UNESCO's Universal Declaration on Bioethics and Human Rights (UDBHR) in 2005 [21]. The UDBHR confirms the pluralistic and multi, inter and transdisciplinary character of bioethics, expanding the thematic agenda beyond the biomedical / biotechnological area, toward the sanitary, social and environmental fields [2].

Although criticism of universalism and the emphasis on the autonomy of the principlist North American model were under consideration, these bioethics had a strong influence on the CEM, which at the same time was reviewed by the Brazilian Federal Council of Medicine. The synchronization of the stages of criticism and revision of the principlist bioethical model and the code did not overcome the mismatch of ignorance or the denial of the advances of Latin American bioethics. In the final proposal of the CEM, autonomy prevailed as an "innovative" principle and "main contribution to society" to inaugurate a new time in the doctor-patient relationship [3]. This paradoxically conservative innovation reaffirms the limits of the code of ethics in individual professional action, unlike the widespread emphasis on Latin American bioethics, which is plural in nature and focuses on the patient and on social issues.

 http://dx.doi.org/10.1590/1983-80422017252184

Brazilian bioethics developed late, appearing organically only in the 1990s; from then on, it shows unusual vigor. If until 1998 Brazilian bioethics was still a colonized copy of the concepts coming from the Anglo-Saxon countries of the Northern Hemisphere, after the emergence and consolidation of several groups of study, research and graduate studies in the country, its history began to change [22,23]. Latin American bioethics, still in conceptual consolidation and far from broader academic and social recognition, was not the basis for the revision of CEM and the codes of the other professions in health [3,23-25].

According to Garrafa [26], Bioethics, unlike professional ethics and legal ethics, is not based on prohibition, limitation or denial, acting on the basis of the legitimacy of actions and situations and positive affirmative action. For this author, the essence in bioethics is freedom, with commitment and individual responsibility, public and planetary. In other texts, the author questions the role that bioethics already plays and may increase in the evolution of the present political / social representations / organizations of the world [18,22].

Until 1998, bioethics prioritized themes and / or biomedical problems / conflicts that are more individual than collective. Since then, the field has expanded its guidelines, including, in the analyses of the quality of human life, questions that were, until then, only tangential. Issues such as preservation of biodiversity, finite planetary natural resources, ecosystem balance, genetically modified food, racism and other forms of discrimination. It also included the topic of priority in the allocation of scarce resources, access of people to public health systems and medicines etc. [2,23]. Garrafa further states that:

At the beginning of this 21st century, therefore, the ethical question acquires public identity. It can no longer be considered only as a question of conscience to be solved in the sphere of autonomy, private or otherwise, of an individual and exclusively intimate forum. Today, it is growing in importance in the analysis of health and environmental responsibilities and in the more accurate historical and social interpretation of the epidemiological frameworks, being essential in determining the forms of intervention to be programmed, in the priority of actions, in the training of personnel... Finally, in the responsibility of the State towards citizens, especially those who are more fragile and in more need, as well as facing the preservation of biodiversity and of the ecosystem itself, assets that must be preserved sustainably for future generations [27].

The UDBHR has been the ethical reference that unifies and universalizes different non-principlist contemporary bioethical theories, with human dignity as the axiological nucleus and ethical-normative foundation for protecting the person [21,28]. Latin American bioethics has its own features and can offer health professional categories important elements for the recognition and extended defense of human rights. It has, as ethical references, not only the four principles of Beauchamp and Childress [5], but the set of values, principles, rules and norms developed by the scholars of bioethics and presented in the UDBHR, in a contextualized way [21,29].

At least three Latin American bioethical currents have their theoretical-epistemological fields defined: protection bioethics [24,30], intervention bioethics [22,23,31] and bioethics of human rights [25]. Feitosa and Nascimento [31] theorize about intervention bioethics (IB), a genuine Brazilian bioethics that emerged in the Bioethics Graduate Program in the University of Brasilia. They point out that, during its first decade of existence, IB has been able, on the basis of its theoretical foundation and collaboration with other Brazilian and Latin American bioethics, to ensure, at the international level, the acceptance of the political dimension in bioethical formulation and practice by establishing, as the focal point of this dimension, the human rights paradigm [31].

This international acceptance demands, in Brazil, the recognition of IB and other currents to, then, review professional and institutional concepts and practices. With the last revision in 2008, still under the great influence of the principlist Anglo-Saxon bioethics, and in the face of theoretical advances in bioethics with Latin American epistemic and political characteristics, we wonder if it would not be prudent to have the current and necessary revision of the CEM based on these reflections.

Deontological ethics and bioethics: antagonistic or complementary?

Deontology as a professional ethical theory is considered, as from the nineteenth century, as the ethics of Kant's duty, whose greatest contribution to deontological theory was due to the emphasis on the autonomy of the subject and to the formulation of the principle of universality, materialized in the categorical imperative: *Act in such a way that you*

treat humanity both in your person and in the person of all others always at the same time as an end, and never simply as a means [32]. It can be defined as a theory in which what makes right or wrong actions are characteristics intrinsic to actions, not just their consequences [33].

The word "deontology" was created by Jeremy Bentham in 1834, giving title to his posthumous work, "Deontology or science of morality", published in London, two years after his death. The words "paleontologist" and "deontological school" more particularly refer to the doctrine of the English moralists of the late nineteenth and early twentieth centuries who oppose the ontological and utilitarian schools and argue that the imperative is external to the subject. Ethics are a kind of normative ethics. They seek to provide guidelines or general principles and are concerned with the study (logos) of moral duties (deon) [33].

Beauchamp and Childress [5] criticize Kantian deontology as a theory for moral life, pointing out some flaws: 1) conflicting obligations - by making all moral rules absolute, Kant seems to compel to the impossible duty of carrying out conflicting actions; 2) Overestimating the law, underestimating relationships, in legal obligations and contracts - family life, life among friends, are not experienced in forms of moral relationship reduced to exchanges governed by laws; 3) limitations of the categorical imperative, considered obscure and not functional in moral life; 4) empty abstraction of concepts with weak bases to a given set of moral rules, such as rationality and humanity.

However, the authors state that the significant contribution of Kantian theory was to sustain mandatory moral decision in similar and relevant circumstances. When moral judgment is sustained for good reasons, these reasons are good and relevant for all circumstances. [5]. Linked to the practice of the traditional liberal professions, such as medicine, law and nursing, among others, deontology generally designates the set of duties bound together in the form of rules in a code of ethics or morals [16].

Being a specific field of knowledge, professional ethics of a predominantly deontological nature, often incorporates the concept of bioethics dissociated from the required theoretical rigor of the discipline, thus requiring definition of theoretical-conceptual limits and application. The application of deontological theory to professional ethics has generated conflicts and impasses since the emergence of bioethics, which has sought to define its limits with this universalizing tradition and, at the same time, to encourage reflection and openness to dialogue for the making of complex moral decisions, characteristic of hyper-modernity. According to Garrafa:

There is, and to some extent this is a quasi-consensus, a link between bioethics and studies related to professional ethics. Both deal with ethics, morals, values, rules of conduct, and finally, themes related to well-being in humanity. The difference, however, is that bioethics, unlike studies pertaining to professional ethics - that is, those based on statutes, codes, laws, or even commandments - does not seek definitive and absolute answers to the moral conflicts that have arisen In the development of professions or in the relationship of health professionals with their patients. While professional ethics brings, in its trajectory, histories of answers and previously established formulas for conflicts, based mainly on the so-called codes of professional ethics, bioethics is characterized by a procedural analysis of conflicts based on a minimalist ethic that allows Mediation and the peaceful settlement of differences. Thus, unlike professional ethics, the role of bioethics is not the obligatory resolution of the conflict, even though there are conflicts (such as abortion, for example) that, in the light of moral pluralism, which is one of the bases of its theoretical support, are simply not solvable from the point of view of an ethic that is universal [34].

The globalized world is characterized by the domination, in the field of politics, of the defense of democratic ideals, which implies living in pluralistic societies. With this, institutions are compelled to modify their practices in a non-corporate and morally plural perspective. Medicine, in particular, has been the permanent target of criticism and pressure for changes in its professional ethical code, still permissive of an oligarchic, vertical, paternalistic physician-patient relationship model, because it is based on principlist bioethics. This model must be surpassed by a more democratic one, that respects the dignity of the persons, autonomous in the decisions about their bodies and their destinies, and balances individual and collective interests in health decisions, privileging, however, public health as constitutional right [2,14,15,18].

Concepts and practices in health change throughout history. Nowadays, the capitalized world invests in the approach to life as a financial asset, transforming the body into a negotiable object and health into a product for trade. The high complexity

 http://dx.doi.org/10.1590/1983-80422017252184

and high cost technological advances required for individual health compete with actions in primary care, draining resources to reach and resolve collective health problems. In addition, there is an accelerated and unequal expansion of institutions providing health services, invading the field of public health management. In this context, patients organize to claim rights, and health becomes a field of justice.

Free access to health knowledge expands claims to rights, and the debate on issues previously restricted to physicians, and medical education prioritizes the teaching of competencies for primary health care. The inter-professional limits have been questioned with claims of other categories to the right to the diagnosis and prescription of medicines, while the epidemiological transition imposes the debate on resource allocation. Finally, health is recognized today as a result of the interaction of all other areas of human activity: education, work, leisure, spirituality, ecology, nutrition, safety, etc. [2,6,7,13-15,18].

All these questions of a social-political nature and the emergence of bioethics since the 1970s have modified the perception of a corporatist medical deontology to one open to the contributions of all segments of society, with the purpose of reformulating the ethical rules of the exercise Of medicine. The current CEM, which has been in force since 2010, was influenced by principlist bioethics, with the contribution of proposals for the changes of 750 physicians [3]. It is presumed that, among these, there were representatives from the health services sector, and no contribution from society at large was reported. This fact can be corrected in the current CEM revision, with the possibility of a broader participation of civil society [35].

The complexity of contemporary biomedicine requires the opening of medical ethics to a more advanced bioethical approach than the principlist bioethics, as well as a new code that also considers contributions from different social, non-medical segments. The formulation of ethical problems, in exclusively deontological terms, guarantees the physician's independence and their opinion regarding political, social, economic and other pressures. However, if the spirit of such ethics is not in conformity with the human rights declarations, that independence does not confer guarantees nor does it constitute a force of moral resistance in countries or contexts in which there is violation of democratic principles [14].

The complexity of the phenomena of life does not allow the monopoly of decisions, especially when we recognize the political-social nature and the multiple possibilities of functioning according to the logic of the market. Therefore, neither the will to monopolize the decision nor the reduction of ethical problems to issues of professional ethics appears justified [2,14,15,20,33]. Hottois states:

It is to this situation that the bioethical point of view seeks to do justice, by opening the ethical debate and by defining deontology and medical ethics stricto sensu as a limited aspect of the general ethical issues posed today by biomedical practices whose frontiers with Biotechnology has become unclear. Deontology and medical ethics approach them from the point of view of physicians and are addressed exclusively to physicians [14].

Recurring to prudence (deontological stance), to the prevention of errors in scientific experiments, the respect for these and the human destiny, the French National Advisory Committee on Ethics for the Life and Health Sciences, according to Durand [20], points out that it is not the knowledge and medicine that constitute a threat, but power and desire. The development of technosciences and biomedicine confers new powers on physicians and researchers, which creates the possibility of threats to individual freedoms, and the need for a call for human rights to regulate them.

Deontology, as a code, presents itself before this framework of necessary vigilance and the establishment of limits as a coercive force, therefore, closing itself to narrower interpretations, unlike bioethics. It is thus not democratic to leave to members of a single profession the decisions that imply important social choices [14,20].

Clinical ethics refers, above all, to the criteria of traditional medical deontology. However, other approaches can be explored, less normative, with an expanded ethical view, contextualizing the reality of local health demands and considering the characteristics of the distribution of powers and their resulting effects on access and allocation of resources.

Clinical practice nowadays has acquired new features and characters: the multiplicity of interlocutors has rendered the "singular colloquy" obsolete, and technological power opens space for uncertainty, an inevitable opening to broader philosophical questions (the medicine of the desire for well-being, subjectively defined and unlimited,

and the inevitable present and future social repercussions of unique choices) [20,36].

The recognition that traditional medical deontology slowly becomes the branch of moral philosophy, of practical ethics, does not prevent us from predicting and preventing the conflicting path of this transformation. Not only does the CEM need to be reviewed and updated to incorporate the contributions of the different social segments towards a Latin American bioethics, but the different health institutions need to transform their ethics committees. These committees are generally composed entirely or largely by physicians and are oriented toward standardization of research in bioethical committees with the equal participation of different professionals and representatives of the community.

We are living a moment of great bioethical influence in debates on broader health issues, in which positions are outlined, taken from concrete and unique cases. These cases can be used as examples of consensus, if they consider problems of social inequality and inequity arising from it, and seek solutions with a Latin American and national ethical-political perspective that is far from principlism.

The Anglo-Saxon colonial heritage and market pressures impose moral blindness on us, which prevents us from considering necessary and real values and principles to guide us: the truly democratic ones. It is suggested, for revisions of the professional codes, to consider the democratic principles contained in UDBHR [21].

This is the reflection necessary to overcome corporatist interests and to understand that our actions are not devoid of values or hostage of an ethic that determines and surpasses us, but which can and should be repaired. In addition, this reflection leads us to absorb contributions from the different areas of knowledge to insert them into the ethical, plural debate, for the construction of new realities.

Gracia suggests that, in order to overcome models of absolutist, belligerent, or liberal tactical neutrality, professions must adopt a deliberative attitude on values, even in the institutional field, with collective deliberation on common goals. The more recent model, liberal, reduces the medical encounter to the mercantile activity regulated by the competence and the laws [37].

It is the articulation of voices, in the plural chorus in defense of the human rights to health, as expanded rights to biotechnological and environmental issues, of coping with inequities resulting from social injustices and protection of future generations, which gives dignity to our acts and, simultaneously, to the person being cared for.

Final Considerations

Society faces current dilemmas in the order of individual, professional, social, national and planetary boundaries imposed by the accelerated technoscientific development, by the horizontality of relations and decisions, and by the hegemony of neoliberal capital. Birth, life and death are legitimized by contributions from the different fields of scientific research, which are not always considered ethical. On an individual level, depoliticization, homogenous behaviors and individualism have induced consumerism without reflection, obsession with youth, search for longevity, perfect body, and planned happiness. As a consequence, they generate anxiety and fear of the other, dysthanasia, xenophobia and environmental disasters.

At the social and health levels, in countries with fragile economies and unstable political systems, dependent and exploited by others with a stronger economy, the effects result in the insufficiency and unequal distribution of the resources allocated, making it difficult for the most vulnerable sections of the population to access services which are essential to the maintenance of life with quality.

In addition to the resurgence or worsening of persistent situations related to social exclusion, these countries must manage emergent situations related to scientific development (genetic engineering, therapeutic use of stem cells, organ donations and transplants, assisted fertilization and embryo discarding, eugenics, surrogate pregnancies, sexual reassignment, cloning, biosafety, etc.), adjusting them to the pressure for poor resources carried out by supplementary health groups.

The complexity of life, the accumulation of scientific knowledge with the contribution of the human and social sciences, the need for recognition and the expansion of human rights require that, in addition to individual ethics, we must take responsibility for the development of ethics Public and planetary. This would allow the protection of individual life, minority social groups and future generations, as well as sustainable management of the environment.

 http://dx.doi.org/10.1590/1983-80422017252184

The UDBHR is the document is designed to highlight these responsibilities, in the management of the present and in the creation of possibilities of the future with dignity, and that must also focus on professional ethics. The Brazilian CEM, influenced and limited by the Anglo-Saxon principlist bioethics, is far from broader principles that allow the contextual and in-depth reflection of local and national issues and that prioritize the most vulnerable groups.

Professional ethical codes should be adapted to the social, economic and political reality, prioritizing values, principles and norms that safeguard and amplify rights, in communion with public and collective health.

The human being is the only meaning and goal for development; therefore, only the human being must be subject to any regulation that is intended to be democratic, participatory and truly bilateral.

Referências

1. Berlinguer G. Bioética cotidiana. 2ª ed. Brasília: Universidade de Brasília; 2015.
2. Garrafa V. Bioética. In: Giovanella L, Escorel S, Lobato LVC, Noronha JC, Carvalho AI, organizadores. Políticas e sistema de saúde no Brasil. Rio de Janeiro: Fiocruz; 2014. p. 741-57.
3. Conselho Federal de Medicina. Resolução CFM nº 1.931, de 17 de setembro de 2009. Aprova o código de ética médica. Diário Oficial da União. Brasília; 24 set 2009.
4. Tealdi J, editor. Diccionario latinoamericano de bioética. Bogotá: Unesco/Universidad Nacional de Colombia; 2008.
5. Beauchamp TL, Childress JF. Principles of biomedical ethics. 7ª ed. Nova York: Oxford University Press; 2012.
6. Testa M. Pensar em saúde. Porto Alegre: Artes Médicas; 1992.
7. Testa M. Op. cit. p. 75.
8. Testa M. Op. cit. p. 76.
9. Pereira Neto AF. Ser médico no Brasil: o presente no passado. Rio de Janeiro: Fiocruz; 2009.
10. Testa M. Op. cit. p. 81.
11. Testa M. Op. cit. p. 82.
12. Paviani J, Sangalli IJ. Ética das virtudes. In: Torres JCB, organizador. Manual de ética: questões de ética teórica e aplicada. Petrópolis: Vozes; 2014. p. 225-46.
13. Rego S, Palácios M, Siqueira-Batista R. Bioética para profissionais da saúde. Rio de Janeiro: Fiocruz; 2014.
14. Hottois G, Missa JN. Nova enciclopédia da bioética: medicina, ambiente, biotecnologia. Lisboa: Instituto Piaget; 2003.
15. França GV. Deontologia médica e bioética. In: Clotet J, organizador. Bioética. Porto Alegre: EDIPUCRS; 2001. p. 58-66.
16. Drumond JGF. Ética, códigos e deontologia em tempos de incertezas. In: Pessini L, Siqueira JE, Hossne WS, organizadores. Bioética em tempos de incertezas. São Paulo: Loyola; 2010. p. 133-50.
17. Foucault M. O nascimento da clínica. Rio de Janeiro: Forense Universitária; 1977. p. 21.
18. Garrafa V. Ampliação e politização do conceito internacional de bioética. Rev. bioét. (Impr.). 2012;20(1):9-20.
19. Pyrrho M, Prado MM, Cordón J, Garrafa V. Análise bioética do Código de ética odontológica brasileiro. Ciênc Saúde Coletiva. 2009;14(5):1911-8.
20. Durand G. Introdução geral à bioética. 3ª ed. São Paulo: Loyola; 2010.
21. Organização das Nações Unidas para Educação, Ciência e a Cultura. Declaração universal sobre bioética e direitos humanos. [Internet]. Genebra: Unesco; 2005 [acesso 20 jul 2015]. Disponível: http://bit.ly/1TRJFa9
22. Garrafa V. Da bioética de princípios a uma bioética interventiva. Bioética. 2005;13(1):125-34. p. 132.
23. Tealdi JC. Op. cit. p. 161.
24. Tealdi JC. Op. cit. p. 165.
25. Tealdi JC. Op. cit. p. 177.
26. Garrafa V. Bioética e ética profissional: esclarecendo a questão. Jornal Medicina; 8(97):28. 1998.
27. Garrafa V. Op. cit. 2005. p. 132.
28. Oliveira AAS. Interface entre bioética e direitos humanos: o conceito ontológico de dignidade humana e seus desdobramentos. Rev. Bioética. 2007;15(2):170-85.
29. Pessini L. Bioética na América Latina: algumas questões desafiantes para o presente e futuro. Bioethikos. 2008;2(1):42-9.
30. Kottow M. Bioética de proteção: considerações sobre o contexto latino-americano. In: Schramm FR, Rego S, Braz M, Palácios M, organizadores. Bioética: riscos e proteção. Rio de Janeiro: UFRJ; 2005. p. 29-44.
31. Feitosa SF, Nascimento WF. A bioética de intervenção no contexto do pensamento latino-americano contemporâneo. Rev. bioét. (Impr.). 2015;23(2):277-84.

32. Kant I. Fundamentação da metafísica dos costumes e outros escritos. Lisboa: Edições 70; 1960. p. 79.
33. Esteves J. Éticas deontológicas: a ética kantiana. In: Torres JCB, organizador. Manual de ética: questões de ética teórica e aplicada. Petrópolis: Vozes; 2014. p. 247-67.
34. Garrafa V. Op. cit. 1998. p. 28.
35. Conselho Federal de Medicina. Mudanças em favor da medicina e da sociedade. Revisão do código de ética médica. [Internet]. Brasília: CFM; 2016 [acesso 20 jan 2017]. Disponível: http://www.rcem.cfm.org.br/
36. Gracia D. Ética y responsabilidad profesional. Santa Fé de Bogotá: El Buho; 1998.
37. Gracia D. Pensar a bioética: metas e desafios. São Paulo: Loyola; 2010.

Participation of the authors
This article was elaborated by Francisco José Passos Soares from the idea proposed by Garrafa who, as Helena Shimizu, also participated in the analysis and final review of the text.

Recebido: 28.11.2015
Revisado: 13.12.2016
Aprovado: 29. 1.2017

Update