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Precariousness of medical work in Paraíba: ethical impacts

Bruno Leandro de Souza[1], *Thiago Guimarães Pereira Souza*[2], *Caio Chaves de Holanda Limeira*[3], *Heloisa Calegari Borges*[3], *Naraiana Chaves Pereira*[3]

1. Faculdade de Medicina do Porto, Porto, Portugal. **2.** Faculdades Nova Esperança, João Pessoa/PB, Brasil. **3.** Universidade Potiguar, Natal/RN, Brasil.

Abstract

Brazil faces an increasing precariousness in public services, as well as in medical work. Paraíba has a peculiar contracting modality called "codification", an unconstitutional employment relationship established without a signed contract, in which the physicians is paid for service provision without guarantee of labor rights. This arcticle discusses the precariousness of medical work in the State of Paraíba by examining the codification system and its bioethical implications. This is a cross-sectional study with data from the transparency portal of the State Court of Accounts on codified physicians. Results show that 1,474 physicians work in the state health care system, 716 (48.6%) of whom were hired through public entrance examinations and 758 (51.4%) by codification. Significantly, 55.8% of codified physicians are men (p = 0.001) and 67.1% work in Paraíba's Zona da Mata region (p = 0.021). More than a third is registered as clinicians. Recognizing the social value of the physician is essential to prevent negative impacts on job stability and on the formation of bonds between workers and users. We must re-establish human dignity in this context.

Keywords: Employment. Physicians. Work.

Resumo

Precarização do vínculo de trabalho do médico na Paraíba: reflexos éticos

Observa-se no Brasil uma crescente precarização dos serviços públicos e do trabalho médico. Na Paraíba, há uma forma peculiar de contratação, denominada "codificação". Trata-se de um vínculo inconstitucional, estabelecido sem assinatura de contrato, por meio do qual o médico recebe por produção e sem garantia de direitos. O objetivo do presente artigo é discutir a precarização do trabalho médico no estado da Paraíba por meio da codificação e suas implicações bioéticas. O texto traz resultados de análise de dados disponíveis no Portal da Transparência do Tribunal de Contas do Estado. Os dados revelam que, no momento da pesquisa, 1.474 médicos trabalhavam na rede estadual de saúde, sendo 716 (48,6%) concursados e 758 (51,4%) codificados. Dentre os codificados, 55,8% são homens (p=0,001), 67,1% trabalham na Zona da Mata Paraibana (p=0,021), e mais de um terço presta serviços para o estado como clínicos. Conclui-se que a codificação é uma forma ilegal de contratação, e que é preciso resgatar o valor social do médico e a dignidade humana, para que a estabilidade desses trabalhadores e a formação de vínculo com os usuários não sejam prejudicadas.

Palavras-chave: Emprego. Médicos. Trabalho.

Resumen

Precarización del vínculo laboral del médico en Paraíba: reflejos éticos

En Brasil existe una precariedad creciente de los servicios públicos, así como del trabajo médico. En Paraíba hay una forma contractual peculiar llamada "codificación", un vínculo inconstitucional establecido sin un contrato firmado en el que el médico recibe para la producción sin garantía de derechos. Este artículo propone discutir la precariedad del trabajo del médico en el estado de Paraíba mediante la codificación y sus implicaciones bioéticas. Este es un estudio transversal con análisis de datos del portal de transparencia del Tribunal de Cuentas del Estado sobre detalles de médicos codificados. De los 1.474 médicos que trabajan en la red de salud del estado, 716 (48,6%) son reclutados públicamente y 758 (51,4%) están codificados. Fue significativo que el 55,8% son hombres (p=0,001>) y el 67,1% trabaja en la Zona da Mata Paraibana (p=0,021). Más de un tercio están codificados como clínicos. Se concluye que la codificación es una forma ilegal de contratación y que el rescate del valor social del médico y la dignidad humana es esencial para que no haya interferencia en la estabilidad de estos trabajadores y en la formación de vínculos con los usuarios.

Palabras clave: Empleo. Médicos. Trabajo.

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Research

According to article 25 of the 1948 Universal Declaration of Human Rights, everyone has the right to a standard of living adequate for the health and well-being of oneself and one's family, including food, clothing, housing, medical care and necessary social services [1]. The right to health is a broad concept encompassing not only health care provided in hospitals or basic health care units, but also the quality of life associated with other basic rights, such as education and sanitation, including preventive actions. Health, therefore, is linked to the right of every human being to a decent standard of living.

Health is the right of all and a duty of the State, a right guaranteed by social and economic policies aimed at reducing the risk of diseases and other health conditions and ensuring universal and equal access to health promotion, protection and recovery actions and services (art. 196 of Brazilian Federal Constitution) [2]. Thus, it is the public authorities' duty, in accordance with the law, to regulate, supervise and control these actions and services, either directly or through third parties, by individuals or private legal persons (art. 197 of the Constitution) [2].

Health policy in Brazil is a reflection of historical, social, economic and political processes. Understanding such processes is fundamental to understand the Unified Health System (SUS). The Brazilian health care system, although unified, comprises a regionalized and hierarchical network whose guidelines are: decentralization, with a single management in each sphere of government; comprehensive care, with priority given to preventive activities, without prejudice to assistance services; and participation of the community (art. 198 of the Constitution) [2].

Despite this ideal of excellence, in practice service provision for the community is still far below the expectations and needs of the Brazilian population. The universal and equal right to health has always been at risk due to underfunding [3]. The increasing precariousness of public services manifests itself in several ways: large assistance gaps, shortcomings in infrastructure, lack of inputs and equipment, outsourcing of labor, administrative and process management problems, lack of public examinations for selecting civil servants, deficit of personnel and instability in the employment relationship [3].

It is important to highlight, among these various aspects of the deterioration of public services, the increasing precariousness of employment relationships in health care. According to Sousa and collaborators [4], studying the pay and hiring systems for medical work is important to formulate public health care policies. In fact, choosing one or another system for hiring and paying physicians – whether through salaried work, or hiring/accreditation with remuneration per procedure, or even by combining these two methods – is strategic for managing health care systems. The choice of system directly impacts the quality of services provided to the population and the level of universality and equity of access [3].

Over the last decades, physicians, who are key actors in SUS, had to adapt to the new scenario in which they are subjected to the structural dynamics of the service provider's organization and operation, under the same conditions as other workers in the modern capitalist system: instability, intensive work, long working hours, reduced remuneration and loss of work autonomy [3].

According to the Brazilian legislation, work performed on a temporary or occasional basis, even if subordinate, does not entitle workers to the benefits arising from the employment relationship, as provided for in Article 3 of the Consolidation of Labor Laws (CLT), which establishes that only someone who provides services of a non-occasional nature is considered an employee [5]. The employment relationship is a qualified labor relationship, which entails a specific legal bond. It is only recognized when all the following criteria are met: the work is performed personally by an individual; it is paid; it is habitual or non-occasional; and it is subordinate [6]. If any of these criteria are not met, the work performed is considered service provision and not formally part of an employment relationship. Thus, the labor relationship is like a genus of which the employment relationship is a species [6].

The formal bond of physicians to health care organizations, especially hospitals, takes different forms in different countries. These forms vary from vertical integration – an individual, salaried, hired directly by the hospital for an indefinite period – to self-employment as an occasional service provider under specific contracts, including some more or less "loose" intermediate forms, in which physicians are hired as individuals or legal persons,

under contracts of varying duration, with or without exclusivity [3].

It has been a common practice in hospitals and clinics to mischaracterize two constitutive elements of the employment relationship – its personal nature and the subordination involved – by hiring the physician as a legal person – a procedure known in Brazilian labor doctrine as "*pejotização*," a term derived from the acronym for *pessoa jurídica* (legal person). This requirement of hiring the worker as a legal person or as a service provider is intended to disguise the existing employment relationship.

Professionals hired under these conditions face great difficulties to unionize and to join forces to claim rights and prevent possible abuses by employers. This contracting modality, as it is being implemented, characterizes yet another form of the increasing precariousness of medical work, since it creates a fictitious business entity, operated solely for the purpose of avoiding the recognition of the employment relationship [7].

Another inadequate form of hiring medical work, regarding the criterion of paid work, is through cooperatives. Cooperatives are an efficient and fair mean of income distribution, as they eliminate intermediation, allow work autonomy and give more security to the associated worker. However, today we observe evidence of fraud in this modality: failure to observe the principles that govern cooperatives, absence of essential characteristics of legitimate cooperatives and, finally, the presence of elements that characterize an employment relationship [8].

Before detailing the case of Paraíba, it is important to note that Brazilian Federal Constitution's article 37 very clearly establishes that *the government and governmental entities of any of the powers of the Union, the States, the Federal District and the Municipalities shall obey the principles of lawfulness, impersonality, morality, publicity and efficiency* [2]. According to item II of the same article, the *investiture in a public office or position depends on prior approval in an entrance examination consisting of tests or tests and presentation of academic and professional credentials, according to the nature and complexity of the office or position, as provided by law, except for appointments to a commission office declared by law as being of free appointment and discharge* [2].

Therefore, hiring workers for public services, according to the Federal Constitution, must necessarily involve a public entrance examination or selection process. The exceptions, provided for in article 37, item IX, are the hiring for a limited period of time – in which case Law 8,745/1993 [9] establishes when hiring to meet a temporary need of exceptional public interest is allowed – and commissioned positions of free appointment and discharge. In this sense, the Superior Labor Court has already ruled that *the hiring of a civil servant, after the 1988 Federal Constitution, without prior approval in a public entrance examination, is restricted by art. 37, II and paragraph 2, which only allows the right to the payment of the agreed compensation, according to the number of hours worked, respecting the hourly minimum wage, and the amounts referring to FGTS deposit* [10].

In the state of Paraíba, a modality not provided for in Brazilian legislation was created for the use of government entities – "codification."

Regionalization in the state of Paraíba

The state of Paraíba has an area of about 56,470 km^2 and a population of 3.996 million, according to 2018 estimates by the Brazilian Institute of Geography and Statistics (IBGE) [11]. Data from the Regional Council of Medicine of Paraíba (CRM-PB) show that in May 2019 there were 7,984 professionals registered and qualified for medical work in the state. The ratio of physicians per inhabitants, therefore, is 2 to 1,000, which represents twice the minimum set by the World Health Organization [12].

Paraíba is administratively divided into four mesoregions – *Zona da Mata Paraibana*, *Borborema*, *Agreste* and *Sertão Paraibano* – which differ in sociodemographic characteristics and health issues. This division facilitates the planning of primary, psychosocial, specialized and hospital care, urgency and emergency services, and health surveillance – actions and services that are covered by the SUS. Decision-making in health care can be more assertive with a broad knowledge of the regional context [13].

The State Health Plan (2016-2019), approved by the State Health Council, exposed the state's mesoregional inequalities. Physicians and medical services are concentrated in some regions, especially in the *Zona da Mata Paraibana*, where the state capital is located. According to CRM-PB data, 52% of the physicians registered in Paraíba work in João Pessoa's metropolitan region [13].

"Codification" and precariousness of medical work in Paraíba

For more than 10 years, the state government of Paraíba has conditioned the "contracting" of physicians and other health professionals on an unconstitutional procedure, widely known by the public, called "codification" [14]. It is important to emphasize that this contracting modality is not used to meet a temporary need of exceptional public interest, neither for filling commissioned positions of free appointment and discharge, not even for hiring through a legal person. Nor does this contracting modality have sufficient characteristics to allow analogies to be drawn with modalities already provided for in law [14].

In the codification modality, initially characterized as temporary and of exceptional public interest, professionals are hired without prior selection and with no contract being signed [14]. From a "spoken" commitment or oral contract, the physician receives a "code," which serves as a kind of registration. When the professionals start their work activities, the health unit informs the State Health Department, which pays for the services according to the number of shifts worked or activities performed. Payment is deposited in a bank account informed by the professional in the month following the work performed. No social security contributions are paid, and the professional does not enjoy fundamental rights, such as paid vacation, 13th salary and paid leave for justified absence or death of a first-degree relative [14].

There is no official record of when codification was instituted to urgently remedy the shortage of professionals in state public services. The reason is that an illegal policy cannot be made official. However, there are reports that the practice has been occurring for at least 12 years under this name. Since it started, four governors from three different political parties have been elected to govern Paraíba. This shows, therefore, that it is not merely a government policy, but a State policy, although illegal [14].

Before codification, there was already another form of labor precariousness that adopted the system of payment of productivity fees, in which the professional informed and gave proof of the number of the Individual Taxpayer Registry, with the fees deposited directly in the bank account. The code would have been created to improve this practice, ensuring better control. Several news stories and statements by the public authorities themselves attest to the fact.

In an attempt to minimize the illegality, the State Court of Accounts (TCE) has made the name, salary and position of all codified employees available in the database of the Monitoring and Management System of Society's Resources (Sagres) on a monthly basis, just as it is done for professionals hired through entrance examinations [15]. The main difference is that, in the case of codified professionals, the illegality of the hiring remains.

For the STF, the theory of the de facto employee applies to the irregular hiring without public entrance examination, and the acts practiced by the agent are valid, even if the situation appears to be legal [16]. Furthermore, a procedure was open by the Federal Public Prosecutor's Office to investigate possible irregularities in the payment of civil servants with resources earmarked for health care (Preparatory Procedure 1.24.000.001214/2017-62) [17].

Physician-state relationship and precariousness of work

The physician and other health professionals started to work routinely in public health care services without the job stability guaranteed to civil servants by Law 8,112/1990. According to article 22 of Law 8,112, civil servants, after a probationary period, will only lose their position due to a final judicial decision or a disciplinary administrative proceeding in which they have the right to a full defense [18]. The physician,

in the codification modality, can be dismissed at any time and regardless of cause.

Moreover, the practice has become especially useful for governments to justify spending as payment for services, instead of payment to people, giving the impression of compliance with Complementary Law 100/2000 [19], known as the Fiscal Responsibility Law (LRF). The state of Paraíba, in 2018, presented accounts showing that 60.3% of the State Current Net Revenue was used to pay personnel expenses. According to the LRF, the limit for these expenses is 60%, so the government argues that it no longer can hire physicians through public entrance examinations.

Some physicians see codification as a way of hiding multiple job-holding, since many codified physicians are not registered with the National Health Facilities Registry [14]. However, Federal Constitution's article 37, item XVI, forbids the holding of three remunerated positions in public services. For the physician who already holds two such positions, codification can be a way to keep a third public service job [2]. In addition to this illegality, as already mentioned, these professionals cannot enjoy the labor rights to which they are entitled.

This diversity of hiring practices reflects interests and strategies – not always consistent with each other – of physicians, hospitals, governments and paying third parties. In addition to legal restrictions, tax and fiscal "convenience," forms of sharing economic and moral risks and the degree of exclusivity in the relationship between the parties are also considered [3].

In this context, it is imperative to carry out an extra effort– within a more global process of adjusting work relationships and the strategies adopted by professionals – to rethink new remuneration and contracting regimes aimed at, within sustainable budgetary limits, maximizing productivity, improving service quality and ensuring adequate levels of cooperation between workers and management and between health professionals [3].

Method

This study aims to discuss the bioethical implications of the increasing precariousness of medical work in the state of Paraíba resulting from a contracting modality called "codification." This is an original, documentary, cross-sectional, descriptive, and exploratory research on the topic, employing a quantitative approach. The study sample consisted of physicians from the state of Paraíba, hired through codification and who were working between December 2018 and November 2019.

To list the number of codified physicians, their remuneration and turnover and work contracts signed, the study searched the Sagres database from the Transparency Portal of the Paraíba TCE [15]. All cities with health services maintained by the state government were included. Health care units managed by non-governmental organizations, whose contracting regime follows CLT provisions, were disregarded.

Data were categorized by gender, mesoregion and specialty and consolidated into contingency tables, showing simple and relative frequencies. Chi-squared test was used to test associations between categorical variables and burnout. Analyzes were performed using SPSS version 20.0.0.0, considering significance level at 0.05.

The study complied with the norms of research involving human beings, according to Resolution 466/2012 of the National Health Council [20]. The basic bioethics principles (autonomy, non-maleficence, beneficence and justice) were observed. The data used were collected from a governmental source and, being secondary, the survey did not require signing an informed consent form and analysis by the Research Ethics Committee.

Results and discussion

In November 2019, 7,984 physicians were registered with the Regional Council of Medicine and authorized to practice the profession. Of these, 1,474 worked in the state health care system, with 716 hired by entrance examination and 758 by codification. The ratio of codified physicians to the total number of physicians working for the state government, therefore, was of 51.4% at the time. Most of the codified physicians were men and worked in Paraíba's Zona da Mata mesoregion (Table 1). More than a third of codified physicians were registered as general practitioners (Figure 1).

Over the period studied, each month we surveyed the number of physicians who did not remain codified (which were identified as "uncodified") and the number of new physicians codified. As shown in Table 2, the largest absolute number of uncodified physicians was observed in the Zona da Mata region (104). However, in relative numbers, it was the Agreste region that showed the greatest number of professionals who left the system in one year (32%). The number of newly codified physicians was lower than that of uncodified ones. As there was no hiring through entrance examinations in the period examined, we assumed that there was a decrease in the number of physicians working at health care units managed by the state.

According to Maciel and collaborators [21], the precariousness of the physician's employment relationship with the state is harmful to public health care provision. The instability resulting from the absence of a contract and the lack of access to labor rights makes the physician a product that can be replaced at any time, without following any technical criteria, which leaves the professional at the mercy of the health care system manager's political convenience. The high rate of physicians leaving the codification system verified in the study is yet another evidence of the physician's vulnerability in these services.

The state of Paraíba itself and its health care system are very fragile in this context, given that job instability leads some physicians to seek other markets, which offer forms of contracting in accordance to law. Saad, Saad and Branco [22] note that the integration of these professionals into the services' work routines can be hindered by high turnover rates. It is necessary, therefore, to review the professionals' employment relationship within a model that provides quality services and a more dignified work relationship [3].

Codification as a contracting scheme can expose the population to risk, since there is no disclosure of the hiring criteria followed, and it is also unknown whether the so-called specialists have or not accreditation and a specialty qualification registered with the CRM-PB. It is also not possible to assess the engagement of these professionals with the community and the health care system, because there is no formal employment relationship and they might leave the public service at any time. This is a serious issue, as no health care system can function without physicians [23].

According to Barchifontaine and Trindade [24], bioethics must be valued in the everyday provision of health care as an important part of the health policy. To achieve quality, humanized care, capable of guaranteeing the dignity of all, it is essential to value the medical work [25].

Table 1. Number of physicians hired via codification and entrance examination by gender and mesoregion, according to data from the Management Monitoring System of Society's Resource for November 2019 (Paraíba)

Codified Physicians	Codification N (%)	Examination N (%)	*P**
GENDER			
Female	335 (44.2)	252 (35.2)	0.001
Male	423 (55.8)	464 (64.8)	-
MESOREGION			
Zona da Mata Paraibana	510 (67.3)	527 (73.6)	0.021
Borborema	128 (16.9)	136 (19)	-
Agreste	63 (8.3)	27 (3.8)	-
Sertão	57 (7.5)	26 (3.6)	-
SPECIALTY			
General practitioner	261 (34.4)	230 (32.1)	0.078
Pediatrician	81 (10.7)	143 (20)	-

continues...

Table 1. Continuation

Codified Physicians	Codification N (%)	Examination N (%)	*P**
Anesthesiologist	76 (10)	23 (3.2)	-
General surgeon	55 (7.2)	63 (8.8)	-
Gynecologist and obstetrician	52 (6.9)	98 (13.7)	-
Intensive Care Medicine	48 (6.3)	32 (4.5)	-
Diagnostic Imaging	32 (4.2)	39 (5.4)	-
Orthopedist and rheumatologist	26 (3.5)	35 (4.9)	-
Other	127 (16.8)	53 (7.4)	-
Total	**758 (100)**	**716 (100)**	

** Chi-square test.*

Figure 1. Physicians hired via codification by specialty, according to data from the Management Monitoring System of Society's Resource for April 2019

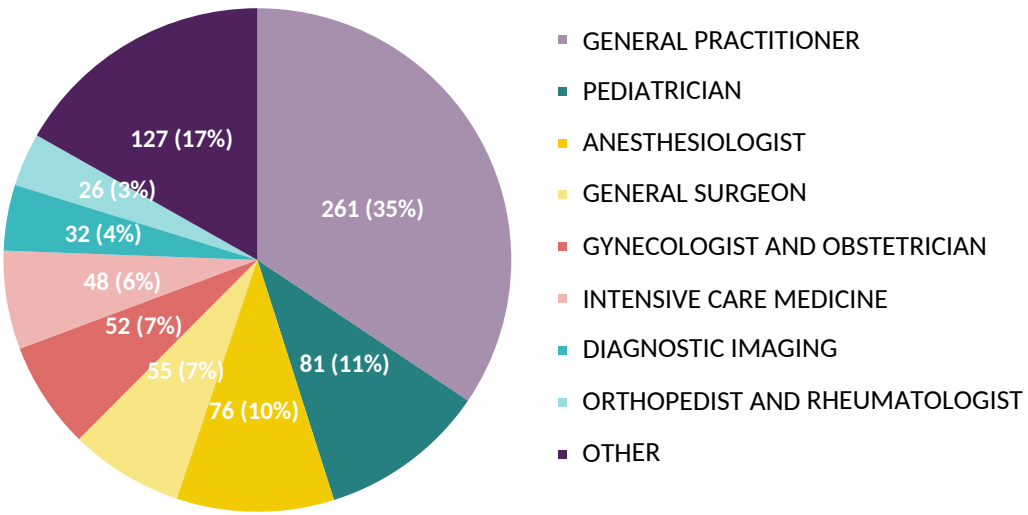

Table 2. Number of uncodified physicians and newly codified physicians from December 2018 to November 2019, by mesoregion (Paraíba)

Physicians	Number (N)	Percentage (%)
Uncodified		
Zona da Mata Paraibana	104	63.5
Borborema	32	19.5
Agreste	18	10.9
Sertão	10	6.1
Total	**164**	**100**

continues...

Table 2. Continuation

Physicians	Number (N)	Percentage (%)
New codified		
Zona da Mata Paraibana	74	56.5
Borborema	30	22.9
Agreste	17	13
Sertão	10	7.6
Total	**131**	**100**

Final considerations

It is absolutely clear that in the state of Paraíba the rights of the physician, as a citizen, are being violated. These professionals are subjected to an increasing precariousness caused by deceptive expedients aimed at disguising their employment relationship through uncertain and atypical hiring modalities.

Codification is a real offense to the national legal system, since in it the publicity of governmental acts is deficient and uncertain. All the labor rights enjoyed by civil servants – whether working in the CLT modality or through entrance examination, or even hired on a temporary basis – are denied to the codified physicians, as there is no contract signed between the governmental entity and the hired citizen. Moreover, there are suspected irregularities in the use of funds to pay this kind of personnel expenses.

Codification violates constitutional principles of social rights, public administration, legality, morality and publicity, while also offending the principles of equity and dignity of all persons. Control bodies' efforts to ensure transparency have not been sufficient to resolve the problem. Hiring via codification has been occurring on a regular basis without the state government presenting management solutions to legalize, in the light of the Federal Constitution, the work of physicians in state public health care services. However, it is necessary to ensure the recognition of the social value of physicians and of the medical work, as precariousness affects job stability, the formation of bonds between workers and users and the quality indicators of health services, going against the very dignity of people.

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Bruno Leandro de Souza – PhD student – drbrunoleandro@yahoo.com.br
0000-0002-1699-2986

Thiago Guimarães Pereira Souza – Graduate – thiagogjsouza@gmail.com
0000-0003-2059-8356

Caio Chaves de Holanda Limeira – Graduate – caiolimeira@yahoo.com.br
0000-0002-9365-6820

Heloísa Calegari Borges – Graduate – heloisacalegarib@gmail.com
0000-0002-8026-262X

Naraiana Chaves Pereira – Graduate – naraianachaves@gmail.com
0000-0003-1407-3940

Correspondence
Bruno Leandro de Souza – Av. Dom Pedro II, 1335, Torre
CEP 58040-440. João Pessoa/PB.

Participation of the authors
Bruno Leandro de Souza, Thiago Guimarães Pereira Souza and Caio Chaves de Holanda Limeira performed the bibliographic review and collected the data. Heloísa Calegari Borges and Naraiana Chaves Pereira participated in the statistical analysis and in the critical review of the results. All authors contributed to the final writing of the article. Bruno Leandro de Souza coordinated the study.

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