Patient safety and deontological codes in the context of Beauchamp and Childress

Telma Rejane dos Santos Façanha[1], *Volnei Garrafa*[2]

Abstract

Patient safety is a persistent issue in public health that has taken a new connotation in the contemporary sanitary context. Beauchamp and Childress, in their pioneering work, Principles of Biomedical Ethics, address the ethical role of health professionals and the influence of deontological codes on patient safety. The present study seeks to demonstrate that codes of ethics are insufficient to address all ethical and moral dilemmas related to patient safety at present. In this sense, it is proposed that this topic should not be discussed only in the ethics councils of the different professions in the health area, but that the dialogue be extended to the interdisciplinary committees of clinical and healthcare bioethics, providing a broader and concrete exercise of bioethical reflection.
Keywords: Bioethics. Codes of ethics. Patient safety. Public health.

Resumo

Segurança do paciente e códigos deontológicos em Beauchamp e Childress

A segurança do paciente é questão persistente de saúde pública e tem assumido nova conotação no contexto sanitário contemporâneo. Beauchamp e Childress, na obra pioneira "*Principles of biomedical ethics*", abordam a atuação ética dos profissionais de saúde e a influência dos códigos deontológicos na segurança do paciente. Nesse sentido, este estudo procura demonstrar que esses códigos são insuficientes para atender a todos os dilemas éticos e morais relacionados à segurança do enfermo na atualidade. Assim, propõe-se que esse tema não seja somente discutido em conselhos de ética da área da saúde, mas também em comitês interdisciplinares de bioética clínica e assistencial, proporcionando exercício mais ampliado e concreto de reflexão bioética.
Palavras-chave: Bioética. Códigos de ética. Segurança do paciente. Saúde pública.

Resumen

Seguridad del paciente y códigos deontológicos en Beauchamp y Childress

La seguridad del paciente es una cuestión persistente en salud pública y ha asumido una nueva connotación en el contexto sanitario contemporáneo. Beauchamp y Childress, en la obra *"Principles of biomedical ethics",* abordan la actuación ética de los profesionales de la salud y la influencia de los códigos deontológicos en la seguridad del paciente. En ese sentido, este estudio procura demostrar que los códigos deontológicos son insuficientes para atender a todos los dilemas éticos y morales relacionados con la seguridad del enfermo en la actualidad. Así, se propone que este tema no sólo sea discutido en los consejos de ética del área de la salud, sino también en los comités interdisciplinarios de bioética clínica y asistencial, proporcionando un ejercicio más amplio y concreto de reflexión bioética.
Palabras clave: Bioética. Códigos de ética. Seguridad del paciente. Salud pública.

1. **Doutoranda** telmarejane68@gmail.com – Universidade de Brasília (UnB) **2.** **PhD** garrafavolnei@gmail.com – UnB, Brasília/DF, Brasil.

Correspondência
Telma Rejane dos Santos Façanha – Universidade de Brasília. Campus Universitário Darcy Ribeiro. Faculdade de Ciências da Saúde. Cátedra Unesco de Bioética. Caixa Postal 04451 CEP 70910-900. Brasília/DF, Brasil.

Declaram não haver conflito de interesse.

The safety of the patient is a persistent issue in the field of public health, present since the times of Hippocrates when he pronounced the celebrated phrase "*primum non nocere*": first, do not harm [1]. However, it is evident that health sciences care and practices have since been undergoing changes, in view of the social, scientific and technological advances. Abusive practices during World War II also contributed greatly to these transformations in the field of health, initiating new and complex moral dilemmas.

Tom Beauchamp and James Childress [2] were based on the need to discuss ethics in clinical and care practice, among other reasons, to publish, in 1979, the book *"Principles of Biomedical ethics*". They recommended that health professionals respect the particular freedom of each individual to decide on aspects of their living condition (autonomy) and refrain from any intervention that would harm the individual (non-maleficence). In addition, health professionals should always act in a fair way [3], in order to do good (beneficence), and develop their practices without discrimination.

From this, the objective of this article was to address the subject of patient safety and its relationship with the ethical practice of health professionals, based on the conception of Beauchamp and Childress. It is also proposed, through the revised literature, possible solutions to moral dilemmas in this context.

Brief historical contextualization of patient safety

The inherent complexity of the health system has been conceived from the contemporary perspective of patient safety, not only considering just the ethical and moral issues related to physicians, but the various competencies that must be mastered by other members of the health team. For this, it is necessary to adequately understand the principles and concepts of the patient's safety and develop new skills, considering the intricate network of contemporary health care and the growing professionalization in the area [4].

The analysis of health care damage in patients has become in the same way as one of the central objectives in events inherent to the health system's user safety. These damages were reported for the first time in the literature in the early 1980s, coinciding with the crisis of neglect in the United States [5] and, more recently, with the focus of the U.S. government on safety and quality of health care and adverse events. The recent attention to harm caused to the sick by health professionals stems especially from the "Harvard Medical Practice Study" of 1990, which showed the extent of adverse events in hospitalized patients [6]. Since its publication, researches in developed and developing countries have continued to reveal unacceptable rates of harm [7].

Although this theme is part of the discussions in the scientific context in recent decades, there is still little evidence of improvement in health systems and many problems persist, even with advances to improve safety and quality of care [8]. Another point is the fact that there are few studies addressing difficulties that physicians, in contrast to other professions, have with notifications. The "culture of guilt" in medicine affects all physicians, but particularly interns and residents, who often are reluctant to rely on the system of clinical reports or discuss them with more experienced colleagues [9].

Unlike nurses, physicians tend to report errors less frequently, and prefer guilt-free approach in mortality and morbidity conferences and peer review processes (which aim to better understand how errors were committed and could have been avoided) instead of notifying them to the hospital incident management system [10]. Despite efforts to reduce adverse events and improve the safety and quality of health care, a safer and more reliable patient-centred health system remains undefined [8]. Therefore, although the notification of these events has been an important tool and is currently used to improve the safety and quality of patient care, their system could be improved.

In view of this, there is broad consensus on the responsibility for adverse events to be mainly attributable to health systems and not to professionals who cause harm by errors of omission or errors of commission. When hospital teams investigate these incidents using root cause analysis, they should generally also consider multiple factors that may have contributed to unexpected outcomes. The fact that adverse experiences arise as a consequence of the (dis) function of the health systems and not of error or individual negligence is surprising, since there are so many professionals involved in the care of people and communities [11].

Patients today depend on skills and knowledge of the most varied health professionals, who must be technically competent and able to communicate

 http://dx.doi.org/10.1590/1983-80422019273323

effectively with patients, caregivers and other members of the team. To understand health care as a system, it is essential to observe that the system depends on efficient, accurate and timely communication among professionals.

In addition, recognizing that the improvement of care provided to patients involves a range of specialists in a given environment, the focus of the physician-patient relationship is transferred to the health system. It also shifts the role and authority of any professional or team to the integration of different activities in the system focused on optimizing patient care and safety [12]. This approach and application of best health practices bring benefits to users of the health system, but they are accompanied by important ethical and moral concerns related to the professionals.

Patient safety in the Hippocratic oath

Although the Hippocratic Oath and the Code of Medical Ethics today presuppose that physicians are able to harm patients, such damage has another origin: health care itself [11]. The physician who acts alone cannot keep the system safe, because the guarantee of health care depends on a team consisting of professionals working in an interdisciplinary way, rather than on a single category as a central and controlling element.

Even when the physician doesn't have the necessary or specialized knowledge to treat the patient optimally, the damages are less remarkable when he or she acts with the health team. Considering only the physician-patient dyad is an inaccurate and unfortunate picture of contemporary health care, since the patient rarely depends solely on one health professional.

Each patient has a network of physicians, pharmacists, physiotherapists, rehabilitation therapists, nurses, receptionists, hospital staff, among many other specialists. Physicians who are limited to the aforementioned dyad not only misinterpret their position in the health system as they increase the possibility of communication errors with the patient. Therefore, it is becoming increasingly clear that better results are achieved when these health professionals act as a team [11].

Unfortunately, some physicians misunderstand this working together, thinking that being the "responsible for the patient" fully satisfies the requirements of their function. However, team activity and multidisciplinary care are complex processes, supported by the application of specific knowledge and skills of each professional category [13].

There is something intuitive about respect for the privacy of patients in the Hippocratic Oath, as well as about questions of life and death and the belief that the physician should not assume the role of God, appropriating the authority of religious faith [1]. Humility, care, responsibility and respect for confidentiality and human dignity represent values that any professional should recognize and support.

Although health care results from the application of bioscientific knowledge by specialists in their respective areas, social and technological factors also determine whether the treatment will benefit or harm the patient, regardless of the place of service (ambulatory, infirmary, clinic, home or community). Other factors, such as knowledge and experience of the professional, environmental aspects and condition and comorbidity of the patient, also affect the continuity of care. This means that safe results depend on the profound understanding of organizations, systems and human factors; error recognition, prevention and management; and willingness and ability to use tools to measure and improve the quality of treatments. Precarious teamwork, inability to communicate effectively with patients, the mistaken understanding of human factors and vague notion about the health system are circumstances linked directly to the occurrence of adverse events [14].

There is no doubt that patients prefer honesty and can accept the fallibility of their physicians. Despite this, many physicians remain reluctant to have a more open attitude in relation to their own mistakes, perhaps due to fear of litigation (largely unfounded), guilt and loss of reputation. The modern oath alludes to the enormous power of the physician and silences about health systems and avoidable damages, as well as the possibility of damage or errors and the duty to stop them. Other barriers to the reduction of human suffering caused by health care reside in the medical *ethos*, in the hierarchical structures institutionalized in academic medicine and services, which discourage teamwork, transparency and clear accountability processes [8].

The patient is presented as a vulnerable person who needs specialized care, whose life can be saved or exterminated by the actions of physicians, that is, patients are rarely seen as active agents. The oath does not mention the patient's desires, preferences for care, values or ability to choose or act. It ignores

autonomy, freedom or rights in the same way, and does not give room for equal partnerships [11]. Whereas oaths, by their very nature, address duties and responsibilities, to establish the physician very clearly as the only actor in the center of activities is totally inconsistent with modern human rights ideas and the ability of patients to conduct their care. Disregarding the patient as a concrete individual, the oath acquires little relevance in contemporaneity and says more about the hegemony of the profession and the barriers to safe and effective assistance than about modern ethics or health care [11].

Moral codes in Beauchamp and Childress

According to Azambuja and Garrafa [15], moral norms are essential in the context of common morality as a historical product. In the work of Beauchamp and Childress [2] moral norms are understood as a grouping of rules and moral principles that constitute a rational and socially stable set of what is understood as right and wrong, so widely accepted and widespread that they form a true "social institution" [15]. Common morality contains abstract, universal and refined moral norms ("telling the truth," for example).

Karlsen and Solbakk [16] understand common morality as a theory applicable to any person, regardless of culture or time. The rules, in this context, are principles that must always be followed at risk of punishment. Moral ideals stimulate prevention and relief from damage, but are not mandatory. The lack of distinction between rules and moral ideals is what is questioned in Beauchamp and Childress [2], given that in general its four principles are not considered duties, sometimes thought of as rules, sometimes as moral ideals [3]. But this does not diminish the importance of their work in the context of bioethics.

According to Beauchamp and Childress, common morality contains particular, concrete and non-universal moralities, such as *making conscious verbal disclosures and obtaining informed written consent from all human research subjects* [17]. In the understanding of these authors, particular moralities are distinguished by specific norms that, however, are not justified if they violate the precepts of common morality. They include the many responsibilities, aspirations, idealisms, attitudes and sensitivities found in various cultural and religious traditions, standards of professional practice and institutional guides.

The authors point out that professional moralities, with their moral and deontological codes, are a type of particular morality. According to them, this type of morality can legitimately vary in the way it deals with certain conflicts of interest, protocol reviews, early guidelines and similar subjects. Moral ideals, as well as charitable goals and aspirations to help people who suffer, are an instructive example of what may be part of certain moralities. By definition, moral ideals such as charity are not mandatory. For Beauchamp and Childress [2], those who do not fulfil their ideals cannot be blamed or criticized by other people. However, these aspirations can be a very important part of personal or community moralities.

All morally committed people share admiration and endorse various moral ideals of generosity and service, which derive from moral beliefs associated with common morality, being well-regarded even if not universally demanded or practiced. When these principles are considered duties (as they are in some monastic traditions), obligations become part of the particular, not universal, morality.

Beauchamp and Childress [2] argue that individuals who accept this particular type of morality sometimes presume they have authority over other people, operating under the false belief that their particular convictions have the legitimacy of common morality. These people may have morally acceptable and even commendable beliefs, but when they are individual they do not link other people or communities.

Rules and their specifications

The specification can be understood as a process to reduce the indeterminacy of abstract norms and create rules with action-guiding content. Without "specifications", "do no harm" is simply a starting point for thinking problems. It is not, therefore, the production or defense of general norms such as common morality – it allows the professional to assume that there are relevant norms.

Example of specification involves the rule that "physicians should put the interests of their patients in the first place". In some countries, sick people can only receive the best treatment available only if doctors distort information in the insurance forms. However, the need to prioritize the patient's demands does not imply that the physician should act illegally, altering the description of the problem in that kind of form. The norms against fraud and

 http://dx.doi.org/10.1590/1983-80422019273323

that guarantee the priority of the patient are, in the Kantian sense, categorical imperatives and, when they conflict, some specification is necessary in order to know what one can or cannot do [2].

All moral rules are subject to specification and need additional content, because the complexity of moral phenomena exceeds our ability to apprehend them in general norms. In addition, many rules already specified must evolve to deal with new conflicting situations.

People and groups have conflicting specifications, which can potentially create multiple particular moralities. They will probably be offered by reasonable and fair parties committed to common morality in any problematic case. Nothing in the specification model suggests that it is possible to avoid discrepant judgements, and to affirm that a question is resolved by specification is to say that the norms have been sufficiently determined to the point of always knowing what should be done.

Obviously, some proposals will not be the most appropriate or justified solution. When competing specifications arise, one should find the most appropriate. Furthermore, the propositions should be based on deliberative processes so that there are methods and models of justification that support some specifications rather than others [2].

Therefore, some standards are practically absolute and do not require further specifications. More interesting are those intentionally formulated to include all legitimate exceptions. For example, *always obtain oral or written informed consent for medical interventions with competent patients except in emergencies, in forensic examinations, in low-risk situations, or when patients have waived their right to adequate information* [18]. This norm needs to be better interpreted, detailing what is "informed consent", "emergency", "waiver", "forensic examination" and "low-risk", and the norm would be absolute if all legitimate exceptions had been successfully incorporated into the formulation. If these absolute rules exist, they are rare. It is concluded that even the more assertive and detailed norms are susceptible to exceptional cases [2].

Residual obligation and moral regret

According to Beauchamp and Childress [2], the agent who points out a certain act as the most appropriate in a circumstance of conflicting obligations may not be able to fulfil all the moral responsibilities attached to it. Even the most morally correct action can be regrettable and leave residues or moral traces – regret of what has not been done, for example, can arise even in clear and uncontested actions.

As pointed out by Tavares [19], this regret predominates in better structured relationships. The professional, with humility, perceives in his or her failure the opportunity to acquire more knowledge, being given another chance by the patient. Conciliation meetings between the parties are common to avoid lawsuits: medical and patient in litigation are put face-to-face to resolve conflicts without taking the case to medical councils or even to the court.

On the other hand, in poorly consistent relationships, when the physician reveals narcissistic and arrogant traits of personality, both physician and patient come to see in the "error" a form of failure, intolerable to the patient, who will not give another chance or even accept a formal apology. In this case, usually the patient intends to convict the professional for "medical error" in judicial proceedings [19].

Prima facie duties do not disappear when replaced, and generate moral residue. Often, when certain tasks are not fulfilled, a new obligation is created. Sometimes, the inability to fulfil a certain obligation can be compensated by notifying people in advance of the impossibility of fulfilling the promise or apologizing in order to reaffirm the relationship and mitigate circumstances so that the conflict does not occur again [2].

Deontological codes and moralities in professions

According to Beauchamp and Childress [2], most professions have their own implied morality, with patterns of conduct generally recognized and encouraged by morally committed individuals. In medicine, professional morality specifies general norms for institutions and practices related to it.

Medicine requires its own rules because of its special roles and relationships. The norms of informed consent and medical confidentiality may not be useful or appropriate out of practice and research in health, but are justified by moral demands of respect for people's autonomy and protection from harm. In recent years, there have been several codes of medical and nursing ethics, codes of ethics in research,

corporate bioethics policy, institutional guidelines on conflicts of interest, reports and recommendations of public commissions.

Beauchamp and Childress [2] state that professionals are generally distinguished by their specialized knowledge and training, as well as by their commitment to providing services or important information to patients, customers, students or consumers. There are self-regulatory organizations that control the entry of professionals in occupational functions, formally certifying that candidates have acquired supervised training and can provide secure service to society.

For the authors, health care organizations specify and enforce the obligations of their members, seeking to ensure that those who establish relations with these professionals deem them competent and trustworthy [2]. Thus, they argue that these duties are determined by the acceptance of a role and comprise the "ethics" of the profession, although there may also be specific rules or ideals for each function. The problems of deontological ethics usually arise from conflicts in standardization or between professional and personal commitments.

When applied to medical professionals, these norms and commitments may conflict, causing errors and, consequently, damage to patients. An example of this are the longer daily journeys, in different locations, to meet the growing number of patients in short consultations. The medical record, which should be the best tool of the professional, ends up being filled improperly (with incomprehensible calligraphy, for example), incomplete, and relevant information about the patient and his or her illness are quite often not recorded [19].

It is also important to note that the physical conditions of the workplace may influence the conduct of the team. Interdisciplinarity and the search for integrality in the professional environment can reduce errors and harm to patients. The established justification that the physician is human as any other professional and, therefore, susceptible to failures still does not have the proper social support, despite its pertinence [19].

As traditional standards of professional morality are often vague, some professions encode them in a detailed document. Their codes sometimes specify etiquette rules, as well as ethical principles. The 1847 version of the American Medical Association Code of Medical Ethics [20], for example, instructed physicians not to criticize colleagues who had been held responsible for error [2]. These professional codes tend to reinforce the identification of members with the prevailing values of the profession. They are beneficial when they effectively incorporate defensible moral norms, but some greatly simplify moral demands, making them too rigid or excessively and unjustifiably claiming their integrity and professional authority. As a consequence, professionals may mistakenly assume that they are satisfying all relevant moral requirements by strictly following the rules of the medical code, as well as many people believe that they fully fulfil their moral obligations by complying with all relevant legal requirements [2].

For Beauchamp and Childress [2] it is pertinent to question whether the specific codes of medicine, nursing and public health are coherent, defensible and comprehensive. Historically, few documents had much to say about the implications of various moral principles and rules such as truthfulness and respect for autonomy and social justice, which have been the object of great discussion in the field of biomedical ethics.

Physicians have created codes for themselves since antiquity, without considering patient safety or submitting their codes to acceptance. These norms rarely appeal to general ethical standards or to sources of moral authority beyond the traditions and judgments of the professionals themselves. Thus, the articulation of professional conducts in these circumstances has served many times more to protect the interests of the profession than to offer broad and impartial moral viewpoint or to address the safety of society in general.

The emphasis on medicine, science and technology and on conservative views about the meaning of ethics influence much of contemporary health education. Throughout the world, the curricula of medical schools are increasingly overloaded with disciplines, subjecting themselves to the expectation that medical studies should produce, besides practitioners, competent researchers. Medical faculties strive to meet the demands imposed by advances in science and biotechnology, often to the detriment of humanities, bioethics and social sciences, which are left in the background.

In this way, ethical education atrophies, concentrating less on reflections and wisdom and more on governance and technicality. Learn about medical errors and how to manage them, understand health systems, human fragility, values, limits and practical skills of interdisciplinary care,

 http://dx.doi.org/10.1590/1983-80422019273323

develop the concept of partnership with patients and the competence to capture cultural diversity are points rarely encouraged in teaching or given the same emphasis as learning technical knowledge and scientific competences [11].

Patient safety and contemporary deontological codes

The codes of ethics and professional practice can be seen as "hallmarks of the profession" or signs of the organization of a particular group, which claims self-regulation and epistemic and moral authority, defining its boundaries and, therefore, relations with other groups, in addition to declaring what they believe is their duty to society. These documents are often internal and exclusive, and may be unrelated to the social and political dimensions of the practice, since they tend to turn more towards maintaining the interests of the profession, when they should emphasize human well-being and the functioning of health systems, moral concerns that relate not only to a particular professional category, but to all citizens [11].

Therefore, it is time for ethical and professional codes to take more into account socio-political aspects of health care and the roles of all professions in the area. It is necessary to understand that the results desired by patients depend on complex care systems and do not derive only from the actions of isolated professionals. This does not mean that these norms should abandon their commitment to fundamental moral values, such as care, compassion, integrity, truthfulness, confidentiality, respect for autonomy and human dignity, but that they need to be complemented by other principles.

Thus, the sick will be able to recognize the human dynamics and the organizational system that can improve the care, and that failures in this system often lead to errors and adverse events. It is proposed to democratize the development of codes of ethics, involve other professionals in the process of health care, insert them into discussions about the ethos of medicine and update the role of physicians in care and human well-being [11].

Because of this expectation, it is understood that both medical law and deontological codes should be reviewed periodically [21] to better contribute to the solution of emerging moral problems. Similarly, Soares, Shimizu and Garrafa state *that health professionals in Brazil deal with periodic reviews of their codes and witness reviews of different systems of codes and laws for other aspects of personal and professional life. These reviews were resumed with the process of redemocratisation of the country, and became a field of conflict due to the development of professions, science and technology, and the hegemony of capitalism in its current neoliberal face that monetizes life. Each change in the professional code system should therefore reflect the professional corporate maturity to understand the more general changes in the codes of laws that must protect the entire nation. It should also dialogue with knowledge from the humanities so that, on a democratic basis, it ensures 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 development of sciences and the market economy seems exaggerated and is criticized as a desire to monopolize the decision. The limitation of ethical problems to matters of professional ethics is no longer justified* [22].

Considering this scenario, it is possible to note that the guiding principles of the deontological codes have proved insufficient to analyze and judge errors harmful to patients and the society, since health care involves not only biomedical aspects, but also socio-political and cultural aspects in the context of diverse moral values. Thus, it is urgent to expand their precepts, so that the judgment of professional duties is not reduced to the individual sphere in the field of health.

Thus, if ethical and deontological issues that permeated health practices were of an exclusively biomedical nature in much of the twentieth century, today they acquired a new public identity. A regional and geopolitical example is the construction of the "latin american bioethics", which incorporates biomedical ethics but is not limited to it and the deontological boundaries of the relationships between professionals and patients. On the contrary, it incorporates broader concepts in its interpretation of "quality of human life" [23,24].

These include the intervention bioethics, which offers useful theoretical-methodological instruments to analyze the harm caused to patients. In addition, it expands in a global context, applying more genuine categories such as responsibility, care, solidarity, commitment, otherness, tolerance, prevention of possible damages and iatrogenesis, prudence in relation to advances and novelties, and protection of the socially excluded who are

more fragile and unassisted [23]. Therefore, is an anti-hegemonic proposal whose epistemological foundation goes beyond that proposed by the 21st century deontological codes.

In this scenario, one should consider the plurality of philosophical, cultural and religious views of the *Universal Declaration on Bioethics and Human rights* [25], an option also important to explore deontological issues, since this document, according to Andorno [26], defends global normative foundations capable of transcending this diversity. In this way, the biomedical activity, which works closely with the integrity of the human body and matters related to the right to life, should also benefit from this important and current universal normative resource.

Finally, the greater contribution that bioethics can offer to the evolution of medical practice is to show that there is no absolute truth to solve every day ethical dilemmas, as well as preserving unconditional respect for the dignity of the patient. In addition, it indicates that relevant skills to make decisions should be acquired with humility, tolerance and respect for the moral pluralism of society [21]. This is how ethics councils of health professions should strive to improve their ethical codes.

Final considerations

In the contemporary view, the safety of the patient involves several health professionals, and the results of the care provided also depend on the interaction of social, organizational, environmental, clinical and economical forces, many of which are outside the individual control of these professionals. Therefore, ethical and moral discussions surpass the competence of only one professional class.

What happens frequently is the punishment of the professional and the maintenance of precarious health systems, which puts the population at risk. It is clear that violations, whether they are indiscretions, negligence and malpractice, must undergo reasonable legal measures but, in a certain way, this punitive culture has prevented the use of correct and effective strategies for patient safety.

The issue addressed here deals specifically with errors related to the failure to comply with the moral obligations and duties associated with the safety of the patient. In this scenario, the damage caused by adverse events that could be avoided are more focused, becoming a key issue in the monitoring of health care and in the discussion of moral dilemmas.

The ethics councils of the health area are insufficient to judge duties and obligations of its practitioners when applied to patient safety, because such resolutions require ethical analysis beyond those in the deontological codes. It is not an easy task to understand how failures happen and what their ethical and legal implications are. For this, it is necessary to broaden the investigation of situations that involve the failure of professional codes of ethics and that compromise the patient's safety.

Finally, it is necessary that interdisciplinary committees of clinical and care bioethics discuss moral and ethical consequences, in view of the patient's safety and quality of life. The relevance of bioethics for public policies is now recognized not only by a large part of developed countries that rely on influential committees, but also by several periphery countries that have not yet adopted these systems, allowing more authentic reflections in the field of bioethics.

Referências

1. Eva KW. Trending in 2014: Hippocrates. Med Educ [Internet]. 2014 [acesso 17 jun 2019];48(1):1-3. DOI: 10.1111/medu.12392
2. Beauchamp TL, Childress JF. Principles of biomedical ethics. 7ª ed. New York: Oxford University Press; 2012.
3. Garrafa V, Martorell LB, Nascimento WF. Críticas ao principialismo em bioética: perspectivas desde o norte e desde o sul. Saúde Soc [Internet]. 2016 [acesso 17 jun 2019];25(2):442-51. DOI: 10.1590/S0104-12902016150801
4. Walton MM, Shaw T, Barnet S, Ross J. Developing a national patient safety education framework for Australia. BMJ Qual Saf [Internet]. 2006 [acesso 17 jun 2019];15(6):437-42. DOI: 10.1136/qshc.2006.019216
5. Brennan TA, Leape LL, Laird NM, Hebert L, Localio AR, Lawthers AG *et al*. Incidence of adverse events and negligence in hospitalized patients: results of the Harvard Medical Practice Study I. N Engl J Med [Internet]. 1991 [acesso 17 jun 2019];324:370-6. DOI: 1056/NEJM199102073240604
6. Kohn LT, Corrigan JM, Donaldson MS, editores. To err is human: building a safer health system. Washington: National Academy Press; 2000.
7. Wilson RM, Michel P, Olsen S, Gibberd RW, Vicent C, El-Assady R *et al*. Patient safety in developing countries: retrospective estimation of scale and nature of harm to patients in hospital. BMJ [Internet]. 2012 [acesso 17 jun 2019];344:e832. DOI: 10.1136/bmj.e832

8. Leape L, Berwick D, Clancy C, Conway J, Gluck P, Guest J *et al*. Transforming healthcare: a safety imperative. BMJ Qual Saf [Internet]. 2009 [acesso 17 jun 2019];18(6):424-8. DOI: 10.1136/qshc.2009.036954
9. Vincent C, Stanhope N, Crowley-Murphy M. Reasons for not reporting adverse incidents: an empirical study. J Eval Clin Pract [Internet]. 1999 [acesso 17 jun 2019];5(1):13-21. DOI: 10.1046/j.1365-2753.1999.00147.x
10. Lawton R, Parker D. Barriers to incident reporting in a healthcare system. BMJ Qual Saf [Internet]. 2002 [acesso 17 jun 2019];11(1):15-8. DOI: 10.1136/qhc.11.1.15
11. Walton M, Kerridge I. Do no harm: is it time to rethink the Hippocratic Oath? Med Educ [Internet]. 2014 [acesso 17 jun 2019];48(1):17-27. DOI: 10.1111/medu.12275
12. James BC, Savitz LA. How intermountain trimmed health care costs through robust quality improvement efforts. Health Aff [Internet]. 2011 [acesso 17 jun 2019];30(6):1185-91. DOI: 10.1377/hlthaff.2011.0358
13. Salas E, Dickinson TL, Converse SA, Tannenbaum SI. Toward an understanding of team performance and training. In: Swezey RW, Salas E, editores. Teams: their training and performance [Internet]. Westport: Ablex; 1992 [acesso 17 jun 2019]. p. 3-29. DOI: 1992-98450-001
14. Neale G, Woloshynowych M, Vincent C. Exploring the causes of adverse events in NHS hospital practice. JRSM [Internet]. 2001 [acesso 17 jun 2019];94(7):322-30. DOI: 10.1177/014107680109400702
15. Azambuja LEO, Garrafa V. A teoria da moralidade comum na obra de Beauchamp e Childress. Rev. bioét. (Impr.) [Internet]. 2015 [acesso 17 jun 2019];23(3):634-44. DOI: 10.1590/1983-80422015233100
16. Karlsen JR, Solbakk JH. A waste of time: the problem of common morality in Principles of Biomedical Ethics. J Med Ethics [Internet]. 2011 [acesso 17 jun 2019];37(10):588-91. DOI: 10.1136/medethics-2011-100106
17. Beauchamp TL, Childress JF. Op. cit. p. 5.
18. Beauchamp TL, Childress JF. Op. cit. p. 19.
19. Tavares FM. Reflexões acerca da iatrogenia e educação médica. Rev Bras Educ Méd [Internet]. 2007 [acesso 17 jun 2019];31(2):180-5. DOI: 10.1590/S0100-55022007000200010
20. Riddick FA Jr. The Code of Medical Ethics of the American Medical Association. Ochsner J [Internet]. 2003 [acesso 31 jul 2019];5(2):6-10. Disponível: https://bit.ly/31KhKUt
21. Siqueira JE. A bioética e a revisão dos códigos de conduta moral dos médicos no Brasil. Rev. Bioética [Internet]. 2008 [acesso 17 jun 2019];16(1):85-95. Disponível: https://bit.ly/2XWFcfJ
22. Soares FJP, Shimizu HE, Garrafa V. Código de Ética Médica brasileiro: limites deontológicos e bioéticos. Rev. bioét. (Impr.) [Internet]. 2017 [acesso 17 jun 2019];25(2):244-54. p. 246. DOI: 10.1590/1983-80422017252184
23. Garrafa V. Da bioética de princípios a uma bioética interventiva. Bioética [Internet]. 2005 [acesso 17 jun 2019];13(1):125-34. DOI: 3615/361533241011
24. Rivas-Muñoz F, Garrafa V, Feitosa S, Nascimento WF. Bioética de intervención, interculturalidad y no-colonialidad. Saúde Soc [Internet]. 2015 [acesso 17 jun 2019];24(Supl 1):141-51. DOI: 10.1590/S0104-12902015S01012
25. Organização das Nações Unidas para a Educação, a Ciência e a Cultura. Declaração universal sobre bioética e direitos humanos [Internet]. Paris: Unesco; 2005 [acesso 9 out 2017]. Disponível: https://bit.ly/2kgv9lt
26. Andorno R. Human dignity and human rights as a common ground for a global bioethics. J Med Philos [Internet]. 2009 [acesso 17 jun 2019];34(3):223-40. DOI: 10.1093/jmp/jhp023

Participation of the authors

Both authors conceived the research. Telma Rejane dos Santos Façanha elaborated and wrote the manuscript. Volnei Garrafa contributed to the final revision of the article.

Telma Rejane dos Santos Façanha
0000-0001-9445-3147

Volnei Garrafa
0000-0002-4656-2485

Recebido: 23. 1.2018

Revisado: 10.10.2018

Aprovado: 15. 4.2019