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Brazilian Code of Medical Ethics from the perspective of principlist bioethics

Francisco José Passos Soares [1], *Volnei Garrafa* [2], *José Lualyson da Silva Santos* [1], *Roberto Vieira dos Santos* [1]

1. Universidade Federal de Alagoas, Maceió/AL, Brasil. **2.** Universidade de Brasília, Brasília/DF, Brasil.

Abstract

Social, technological and scientific advances induce changes in values and the need for periodically reviewing professional codes of ethics. This article verifies the influence of principlist bioethics as an ethical and normative model guiding the Brazilian Code of Medical Ethics. Document analysis was used to evaluate two versions of the professional code: 2010 and 2018. There were similarities between both versions, with a deontological predominance shaped by virtue and technical competence. The principle of non-maleficence trumps beneficence (15% *versus* 6%); physician autonomy is more common than that of the patient (17% *versus* 12%); and 15% of context units correspond to the principle of justice. Deontological, virtuous and technical aspects, predominant in the Code of Medical Ethics, reveal the need to adapt it to current medical work, emphasizing patient rights, justice, public health and increased protection for research subjects.

Keywords: Ethical theory. Codes of ethics. Ethics, medical. Bioethics. Ethics, professional.

Resumo

Código de Ética Médica brasileiro na perspectiva da bioética principialista

Avanços sociais, tecnológicos e científicos induzem mudança de valores e necessidade de revisão periódica dos códigos de ética profissional. Este artigo teve como objetivo verificar a influência da bioética principialista como modelo ético e normativo orientador do Código de Ética Médica brasileiro. Utilizou-se o método análise documental para avaliar duas versões do código profissional: 2010 e 2018. Observou-se similaridade entre as duas versões do código, com predomínio deontológico conformado pela virtude e competência técnica. O princípio da não maleficência supera a beneficência (15% *vs*. 6%); a autonomia do médico se sobrepõe à do paciente (17% *vs*. 12%); e 15% das unidades de contexto correspondem ao princípio da justiça. Os aspectos deontológicos, virtuosos e técnicos, predominantes no Código de Ética Médica, revelam a necessidade de adaptação para o trabalho médico atual, com ênfase em direitos do paciente, justiça, saúde pública e ampliação da proteção aos sujeitos da pesquisa.

Palavras-chave: Teoria ética. Códigos de ética. Ética médica. Bioética. Ética profissional.

Resumen

Código de Ética Médica brasileño desde la perspectiva de la bioética principialista

Los avances sociales, tecnológicos y científicos inducen cambios en los valores y la necesidad de revisión periódica de los códigos deontológicos profesionales. Este artículo tuvo como objetivo verificar la influencia de la bioética principialista como modelo ético y normativo orientador del Código de Ética Médica brasileño. Se utilizó el método de análisis documental para evaluar dos versiones del código profesional: 2010 y 2018. Se observaron similitudes entre las dos versiones del código, con un predominio deontológico formado por la virtud y la competencia técnica. El principio de no maleficencia triunfa sobre el de la beneficencia (15% *vs*. 6%); la autonomía del médico se solapa con la del paciente (17% *vs*. 12%); y el 15% de las unidades de contexto corresponden al principio de la justicia. Los aspectos deontológicos, virtuosos y técnicos predominantes en el Código de Ética Médica revelan la necesidad de adaptación del quehacer médico actual, con énfasis en los derechos del paciente, la justicia, la salud pública y la ampliación de la protección de los sujetos de investigación.

Palabras clave: Teoría ética. Códigos de ética. Ética médica. Bioética. Ética profesional.

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Research

Contemporary health work requires professional councils to constantly review regulations, which guide ethical practices defined as responsibilities, concerning changes in the national and regional socio-political-economic context. Class councils regulate professional practice in their codes, incorporating current reflections on the limits of practice in front of moral and ethical challenges, imposed both by scientific and technological development and by contemporary approaches to social coexistence, considering political, religious and cultural contribution [1].

In this context, an update of the Brazilian Code of Medical Ethics (CEM) was published by the Federal Council of Medicine (CFM) [2] in 2010. However, this standardization, which guided medical practice for almost a decade, was criticized by different social sectors.

Until the first half of the 20th century, codes of conduct and codes of medical ethics were strongly influenced by Hippocratic medicine and Christianity. Benignity or beneficence, strongly paternalistic in character, and virtue prevailed as other values were incorporated, depending on technological and scientific evolution, and the emergence of bioethics at the end of the 20th century. These changes prompted discussions on new standards for physician-patient relationships, focused on public health, justice and public law over private law [3,4].

Beauchamp and Childress state that *unfortunately, some professional codes oversimplify moral requirements or claim more perfection and authority than they are entitled to* [and] *since Hippocrates' time, physicians generated codes without the patients' and the publics' examination and acceptance.* They also state *all moral norms are, in principle, subject to revision, specification and justification. The reason for constantly needing other contents* (...) *is that the complexity of moral phenomena always surpasses our ability to capture them in general norms* [5].

For these authors, the underlying question is: are the prescriptions described in each code defensible? In 2018, a new version of the CEM was published [6], sparking an investigation around the influence of principlist bioethical theory on the current model.

Method

This is a qualitative study, using document analysis as methodological support, set to describe and understand meanings attributed to the phenomena [7,8], considering knowledge is always subject to socially contextualized ethical and moral principles and constitutes a possibility of confirming reality.

Documental research is justified by descriptive ethics, which studies how people reason and act, and determines which moral norms and attitudes are expressed in professional practice, codes, and public policies [7]. This study is limited to the following units of analysis: Brazilian Codes of Medical Ethics, versions published in 2010 and 2018.

In 2018, the CFM presented the new CEM, after almost three years of discussions and analyses. The new code contains 26 fundamental principles for medical practice, 11 ethical norms, 117 deontological ethics and four general provisions. Compared with the 2010 version, a fundamental principle and deontological norm was added, and an ethical norm was removed [6].

For the CFM, the CEM represents a body of *standards that must be followed by physicians while exercising their profession, including activities related to teaching, research and managing health services, as well as activities in which knowledge arising from the study of medicine is used* [2,6].

The following chronological steps were followed for the document analysis: 1) definition of categories of analysis; 2) definition of registration units; 3) documentary exploration in search of context units that encoded registration units; and 4) treatment of results and interpretation. "Categories of analysis" are groupings of contents of interest (principlist bioethics, in this case) that are connected. "Registration units" refer to the very contents of interest, grouped into each "category of analysis."

"Context units" are excerpts from the documents under analysis that allow codifying the "registration units," that is, verifying which registration units (contents of interest) are covered by the analyzed text. Categories of analysis and registration units were previously determined by the researchers according to specific contents of each principle related to the principilist theory, based on the book *Principles of biomedical ethics*, 2013 edition [5].

As categories of analysis, bioethical principles (beneficence, non-maleficence, respect for autonomy and justice) were used, respecting a subjective criterion of adequacy according to Beauchamp and Childress' [5] conceptualization—an ethical category, related to virtue, and another of a technical nature.

The virtue and technique categories were adopted from a previous study with a similar methodology, which analyzed the The Brazilian Dentistry Code of Ethics [9]. Considering the authors' conclusions, subdivisions were maintained for the categories of respect for autonomy and virtue, according to the beneficiary of moral conduct, the patient (respect for autonomy P and virtue P) or the physician (autonomy Ph and virtue Ph).

Principlist bioethics is articulated simply and based on four principles, trying to regulate dilemmas of daily work and research in health. The principles of beneficence and non-maleficence are complementary to the obligation of achieving maximum benefits and reducing possible harm to a minimum. The principle of autonomy incorporates respect for people's self-determination, with special reference to the protection of those who, for permanent or temporary reasons, have their autonomy threatened; the principle of justice refers to the obligation to give each person their due, ensuring equitable distribution of health care costs and benefits [5].

The guiding registration units on the search for context units were:

- Beneficence: do or promote good; benefit; protect and defend the rights of others; prevent others from suffering harm (prevent or avoid harm); eliminate conditions that will cause harm to others; help unfit people; and help people who are in danger;
- Non-maleficence: not cause harm to patients; not cause harm to research subjects; not cause risks of damage; the right to not know; negligence; recklessness; malpractice; not initiate/suspend treatment; optional and mandatory treatment; usual and extraordinary treatment; medical treatment and technological support; rule or principle of double effect; and advance directives of will;
- Respect for patient autonomy: respect for people's self-determination; inviolability; privacy; confidentiality; free and informed consent; consent replaced; non-acceptance of the treatment; and respect;
- Physician autonomy: adequate information; publication of negative survey results; limited autonomy; the right to renounce care; and conscientious objection;
- Justice: distribution or allocation of resources; distribution of treatments; access to resources; right to treatment; right to health; equity; non-discrimination; non-exploitation; access to research; and access to research results;
- Technical: technical and legal aspects of the profession; and
- Virtue: socially desirable professional behaviors (compassion, discernment, trustworthiness, integrity, conscientiousness).

Registration units, thus predefined as expressions or concepts proper to bioethical theory, gave meaning to context units found in articles of both CEM versions. This is a necessary consideration when analyzing documents of moral nature, in which the meaning cores need a conceptual predefinition, unlike the analysis of conventional documents, which depend, in most cases, only on identifying terms, without any moral connotation.

Context units were defined in selected texts and chapters, sections, articles and items in the CEM. Textual units that inform moral aspects unrelated to principlist bioethics and those that inform socially desired professional behaviors were classified in the virtue category.

Textual units on the profession's technical, procedural, legal and conceptual aspects were classified in the technical category. Categorizing

an item as technical implied inadequacy of other classifications and absence of moral reference in the unit of analysis.

When units expressed technical aspects simultaneous to some bioethical principle, this classification overlapped the first. Non-technical units with simultaneous aspects were considered in all corresponding principles. Context units compatible with the utilitarian theory identified during analysis were considered: personal merit, an individual's social value, the majority's welfare.

After text analysis and categorization, the resulting data were added to each group of texts, obtaining the accumulated frequency. Inferences were derived by analyzing these objective data, enabling comparisons and conclusions.

Results

Chart 1 describes distribution and correspondence between units of registration and of context related to the principilist bioethical theory, found in both versions of the CEM.

Chart 1. Correspondence between registration and context units in the 2010 and 2018 codes of medical ethics

Registration units	CEM %	Articles 2010	CEM %	Articles 2018	Registration units
Beneficence	1. Do or promote good	3/7 (43%)	Chapter: I 2,17 and 23	–	–
	2. Benefit	2/7 (29%)	Chapter: I 2 and 23	–	–
	3. Protect and defend the rights of others	0/7 (0%)	–	–	–
	4. Prevent others from harm (prevent or avoid harm)	2/7 (29%)	Chapter: I 12 and 13	Equal	Equal
	5. Eliminate conditions that will cause harm to others	2/7 (29%)	Chapter: I 12 and 16	–	–
	6. Help unfit people	1/7 (14%)	Chapter: V: art. 36 §2nd (6)	–	–
	7. Help people who are in danger	0/7 (0%)	–	–	–
Non-maleficence	1. Not cause harm to patients	3/17 (18%)	Chapter: I 6; III: 10; V:41	–	–
	2. Not cause harm to the research subject	0/17 (0%)	–	–	–
	3. Not cause risks of damage	11/17 (65%)	Chapter: I 6; III: 2, 7, 8, 10, 12; IV: 25; V: 34 and 35; IX: 74; XIV: 2	–	–
	4. Right to not know	1/17 (6%)	Chapter: V 2	–	–
	5. Negligence	7/17 (41%)	Chapter: III 1, 2, 7, 8 e 12; V: 32 and 33	–	–
	6. Recklessness	5/17 (29%)	Chapter: I 19; III: 1, 10, 11 and 14	–	–
	7. Malpractice	1/17 (6%)	Chapter: I 1	Equal	Equal
	8. Not initiate/discontinue treatment	0/17 (0%)	–	–	–
	9. Optional and mandatory treatment	2/17 (12%)	Chapter: I 22; V: 35	–	–
	10. Usual and extraordinary treatment	2/17 (12%)	Chapter: I 22; V: 41	–	–
	11. Medical treatment and technological support	1/17 (6%)	Chapter: I 22	–	–
	12. Rule or principle of double effect	0/17 (0%)	–	–	–
	13. Advance directives of will	1/17 (6%)	Chapter: V 41	–	–

continues...

Chart 1. Continuation

Registration units	CEM %	Articles 2010	CEM %	Articles 2018	Registration units
Respect for patient autonomy	1. Self-determination	7/14 (50%)	Chapter: IV 24, 26 and 28; V: 31, 39 and 42; VI: 45	–	–
	2. Inviolability	3/14 (21%)	Chapter: IV 27; V: 41 and 42	–	–
	3. Privacy	2/14 (14%)	Chapter: V 38 and 40	–	–
	4. Confidentiality	1/14 (7%)	Chapter: V 40	–	–
	5. Free and informed consent	2/14 (14%)	Chapter: IV 22; XII: 110	–	–
	6. Consent replaced	0/14 (0%)	–	–	–
Physician autonomy	1. Adequate information	0/20 (0%)	–	–	–
	2. Publication of negative research results	0/20 (0%)	–	–	–
	3. Limited autonomy	16/20 (80%)	Chapter: I 24; II: 1, 4, 5 and 6; IV: 22; VI: 43; IX: 73-79; XII: 104; XIV: 1	Equal	Equal
	4. Right to withdraw from service	0/20 (0%)	–	–	–
	5. Conscientious objection	4/20 (20%)	Chapter: I 7 e 21; II: 9; IV: 29	–	–
Justice	1. Distribution or allocation of resources	0/19 (0%)	–	–	–
	2. Distribution of treatments	3/19 (16%)	Chapter: II 2; III: 20; V: 32	–	–
	3. Access to resources	0/19 (0%)	–	–	–
	4. Right to treatments	0/19 (0%)	–	–	–
	5. Right to health	0/19 (0%)	–	–	–
	6. Equity	0/19 (0%)	–	–	–
	7. Non-discrimination	3/19 (16%)	Chapter: I 1 and 25; IV: 23	–	–
	8. Non-exploitation	13/19 (68%)	Chapter: I 24; IV: 25; V: 40; VI: 45 and 46; VIII: 64, 65 and 66; XII: 99, 100, 102, 103 and 106	–	–
	9. Access to research	0/19 (0%)	–	–	–
	10. Access to search results	0/19 (0%)	–	–	–

CEM: Code of Medical Ethics

Chart 2 describes distribution and correspondence between registration and context units related to technique and virtue, present in the 2010 and 2018 versions of the CEM.

Chart 2. Connection between registration and context units on technique and virtue in the 2010 and 2018 codes of medical ethics

Categories of analysis	Registration units	CEM	2010 articles	CEM	2018 articles
Physician virtue	–	90/118 (76.2%)	Chapter: I 4, 5, 15, 18, 20; III: 1-21; IV: 30; VII and VIII; IX: 73-79; X: 80-91; XI: 92, 93, 94, 96, 97, 98; XII: 104, 105, 107, 108, 109; XIII	Equal	Equal
Patient virtue	–	0	0	0	0

continues...

Chart 2. Continuation

Categories of analysis	Registration units	CEM	2010 articles	CEM	2018 articles
Technique	–	23/118 (19.5%)	Chapter: I 3, 9, 10; II: 3, 7, 8, 10; III: sole paragraph of art. 9; V: 36 $1st and §2nd, 37 §1st and §2nd; VIII: sole paragraph of art. 66; IX: 78; X: 87 §1st, §2nd and §3rd; 89 §1st, §2nd; XI: 95 and sole paragraph of art. 98; XII: 101 §1st and §2nd; XIII: sole paragraph of art. 117; XIV: 3 and 4	26/118	Addition of art. 37 §2nd chap. V, art. 87 §3 of chapter X and art. 101 §2 of chapter XII

CEM: Code of Medical Ethics

Table 1 shows, in summary, the similarity observed in both versions of the CEM, demonstrated by the accumulated (%) frequencies on importance of principles and standards. Norms related to medical virtue (76%) and technique (20%) predominate. Non-maleficence outweighs beneficence (15% *versus* 6%); physician autonomy is more common than that of the patient (17% *versus* 12%); 15% of the units of context observed correspond to the principle of justice.

Table 1. Distribution of principles, technical standards, and values present in the 2010 and 2018 versions of the CEM

Principlism	CEM 2010	CEM 2018
Beneficence	7/118 (6%)	7/117 (6%)
Non-maleficence	17/118 (15%)	17/117 (15%)
Physician autonomy	20/118 (17%)	20/117 (17%)
Respect for patient autonomy	14/118 (12%)	14/117 (12%)
Justice	19/118 (16%)	19/117 (16%)
Deontological ethics		
Physician virtue	90/118 (76%)	90/117 (76%)
Patient virtue	0	0
Technique	23/118 (19.5%)	26/117 (19.5%)

CEM: Code of Medical Ethics

Discussion

The Brazilian CEM of 2010 is influenced by the Anglo-Saxonic principilist bioethical model and was in force when this paradigm was under criticism, which is maintained today [10-12]. Choosing principlistic bioethics proved to be an attempt by physicians and the CFM to reflect on current health demands, with new values.

As demonstrated in this study, this model offered society an updated version of the normative, deontological tradition, combining technical competence with virtue ethics. Organization and wording of the CEM articles on rights and duties maintains the predominant structure, compatible with the deontological normative ethical theory.

In both versions of the Brazilian CEM, aspects related to medical virtue predominate, reaffirming Aristotelian tradition, and the renewing technique of a virtuous and competent profile conformed by current technological biomedical advances. This scenario is aligned with Durand [13], who argues that participants in their study insist on Aristotelian-inspired qualities or virtues when considering clinical ethics.

Text modifications of the 2018 version [6] presume a new trait, of utilitarian nature [14], recognizable in the introductory chapter ("Fundamental principles"), in articles XXIII ("When involved in the production of scientific knowledge, the physician shall act with impartiality, independence, truthfulness and honesty, aiming at the greatest benefit to

patients and society") and XXVI ("Medicine shall be exercised using available technical and scientific means aimed at the best results").

Despite CFM assertions that the new code of ethics would bring significant changes over the previous model, a comparative analysis of both versions shows the qualitative changes implemented require improvement regarding patient autonomy, with protection in clinical practice and research, and changes that favor public health, linked to values specific to the principle of justice.

Regarding the principle of beneficence, registration units that confer direct benefit or prevent/avoid harm predominated, but no units were found for protection and defense of the rights of others and for helping people in danger. The principle of non-maleficence is contemplated with greater concern in not causing a risk of harm; ethical rules, negligence and recklessness; not cause harm; treatment modalities in dilemmatic situations: optional and compulsory treatment; and usual and extraordinary treatment.

According to Evans [15], applying these principles challenges the definition of what counts as benefit or harm in a given situation, and to set ethical limits to maximize benefits and minimize potential harms. Maximizing benefits can be ethically questionable in the allocation of resources and health care, as well as offending the rule of equity.

These principles become more objective when applied to individuals, but ethics can be enhanced if they are articulated with others, present in the *Universal Declaration on Bioethics and Human Rights* (UDBHR) [16], such as social responsibility, solidarity, cooperation and sharing of benefits. In this sense, Paranhos, Garrafa and Melo [10] attest to the epistemological insufficiency of principlism to justify and make clinical and research decisions with vulnerable populations and peripheral countries.

Mainetti states that considering values in the definition of health and illness is not merely an exercise in philosophical idleness with no consequences on reality, in a way that *the nature of medicine and health care depend on those fundamental concepts-values that determine the scientific objectivity, technical operability and moral justification of clinical and health practices, shaping the ideology of medical, professional and institutional power in the political, economic and social order* [17].

For him, the new bioethical paradigm unveils rich possibilities for medicine and health care, modifying the paternalistic medical order, historically associated with power to the detriment of social demands [17].

Complementary and consistently with the modern deontological approach influenced by principlist bioethics, Manzini [18] states that the physician-patient relationship usually remains asymmetrical, despite all efforts. The health team's role is to compensate for asymmetries as much as possible, since *professional integrity of those who act is fundamental. No moral or legal norm will fulfill its purpose if it is not incarnate, if there is no intimate conviction of fulfilling it on the agent's part. The concept of professional integrity is one of the virtues required of health workers, and refers us to ethical theories of social virtue* [18].

No major changes were observed in the CEM regarding respect for patient autonomy in almost a decade. Maintaining the predominance of physician autonomy, albeit partial, over that of the patient, reaffirms the persistence of the paternalistic model with strong Hippocratic influence, which is currently criticized. Reflecting from a Kantian perspective, the patient is a subject of the process, while the professional is a mere object to fulfill a virtue, which is to care for the patient.

Although insufficient, the changes induce reflection on the bioethical principle of respect for autonomy, faced with difficulties in daily professional life. Currently, autonomy is a patient right, and suffering individuals experience a new status in their relationship with the physician, that of an autonomous citizen. However, patients are historically vulnerable due to the asymmetry of care dependence, often originated by economic conditions and manifested in the professional hierarchy for sometimes complex care, low education and ignorance of scientific semiotics, suffering, etc.

Hence, respect for patient autonomy gains ethical contours of respect for self-determination, privacy and confidentiality, and free and informed

consent. Respect for autonomy is expressed, among other ways, in obtaining informed consent, which presupposes the patient's decision-making capacity [5]. Criticism of informed consent makes sense here, revealing how insufficient the CEM is to guide an ethical standard when it comes to achieving, protecting and guaranteeing the rights of participants and communities involved in Brazilian research.

The predominance of physician autonomy over that of the patient shows two features: partiality and concern with conscientious objection, normative defenses of medical authority in professional practice that require permanent reflection and social contribution. The organization and drafting of the CEM, firmly supported by deontological tradition, with an extensive composition of articles as a guide to exemplary virtues of good conduct, leaves little room for concern with public health and social and distributive justice in situations of scarce resource allocation.

This understanding puts autonomy in physician-patient relationships at a level of idealized psychological or ethical conflict, abstracted from the reality of broader political, community and social conflicts. Likewise, the principle of justice is delimited by concerns about non-exploitation, non-discrimination and distribution of treatments, but not with the right to treatment (a current utilitarian trait, reducing the autonomy of people under care) with equity, access to research and research results.

The CEM contains a chapter on human rights, in which dignity is considered a right and value to be protected, and condemns torture practices and death penalty. In general, justice is cited as a medical virtue that facilitates individual rights. Public health is not a main concern in physicians' reflection to guide decision-making in situations like scarcity of resources and uncertainties, for example, and expanded protection for research subjects is not ensured.

Reflecting on the ethics of scientific investigation, Rivera states (...) *the basis of a deontological, universalist and formal model frustrated the potential for reflection on values that govern research, separating research ethics from both epistemological review and the analysis of its political implications*. The author adds (...) *regulatory codes of ethics that focus on the so-called "informed consent"—and on the "protection of vulnerable populations," that is, those whose capacity for self-determination is diminished in some way—can only provide a minimal, and in my view, insufficient, ethical framework for an effective orientation of research* [19].

The instrumental ease to apply rules and norms derived from principlistic ethics, internally conflicting, imposes risk of uncritical and decontextualized generalization when solving moral conflicts. Furthermore, the three normative ethical theories show internal conflict in their influence: two of them are incompatible with each other, deontology and utilitarianism. Codes of ethics are insufficient to respond to unforeseen situations in all possible future scenarios, and no principle can be applied in all circumstances, and may even conflict in decision-making [20].

A code restricted to physicians does not account for current dilemmas in health, considered no longer just the antithesis of disease and the body in suffering, but a historical byproduct of broad conditions that allow, in addition to survival with a body fit for labor, the right to quality of life with real possibilities of creation and enjoyment of spaces and healthy modes of sociability [21].

Reflecting the absence of a common moral theory in principlist bioethics [11,12], with a relative distance from public health, the CEM points out situations or examples of quasi-dilemmas, or maxims, that physicians should be concerned about. These maxims depend on the organizing and influencing principle of the idea contained in the article, determining a behavior, which results in preserving a traditional, deontological and virtuous model.

Virtuous aspects of the CEM initially link responsibility and solidarity with the medical profession, aiming at ethics, prestige, good reputation of the profession, scientific improvement and non-commercialization. Then, they guide respect for the patient and other health professionals.

Considering the application of elements contained in the CEM around professional routine, CFM is interested in changing the

medical power relationship. However, the interpretation of the text for application in everyday life depends on factors such as: critical and contextualized bioethical reflection in undergraduate and graduate courses; continuing education in the workplace, fostered by international class bodies [22] and regional councils, for shared decision-making; constitution and activation of interdisciplinary bioethics committees; and, above all, strengthening democracy in the country.

If CFM wishes to overcome the model of the deontological code in favor of one more flexible and closer to bioethics, let it be through epistemological and biopolitical paths that define Latin American bioethics. This strand is concerned with a democratic agenda to reduce injustices and social inequalities, guaranteeing the right to basic healthcare, as well as care provided by the most advanced scientific and technological development [23].

Garrafa defends, more than individual autonomy, an institutional political autonomy to adopt national values, contextualized in the reality of the wronged majority, and independent of moral imperialism.

> *It is essential that a new bioethics, more dynamic and politicized, builds and provides to nations and communities most in need of minimum consumer goods for human survival a set of concrete tools of scientific theory and method that, while respecting the historical plurality of each place, makes it possible to cooperatively seek their own destinies, without spurious interference and with due dignity* [4].

Thus, recognizing the decisive participation of Latin American bioethics representatives, especially Brazil, in changing and expanding the agenda of the UDBHR [16,23], we propose this declaration guides future revision work for a new code of medical bioethics based on national bioethical theories. This will imply a review based on suggestions from organized parts of civil society and formatting a model code geared towards integrated teamwork for proposing shared decisions, oriented mainly to public health.

Advancement in the codes of other health areas to maintain political and epistemological identifications, as well as openness to interprofessional work, will be of equal importance. Authors who analyzed Brazilian codes of ethics of dentists [9], physical therapists [24] and occupational therapists [25] identified corporatist and legalistic conceptions, in which a view of professional autonomy prevails, diverging from scientific articles with a bioethical framework, in which patient-focused autonomy predominated.

If political reasons and social criticism demand more coherence with the contextual reality from physicians, health and disease as social phenomena require political solutions, open to dialogue with society. Therefore, shared decisions are possible in the interest of all individuals and protection of those in situations of greater vulnerability, which implies considering expanded values, beyond principlism, and less deontological code formats.

Rivera ponders, precisely from dialogue, that the possibility of building new consensuses arises as guiding frameworks, no longer deontological, but axiological. That is, not based on principles or duties, but on valuable objectives that each community determines to guide its own technological and scientific development. Because there is no single path to progress and not a single ideal that guides us. We are decidedly responsible for building the path and defining the values we choose to establish the "progress" of science and technology as a community [19]. Fundamental human rights must remain the basis for solving ethical and legal problems in biomedicine [21], because humans are the sole meaning and goal for development. Thus, reflecting on professional ethical codes, only humans should be the subject of any regulation that intends to be democratic, participatory and truly bilateral [4].

Medical ethics acts as moral philosophy when it examines all delicate issues that are directly or indirectly raised by medicine from its focal core: the patient not only as an object, but also as a subject of care [26].

Research

Final considerations

The material analyzed from both versions of the CEM provides a model of professional ethical orientation for the similar deontological physician-patient relationship, with a predominance of technical procedural aspects, virtues and autonomy of physicians, organized as a code of conduct for the competent and virtuous professional. However, codes of ethics for health professions in Brazil and worldwide emphasize the principle of respect for autonomy, referencing the physician-patient relationship, with a decrease in medical power and medical research focused on informed consent.

By articulating three normative ethical theories (virtue, deontology and utilitarianism) in a single document, the CEM demonstrates the search to overcome antagonistic theoretical aspects in professional routine. Predominant deontological aspects in the CEM reveal the need for periodic updating oriented to health work today, stressing patient rights and aspects related to promotion of justice, especially those ensuring equity in access to care, and quality public health.

Codes of ethics are insufficient to respond unforeseen situations in all possible future scenarios, and no principle can be applied without conflict in any circumstance.

Facing current challenges, such as the indiscriminate opening of medical schools, concern with the quality of medical training, the need to internalize medicine, criticism of the Medical Act [27], invasion of competences by other professionals, accelerated development of technologies for diagnosis and treatment, health policies, coexistence between persistent and emerging diseases, and development of bioethics with the requirement to consider moral pluralism in health decision-making, the CFM should propose modifications to the code of ethics, aiming at less deontologizing and more axiological understandings and considering these conditions.

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Francisco José Passos Soares – PhD – francisco_passos01@hotmail.com
0000-0002-5872-2183

Volnei Garrafa – PhD – garrafavolnei@gmail.com
0000-0002-4656-2485

José Lualyson da Silva Santos – Undergraduate student – lualysonjose@gmail.com
0000-0001-8619-6064

Roberto Vieira dos Santos – Undergraduate student – roberto.santos.rvs@gmail.com
0000-0003-3609-2376

Correspondence

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

Participation of the authors

Francisco José Passos Soares participated as main researcher, preparing the project, guiding and supervising the collection of data, results and discussion, and completed the preparation of the article. Volnei Garrafa idealized the project, supervised results and discussion, and approved the final version. José Lualyson da Silva Santos contributed to data collection, organization of results, discussion and preparation of the article. Roberto Vieira dos Santos participated in data collection, organization of results, discussion and preparation of the article.

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