

# Decolonial bioethical reflections on corporeality in medical education

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## Abstract

This study proposes a decolonial bioethical reflection in medical education, going through the crossings of the body as a place for a human, sensitive training with ethical commitments necessary for a more just and supportive social transformation in Latin America. In a narrative review, three bioethical reflections are proposed: on decoloniality, on corporeality and on medical training. The training of students in medicine implies the construction of a repertoire of life experiences that can bridge the hegemonic distance existing in the doctor-patient relationship promoted by the alleged Cartesian scientific neutrality, which has in its deepest mechanisms elements of the coloniality of power and knowledge. Proposing 'opening corporeities' dialogues with a paradigm shift to another, whose relational corporeality is focused on caring for the dynamic health needs of populations in their diversity, the ability to deal with challenges and powers within the health system, from a bioethics perspective of intervention.

**Keywords:** Bioethics. Medical education. Human body. Decolonization.

## Resumo

### Reflexões bioéticas decoloniais sobre a corporeidade na educação médica

Este estudo propõe uma reflexão bioética decolonial na educação médica, passando pelos atravessamentos do corpo como lugar de uma formação humana sensível e com compromissos éticos necessários a uma transformação social mais justa e solidária na América Latina. Em revisão narrativa, são propostas reflexões bioéticas sobre decolonialidade, corporeidade e formação médica. A formação de estudantes em medicina implica a construção de um repertório de experiências de vida que possam aproximar o distanciamento hegemônico na relação médico-paciente, promovido pela pretensa neutralidade científica cartesiana, que tem em seus mecanismos mais profundos elementos da colonialidade do poder e do saber. Propor "corporeidades em abertura" dialoga com uma mudança de paradigma para um outro cuja corporeidade relacional é voltada ao cuidado das necessidades dinâmicas de saúde das populações em sua diversidade e à capacidade de lidar com desafios e potências dentro do sistema de saúde, numa perspectiva da bioética de intervenção.

**Palavras-chave:** Bioética. Educação médica. Corpo humano. Decolonialidade.

## Resumen

### Reflexiones bioéticas decoloniales sobre la corporeidad en la educación médica

Este estudio reflexiona sobre la bioética decolonial en la educación médica, recorriendo las travesías del cuerpo como lugar para una formación humana, sensible y con compromisos éticos necesarios para una transformación social más justa y solidaria en América Latina. En una revisión narrativa se proponen tres reflexiones bioéticas sobre: la decolonialidad, la corporalidad y la formación médica. La formación de estudiantes de medicina implica la construcción de experiencias que puedan salvar la distancia hegemónica en la relación médico-paciente promovida por la supuesta neutralidad científica cartesiana, que tiene en sus mecanismos más profundos elementos de la colonialidad del poder y del saber. Proponer "corporeidades abiertas" dialoga con un cambio de paradigma hacia otro, cuya corporeidad relacional se centra en la atención de las necesidades dinámicas de salud de las poblaciones en su diversidad, la capacidad de afrontar desafíos y competencias dentro del sistema de salud desde una perspectiva bioética de la intervención.

**Palabras clave:** Bioética. Educación médica. Cuerpo humano. Decolonización.

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The training of healthcare providers in Brazil, including physicians, is directly related to the Brazilian Unified Health System (SUS)<sup>1,2</sup>. This connection is established in the 1988 Federal Constitution and in the Organic Health Law, which assign to SUS the responsibility of training human resources in healthcare<sup>3</sup>. The system encompasses individuals in their daily work, life, and religious practices, within a diversity of cultures that shape not only clinical encounters but also public health surveillance, management, and social participation. This broad interaction inevitably establishes a relationship with bioethics.

This article aims to analyze the role of bioethics in medical training, specifically by reflecting on the interface between intervention bioethics and studies on decoloniality and corporealities at play, as well as on how these (de)constructions and shifts may influence, in practice, the physician-patient relationship experienced by students in training.

Medical education in Brazil began in 1808, with the arrival of the Portuguese royal family, the opening of the medical-surgical course in Salvador, Bahia State, in February of that year, and later in Rio de Janeiro in November<sup>4</sup>. From its inception, the dominant model of medical training—the biomedical model—has centered the teaching-learning process on specialized and fragmented disciplines, with little or no dialogue across fields and minimal inclusion of education aimed at students' holistic development—such as emotional, social, and humanistic skills<sup>5</sup>. As a result, physicians often struggle to integrate knowledge and develop a practice that meets the needs of individuals and communities while valuing the healthcare system.

In contrast, contemporary medical education has emphasized the need to train professionals with competencies that go beyond the technical and scientific expertise, fostering in students a sense of social commitment (civic training) and engagement with the development of SUS. This shift in perspective stems from the specific needs of SUS, driven by national movements and social participation aimed at transforming medical education<sup>3</sup>.

Thus, based on the 2001 and 2014 National Curriculum Guidelines (DCN) for medical courses, the development of innovative curricula that

integrate different areas of knowledge into medical training has been encouraged<sup>5</sup>. Despite these incentives, medical education remains grounded in the biomedical and hospital-centered model<sup>6</sup>, meaning that SUS will continue to receive physicians whose training is inadequate to its strengthening.

This study engages with medical education and bioethics but is not limited to the teaching of bioethics within medical curricula—although the importance of such inclusion is recognized, especially when the approach goes beyond Beauchamp and Childress' principlist bioethics<sup>7</sup>. This perspective, criticized by several authors, proves insufficient not only as a philosophical foundation<sup>8</sup> but also as a limited tool to address diverse bioethical dilemmas and conflict situations in contexts of greater social and historical vulnerability<sup>9-11</sup>.

Bioethics encompasses the confluence of various fields of knowledge and seeks to discuss the challenges, problems, and conflicts present in numerous spheres of life, in interhuman relationships, and in relation to the environment, in light of moral principles and values<sup>12,13</sup>. By its multidisciplinary nature—precisely because it deals with heterogeneous problems of human life and the environment, within cultural and scientific complexity—bioethics requires dialogue with different fields.

According to Silva and collaborators<sup>14</sup>, Latin American bioethics, by incorporating paradigms of complexity and transdisciplinarity, effectively contributes to a proposal for a medical curriculum that goes beyond a biomedical view of the body and human reality, drawing on other aspects in the contexts of discussions, such as human dignity and social injustices in society.

Bioethics, therefore, as a multi, inter, and transdisciplinary field of knowledge, should not be restricted to a principlist approach in medical education, as such a limitation proves ineffective both in addressing the population's health problems—with detriment to the healthcare system as a whole—and in fostering a more humane and satisfactory relationship between caregiver and care recipient.

Medical training must require more comprehensive repertoires to adequately prepare

these professionals, in a society in which complex issues emerge, some new, such as the use of artificial intelligence, as well as persistent problems such as violence, gender-based phobias, sexism, and racism.

Therefore, there is a broader relationship within the bioethical field in dialogue with decolonial studies, capable of influencing medical education in Brazil. The way bioethics is taught cannot be restricted to a purely disciplinary approach, as this would maintain the paradigm of Eurocentric modernity<sup>15</sup> and the assumptions of the body as property, which sustain the understanding of the modern subject as the possessor of something with and under which they can negotiate<sup>16</sup>. This reinforces a paradigm in which there is a science capable of objectifying the body and excluding its subjectivity from knowledge production.

From this perspective of a biomedical view of the body, a reductionist idea of bioethics as merely medical ethics still predominates. As Bellino<sup>12</sup> argues, bioethics is different from the ethics of science, since the latter is part of the former but does not reduce it. For him, *the ethics of science cannot exhaust bioethics, because knowledge, even though it is an important value, is not the only, supreme, or absolute value*<sup>17</sup>.

Furthermore, *“scientific ethics” not only denies human freedom and responsibility, but even when managing to construct a more geometrico as a normative code, its application would be impossible and would not ensure the expected results. Seeking to restrict a priori the complexity and multiplicity of human situations under the legislation of a few abstract moral principles means rejecting the historical condition of human beings, their finitude*<sup>18</sup>.

Understanding bioethics as applied ethics, a theoretical concept alone, however, may not be enough to understand how moral conflicts unfold in practice, even if it influences our way of thinking and acting in real situations. Considering the theory of decoloniality applied to practical experiences can add perspectives to training, destabilizing hegemonically pre-established concepts in medical education and, especially, in bioethical approaches, while singularizing the corporealities of historical subjects in their relationships.

## First reflection: bioethics and decoloniality

The discussion on coloniality and decolonial studies may seem long-standing, but it has gained strength with works by authors such as Aimé Césaire<sup>19</sup>, Aníbal Quijano<sup>15</sup>, Walter D Mignolo<sup>20</sup>, Enrique Dussel<sup>21</sup>, and Silvia Cusicanqui<sup>22</sup>. The latter, for example, demonstrates that the questioning of colonial power began much earlier, among Indigenous peoples—those subjected to the process of colonization in the Americas by white Europeans—and highlights Waman Poma de Ayala<sup>23</sup>, an Indigenous chronicler born in Peru, as one of the first to inspire such thought and practice.

Coloniality is a complex device that emerged with colonialism but persists beyond it, sustaining ideas related to the myth of Eurocentric modernity, which remains predominantly hegemonic. It encompasses colonial difference and the original violence of modernity—aspects of this same discussion that can be understood within coloniality studies<sup>24</sup>.

Specifically in the context of healthcare, coloniality perpetuates aspects ranging from the maintenance of unequal relations between core and peripheral countries to income concentration, the uneven development of technologies aimed at physical and emotional well-being, and the differential valuation of bodies and lives in scientific research. This is reflected, for instance, in the denunciations regarding the design of research studies published in the early 20th century<sup>25</sup>.

In this context, intervention bioethics has been examined by some authors as a form of bioethics open and equipped with tools to be decolonial<sup>24,26</sup>. This is due to its foundation on principles such as the paradigm of complexity; its multi, inter, and transdisciplinary nature; moral pluralism; the prerogative of human rights as established in the Universal Declaration on Bioethics and Human Rights (UDBHR); and the notion of corporeality that guides intervention bioethics<sup>27-29</sup>.

Intervention bioethics emerged among Latin American bioethical approaches at a propitious moment, marked by the convergence of debates on social injustices across the continent and by the promulgation of the UDBHR<sup>27,30</sup>. Garrafa and Cruz<sup>27</sup>

critically describe the historicity of intervention bioethics in Brazil, situating its origins in discussions surrounding the Brazilian Sanitary Reform and the creation of SUS. This trajectory stems from a “hard” conception of bioethics, in which the State was expected to ensure protective policies for the most vulnerable, and evolves into a bioethics that, from its inception, incorporates justice, equality, equity, vulnerability, alterity, among others. Throughout its epistemological development, intervention bioethics also came to encompass elements such as complexity, social inclusion, empowerment, corporeality, dialogue grounded in coherence and the pursuit of consensus, emancipation, and liberation—eventually consolidating itself around concepts of bioethical pluralism, interculturality, and critiques of moral imperialism and coloniality.

Feitosa, in studies on the epistemological territories of intervention bioethics, underscores that *it constitutes a pluriversally open proposal for inter-epistemic interactions with other forms of knowledge that serve the processes of constructing autonomy*<sup>31</sup>. The author further proposes the incorporation of elements such as critical interculturality, emphasizing an understanding of intervention as something distinct from intrusion, while also suggesting the inclusion of the rights of nature and the concept of *sentipensar*—the integration of emotion and reason in the production of knowledge.

For Garrafa and Feitosa, the role of the founders of INTERVENTION BIOETHICS was fundamental, both for their theoretical contributions and for their practical engagement within the Brazilian Society of Bioethics and the Latin American and Caribbean Bioethics Network of UNESCO. Their efforts culminated in the approval of the UDBHR, which is now regarded as a major global achievement in bioethics<sup>31</sup>. In an era in which human rights still fail to reach all humans, the activist construction of INTERVENTION BIOETHICS, strongly anchored in these rights, also emerges as a tool of struggle alongside the most exploited and vulnerable members of society.

## Second reflection: bioethics and corporeality

Corporeality is a notion addressed from different theoretical perspectives, which generally gains

prominence in publications in philosophy, social sciences, and anthropology. It is understood as a concept that seeks to move beyond the Cartesian paradigm of modernity—marked by the mind-body split—in which the body has been relegated to a secondary role in relation to cognition, an attribution that, according to Quintero<sup>16</sup>, dates back to Descartes. Discussing corporeality here means bringing the body (or bodies) back into the scene, not as objects of study or analysis, but as entities that must be granted visibility, voice, and place in how they are understood, so they may tell their own stories and reveal other ways of seeing, doing science, and producing knowledge.

The question of “good” as the core of moral relations is a foundational element of human ethical reflection. For authors such as Bellino, the novelty of bioethics lies in the body—not in the “being” itself, but in that which is no longer: *the unborn, the fetus, the dying, the corpse, and the organs of the deceased*<sup>32</sup>. These ambiguous entities are almost always at stake in medical bioethics. According to the author, by extending the discussion to environmental and animal spheres—thus moving beyond an anthropocentric perspective—bioethics challenges basic categories of ethics, placing the figure of the “other” at the center of moral relations.

Here, Bellino opens space for decolonial insurgencies to emerge and integrate themselves. Therefore, corporeality is placed at the center, the apex, of the bioethical debate, inverting the logic of bioethical reason:

*(...) one of the tasks of bioethical reason is precisely to unmask the verbal, rather than real, nature of the denial of certain fundamental ethical principles. The philosophical task, especially in ethics, is not so much to construct new principles or invent new values, but rather to bring to reflective consciousness what is already present in non-reflective consciousness; to turn into a theme that which, in any case, remains unthematized; to point out the limits of certain statements; to clarify what has been said incorrectly or confusedly; and to interpret what has not yet been said, yet is present and operative in the culture of every society and in human consciousness*<sup>33</sup>.

When, during the colonial period, the bodies of dominated peoples of Africa and Latin America

were deemed “non-human” or “soulless,” they became victims of the expropriation of their cultures and historicities, relegated by the colonizer to the place of “non-being.” As Aimé Césaire highlighted:

*(...) between colonizer and colonized, there is room only for forced labor, intimidation, pressure, the police, taxes, theft, rape, cultural imposition, contempt, distrust, the morgue, presumption, vulgarity, brainless elites, and degraded masses. No human contact, only relations of domination and submission that turn the colonizing man into a pawn, an overseer, a jailer, a whip, and the native man into an instrument of production. It is my turn to offer an equation: colonization = thingification*<sup>34</sup>.

In the same way the Enlightenment culture of the 18th century influenced biomedical sciences with Cartesian positivism, philosophy was not immune to its effects. On the contrary, it was within this context that the foundations of modern and transcendental philosophy were established. It was only in the 20th century that it became clear the Enlightenment had given birth to an anthropocentric instrumental rationality<sup>35</sup>, one that legitimates moral actions of an exploitative nature toward dominated cultures and the natural world.

According to Ruiz and Maciel, the use of Kantian maxims of knowledge through reason and power, and the consequences of their applications, brought about a foundational shift in moral relations:

*This slippage from knowledge to power, mainly in the form of useful benefit, generated the ethical matrix of narcissism as the domination of the other, legitimizing individual interest as the moral engine of all actions. Within this ethics, the aspiration for self-benefit culminates in a kind of naturalized hedonism*<sup>36</sup>.

This scenario endured for centuries until new forms of knowledge production opened up other perspectives. The body, distanced from cognition, was relegated to a bestial, inferior, and non-replicable zone, and therefore deemed unreliable. According to Nascimento, the history of Western modernity imposed upon non-white, non-masculine, and non-Western bodies a form of imprisoning corporeality in a perverse

manner, amid the wreckage caused by racism and the patriarchy<sup>37</sup>. Nascimento also identifies intervention bioethics as a bioethical framework with potential for decolonial practices and devices, emphasizing the discussion of corporeality as an essential aspect of ethical debate<sup>24</sup>.

In one of the foundational articles of intervention bioethics, Garrafa and Porto<sup>38</sup> identify corporeality as an essential marker of the theory. Born out of Latin American propositions against the North American principlist hegemony, intervention bioethics establishes the body as a fundamental concept, understanding that it is upon the body that ethical issues act, it is through the body that individuals live their concrete realities—such as poverty—and it is by means of the body that they perceive the world and experience pain or pleasure within somatic corporeal complexity. The authors explain:

*The defense of the recognition of human concreteness, as advocated by Intervention Bioethics, is based on the idea that any approach or dimension from which the human being is analyzed will, a priori, be grounded in the human body; on interpretations that common sense and each field of knowledge attribute to it. As the vehicle of physical existence, it is the obvious universal*<sup>39</sup>.

Although it is not limited to a purely physiological basis, the attempt to identify essential and universal human somatic markers, derived from pain and pleasure, proves to be a complex task. Damasio had already explained that emotion and reason are intrinsically intertwined in the construction of our bodily maps of sensation and perception, serving as neurochemical foundations for decision-making in practice<sup>40-42</sup>.

According to Dukes and collaborators<sup>43</sup>, we are possibly living in the era of affectivism, surpassing cognitive and behavioral paradigms. These authors emphasize that *emotions not only shape the way we interpret the world but also determine which of its aspects demand our attention and which can safely be ignored; emotions concern not only what is, but above all, what matters*<sup>43</sup>. It is in this body-place that experience must be taken and felt, preserving the integrality of

bodily processes as the foundation of reflective, and even bioethical, action.

It is related to experience, and to the knowledge derived from experience, understood as that which happens to us, with all its potential for uncertainty, openness to the unknown, and the uniquely lived dimension of each subject. According to Larrosa Bondía,

*(...) the knowledge of experience is particular, subjective, relative, contingent, personal. If experience is not what happens, but what happens to us, then two people, even if they face the same event, do not have the same experience. The event is shared, but experience belongs to each one, singular and in some way impossible to be repeated. The knowledge of experience is knowledge that cannot be separated from the concrete individual in whom it takes shape. It is not, like scientific knowledge, outside of us, but only makes sense in the way it configures a personality, a character, a sensibility, or, ultimately, a singular human way of being in the world, which is at once an ethics (a mode of conduct) and an aesthetics (a style)<sup>44</sup>.*

The clinical encounter also constitutes a place of experience. As Merhy<sup>45</sup> affirms, this *living work in action* within health care is configured as a know-how of bodies, grounded in the encounter between two (or more) individuals and in the emergent that results from it, including uncertainties inherent to that moment. This experience of the clinical encounter is built (or not) by means of bonds and affections, nurturing processes of health-disease production and reaching other universes of the human, sometimes not directly observable. In this place of productive work in health, conceptions of health—whether as a right or as a commodity— influence how we view health acts and the type of engagement that guides the attitudes of those involved, especially healthcare workers.

Similarly, the founding bases of Eurocentric modernity—anchored in the coloniality of power and knowledge and in the understanding of Black and poor bodies as inferior—affect healthcare professionals and consequently those in training, who tend to be less inclined to invest time in both educational processes capable of transforming the health-disease reality and in the creation of bonds that could enhance and deepen the care relationship.

It is not possible, however, to approach this topic naively, for it is not limited to an individual issue within the doctor-patient relationship. It is necessary to consider macro-political factors that govern and influence health systems, marked since the 20th century by the dispute between the capitalist neoliberal model and the model proposed by the Brazilian Sanitary Reform, grounded in Marxist principles.

As Larrosa points out, this way of being in the world as a body—or, as Nascimento<sup>37</sup> suggests, a corporeality in openness—constitutes a (new?) bioethical mode, as it is a practical situation applied to the clinical encounter in healthcare. This corporeality in openness is presented as a counterpoint to the view of an *imprisoning* corporeality, derived from the idea of the body as property and sustained by the modern individual<sup>16</sup>.

Drawing on the recovery of resistance processes and the reconstruction of traditions of African peoples via Candomblé, Nascimento highlights at least two relevant aspects that break with the paradigm of colonial modernity: orality and the relationship with nature. In the first, the word can be body and the body can be word. The author states:

*Orality erases the distinction between mind and body, which assigns to the former the “place” where the word would come into existence, leaving the body only the responsibility of externalizing it, whether in writing or speech. Orality throws us into an encounter between subjects who are also bodies. And, in this phenomenon, not only does the whole body speak, but it also fosters a bond between those engaged in the process of speaking and listening<sup>37</sup>.*

Thus, orality establishes a commitment between body, word, and speakers: those who speak engage with the words they utter, and those who listen transform themselves, welcoming within themselves the one who addresses them. Orality functions as a mechanism for constructing a community sustained by the bond of the word, and this collectivity cannot be understood merely as the sum of individuals who speak or listen, but rather via the multiple encounters and the many “betweens” that such encounters foster<sup>46</sup>.

When discussing the role of teaching and pedagogical tools in medical education, it is

possible to refer to the singular experiences of each act of speaking and listening in class, as well as to each practical encounter in the trajectory of a healthcare worker's training, from the perspective of a collectivity that expresses and mutually recognizes itself. The use of metaphors or storytelling can function as a strategy to re-signify the lived experience, shaping a space for reflective integration that goes beyond the merely cognitive. In this context, orality presents itself as both an invitation and an engagement of an integrated bodily whole.

For Candomblé communities, relationships with nature represent a bodily continuum within a communal relationship, describing a corporeality of (collective) care:

*(...) what sustains both the idea of nature as home or as environment is precisely a separation between the "I" that humans would represent and an "other," which would be nature. For the terreiros, nature is part of the great "we" that is the communal world present in the cosmologies of Candomblé. The terreiros understand there is a continuum in the world of which we and nature are part, so that to speak of nature is also to speak of ourselves<sup>47</sup>.*

This world/nature is, therefore, always embodied, always produced in the body, and always makes the body. Thus is founded a corporeality of care, configured as a fundamental tool to confront the historical self-hatred imposed by racism on Black people in society. Behind this ecological care lies a caring corporeality that guides this way of being in the world, shaped by a reality that constitutes it<sup>31-48</sup>.

The same author underscores that intervention bioethics, by means of dialogue, offers tools that reposition corporeality at the center of the bioethical debate, situating the bodies at stake<sup>24</sup>. Garrafa and Cruz also argue that, beyond markers of pain and pleasure, it is in the body that the concrete reality of people is manifested, revealing their relationships with the environment—whether in a context of everyday life, related to individual rights that guarantee physical and social survival, or in macrosocial conditions related to economic and social organization<sup>27</sup>.

Other Latin American bioethics approaches, such as narrative bioethics<sup>49</sup>, also present

counter-hegemonic proposals by situating the singular and contextual reality in the experience narrated by the person themselves.

### Third reflection: bioethics, body, and art in medical education

In Brazil, significant changes in medical schools have been occurring since the beginning of the 20th century, although the debate on the shortcomings of medical training has a long history<sup>1,4</sup>. The publication of the new NCG for medical courses in 2014<sup>50</sup> marked a seminal moment within a broader project to transform medical education. This change was strongly influenced by the implementation of the *Mais Médicos* Program across the country, structured around three axes of action, one of which is training, envisaging the opening of new medical schools and the regulation of training based on this guideline.

As this program was aimed at expanding access for populations that had never received continuous care within the scope of primary health care—especially by the axis of providing physicians—it focused on the health needs of the population within their own territories, revealing great potential to promote a structural, decolonial change.

In this context, the "value" of the body in the teaching-learning process of medical education in general, as well as of corporealities in the construction of knowledge and capacities in each encounter within the clinical setting, becomes evident. Thus, the following aspects are revisited as fundamental to this discussion in the field of health education:

1. Placing the body and corporeality at the center of training processes is a bioethical issue, as it directly relates to the themes discussed: the objectification of bodies by modern sciences that, supported by coloniality, render the subjectivities of these bodies invisible; and
2. Promoting and valuing initiatives in medical training (and in other health fields) that develop mechanisms capable of breaking with the coloniality of knowledge and power by various pedagogical paths.

Among the initiatives within the medical curriculum, the incorporation of art and its

contributions as a field of practical knowledge has been occurring in a singular way at the beginning of the 21st century. Even considering that the relationship between medicine and art is not new and presents several interfaces, there is notable emphasis on the so-called “art-based interventions” in professional health training<sup>51-53</sup>. Increasingly, medical education values skills and attitudes that go beyond technical aspects restricted to biomedicine, recognizing that competencies linked to humanistic dimensions of inter-human relations positively impact practical outcomes in professionalism and leadership.

In some reviews of the subject, it is possible to find different strategies for using art in the approach to specific pedagogical content, which makes it difficult to develop comprehensive reviews with more targeted results, given the great heterogeneity of interventions and clinical settings.

Osman, Eacott, and Willson<sup>51</sup> point to the need for more focused studies. These authors also criticize the lack of adequate inclusion of artists, who could contribute consistently both in theoretical aspects and practical applications, according to their training in the arts. This demonstrates how medicine, as a field colonized by Eurocentric modernity, tends to overvalue its own knowledge and exclude other forms of knowledge that, historically, shape and (de)construct imaginaries, repertoires, and aesthetic experiences, contributing to human formation in a transdisciplinary manner.

In Brazil, interesting initiatives can be found in several regions, with varied approaches in medical courses: Medical Education Empowered by Theater (MEET) at the University of Campinas<sup>54</sup>; *Laboratório de Sensibilidades* (Labsensi) in the medical course of the Federal University of Pernambuco, in Caruaru, Agreste campus<sup>55</sup>; Labsensi at the Federal University of São Paulo, in Santos, São Paulo State<sup>56</sup>; Laboratórios de Sensibilidades e Devires (LSD) at the University of Rio de Janeiro; and Laboratório de Subjetividade e Corporeidade (CorporeiLabS), in Niterói, Rio de Janeiro State<sup>57</sup>.

All of these initiatives draw on the arts to propose experiences, practices, discussions, engagements, and creative constructions that impact the traditional way of teaching in health and training caregivers, indicating that there are other paths for transformation and the

development of human and civic competences, which can also be called bioethical competences.

It is necessary to point out that the discussion about corporeality in medical education, when guided by the inclusion of transdisciplinary fields of knowledge and oriented towards training closer to the current requirements of the NCG, must necessarily include the arts in its structure. In this sense, it is not a utilitarian inclusion, subordinated to a hierarchy that trivializes the relationships between fields of knowledge, but rather a valorization of potentially decolonial contemporary arts in the context of medical and health education.

Just as different fields of knowledge were colonized in the process of Eurocentric modernization, art and aesthetics were as well, as Mignolo emphasizes<sup>58</sup> in his criticism of the colonization of *aesthesis* by aesthetics. By distancing himself from a merely representative function to assume a place of creative catharsis, the author identifies sensitive differences in artistic manifestations that expose contemporary problems via performances and installations addressing the place of Black bodies, female bodies, and human relations in society. These interventions leave no room for indifference, and their central role may lie precisely in enhancing, seizing, and creating moments of openness to let themselves be affected by these doings-sayings of bodies that problematize bioethics in another way: based on their realities and life histories, transforming themselves into decolonial art materialized in the world.

## Final considerations

The three proposed reflections make it possible to consider medical training not only in terms of what is taught or what is considered as theoretical-practical content for medical practice, but also in terms of the way of teaching and conducting the formative process. Bioethics, decoloniality, corporeality, and art thus explore boundaries of what a biopsychosocial education can offer.

Decolonial studies broaden the understanding of our place within the colonial matrix and should be incorporated into bioethical reflections that address cultural and behavioral diversity,

dealing with diverse cultures and behaviors in both everyday and emerging health challenges. The relationship between decoloniality and bioethics, specifically intervention bioethics, makes this approach a potential tool to advance debates in medical education, focusing on practical situations that can be experienced by students.

Corporeality should be assumed as a fundamental axis in the theoretical-practical training of health students, especially in medicine, in close dialogue with decision-making processes in healthcare, in the way of engaging with patients, and in the exercise of professionalism and teamwork.

Art and bioethics can work together in the training of medical professionals, contributing to new (dis)organizations of corporeality in clinical encounters. Bioethics, in its broadest sense, should guide the entire medical education process. Understanding bioethics as transdisciplinary

and open to dialogue with various fields of knowledge, it incorporates contributions of the arts. Additionally, as discussed throughout this study, the artistic experience—whether by creation, fruition, preparation, or other paths—should engage with the different universes of corporealities in question, pointing to unique ways of perceiving experience in the world, capable of affecting us and enhancing internal transformations, touching upon decoloniality as a space for reflection and practice.

Part of the challenge lies in the fact that this proposal does not operate as a recipe, but as an experience, not being repeatable or automatically replicable. In each context, when the questions raised in the three reflections are raised, a range of challenges, possibilities, and potentialities emerges. In each organization, it is necessary to recognize how coloniality permeates formative practices and which creative solutions become concretely possible.


## References

1. Batista NA, Vilela RQB, Batista SHSS. Educação médica no Brasil. São Paulo: Cortez; 2015.
2. Ceccim RB, Feuerwerker LCM. O quadrilátero da formação para a área da saúde: ensino, gestão, atenção e controle social. *Physis: Rev Saúde Coletiva* [Internet]. 2004 [acesso 10 out 2024];14(1):41-65. DOI: 10.1590/S0103-73312004000100004
3. Ceccim RB, Armani TB, Rocha CF. O que dizem a legislação e o controle social em saúde sobre a formação de recursos humanos e o papel dos gestores públicos, no Brasil. *Ciênc Saúde Colet* [Internet]. 2002 [acesso 10 dez 2024];7(2):373-83. DOI: 10.1590/S1413-81232002000200016
4. Romano VF. Tendências de mudanças na formação médica no Brasil: tipologia das escolas. *Trab Educ Saúde* [Internet]. 2005 [acesso 10 dez 2024];3(1). DOI: 10.1590/S1981-77462005000100016
5. Machado CDB, Wuo A, Heinzle M. Educação médica no Brasil: uma análise histórica sobre a formação acadêmica e pedagógica. *Rev bras educ med* [Internet]. 2018 [acesso 10 dez 2024];42(4):66-73. DOI: 10.1590/1981-52712015v42n4RB20180065
6. Matias MC, Verdi M, Finkler M. Instituintes e instituídos na formação médica: movimentos desencadeados pelo Programa Mais Médicos. *Saúde Debate* [Internet]. 2023 [acesso 10 dez 2024];47(138):504-15. DOI: 10.1590/0103-1104202313810
7. Beauchamp TL, Childress JF. *Principles of biomedical ethics*. New York: Oxford University Press; 1979.
8. Clouser KD, Gert B. A critique of principlism. *J Med Philos* [Internet]. 1990 [acesso 10 out 2024];15(2):219-36. DOI: 10.1093/jmp/15.2.219
9. Garrafa V, Martorell LB, Nascimento WF. Críticas ao principlismo em bioética: perspectivas desde o Norte e desde o Sul. *Saúde Soc* [Internet]. 2016 [acesso 10 out 2024];25(2):442-51. DOI: 10.1590/S0104-12902016150801
10. Serodio A. Revisitando o principlismo: aplicações e insuficiências na abordagem dos problemas bioéticos nacionais. *Rev Bras Bioét* [Internet]. 2008 [acesso 10 out 2024];4(1-2):69-79. DOI: 10.26512/rbb.v4i1-2.7875

11. Figueiredo AM. Bioética: crítica ao principalismo, Constituição brasileira e princípio da dignidade humana. *Rev. bioét. (Impr.)* [Internet]. 2018 [acesso 11 set 2024];26(4):494-505. DOI: 10.1590/1983-80422018264267
12. Bellino F. Fundamentos da bioética: aspectos antropológicos, ontológicos e morais. Bauru: Edusc; 1997.
13. Garrafa V. Bioética. In: Giovanella L, Escorel S, Lobato LVC, Noronha JC, Carvalho AI, organizadores. Políticas e sistema de saúde no Brasil [Internet]. Rio de Janeiro: Editora Fiocruz; 2012 [acesso 15 set 2024]. p.741-58. DOI: 10.7476/9788575413494
14. Silva VXL, Vieira VB, Feitosa SF. Complexidade e transdisciplinaridade no currículo médico comprometido com bioéticas latino-americanas. *Rev. bioét. (Impr.)* [Internet]. 2022 [acesso 10 out 2024];30(3):548-57. DOI: 10.1590/1983-80422022303548PT
15. Quijano A. Colonialidade do poder, eurocentrismo e América Latina. In: Lander E, organizador. A colonialidade do saber: eurocentrismo e ciências sociais [Internet]. Buenos Aires: Consejo Latinoamericano de Ciencias Sociales (CLACSO); 2005 [acesso 10 out 2024]. p. 117-42. Disponível: <https://bit.ly/46uMnBj>
16. Quintero CS. Propriedade do corpo: sujeito, direito e trabalho [tese] [Internet]. Florianópolis: Universidade Federal de Santa Catarina; 2017 [acesso 10 out 2024]. Disponível: <https://bit.ly/4mXK6oh>
17. Bellino F. Op. cit., 1997. p. 49.
18. Bellino F. Op. cit., 1997. p. 50.
19. Césaire A. Discurso sobre o colonialismo. São Paulo: Veneta; 2020.
20. Mignolo WD. Histórias locais/Projetos globais: Colonialidade, saberes subalternos e pensamento liminar [Internet]. Belo Horizonte: Editora UFMG; 2020 [acesso 10 out 2024]. Disponível: <https://bit.ly/46vFxxv>
21. Dussel E. 1492 – o encobrimento do outro: a origem do “mito da modernidade”. Conferências de Frankfurt [Internet]. Petrópolis: Vozes; 1993 [acesso 10 out 2024]. Disponível: <https://bit.ly/48gC19o>
22. Cusicanqui SR. Ch'ixinakax utxiwa: uma reflexão sobre práticas e discursos descolonizadores. São Paulo: N-1; 2021.
23. Böschemeier AGE, Quispe-Agnoli R, Greco L, Waman Poma de Ayala, um autor indígena do século XVII: questionando antropocentrismos no colonialoceno. *TECCOGS – Revista Digital Tecnologias Cognitivas* [Internet]. 2021 [acesso 10 dez 2023];(24):157-203. DOI: 10.23925/1984-3585.2021i24p157-182
24. Nascimento WF, Garrafa V. Por uma vida não colonizada: diálogo entre bioética de intervenção e colonialidade. *Saúde Soc* [Internet]. 2011 [acesso 11 set 2023];20(2):287-99. DOI: 10.1590/S0104-12902011000200003
25. Beecher HK. Ethics and clinical research. *N Engl J Med* [Internet]. 1966 [acesso 10 set 2023];274(24):1354-60. DOI: 10.1056/NEJM196606162742405
26. Nascimento WF, Martorell LB. A bioética de intervenção em contextos descoloniais. *Rev. bioét. (Impr.)* [Internet]. 2013 [acesso 10 nov 2023];21(3):423-31. Disponível: <https://bit.ly/4piezPe>
27. Garrafa V, Cruz E. Bioética de intervención: una agenda latinoamericana de re-territorialización epistemológica para la bioética. In: Pfeiffer ML, Castillo-Manchola C, editores. Manual de educación en bioética – fundamentar la bioética: conocimientos, valores y visiones desde América Latina y el Caribe [Internet]. Cidade do México: Universidad Nacional Autónoma de México/Unesco; 2022 [acesso 10 nov 2023]. p. 37-65. (volume 2). Disponível: <https://bit.ly/3HUQL3j>
28. Garrafa V. Apresentação: o novo conceito de bioética. In: Garrafa V, Kottow M, Saada A, organizadores. Bases conceituais da bioética: enfoque latino-americano. São Paulo: Gaia/Unesco; 2006. p. 9-15.
29. Garrafa V. Multi-inter-transdisciplinaridade, complexidade e totalidade concreta em bioética. In: Garrafa V, Kottow M, Saada A, organizadores. Bases conceituais da bioética: enfoque latino-americano. São Paulo: Gaia/Unesco; 2006. p. 73-86.
30. Garrafa V, Porto D. Bioética, poder e injustiça: por uma ética de intervenção. *Mundo Saúde* [Internet]. 2002 [acesso 10 nov 2024];26(1):6-15. Disponível: <https://bit.ly/47CSzbc>
31. Feitosa SF. O processo de territorialização epistemológica da Bioética de Intervenção: por uma prática bioética libertadora [tese] [Internet]. Brasília: Universidade de Brasília; 2015 [acesso 10 nov 2024]. p. 6. DOI: 10.26512/2015.02.T.18950
32. Bellino F. Op. cit., 1997. p. 28.

33. Bellino F. Op. cit., 1997. p. 29.
34. Césaire A. Op. cit., 2020. p. 24.
35. Ruiz CB, Maciel JC. A ética do cuidado do outro e a bioética ambiental. *Rev. bioét. (Impr.) [Internet]*. 2020 [acesso 10 out 2024];28(3):440-8. DOI: 10.1590/1983-80422020283405
36. Ruiz CB, Maciel JC. Op. cit., 2020. p. 441.
37. Nascimento WF. Corporalidades em abertura: os candomblés e percursos da resistência incorporada. *Humanidades e Inovação [Internet]*. 2020 [acesso 10 nov 2023];7(25): 79-87. Disponível: <https://bit.ly/42qTyYO>
38. Porto D, Garrafa V. Bioética de intervenção: considerações sobre a economia de mercado. *Rev. bioét. (Impr.) [Internet]*. 2005 [acesso 11 set 2024];13(1):111-23. Disponível: <https://bit.ly/4pfHhQH>
39. Porto D, Garrafa V. Op. cit., 2005. p. 116-117.
40. Damásio A. O mistério da consciência. São Paulo: Companhia das Letras; 2000.
41. Damásio A. Em busca de Espinosa: prazer e dor na ciência dos sentimentos. São Paulo: Companhia das Letras; 2004.
42. Damásio A, Carvalho GB. The nature of feelings: evolutionary and neurobiological origins. *Nat Rev Neurosci [Internet]*. 2013 [acesso 10 out 2023];14(2):143-52. DOI: 10.1038/nrn3403
43. Dukes D, Abrams K, Adolphs R, Ahmed ME, Beatty A, Berridge KC *et al.* The rise of affectivism. *Nat Hum Behav [Internet]*. 2021 [acesso 15 set 2024];5(7):816-20. DOI: 10.1038/s41562-021-01130-8. Tradução livre.
44. Bondía JL. Notas sobre a experiência e o saber de experiência. *Rev bras educ [Internet]*. 2002 [acesso 11 set 2024];(19):20-8. Disponível: <https://bit.ly/4nqZdGC>
45. Merhy EE. Saúde: a cartografia do trabalho vivo. 4ª ed. São Paulo: Hucitec; 2014.
46. Nascimento WF. Op. cit., 2020. p. 82.
47. Nascimento WF. Op. cit., 2020. p. 83.
48. Nascimento WF. Op. cit., 2020. p. 84.
49. Manchola C, Brazão E, Pulschen A, Santos M. Cuidados paliativos, espiritualidade e bioética narrativa em unidade de saúde especializada. *Rev. bioét. (Impr.) [Internet]*. 2016 [acesso 10 out 2024];24(1):165-75. DOI: 10.1590/1983-80422016241118
50. Brasil. Ministério da Educação. Resolução CNE/CES nº 3, de 20 de junho de 2014. Institui diretrizes curriculares nacionais do curso de graduação em Medicina e dá outras providências. *Diário Oficial da União [Internet]*. Brasília, p. 8-11, 23 jun 2014 [acesso 10 out 2024]. Seção 1. Disponível: <https://bit.ly/46oaFwI>
51. Osman M, Eacott B, Willson S. Arts-based interventions in healthcare education. *Med Humanit [Internet]*. 2018 [acesso 10 out 2023];44(1):28-33. DOI: 10.1136/medhum-2017-011233
52. Lake J, Jackson L, Hardman C. A fresh perspective on medical education: the lens of the arts. *Med Educ [Internet]*. 2015 [acesso 10 out 2023];49(8):759-72. DOI: 10.1111/medu.12768
53. Haidet P, Jarecke J, Adams NE, Stuckey HL, Green MJ, Shapiro D *et al.* A guiding framework to maximise the power of the arts in medical education: a systematic review and metasynthesis. *Med Educ [Internet]*. 2016 [acesso 10 out 2023];50(3):320-31. DOI: 10.1111/medu.12925
54. Carvalho Filho MA, Ledubino A, Frutuoso L, Wanderlei JS, Jaarsma D, Helmich E *et al.* Medical Education Empowered by Theater (MEET). *Acad Med [Internet]*. 2020 [acesso 10 out 2024];95(8):1191-200. DOI: 10.1097/ACM.0000000000003271
55. Araújo EG, Paz CA, Melo LA. Pistas para um estudo do sensível. *Interritórios [Internet]*. 2020 [acesso 10 out 2023];6(10):393-414. DOI: 10.33052/inter.v6i10.244917
56. Henz AO, Rodrigues A, Capozzolo AA, Moreno HV, Baldo RC, Casetto SJ. Pactos do sensível. *Interritórios [Internet]*. 2019 [acesso 10 out 2023];5(9):140-54. DOI: 10.33052/inter.v5i9.243606
57. Rocha M, Santos ARC, Resende C. Polissemias do sensível: resistência e ethos na formação em saúde. *Interritórios [Internet]*. 2019 [acesso 10 out 2023];5(9):124-39. DOI: 10.33052/inter.v5i9.243599
58. Mignolo WD. Aisthesis decolonial. *Calle14 [Internet]*. 2010 [acesso 10 out 2023];4(4):10-25. DOI: 10.14483/21450706.1224

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Eline Gomes de Araújo participated in the study conception, narrative review, writing of the manuscript, review, and final editing. Carolina Albuquerque da Paz participated in the narrative review, writing of the manuscript, and critical review. Pedro Egnardo Gontijo participated in the critical review and final editing. Saulo Ferreira Feitosa participated in the critical review. All authors take full responsibility for content integrity.

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