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Professional councils and the oversight of medical training: legal and ethical foundations

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Abstract

The accelerated and disorderly expansion of medical courses in Brazil has raised ethical and social concerns about the quality of medical training. This article addresses the role of regional medical councils in overseeing medical training, not as interference in university autonomy, but as a legitimate and necessary exercise of their institutional mission to protect society by overseeing the exclusive medical act of teaching specifically medical disciplines. The research method used is normative analysis. The analysis is based on Brazilian legislation, the principles of bioethics, and the legal theory of implied powers. Resolutions 7/2024 and 8/2025 of the Regional Medical Council of the State of Rio Grande do Sul are also analyzed. It is argued that poor professional training is a form of structural violence against patients and compromises the very ethical pact of medicine.

Keywords: Schools, medical. Organization and administration. Bioethics.

Resumo

Conselhos profissionais e a fiscalização da formação médica: fundamentos jurídicos e éticos

A expansão acelerada e desordenada dos cursos de medicina no Brasil tem gerado preocupações éticas e sociais sobre a qualidade da formação médica. Este artigo trata da atuação dos Conselhos Regionais de Medicina na fiscalização da formação médica, não como interferência na autonomia universitária, mas como exercício legítimo e necessário de sua missão institucional de proteção da sociedade pela fiscalização do ato médico privativo de ensinar disciplinas especificamente médicas. O método de pesquisa utilizado é a análise normativa. Fundamenta-se a análise na legislação brasileira, nos princípios da bioética e na teoria jurídica dos poderes implícitos. Também são analisadas as Resoluções do Conselho Regional de Medicina do Estado do Rio Grande do Sul 7/2024 e 8/2025. Argumenta-se que a má formação profissional é uma forma de violência estrutural contra o paciente e compromete o próprio pacto ético da medicina.

Palavras-chave: Faculdades de medicina. Organização e administração. Bioética.

Resumen

Comités profesionales y supervisión de la formación médica: fundamentos jurídicos y éticos

La expansión acelerada y desordenada de los cursos de medicina en Brasil ha generado preocupaciones éticas y sociales sobre la calidad de la formación médica. Este artículo trata sobre la actuación de los consejos regionales de medicina en la supervisión de la formación médica, no como una interferencia en la autonomía universitaria, sino como un ejercicio legítimo y necesario de su misión institucional de proteger a la sociedad mediante la supervisión del acto médico exclusivo de enseñar disciplinas específicamente médicas. El método de investigación utilizado es el análisis normativo. El análisis se basa en la legislación brasileña, los principios de la bioética y la teoría jurídica de los poderes implícitos. También se analizan las Resoluciones del Consejo Regional de Medicina del Estado de Rio Grande do Sul 7/2024 y 8/2025. Se argumenta que la mala formación profesional es una forma de violencia estructural contra el paciente y compromete el propio pacto ético de la medicina.

Palabras-clave: Facultades de medicina. Organización y administración. Bioética.

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In recent years, Brazil has witnessed a proliferation of medical courses in municipalities lacking minimum structural conditions, driven by market interests and poorly calibrated public policies. This phenomenon represents not only a threat to the quality of training but also an ethical and bioethical risk to society, which depends on the adequate preparation of physicians. In this scenario, the Regional Medical Councils (CRM) need to serve as oversight bodies for medical training. This function, although challenging, finds legal and ethical support, as this article demonstrates.

A poorly calibrated public policy is one that, despite being based on legitimate objectives, is implemented without careful consideration of empirical data, operational feasibility, and its effective impacts on the target system. This approach tends to neglect the institutional capacities and structural limitations of the actors involved and frequently results in systemic imbalances, functional distortions, and counterproductive or adverse effects on the initial purposes.

In the context of medical training, the proliferation of courses lacking adequate hospital infrastructure and faculty with the required qualifications illustrates a government intervention that does not align its goals with the real contingencies and capabilities of the health and education systems. This misalignment compromises the quality of the training process and, prospectively, the safety of medical care delivery.

The training of competent medical professionals capable of practicing the profession effectively requires a sufficient number of qualified faculty members and clinical practice settings that provide high-quality medical care. Such environments must have properly trained preceptors and a specific time allocated for teaching and learning activities. Medical students must learn a great deal, including developing the capacity for continuous updating and self-directed learning.

In addition, this student must bring to the course a prior knowledge base that enables them to understand the numerous factors that affect an individual's or community's health. Teaching medicine is not easy; it requires training that must be long, broad, and deep, often during medical care provided to human beings seeking help to alleviate or resolve their suffering and fear. Therefore, unconditional respect for the dignity and rights of patients participating in the educational process is imperative and ethical.

Legal basis

The Federal Constitution [1] elevated the freedom to practice any profession to the level of a fundamental guarantee. However, to ensure the effective safeguarding of fundamental rights, it promptly conditioned this freedom on the observance of professional qualifications established by law, as stipulated in the final part of Article 5, item XIII. It is in the achievement of this indispensable "professional qualification," of a constitutional nature, that professional councils find their first foundation for existence and state power. Article 200, item III, confers upon the Unified Health System (SUS) the responsibility for organizing the training of human resources in the health field. In this context, the Federal Council of Medicine (CFM), as a federal autonomous entity with legal personality under public law, linked to ethical-professional control and the defense of society, figures as a co-responsible party. Its role as guarantor of the public interest is demonstrated by ensuring that the training of future physicians meets minimum quality and safety standards, thereby directly contributing to the effectiveness of SUS.

The legal framework for the CFM's actions begins with Law 3,268/1957 [2], which, in its Article 2, establishes the Councils as supervisory bodies of professional ethics at the national level, responsible for ensuring the proper ethical performance of medicine and the prestige of the profession. Additionally, Article 15, subparagraph "c", confers on the Regional Councils the competence to supervise the professional practice. This supervisory prerogative, inherent to the state police power delegated to the Councils, aims to ensure that medical practice is conducted ethically and responsibly, in strict accordance with current technical and legal regulations.

While Law 3,268/1957 [2] does not explicitly detail the oversight of educational institutions, the systematic and teleological interpretation of these regulations, strengthened by the theory

of the implied powers of public administration [3,4], is what emerges from the Constitution as the basis for the State, through its organs, to legitimately achieve the ends intended by the Constitution itself, conferring powers, even if not expressly stated in the text, that are indispensable to the objective pursued. There are exceptions to this theory, especially when it is intended to attribute to an organ powers that the Constitution explicitly granted to another. This is, for example, what was seen in the debates brought before the Supreme Federal Court (STF) in emblematic cases, such as the judgment on the investigative powers of the Public Prosecutor's Office.

Regarding the hypothesis discussed in this article, it is important to emphasize that the national legal system entrusts oversight of medical ethics exclusively to the Medical Councils, which, according to the aforementioned theory, grants the necessary powers to fulfill the constitutional mission of qualifying medicine. According to this postulate, by assigning to the Councils the primary competence of ensuring the "perfect ethical performance of medicine" and the quality of professional practice, the legislator implicitly conferred upon them the necessary tools to achieve this purpose effectively. Thus, the oversight of teaching conditions, which directly affect the quality of future professionals and, consequently, the safety of healthcare, emerges not only as a prerogative but also as an instrumental duty to fulfill the Council's final responsibilities.

Corroborating this perspective, Law 12,842/2013, known as the Medical Act Law [5], after defining the exclusive acts of physicians in its Article 4, establishes in Article 5, items III and IV, that the teaching of specifically medical subjects and the coordination of training courses in medicine, medical residency programs and specific postgraduate courses for physicians constitute exclusive prerogatives of this professional category. By defining such activities as exclusive, the law subjects those who perform them—medical teachers and coordinators—to the oversight of the Medical Councils, which, by logical extension, includes the evaluation of the conditions under which this medical teaching is given and coordinated.

In effect, this designation of the teaching of medical subjects as an exclusive act underscores the legal recognition of the complexity and specificity inherent in this activity, which demands specialized technical and ethical expertise. Consequently, the responsibility for comprehensive medical training lies with professionals in the field, who must ensure the faithful transmission of fundamental knowledge and deontological values.

The combination of this formative responsibility with the supervisory competence of the Medical Councils confers full legitimacy to their role in supervising health establishments that function as practice fields. These places are crucial, as they represent the setting where students experience their first contact with professional reality, develop interpersonal skills with patients, perform procedures, and internalize the clinical decision-making process.

The Code of Medical Ethics (CEM) (CFM Resolution 2,217/2018) [6] reinforces this responsibility by stating, in its fundamental principle III, the need for good working conditions for the dignified and honorable practice of medicine. Additionally, Article 19 prohibits physicians in management positions from neglecting to guarantee the rights of physicians and *other adequate conditions for the ethical and professional performance of medicine* [6]. Regarding the minimum conditions for such performance, CFM Resolution 2,056/2013 [7], which approves the manual for inspection and supervision of medicine in Brazil, specifies the parameters to be observed in health establishments to ensure the safety of the medical act, which include physical infrastructure, availability of adequate equipment, qualification of human resources, and implementation of care protocols, among others.

Specifically regarding the requirements for medical education institutions, Law 12,871/2013 (*Mais Médicos* Law) [8], Article 3, paragraph 1, II, imposes the need for *adequate and sufficient public equipment* integrated into the SUS health care networks to enable the courses. The joint analysis of these regulations shows that the Brazilian legal system imposes on healthcare establishments the obligation to provide minimum conditions for the practice of medicine in both the healthcare and educational spheres. Failure to comply with this obligation compromises patient safety and the quality of medical training,

thus legitimizing the supervisory intervention of the Medical Councils.

In fact, the protection of patient health constitutes a fundamental right, hierarchically superior to other interests, including the institutional autonomy of educational institutions. Furthermore, deficient medical training results in technically unprepared professionals and increases the risk of medical errors and iatrogenic events. Therefore, the supervisory activities of medical councils are crucial to ensure compliance with ethical and legal standards and to hold non-compliant establishments accountable. Ensuring that medical students are trained in environments that respect these principles and provide adequate conditions for technical and ethical learning is therefore inseparable from the Council's mission.

The oversight role of the Medical Councils should not be understood as a manifestation of corporate interest, but rather as an expression of their legal nature as federal autonomous entities with a delegated public function. The Councils exercise typical State functions, guided by the protection of society and the ethical regulation of professions. Professional councils are not to be confused with trade unions or category representative entities, as their mission is to ensure that professional practice occurs within standards that guarantee safety, dignity, and the rights of citizens who use the regulated services [9].

In this context, oversight activity represents not only a prerogative, but also an institutional and ethical duty of the Councils, especially in the face of imminent risks to the integrity of medical care. This action is based on the precautionary principle and the social responsibility of the institutions that train health professionals. Action is taken before the damage occurs, prioritizing the protection of the population without compromising university autonomy, while also aligning with it from a professional ethics perspective. By overseeing practice fields and holding inadequate training structures accountable, the Councils operate as legitimate instruments of the State in defense of human life and health.

In conclusion, oversight of medical learning locations is a concrete manifestation of the Councils' fulfillment of their co-responsibilities in the training of human resources, insofar as they ensure that future professionals can meet the population's health needs with competence and ethics.

Bioethical basis

The practice of medicine requires complex skills that can only be acquired through supervised practical training. The absence of adequate clinical and hospital practice settings constitutes institutional negligence, violating the principle of non-maleficence, one of the pillars of bioethics. According to Beauchamp and Childress [10], a poorly trained student poses a risk to future patients.

In addition, justice, another bioethical principle, is violated when medical courses are offered in places where students lack equal access to qualified training experiences. Such inequalities perpetuate a cycle of poor training to the detriment of the most vulnerable populations. The principle of responsibility, discussed by Jonas [11], also applies: institutions that train physicians have a moral duty to anticipate the future consequences of their actions on human lives. Councils, as instances of collective responsibility, must act before the harm occurs.

As Rui Nunes points out, institutional responsibility is a structuring component of contemporary bioethics. It requires that public policies and training practices be systematically evaluated in light of their potential impact on patient safety and human dignity. The author argues that *modern bioethics is not limited to clinical care, but includes the social responsibility of institutions that train healthcare professionals, especially when their actions or omissions may cause future harm to the population* [12].

It is essential to recognize the serious risks of a lack of oversight in the teaching of medical disciplines, including an increased likelihood that unethical conduct by medical professors, internship supervisors, and medical students will go unnoticed and uncorrected, seriously damaging the profession's reputation and public confidence in medicine [13].

When medical training lacks external oversight and relies solely on self-regulation by schools, the quality of teaching and outcomes can vary widely. This results in inconsistencies in students' acquisition of basic skills and in the training of physicians who are unprepared for clinical practice, compromising patient safety and the quality of care [14].

In seeking to increase the number of physicians in the country, it is crucial to remember that medical training depends on pillars such as well-prepared and qualified teachers and practice fields with adequate technical infrastructure for learning the medical act. Recognizing the great importance of having qualified professionals to perform medical procedures, such as professors or preceptors of medicine, bioethicist Paul Farmer and general practitioner Joseph Rhatigan [15] suggested that American physicians settle in low- and middle-income countries to teach medicine.

Another factor that can generate inequality in medical training is the intellectual background prior to entering medical school, which depends on access to good schools (primary and secondary education) and the student's intellectual capacity. Evidence shows that good performance on entrance tests, especially in biology, physics, and mathematical reasoning, is associated with better academic performance throughout the medical course, both in the pre-clinical and clinical phases [16,17]. From a neuroscientific point of view, prior knowledge facilitates the acquisition of new information and allows the construction of mental schemas that accelerate the learning of compatible data [18].

We believe that individual differences should be respected and that young people should not be subjected to excessive pressures that could compromise their health. This responsibility falls on medical schools that admit students without a comprehensive evaluation or with low scores. The questions arise: Do these students receive the necessary support? Do medical schools expel students who do not meet the minimum requirements?

Given that the regulatory system (CFM and CRM) can and should oversee only medical disciplines, the Ministries of Education and Health must be involved in evaluating students upon completion of the basic medical cycle. This measure would prevent less-qualified students from entering practical disciplines, thereby optimizing the use of internship fields and protecting the population from poorly trained professionals.

Currently, Brazil presents an unequal reality in medical training: on the one hand, medical schools (mainly public ones with university hospitals) that offer high-level practice fields, with professors/preceptors who train competent students and generate knowledge and teach critical thinking; on the other hand, there are practice sites proposed by some schools that fall far short of what is necessary for quality training, often in ethically dubious conditions. Given this disparity, how is it possible to instill medical ethics in students who experience training in such inadequate environments? Oversight can and should contribute to improving the ethical conditions of practice fields.

According to Rui Nunes, modern society adopts a pluralistic ethical stance, with diverse beliefs and opinions, which makes it essential that care be centered on the individual. Thus, bioethics must be grounded in the dignity of the person and the right to self-determination. This implies, for the medical student, respect for the human person and their rights, which must be safeguarded by free and informed consent obtained before studying a patient [19]. In addition, the principles of beneficence, non-maleficence, and justice must be applied in dealing with patients, and their effectiveness depends on certain essential virtues [20].

The rigorous oversight of medical training by professional councils emerges as a fundamental bioethical imperative, constituting an essential mechanism to ensure that the principles of beneficence, non-maleficence, and autonomy are preserved by guaranteeing uniform standards of formative excellence, protecting both professional integrity and the safety and dignity of patients, and consolidating the ethical responsibility of regulatory institutions in promoting equity in health.

The actions of CRMs sometimes require establishing their own regulations, which embody local ethical and regulatory understandings in the face of gaps in federal legislation. In the case of Rio Grande do Sul, two recent resolutions from

the State Regional Medical Council (CREMERS) stand out, reflecting the growing concern about the quality of medical training.

CREMERS Resolution 7/2024 [21] establishes the minimum technical criteria for evaluating medical practice fields. Among its main points are: the requirement for a hospital structure with medium- and high-care complexity, compatible with the internship; the presence of medical preceptors duly registered with the CRM; and proof of a formal link between educational institutions and the health establishments used for training. This rule reinforces the idea that the mere existence of agreements does not compensate for the absence of real structure, and that, in its oversight, CREMERS neither interferes with university autonomy nor undermines its public mission of protecting the patient and the future professional.

CREMERS Resolution 8/2025 [20] regulates the procedures for ethical inspections in medical teaching institutions. It establishes deadlines, investigative tools, and possible corrective measures, including the ethical prohibition of training activities in places that do not meet a minimum level of teaching quality. These rules demonstrate the legitimate exercise of the Council's function. They are the result of the Councils' institutional understanding of their supervisory role and exemplify how bioethics can be operationalized in normative acts to guarantee justice and non-maleficence in medical training.

Therefore, the CRMs are recommended to intensify their preventive oversight actions, especially through their own resolutions and normative instruments. Coordinated action with bodies such as the Public Prosecutor's Office, Court of Accounts, and Health Councils can amplify the effectiveness of these measures. In addition, it is necessary to promote dialogue with civil society and educational institutions committed to ethics and excellence to foster a culture of co-responsibility in medical training. Finally, the CFM must consolidate national guidelines that support the actions of the CRMs, to ensure uniformity, legal backing, and legitimacy to oversight actions.

The ethical prohibition on medical education is one of the instruments provided for in the CRMs' actions. This is an exceptional measure, which should be applied when the practice fields or training conditions offered by educational institutions jeopardize the integrity of the future physician's training and, consequently, the safety of patients. It is an ethical sanction, provided for in the Councils' internal regulations and justified by the understanding that poor medical training increases the risk of future ethical infractions, thereby serving a preventive purpose.

It is important to emphasize that the ethical prohibition on teaching does not exceed the legal functions of the Councils, as it is not direct interference with the educational institution but rather an ethical prohibition on physicians from carrying out teaching activities in places that do not meet the minimum conditions required for adequate medical training. Thus, the focus of the sanction is the professional conduct of physicians linked to the training process, rather than the university's structure itself. The objective is not to punish the institutions, but to protect society against the perpetuation of inadequate training practices.

It also aims to protect medical students, since medical schools, being subject to inspection, will seek to address the legal and ethical aspects of medical training. Another important point to remember: medical care should not be reduced if inspections impede medical education, since medical students are not qualified to provide it.

The Code of Medical Ethics [6] establishes, in its preamble, that the focus of all the physician's attention is the health of the human being. Allowing poorly trained professionals to enter the market betrays this precept. In addition, the National Education Council (CNE) [21] requires that courses have consistent hospital partnerships and medical faculty with practical experience. When these guidelines are ignored, the CRMs, as defenders of society, must act. The oversight role of the Medical Councils does not usurp the competencies of the Ministry of Education, but complements them from the perspective of ethics and the protection of society. This is a finalistic oversight approach, focused on the real impact on healthcare rather than merely on bureaucratic requirements.

Final considerations

The CRMs' oversight of medical training is not only legitimate but essential. As demonstrated, the Brazilian legal system contains ample normative content that entrusts the Medical Councils with ensuring the proper technical and moral performance of medicine. Given the risk to medical education under inadequate conditions, the CRMs must exercise their protective function in accordance with legal, ethical, and bioethical principles. Defending the quality of training is not a corporate act, but an imperative of social responsibility. Ignoring this duty is to close one's eyes to the errors of the present that will cost lives in the future.

In short, the legitimacy of the oversight role of the Medical Councils stems simultaneously from three pillars: the normative framework, where oversight finds explicit foundation in Law 3,268/1957 [2] and its regulation (Decree 44,045/1958) [22], as well as in the Medical Act Law (Law 12,842/2013) [5], which subjects the act of teaching medical subjects to ethical supervision; the principles of bioethics, since the intervention is essentially guided by non-maleficence (avoiding harm by preventing medical malpractice, which increases the risk of medical errors); and institutional responsibility, since the Councils, as federal autonomous entities, act as guarantors of healthcare safety and the quality of medical training, fulfilling their mission of protecting society.

Therefore, the oversight of medical education conditions constitutes the inalienable exercise of the police power granted to the Councils to ensure that the ethical pact of medicine is maintained from the professional training stage, thereby defending the patient's life and health as supreme legal rights.

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Contribution of the authors
Eduardo Neubarth Trindade participated in the study conception, research, writing of the original manuscript, writing, revision, and editing. Tania Furlanetto, Manoel Roberto Maciel Trindade, Bernard Rodrigues Netto, Juliano Lauer and Márcia Vaz participated in the research, writing of the original manuscript, writing, revision, and editing.

Data availability: All data used or generated in this study are described and presented in full in the body of the article.

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