Bioethical aspects of the social security medical expertise

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Abstract The physician-patient relationship is guided by mutual trust and, on physician's side, by concerns with beneficence, non-maleficence, justice, and respect for autonomy, present in variable proportions at each assistance, according to the principialist bioethics. Aiming at dimensioning relative representativeness of each of the four principles in expert-investigated relationship, one hundred and eighteen experienced social security medical experts from 20 Brazilian states were surveyed, through questionnaire. The result showed that, in social security medical expertise, in legal medical procedure, whose purpose is the recognition of rights to social security benefits, experts have little concern about being beneficent and, in any way, they are not concerned with the autonomy of the applicants' will. The predominant concern showed by medical experts was the correct application of legislation, while it not possible to state that guiding principle of justice was the predominant concern.

Key words: Personal autonomy. Bioethics. Vulnerability. Health policy, planning and management. Authoritarianism. Physician-patient relations. Coroners and medical examiners.

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Medical investigation is the medical procedure designed to gather evidence. It is not directed to any therapeutic purpose, which fundamentally distinguishes it from most other medical activities. As such, it is the greatest act of asymmetry of power between physician and patient, better called here an evaluation subject, to the extent that there is no exchange, but collection, an almost unilateral flow of information.

In terms of medical investigations, the physician-patient relationship has not been studied much. Moreover, there are those who deny that there even is a physician-patient relationship in the forensic context [1]. In a diametrically opposite sense, there are those who are unable to understand the peculiarities of investigative medicine in relation to medical practice and, in so doing, invested with power as

public officials, increase the potential misunderstandings and conflicts that, to some extent, are inherent to the investigative activity and arise from expectations dissociated from the real goal of medical investigations. Managers who have more welfare-related characteristics tend to want more beneficent investigations, and may even raise expectations to that effect among users, encouraging conflict between experts and evaluation subjects

Ethics is one of the categories of mind and human thought, such as logic and aesthetics [2]. Segundo Nunes, ética nada mais é do que o livre exercício do raciocínio, característica suprema do ser humano [3]. Each member of the community has the task of ensuring that these arguments are converted into rules that can take outlines of moral principles[3]. In daily life problems we have to find arguments to justify the correct orientation to take, i.e. what is the foundation, the reference point of the values that as a community we believe are essential [3].

The technique itself is ethically neutral and the objective and consequences of its use define their ethical boundaries [4]. The expert, in interaction with the evaluation subject is not a mere applier of technical standards for social security legal medicine, reason why he is not a technical but a judge, and his attitudes can be analyzed from the standpoint of bioethics. Knowing how medical experts from the National Institute of Social Security (INSS) perceive themselves in this scenario that includes ethics, science and interpersonal relationships is the goal of this study.

Research Methodology

For this descriptive qualitative and quantitative research article, 458 medical experts at last career level [5] were asked to complete a structured questionnaire and to choose from among four principialist bioethical principles by Beauchamp and Childress [6] the one that they most value in daily investigative activity. These professionals, for over 25 years in the activity, pursue graduated courses in Social Security Medical Skills at Pitagoras Faculty, by agreement between that institution of learning and the INSS.

To apply the questionnaire, the site *www.kwiksurvey.com* was used. The *kwiksurvey* questionnaire allows only one access (blocked by IP), accepts only those invited by email and its questions are not numbered, but presented randomly. We asked medical experts to mark the option that best matched their main concern when performing investigations, from among the possibilities below. It was stressed that the four options were legitimate, there was no wrong answer, assuming that the expert decisions are correct and legal.

My concern is to do what *is best* for the applicant;

My concern is to do what is more correct in terms of *legislation* and standards;

My concern is to understand what the applicant needs, focusing the expert's decision on his *will*;

My concern is to make a decision that *will not deny the rights* of the applicant.

The questions sought to correspond, respectively, to concerns about beneficence, justice, autonomy and non-maleficence, the definition of which in the instrument will be detailed below

Those who replied were sent an e-mail with a supplementary question for free and dissertational answer, justifying the previous response. By participating the expert consented to the disclosure of the results, being protected their confidentiality and privacy. The project was submitted to the Ethics Committee of the Belo Horizonte INSS Executive Management and approved without reservations.

Objectives

To check the extent to which welfare medical experts consider the bioethical principles of autonomy, beneficence, non-maleficence, and justice in their interactions with the investigated subjects and application of social security standards.

From this diagnostic, the work aims to bring to debate the posture of the medical expert and his social integration, understanding it from the appreciation of bioethical principles that take on different proportions when faced with concrete cases. From the result we will be able to infer the behavior of the medical examiner and his sensitivity to these four principles that, to some extent, always guide along with physician's conduct in face of any patient.

Working hypothesis

Welfare medical experts probably prioritize justice as a guiding principle of their activity, since they have a mission to collect evidence and, immediately, to *judge* whether it is in conformity to the legal framework required by the applicant. Like any trial, the text transcends from the norm and takes into consideration the perception of justice in recognizing the right with considerations that belong to the bioethical thinking. Thus, it is also likely that little consideration is given to the autonomy, a principle that is increasingly valued in the current therapeutic relationship,

Table 1. Distribution of medical experts surveyed by Federate unit

Alagoas	1	Pernambuco	6
Bahia	2	Piaui	1
Ceara	1	Paraná	2
Distrito Federal	4	Rio de Janeiro	14
Espirito Santo	3	Rio Grande do Norte	3
Goias	3	Rondonia	1
Minas Gerais	17	Rio Grande do Sul	17
Mato Grosso do Sul	2	Santa Catarina	8
Mato Grosso	2	Sergipe	2
Paraiba	5	Sao Paulo	24

beneficence and non-maleficence, the latter very present in more paternalistic relations of past century medicine.

Results

The 118 medical experts who answered the questionnaire were distributed according to the following units of the Federation: Table 1.

As for the answers, 79.66% (94/118) were concerned with justice, 19.49% (23/118) with non-maleficence, 1.69% (2/118) with beneficence and with none with autonomy.

The answers to the open question of the survey are presented below by the speeches of some professionals that reflect the opinion of the vast majority:

> *"We are experts and as such we must act within the ethics that guides our function. Preserving what is just providing benefits to those who really have the right and try not to benefit those who try to circumvent the law. We are governed by rules and laws and we can not dodge them. There is no sense in doing benevolences with resources of the government which are due to the contribution of all Brazilian citizens involved in the socioeconomic and cultural development of our country"* Santa Catarina.

> *"The medical expert's activity must take into account the Hippocratic maxim 'primum non nocere'. First do no harm - because it permeates the justice to both the insured and to the Institute. In trying to be 'fair', the expert must always take into account the law and the legitimacy of the request of the insured, paying attention not to become charitable enough as to grant what is not legal, because there are other possibilities for the insured to reaffirm his request and in the case of benevolence, the squandering of public assets can be initiated"* Rio Grande do Sul.

> *When I started I had a very different attitude than the one I have now. After being called to the internal affairs office once for failing to put in an investigation in system that was favorable to the insured in court, and that the institution has treated me as if I were a criminal, I felt on my skin the extension to which the institution does not protect its employees. You are alone in this work of medical investigation. So today, I try not to get involved with the insured. I treat him very well, say good morning, good afternoon, I explain everything that he can understand, but I follow the rules to the letter"* Pernambuco.

> *"When the expert performs his examination he has no personal commitment to the investigated subject. He is doing a medical-legal act where there is his interest (investigation subject) against the whole society that is willing to help him, during a misfortune that prevents him from obtaining the needed gain for his livelihood. So, there isn't an individual concern, but a social one in the outcome of the investigation. This is the engagement of an expert: to do the balancing of individual rights against the collective" Sao Paulo.*

"We are not paid to do charity, nor for politics or for catering to private interests. We are paid by the population to practice justice, i.e. those who are entitled to the benefit have to get it and those who do not can not burden the public coffers. Often I am moved by the stories that are told by the insured, but do I not think it is honest to invent an inability, for him to get money for food. I think the government should have a separate budget to take this assistance to the hungry and those who owe money, but it is not right for us to lie, just to give a benefit, since this is a fraud, a lie, a crime (...) Once I heard from a prosecutor during a meeting in which I childishly said I felt pity for these people (...), who sharply told me, 'Doctor, you are not paid to feel pity', you are not paid to do charity, this you should do with your money, you are paid by the people to promote justice and that is what I believe. I feel bad when I hear news of fraud. I loathe those who commit it, find them unpatriotic" Sao Paulo

"We are employees of an insurer to which all contribute monetarily by providing benefits the rules for the obtaining of them are governed by laws and regulations. The medical expert must be knowledgeable of these regulations and abide by them. We have to give benefit to those eligible and deny it to those who aren't. The population lacks welfare education, they often start their contribution in advanced age, with a disabling disease, not knowing their rights and duties. The expert is not entitled to do charity, but to assert the rights and duties" Goias.

In the exercise of medical expert activities we are submitted to the Ethics Code, In the exercise of medical expert activities we are submitted to the Ethics Code, Civil Code, Criminal Code, laws and regulations of Social Security. Given that the insured searches for a benefit, and involved in so many responsibilities, ethics, civil, criminal, etc., it is really not easy to also meet the principles not to do harm, do good, respect the will of the insured. In preparing a medical investigation report I always think to seek evidence to a truthful, just conclusion. In my opinion, a correct, impartial, and legal opinion is not characterized as 'maleficent' or 'not benevolent'. As for the 'will of the patient', depending on their degree of knowledge about their rights and duties before Social Security. In short, everything depends on the expert's point of view - 'I acted correctly, did not alter data to deny or grant', and on the evaluation subject's -'my intention was (or not) served' Santa Catarina

Discussion

Bioethical principles

Under the primordial focus of research involving humans, several ethical codes were created and have proven insufficient, as the Nuremberg one [7] (1947), the Declaration of Helsinki [8] (1964 and 1975), and the 1975 U.S. guidelines the committee of which, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, established in 1974, later produced the Belmont Report[9] in 1978 - which has presented the ethical principles considered basic that should guide the biomedical research involving human subjects:

a) the principle of respect for the person, b) the principle of beneficence, c) the principle of justice.

In 1977, in the first edition of the Principles of Biomedical Ethics, Tom Beauchamp and James Childress [6] developed the principlist theory and based it on four principles: autonomy, beneficence, non-maleficence, and justice. These principles are rooted in the history of philosophy or in the tradition of medical ethics, from which they earn their justification. Although there is no hierarchical arrangement among them, autonomy seems to have the preference among the defenders of the principialist theory[10].

Traditionally, principles are *drivers* or *action guides* that summarize and encapsulate a whole theory, as does the principle of utility to utilitarianism. Principlism seeks to give basis to bioethics from its principles, and thus being a pluralistic theory by adopting four formulations. Beauchamp and Childress argue the *prima facie* validity of the principles. *Prima facie* principles can only be breached if another principle or obligation of equal force opposes to them in a particular situation. However, the authors assert that there is no hierarchy, since at first everyone has worth and should be respected, except when other reasons are strong enough to demand the adoption of another principle or moral standard that they conflict with[11].

Beneficence in the medical context is the duty to act in the patient's interest [12]. Thus, the term beneficence is understood broad way in ethical theory, as it includes all forms of action meant to benefit or promote the welfare of another person. Morality requires not only that we treat people independently, refraining from causing them harm, but also that we contribute to their well-being [6]. Authors argue that while many acts of kindness are optional, the principle of beneficence refers to the moral obligation to act on behalf of others [6].

Beneficence and benevolence are present in the different moral theories. For Beauchamp and Childress [6] the requirement to produce benefits, avoid damages, and weight the costs and benefits of actions is central in moral life. The theory of moral sentiment of David Hume, for example, extolled the benevolence as a core principle of human nature, associating it with the goal of morality itself. For Pellegrino and Thomasma[13], medicine, as a human activity is, by necessity, a form of beneficence.

Beneficence and non-maleficence should be distinguished, also being important not to confuse beneficence with benevolence, which is the virtue of being willing to act in the benefit of others [6]. A beneficent action that may result from another that has produced harm to someone may not be morally defensible; however, as the principles of beneficence and non-maleficence are not ranked, harmful actions that justifiable involve setbacks for other interests are not necessarily wrong [6]. Drumond [14] Drummond 14 argues that medicine and

physicians strongly impregnated with the beneficent paternalism of Hippocrates, whose oath is still a tradition in almost all the graduations of physicians.

As stated by Gert et al [15], patient is identified. Thus, beneficence - and non-maleficence - are present in paternalism and explicitly expressed in paragraph 2 of the Hippocratic oath: *I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone. I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan; and similarly I will not give a woman a substance to cause an abortion*[16].

Paternalism requires beneficence, or at least benevolent intention; in turn, the exercise of the principle of beneficence does not necessarily require paternalistic attitudes. Hurwitz and Richardson [17] state that one purpose of the medical oath is to *declare the core values of the profession and to produce and strengthen the necessary resolve in physicians*. These core values are under constant review and need to be rethought by the new members of the profession [18].

One of the oldest and most fundamental pillars of the medical profession is the obligation to act in pursuit of the benefit of the patient, *bonum facere*. That the first and primary duty of the physician is to his patient[19] there is no doubt. Physician's commitment of the should always be to the welfare of patients and their best interests, whether it be in the prevention or treatment of diseases or even helping them to cope with the disease, sequelae and death [19].

Physician has been recognized and accepted as the guardian who uses his expertise to the benefit of his patients, including unilateral decisions about what is effective, but political activism in health, the democratization of information and the emergence of other professions on the list of health care brought intriguing twists in the last two decades [20]. These manifestations of patients' rights have many implications, and to some extent, contradictory to the medical authority [20]. For the author, the American public appears ambivalent about the medical authority and segments of society differ in their expectations of the doctor-patient encounter, attitudes towards physicians and level of trust and disillusionment with the profession.

Autonomy is obedience to the law we prescribe to ourselves, as Rousseau says, and this is what is being free. Autonomy in the Kantian view, is the power of oneself on oneself (freedom), but through the mediation of a law (nomos) that reason imposes on itself, which is the moral law. Autonomy and freedom are supportive, but not coincident. Whoever does evil, acts freely, but without autonomy: he submits himself freely to that part of him that is not free, their instincts, passions, weaknesses, interests, fears [21].

The recognition of human dignity and human right to freedom inscribe the concept of autonomy in the daily *praxis* of contemporary societies. Therefore, the principle of autonomy, the name by which is known the principle of respect for persons, requires that they self-rule, i.e. that they are autonomous in their choices and actions, although within the idea of full respect for autonomy, perceived as a concept of respect for the other[22]. The doctrine of human dignity that underlies the principle of the autonomy of the person, who is able to discuss their personal goals and act in such a way that is both more autonomous and better the more it is capable of self-determination in an intellectual and affective way, voluntarily[10]. The respect for autonomy has become to give the patient the right to share with his physician the responsibility in making clinical decisions, overcoming the paternalistic vision of the physician in his relationship with the patient [10].

The modern concept of respect for patient autonomy is unparalleled in Hippocratic medicine, which is based on the concept that the patient does not know what is good for him [23]. The Brazilian Medical Code of Ethics, for example, prohibits physicians from *failing to obtain consent from the patient or his legal representative after clarifying him on the procedure to be performed, except in case of imminent risk of death* (art. 22) and also forbids the *failure to ensure patient the right to decide freely on their person or welfare, as well as exercising his authority to limit him* (art. 24) (Federal Council of Medicine, 2010). Therefore, the same code of ethics which contains ancient Hippocratic precepts makes reference to the principles of bioethics, such as informed consent, confirming the assertion of McNeill [18] as to the constant review of core principles and values that characterize medical ethics.

Beauchamp and Childress principialist bioethics states that biomedical conducts take into account four basic principles, present in greater or lesser extent [6] in every physician-patient relationship that involves decision making, so therefore it would succeed also in the medical-investigative relations. Accordingly, as emphasized Montejo et al [24], the bioethical principle of *justice* would be prevalent: *Patients' desires and physician's trend to seek for the greatest benefit bump into the responsibility that physician has, who manages public funds, to look for a fair distribution of resources that society places at his disposition. If there is not clear indication for the sick leave (it is not maleficent to discharge patient), the principle of justice that seeks for the common good should prevail over autonomy and beneficence and, thus, we should not provide sick leave for social reasons.*

The collective responsibility of the physician before the particular interest of his patient, even when a collective means his own family, falls within the meaning of justice for the application of available financial resources, the equity in access to public services. For Nunes, the principle of respect for the equal dignity of human beings is also the basis for genuine social justice of material

resources for health [4] and to the social security service, I add for the same reasons. Thus, the ethical principle of justice also involves choices that are effected in accordance with criteria of transparency, i.e., according to the principle of public accountability [25]. According to Daniels and Sabin [26] resource allocation for health is one of the most important ethical problems of today and it is up to physicians, in particular, to apply ethical principles that reflect the *distributive justice*. According to Snyder and Leffler [19], *considerations of justice must be done by the physician as a citizen in their clinical decisions about resource allocation. The principle of distributive justice requires that we seek to distribute equitably opportunities for improvement of life provided for health care and, by extension, to pension funds*. The medical expert, on the condition of public expenditure officer, dose not have nor should have a preoccupation to contain costs; but to rationalize costs, which can be achieved through the pursuit of fair and unbiased expert assessment.

In a study on the expert decision in Social Security, Melo and Assunçao, quoting Dworkin, remember that *faced with a specific case, the principles can be confusing, conflicting, and the operator of the law balances the weight of each principle involved in that situation. Therefore, the decision is not an accurate measurement. Often the judgment may be controversial among law enforcement officers, due to the different valuations of principles between these actors*[27].

Insertion of welfare medical investigation

As administrative procedure inserted in public service, the welfare medical investigation must meet the constitutional principles, especially the principles that guide public administration listed in Art. 37 of the Constitution [28]. Of these, we highlight the principles of legality and morality. Legality is understood as the acts of the public servant must be substantiated and justified by relevant laws, while morality must be a remedy for legal shortcomings or guide interpretations by the applicator of the norm. The constitutional principles of legality, impersonality, morality, transparency, and efficiency as well as bioethical principles may conflict in certain situations, leaving it to the medical expert server to register the grounds for his decision, particularly in the case of value judgments, as work capacity.

As an example, the repeated appearance of the same applicants for sick pay, without any restriction and in the same instance after repeated rejections, besides violating the constitutional principle of efficiency [28] make explicit distorted goals as to the purpose of disability allowance, a socio-cultural reality in Brazil. It is for the expert to apply the principles of justice and morality against situations that affront the equity in access to public financial resources and hone in identifying welfare fraud attempts.

As exemplified by Beauchamp and Childress, social benefits must be

distributed with criterion and not as a lottery[6], and highlights the guiding characteristics such as accessibility, qualifications, merit, experience, contribution, need, privation and effort [6].

Justice, as a bioethical principle applied to the subject of this article, means equality of access to benefits for employment disability. Although the structured questionnaire used in this work does not ensure full understanding by the respondents, the open responses indicate a concern for meeting and interpret rules, applying them in pursuit of equality.

Medical investigation is a medico-legal activity exercised in the context of the INSS for evaluating employment disability for purposes of benefits, at least in most cases. Such experts shall judge the impact of coexisting diseases and social conditions on the work capacity and the possibility of legal framework for recognition of pension rights, which are grounded in work capacity. In exercising this role of judge the expert takes into account technical criteria for valuation, modulated by beliefs, attitudes, training, personality, and other aspects including, even, their personal safety.

The medical investigation procedure consists of a medical procedure the purpose of which is not the patient, at least not primarily. It would therefore be a medical activity that consists in investigating the evaluation subject for other purpose, that of justice. The expert has no commitment to what is best for the examined subject and he is not exactly his patient. In fact, the evaluation subject is perceived before as an object that is a goal for the medical investigation, a perception that, if radical, can lead to excessive impersonal service.

Investigation, as understood here, is a legal medicine tool, a procedure (not quality, *expertise*) of medical action that will collect evidence, will record them in an orderly and formal way as a report, whereby the medical knowledge applied to the case translates into understandable terms and language that provide evidence supporting the arbiter to act in a judicial or administrative process. What makes a physician an expert is the fact that he manifests himself through reports (not certified), that will integrate processes for recognition of rights. The expert refers to the authority and his commitment is to truth and justice, unlike the assisting physician, who refers to his patient and has with him the dedication to confidentiality and commitment to the cure or alleviation of suffering. Scientific behavior, impartiality and objectivity characterize the investigations, according to Galvan [29]. It is for the well prepared expert to reconcile the cold and technical features of the expertise approach to the respect dedicated to the evaluation subject. Feeling respected is a central ingredient of perceptions of equity [30], a value that was highlighted in the responses of experts in this work, which, however, have been classified as inhuman in the application of fair trials of disability even by the Minister of Welfare, a trade unionist [31-33]. According to

Campos [34], *one tends to describe as inhuman social relations in which there is a huge imbalance in power and the powerful side exploits this advantage to disregard the interests and desires of the other, reducing him to condition of object that could be manipulated according to interests and desires of the dominant*. It is noteworthy in this sense that the union leaders are calling for a greater sensitivity of the experts to the concerns of those they represent [31].

It would be expected that, because of the asymmetrical nature, almost unilateral, of medical investigation, the charitable concerns and the respect for patient autonomy would not be configured as values highlighted in the attitude of medical experts. However, it is necessary that the expert and the subjects are aware of their roles and, thereafter, can build a relationship less stressful that can have educational, constructive and respectful contours. I consider it essential that the expert takes an empathic attitude that allows the evaluation to subject perceive him as someone who understood their complaints and allegations; in parallel, he has the task of ensuring that the collective heritage is respected, which also belongs to the evaluation subject. I also believe it is possible, in front of legitimate possibilities, that the expert acts in line with the evaluation subject and respects his autonomy by adopting the best decision, that should be explained to him.

Sickness benefit and the disability concept

There is something to be said about the *sickness benefit*, the main social security right that requires medical investigation. For this purpose, the expert must verify diseases and measure the impact thereof on work capacity, i.e., assess the extent of inability for the activity normally performed by the evaluated subject [35]. As you see, it is for the medical examiner to issue their opinion on disability, an always relative concept. Thus, their mission is very similar to that of a judge [36, 37].

How public social security, as defined in the 1988 Constitution,[28] must judge labor disability through its medical experts? Would it be the same way as a private insurer would do? Once the medical investigation for welfare deals with the inability to work, one must seek the conceptual basis of disability, ability, health and disease. Art. 3 of Law 8080 [38], when conceptualizing health, states that some needs such as transportation and access to services, form the core of health:

> *Art. 3 Health has as its determinants and constraints, among others, food, housing, sanitation, environment, work, income, education, transport, leisure and access to essential goods and services; the health levels of the population reflect the social and economic organization of the country*.
>
> *Single Paragraph. Health relates also to actions that,as previous*

sets forth, are intended to ensure people and the collective conditions of physical, mental and social well-being.

By reflex, therefore, they should be considered in an assessment of incapacity[39]. Considering the social dimension of this law to conceptualize health, it is observed that it extends the factors far to consider the risks of the INSS examination to bias the fair and necessary support for assistance. The social sensitivity of the medical expert is an indispensable prerogative to judge apparently similar situations differently, differentiating and making them particular, among other reasons, for social reasons.

The Ministry of Social Security defines itself as *the insurer of the Brazilian worker*. In fact, there is much similarity between social security and insurance contract, once the person has contributed and has coverage of certain events, and some scholars have come to conclusion that one is sort of the other. Actually, there are only similarities, and they are in essence of different species, mainly because insurance brings the idea of contract, linked to private law, while social security is essentially public, given the social consequences of its actions[40].

It is from this social sensitivity that Correa[40] ponders that the social security medical expert must have knowledge that he does not act in an insurer, but in an integral organ of the constitutional concept of *Social Security*.

The therapeutical approach and the expert approach: differences

As Santos says: *Unlike the therapeutic relationship, traditionally based on trust between physician and patient, which is one of the main foundations of the therapeutic process, the medico-legal intervention serves a different purpose, which gives its own appearance* [41]. The following table outlines the major differences between the therapy approaches for medical purpose and those with examination characteristics.

Table 2. Differences between the physician's therapeutic relationship and the welfare

Seeks health	Seeks money
Medical commitment to patient	Medical commitment to justice and truth
Right to health is universal	Welfare support presupposes membership and contributions
Free choice of physician favors the therapy process	Constitutional principle of impartiality forbids the choice of medical expert
Mutual trust is fundamental pillar	Hiding/overvaluation are elements present in applicants' reports
Empathy	Asymmetry
Hidden reason, if any, is usually emotional	Hidden reason, if any, is usually labor/social
Satisfaction = comprehension, listening,	Satisfaction = grant of benefit

Referring to the therapeutic relationship, Ismael [42] says that *if, on the one hand, the physician cannot be cold and distant, on the other, his emotional involvement with the patient can be harmful to both*. *As usual, perfection is in the middle ground*.

This equidistance ensures the authority the impartiality necessary to the therapeutic process, but its gauging is delicate and it needs to be individualized for each patient

Assuming this, it is indisputable that the physician-patient relationship is necessarily asymmetrical [42]. It is in the spectrum of this asymmetry that the physician can lead himself to an authoritarian (when the asymmetry is greater) or more empathic way (when the asymmetry is smaller or when the physician is aware of his role in an asymmetric relation).

In social security medical investigation the balance is to show empathy, listen to the arguments without allowing oneself to be maneuvered or controlled by the evaluation subject who commonly seeks control of care through, for example, exposure of successive documents of little or no interest. The clarification also should be given with courtesy and attention, but without excesses or repetitions that can be interpreted as insecurity. Asymmetry is inevitable in medical investigations, and it may be reduced under the expert's control, favoring good relationship with the examined individual.

Galvao refers to this asymmetry as *verticality in physician-patient relationship*, arguing that *there was a time when the medical opinion weighed above all, his authority was unquestioned exactly because there were no criteria to evaluate these procedures. The professional, then without a direction or course, used to follow a particular 'school' of certain renowned physician* [16].

Nowadays, men eagerly (if not compulsively) seek technology resources, and physicians are no exception, fascinated by new therapeutics and possibilities for therapies. Seduced by the fetish of exercising their power by means of sophisticated machines, they deviate from the principal in the relationship with their patients. Potter says that *as we move into the twenty-first century, we become more aware of the dilemma posed by the exponential increase of knowledge, but unfortunately without a growth in the wisdom needed to administer it* [42]. Excesses in the specialization and division of labor may obscure the physician's perception about himself and the patient [43] and the social security medical expert, highly specialized, also devotes much of his time and attention to the computer in which he registers his computerized report.

In this regard, Salles [44] highlights that the tendency of increasing computerization is to cover all areas of human activity, since the transformations are clear in the area of health care. It is at this point, when there is a clear tendency to ensure the presence of computers and sophisticated technologies in all acts related to medicine, that it is necessary to question whether the results are in harmony with the objectives of the changes, he finds that: *the attitude of producing the maximum possible in the shortest possible time, advocated by the modern capitalist and mechanistic society may prove effective, but it also proves incompatible with the exercise of a medicine based on the principles that guide the bioethical actions of the physician to his patient*[44].

Not least relevant, the burden of daily consultations driven solely by administrative criteria rather than the needs of good technique makes it more difficult for good physician-patient relationship both within assisting and welfare care.

The information in the biological sciences is vast and reaching it, as a goal, drives the physicians away from social life and even from their own patients. The professional must balance his scientific and technical development with his humanistic improvement. *The physician who knows only Medicine knows nothing of Medicine*, wrote Jose Letamendii wisely. For the expert, medicine is a true instrument of social justice and the disease, much more than a biological event, is an event in the biography of the subject, with repercussions on their ability to work with the potential to redirect their professional training and even stop it permanently.

Xavier [45] was concerned with medical education today and wrote that *by exchanging the rich socio-anthropological variables of sick humans for a biologist-only perception, we turn the young medical students into simple 'disease, not sick people, caregivers'*. To explain the phenomenon, Galvão [16] states that *the cult of technology is motivated both by a desire to help the patient but also by the search for prestige, fame and earnings, besides the vain pleasure of being able to manipulate new inventions and newly discovered techniques*.

Siqueira focuses on the issue and concludes that *given this situation, the patient is only a supporting actor and worth of supporting roles, limited in the exercise of their autonomy, as the doctor intervenes on his body as if he* (the patient) *was unable to make decisions* [46]. *It is considered unnecessary to hear him, given that the devices speak for him*. Also according to this author, *the moment demands respect for patient autonomy, spirit of tolerance, humility, and wisdom to build relationships between physician and sick human being more symmetrical* [46].

Historically the patient has always been a passive person without the right to take part in his treatment carried out in accordance with the physician's knowledge, his unquestionable reasons and professional opinion, keeping the patient as a total receiver of what physician determines, wrote Galvao [16], and he continues, *thus Hippocratic medicine always preached a paternalistic beneficence, as some scholars want, by prohibiting the patient any freedom or autonomy under the pretext that 'those who ignore have no opinion, and he who does not know should be silent'*.

On the doctor-patient relationship in which professionals are more concerned with the interesting cases than with the people they serve, which affects the asymmetry between doctor and patient, Ribeiro[47] analyzes *the culture of individualism, characteristic of modern times, also counterposes quality of life to the requirement of other and the person*

(human relations), with its virtues and defects, turns easily into the case (technical relationship) or the interesting case (relation with the intellect, elimination of feeling). And the doctor-patient relationship becomes a power-submission one

The medical expert's autonomy

For decades, medicine is going through profound changes, which bring changes to the role of the physician. In the 70s Haug[48] proposed the term *deprofes-sionalization* to refer to the loss, by physicians, of the monopoly over medical knowledge and authority over patients [48]. Since then the author highlighted as causes, from organized social movements to skepticism as to physicians and access to medical information, *narrowing the gap of knowledge between physicians and patients*. Fifteen years later, she reiterated that physicians' monopoly of knowledge had been challenged by computer technology, unimaginable in the 70s, and the increasing improvement of the educational qualification of the population. She even affirms that *their authority has eroded as patients adopt a more questioning attitude toward medicine* [49].

Today, the medical profession has difficulty even in defining itself legally in Brazil, as evidenced by the debate on Senate Bill 262/02, aimed at defining medical action [50]. Uncertainties such as this and the medical profession crisis impact in the ability of the medical expert to post himself as an agent of health and to make the expertise a point of encounter and exchange. The applicant, in turn, has the specific goal of obtaining a pecuniary benefit, and often detains detailed information both about his alleged illness and about the benefit required. There is no room for meeting before the objectivity of interest both of the expert and the evaluation subject. Without having autonomy even to determine the time to be allocated to investigations, medical investigation is similar to the medical care that Potter and McKinlay [51] mock when comparing the empathy of a physician's consultation today to what happens in a shoe store or with the taxi driver & typical consumer relationships.

Montejo *et al* [24], describing the Spanish model of management of medical leaves, points out that it creates conflicts of interest (*conflicto de lealtades*) in the responsible physicians, for they accumulate the expert role with assistance to patients, *especially when socio-economic problems befall that often produce distress in professionals (...) intense discomfort when we give an welfare discharge that involves termination of the grant a worker one has known for years receives and whose personal and family needs as well as the labor situation of unemployment, are known to the physician*.

The Spanish model is contradictory, since it considers the removal (*baja laboral*) a part of the therapeutic arsenal, but only those of *los facultativos de la Seguridad Social*; not of private physicians (except for labor accidents, in which mutual

physicians may discharge from work). Such a conflict would not be possible in Brazil, where the Code of Medical Ethics prohibits in its art. 93 exercise medical investigation of one's own patient, exactly to ensure the independence and impartiality essential to the medical expert: *Being an expert or auditor of one's own patient, of person in one's family or any other with which one has relationships that can affect one's work or of company in which one acts or has acted* [52].

Medical investigation in welfare is eminently to characterize the presence or absence of labor disability for Social Security, local authority acting as compulsory insurer of the ability to work as usual. Not being a physician-patient relationship with the assumptions of mutual trust, it is more likely that the manifestations of alienation and authoritarianism, which are identified even in the Propedeutics physician-patient relationships and even in the therapy ones, are pontentialized.

Almost all of the benefits paid by the Brazilian social security system are compensation for the inability to generate income as a result of incapacity by age, motherhood, incarceration, illness or disability. Thus, the legal and social asset insured by Social Security is the ability to work. Disability, in any sense, it is trial, considering it doesn't exist as a concept *per se*, but is always related to some ability; and it is for the expert to verify whether the concept applies to the case he examines, that is, transcends the main nosologic diagnosis and takes into account other comorbidities, social aspects and personal and ideological beliefs of the medical expert himself. The name *sick-support*, if were not enough the already inevitable difficulties, leads to mistakes by suggesting that it is the disease and not the disability, what Social Security aims to support.

Due to training, inexperience or personal beliefs, experts may have more legalistic attitudes or more sensitive to the social components that comprise the concept of health [33] and, by reflex, that of sickness and disability. Some are authoritarian and other empathic and their personal attitudes can result in various medical expert conclusions.

Drumond [14] argues that *medicine and physicians are impregnated strongly with the Hippocrates' beneficent paternalism,* whose oath is still a tradition in almost all graduations of doctors. We must distinguish, also, when the paternalism results from a physician-patient relationship of trust and understanding, in which the doctor exercises his authority in favor of what he believes is best for the patient. When, on the other hand, the physician does not build an empathetic relationship with the patient, is concerned strictly with the disease, tests, technologies and his own time, he may more easily be taken as authoritative, even if being beneficent. Thus, I think it is important to distinguish authority from authoritarianism in the beneficent and paternalistic physician-patient relationship,

for it is known that the medical authority is crucial for a successful treatment

According to Margotta[53], Paracelsus claimed that *the personality of a physician may have more influence on patient recovery than any medicine*. Ismael[42] writes that there are three types of physicians, those who studied medicine, those who were born physicians and the physicians who were born and were fortunate enough to study medicine, because the art of healing transcends scientific knowledge and, therefore, derive from the harmonious balance between the talent of the professionals, their training and the *human capital* emanating from those who have a natural vocation to cure or alleviate the suffering of their fellows. The physician-patient relationship is built on the basis of a bilateral agreement, claim Leffe and Snyder [19], where there must be mutual understanding, both of the medical expert as of the evaluation subject on what it is and what is the aim of the social security medical investigation.

Final considerations

Medical investigation, here understood as a procedure, medical-legal act, includes rather peculiar aspects of the physician-patient relationship, to the point of not being referred to as such, being preferred the reference to the expert-evaluation subject relationship. It is a medical procedure where the relationship has in power asymmetry a striking feature, in which the examined has the role of providing input so that the expert's conclusion is favorable to their claims when requiring a social security benefit. This asymmetry is evident in this study where none of the medical experts interviewed expressed concern mainly with the autonomy of the evaluation subject, setting up, the majority, in deciding in a fair and equitable manner as for the right claimed. It seems unnecessary that social security education of population, medical experts' continuing improvement and government understanding of the differences between therapeutic and investigative medicine take into account the recognition and the perception of inevitable peculiarities (and some, not as much) of the medical expert-evaluated subject relationship as a way of reducing the tensions inherent in asymmetric interpersonal relationships. Social security education is presented as a way to provide justice through better-informed decisions and better understood by applicants, stream-lined among public social security compulsory user population, as well as physicians in general, to ensure equitable application of always limited resources. This bioethical principle, of outstanding importance in social security expertise, must be the goal to be pursued by society as a whole.

Resumen

Aspectos de la bioética en la gestión médica de las bajas laborales

La relación médico-paciente es guiada por la confianza mutua y, de la parte del médico, por sus preocupaciones de beneficencia, no maleficencia, justicia y el respeto por la autonomía, presente en proporciones variables, de acuerdo con los principios bioéticos propuestos por Beauchamp y Childress (1979). Ciento dieciocho expertos médicos de la seguridad social brasileña, de 20 estados de Brasil fueron encuestados usando el cuestionario a fin de ampliar la representación relativa de cada uno de los cuatro principios en la relación de expertos con sus examinados. Los resultados mostraron que los conocimientos médicos en la seguridad social, procedimiento médico legal que tiene por objeto el reconocimiento de los derechos de seguridad social, los expertos se preocupan poco de ser beneficientes y de ninguna manera con la autonomía de la voluntad del demandante, el principio rector de la justicia es lo predominante.

Palabras-clave: Autonomía personal. Bioética. Vulnerabilidad. Políticas, planificación y administración en salud. Relaciones médico-paciente. Autoritarismo. Médicos forenses y examinadores.

Resumo

Aspectos bioéticas da perícia médica previdenciária

A relação médico-paciente pauta-se pela confiança mútua e, da parte do médico, por preocupações beneficentes, não maleficentes, justiça e respeito à autonomia, presentes em proporções variáveis em cada atendimento, segundo os princípios da bioética principialista. Com a finalidade de dimensionar a representatividade relativa de cada um dos quatro princípios na relação perito-periciado foram pesquisados, mediante questionário, 118 peritos médicos previdenciários experientes de 20 unidades da Federação. O resultado revelou que em perícia médica previdenciária, ato médico legal cuja finalidade é o reconhecimento de direitos previdenciários, os peritos pouco se preocupam em ser beneficentes e em nada se preocupam com a autonomia da vontade do requerente; a preocupação predominantemente demonstrada pelos peritos médicos foi a aplicação correta da legislação, não se podendo, entretanto, afirmar que o princípio norteador predominante foi o da justiça.

Palavras-chave*:* Autonomia pessoal. Bioética. Vulnerabilidade. Políticas, planejamento e administração em saúde. Relações médico-paciente. Autoritarismo. Médicos legistas.

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