# Knowledge of physicians in the state of Sao Paulo regarding the Code of Medical Ethics

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**Abstract**

In force since April 13, 2010, the Brazilian Code of Medical Ethics (CEM) updated the 1988 document, improved the writing of articles, inserted new contexts and highlighted the fundamental principles of ethics. The article, besides addressing historical aspects and considerations on the new Code of Ethics, concludes that there was wide acceptance by doctors, strengthening its usefulness as a source of permanent consultation. One year after starting to be effective, CEM was already part of doctors' daily routine, with everyone being aware of its publication and most of them would already have consulted the code three times in average, according to primary survey data carried out by the Regional Medicine Council of São Paulo State, analyzed by the authors.

**Key words:** Codes of ethics. Ethics, medical.

**Resumo**

**Conhecimento dos médicos do Estado de São Paulo e considerações sobre o Código de Ética Médica**

Em vigor desde 13 de abril de 2010, o Código de Ética Médica (CEM) brasileiro atualizou o documento de 1988, aperfeiçoou a redação de artigos, inseriu novos contextos e destacou os princípios fundamentais da ética. O artigo, além de abordar aspectos históricos e tecer considerações sobre o novo Código de Ética, conclui que houve ampla aceitação pelos médicos, reforçando sua utilidade como fonte permanente de consulta. Um ano após sua entrada em vigor, O CEM já fazia parte da rotina dos médicos, sendo que todos estavam cientes da sua publicação e a maioria já havia consultado o código, três vezes em média, segundo dados primários de levantamento feito pelo Conselho Regional de Medicina do Estado de São Paulo, analisado pelos autores.

**Palavras-chave:** Códigos de ética. Ética médica.

**Resumen**

**El conocimiento de los médicos del Estado de São Paulo sobre el Código de Ética Médica**

En vigor desde el 13 de abril de 2010, el Código de Ética Médica (CEM) brasileño actualizó el anterior, del 1988, perfeccionó la redacción de artículos, introdujo nuevos contextos y destacó los principios fundamentales de la ética. Además de abordar los aspectos históricos y hacer análisis sobre el nuevo Código de Ética, el presente trabajo llegó a la conclusión de que este fue ampliamente aceptado por los médicos, fortaleciendo su utilidad como una fuente permanente de consulta. Un año después de su entrada en vigor, el CEM ya formaba parte de la rutina de los médicos, siendo que todos tenían conocimiento de su publicación y la mayoría ya lo había consultado tres veces, en promedio, según datos primarios de un estudio hecho por el Consejo Regional de Medicina del Estado de São Paulo y analizados por los autores.

**Palabras-clave:** Códigos de ética. Ética médica.

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Authors declare that there is no conflict of interest

Research article

Result of intense debate and wide public consultation, the updating of the Brazilian Code of Medical Ethics (CME), in force since April 13, 2010, has preserved the essence of the previous Code, of 1988, emerged in the wake of the social achievements of democratization which in turn resulted in the Federal Constitution (FC), and in the consecration of human dignity, fundamental rights, the rule of law, freedom, equality and justice.

The revision of the CME was approved in August 2009, with the participation of around 400 delegates, among whom federal and regional medical advisers, members of trade unions, societies of specialties, representatives of other medical entities and experts in ethics and bioethics. The reviewing process also included three national conferences on medical ethics, receiving 2,677 suggestions in public consultation over the internet from physicians, other healthcare professionals and organizations from organized civil society.

In relation to the previous one, the new text has perfected the writing of articles, removed dark or duplication points, entered new contexts and highlighted the fundamental principles of ethics. It met what is expected of a Code that can be defined as the set of standards of conduct morally accepted and expected by the social group that drafted it, circumscribed in a given historical moment and devoted to maintain, promote and preserve the prestige, the unity, the values, the duties and the virtues of the medical profession [1, 2]

CME is thus a product of the "normative ethics" that seeks to answer the question: what are the *general rules that should be morally accepted - and for what reasons - for guidance and evaluation of the doctor's professional conduct*? Or even a product of "practical ethics", which makes use of general theories used in moral judgments and evaluations of specific conduct, applied in several fields, notably in public policies and in professions [3, 4].

Many ethical issues arose from the evolution of knowledge and practices in medicine over the last past decades. In addition to paying attention to the social, legal and scientific changes, the revision of CME by the Federal Council of Medicine (CFM) considered the ethical codes of other countries and absorbed elements of jurisprudence, positions that make up opinions, judicial decisions, definitions of local ethics committees, as well as ethical decisions of regional councils and of the CFM itself and regional councils of medicine (CRM). To the traditional codes of medical ethics, like the Hippocratic Oath, and bioethical principles of medicine, especially compassion, beneficence, non-maleficence, respect for people and the justice, concepts and theories related to human rights and recent bioethical discussion were also added.

A code of ethics cannot be determined only by the medical profession. It must be able to absorb the regulations governing the society in which medical professionals are inserted [5]. The CME is, therefore, subject to the Constitution, the laws, moral requirements and the ethical concerns of the Brazilian society. It thus responds to the demands of a democratic conception of professional responsibility, which involves the ethical dimension, but also the social and political philosophy, [6]

In addition to addressing the historical aspects and considerations on the CME, the following is presented as data from survey on its knowledge and use by doctors.

## Method

For the critical analysis of content, historical aspects, comments and considerations on the CME, this article has held national and international literature review from a search in the PubMed and Bireme databases. To assess the level of knowledge and use of the Code by the doctors, we used the database of the Regional Council of Medicine of the State of Sao Paulo (Cremesp) concerning the quantitative opinion survey, conducted by the medical institution in that state.

With telephone approach of respondents, as structured questionnaire, the study collected the opinion of Sao Paulo doctors in a probabilistic sample of 644 members, representative of the population of 103,695 doctors acting in the state. The selection of the sample was proportional to the strata of sex (male/female), age groups (25-34, 35-44; 45-59, 60-80 years) and region of operation or domicile (capital, greater Sao Paulo and interior). The fieldwork was conducted between February 16 and March 11, 2011. The research done by Cremesp included issues related to job satisfaction, opinions and relationship of physicians with institutions. This article used data generated by research pertaining to the Code of Medical Ethics

## Historical aspects

In addition to creating instances of self-regulation, setting ethical rules of access and perma-

nence in the profession, doctors have, over time, to draw up codes of conduct to be followed by their peers. These are ethical rules for professional conduct generally recognized by the state and accepted by society. Thus, it emerged the medical statutes in Belgium (1849), England (1858), France (1892) and Germany (1935), among others. When addressing ethical precepts and establishing the place of medicine, they intended to oppose to any outside administrative power that tried to regulate and interfere in medical practice.

In Brazil, the first record of conduct dating back to 1867 was a translation made by the Medical Gazette of Bahia, of the code of the American Medical Association (AMA) [7]. At that time, it was significant in the whole world the influence of Thomas Percival, author of Medical ethics. This seminal work, considered the initial milestone of medical ethics, was written in 1792 and published in 1803 as a hospital regulation of England - the Manchester Royal Infirmary.

Percival had the task of defending a more normative ethics, while preserving the doctrinal foundations of Hippocratic ethics. Without abandoning the virtues, he added professional rights and obligations. In 1948, with the creation of the World Medical Association (AMM), the international code of medical ethics was published, guided by the medical standards of conduct in various countries [8].

Besides the AMA code (1867), Brazil had subsequently with other translations - as performed by the Brazilian Medical Association from the Medical Moral Code, approved by the 4th Latin American Medical Congress in 1929 [7]. The country also had codes adapted, as the one produced during the Medical Unionist Conference, in 1931, or even with the document approved during the 4th Medical Unionist Congress in 1944 [7].

In 1953, the Brazilian Medical Association (AMB) produced the first Code of Medical Ethics [7], integrated soon after by the CFM, the newly created judicial and Supervisory Council of medical ethics, as per Federal law 3,268, of 1957. Since then, CFM assumed the prerogative of upgrading the ethical standards, a task accomplished during the congress which brings together regional boards of medicine.

In 1965, the new code was published, which ran until 1984, when it was promulgated the so-called Brazilian Medical Ethics Code [7]. With short term for having faced widespread resistance and have been produced on a *centrally and almost sensitive* way [9] by the Federal Council of Medicine of that time, the 1984 code was revised three years later, in the historic First National Conference on Medical Ethics of 1987. The document drawn up at this meeting was released the following year (1988), a period of democratic opening with positive changes in the national political scenario.

During the 19th century important findings changed the scientific knowledge and delegated to doctors a predominant role. The discovery of the vectors of diseases (for example, the discovery of the bacilli by Koch, and bacteria and microbes by Pasteur) made advances in public health and had the best interventions by doctors, especially in surgeries, since they themselves are no longer agents of infection. The progress in diagnosis, with the help of chemistry and biology, and more accurate observation provided by microscope and stethoscope are other examples that have contributed to the advancement of effective medicine and for the consequent improvement of codes of ethics. [10]

After its scientific development, medicine met a decisive change in its status, acquiring full authority about the illness and treatment. Such evolution was accompanied by a position called profession status by sociologists who study the processes characteristic of modern societies. According to some authors, medicine is considered the prototype of the profession [11]. So, doctors are distinguished from others by the high level of abstract and specialized training and an orientation geared to serve the population, which corresponds to the idea of vocation.

For decades, the codes of ethics held the field of profession, protected from cultural changes. The Hippocratic tradition, remodeled by philosophical research in the 60s, started to be followed by a period in which competing moral theories begin to challenge the primacy of the principles. At present, the current codes coexist with new tensions, as the medical ethics has become a subject of public interest. Thus, principles have been questioned; moral support, weakened; and the precepts, dismounted, making the code susceptible to recast [12]

## Fundamental principles

Most of the codes of medical ethics, including the Brazilian one, have strong influence of traditional principles that govern medical practice since the Hippocratic Oath: doctor's honesty and competence, his obligation to preserve life and not harming patients, but rather respecting their interests, privacy and confidentiality, always with zeal and dedication [13].

The current Brazilian CME is comprised of 25 core principles that govern medical practice, 10 rules related to rights and 118 norms on the duties of doctors, in addition to four general provisions. Its subheadings I and II, Chapter I (Fundamental Principles), define Medicine as *a profession in the service of human health and of the community and will be exercised without discrimination of any kind* (...) *The target of all the medical attention is the health of human beings, to the benefit of which must act with as much zeal and the best of his professional capacity.* [14]

Therefore, it was preserved the dual purpose of medical ethics, which supposes the autonomy of professional practice as well as its regulation. So, the CME serves as a reference to the judicial practice of the boards of medicine, while it is the guide of doctors in their daily practice, whether in clinic, in teaching, in research or in establishments providing medical care

Subordinated to the Constitution and to the Brazilian legislation, the new CME reaffirms the rights of patients and the need to inform and protect the assisted population. Additionally, it emphasizes that the respect for life is not exclusive of the doctor, but is particularly applicable to it. Therefore, in any event, he may give up their professional freedom or allow restrictions and taxes that affect their performance in the service of the well-being of the patient.

Medicine in Brazil, as well as in most countries, is an established profession, with clear representation, based on the unique and national character of the diploma mandatorily registered with the professional board. In recognition of medical knowledge, it is reserved the exercise of medicine only to holders of diplomas authorized by the Ministry of Education. Although medicine has this status clearly identified and there is a relatively homogeneous perception of its characteristics and activities, there are threats and obstacles to this recognition. The updated CME, therefore, also has the role to preserving the dimensions and parameters considered essential to medicine.

The CME is self-regulation mechanism that promotes ethics, protects the population and is able to inhibit market or state impositions on the profession, which has a common representation shared by professionals. [15] To its full expression, it needs to be supported by a mechanism of ethical and professional sanctions - medical councils' assignment, which act as ethical courts.

It is a fact that the liberal medicine model, in the condition of individual exercise coated with great autonomy, has long ceased to be a reference in medical practice. Still, the doctor's competence has prevailed in defining what is disease and how to treat it [11, 16]

If it is correct to say that we are facing an occupation whose exercise is dictated by pairs - materialized by a code of conduct – and partly controlled and countersigned by the State, one cannot also fail to consider that the market and the evolution of health systems have nowadays strong influence on the forms of organization of doctors. This occurs due to commercial interests that currently involve the health market, the financiers and the precarious conditions offered by private employers and public managers. Given these multiple confluences of interests, professionals of this class have increasingly difficult to secure the autonomy of their practice and defense of their principles.

Not by chance the CME seeks, in sub sections IX and X, Chapter I of the same Fundamental Principles, to preserve the essentiality of the profession: *Medicine cannot, under any circumstances or form, be exercised as trade (...) The doctor's work cannot be exploited by third parties with profit goals, political or religious purpose* [17].

## Autonomy and freedom

The Brazilian CME should not be reduced to an instrument of defense or framing of the medical corporation. Even because, with the expansion of collective public assistance and intervention of the State, the medical practice migrated from the individual practice with full autonomy – the doctor worked where he wanted, at times he chose and with the remuneration he stipulated - to a contractual practice, in public and private bodies. As a result, doctors have become, in some ways, hostages of employers and middlemen of medical work — which has huge influence, often negative, in practice and in the full guarantee of ethics. For such reasons, the CME emphasizes, in section III, chapter I of the fundamental principles, that *to exercise Medicine with honor and dignity, the doctor needs to have good working conditions and be fairly remunerated* [14].

Ideally endowed with scientific intelligence related to competence, focused on the technical problems to be solved (for example, the diagnosis, treatment, understanding the biological mechanism, the interpretation of data), the doctor needed to be increasingly aware of the context of his work and to defend the interests and rights of patients [18]. In this sense, CME, although it requires the doctor to used

in favor of the patient all means available for diagnosis and treatment, scientifically recognized and at his fingertips, also states, in section IV, Chapter II (rights of doctors) that it is the professional right: *refusing to exercise their profession in a public or private institution where the working conditions are not worthy or may affect the patient's and his own health, as well as that of other professionals. In this case, it shall immediately notify its decision to the Ethics Committee and the Regional Medical Council* [17].

The doctor, who before had more influence from the evolution of science, began to be influenced by the regulation of systems and health policies, and became susceptible to shortages or the unavailability of public and private resources, as well as to working conditions and remuneration. Therefore, article 20 of the CME, Chapter III (Professional Liability), prohibits to the doctor: A*llowing that pecuniary, political, religious interests or any other orders, by his employer or supervisor or by public or private funder of health care, interfere in the choice of the best means of prevention, diagnosis or treatment available and scientifically recognized in the interest of patient or health* [19]. In addition, several factors are also related to the professional activities of the doctor. Emphasis is given to the expertise, skills, common sense, motivation, standards of judgment, accumulation of knowledge, clinical experience, time devoted to updates, relationship with the companies of the production complex of health, level of expertise, time, place of work and socializing with colleagues [20].

Given the speed of change and the accumulation of scientific knowledge, the professionals who do not have opportunity of permanent training and continuing education will be further away from good medicine. On the basis of this reality, the CME is emphatic in stating, in its section V, chapter I (fundamental principles), that it is for the doctor to continually improve his knowledge and use the best of scientific progress for the benefit of the patient [14].

When analyzing medical ethics, since the Hippocratic Oath up to current codes, the attention turns more to the individual responsibility of the doctor, the professional freedom and autonomy than to the collective commitment. If, on the one hand, this individualist perception protects the patient, it can also, on the other hand, impose difficulties to understanding decisions consistent with public health policies and scarce resources [21]. From all this it can be seen that the CME will always be a reference for the current debate, contrasting, sometimes the individual rights and collective interests.

The doctor, as decision maker [22, 23], suffers, among other factors, the influence of the regulation of systems of health policies, resource scarcity and scientific evidences formalized in medical directives. Although subject to various technical issues, moral and legal ethics, the medical decision is also subject to situational influences. Additionally, the category is heterogeneous, because the doctor is a skilled worker who participates in the labor market, in which he relates to the various ways and means of production of health services [24, 25] .

Autonomy can be understood as the full exercise of the professional's subjectivity, since the medical act involves personal decision, as well as the application of scientific knowledge. This is a concern that CME emphasizes in its title VII, chapter I (fundamental principles): *The doctor will exercise his profession with autonomy, not being forced to provide services that violate the dictates of his conscience or to whom he does not wish to, except for the absence of another doctor, in case of urgency or emergency, or when his refusal may bring harm to patient's health* [17].

The doctor, besides being autonomous, is free in is prescriptions and acts, which he judges to be the most appropriate in every circumstance. In section VIII, Chapter I (fundamental principles), CME says that the doctor cannot, under any circumstances or under any pretext, renounce his professional freedom, nor allow any restrictions or impositions that may hinder the efficiency and correctness of his work [17]. It is clear, however, that this freedom must be relativized, as the doctor, without neglecting its duty to treat and care for, can limit his actions if this is necessary to ensure the quality, safety, effectiveness of treatment and rational use of resources. This means, for example, that the medical professional should have the common sense to observe the laws and regulations in force, to follow clinical guidelines and therapeutic consensuses, to prescribe generic medicines, to consider the cost-effectiveness of treatments and the impact of his prescriptions for individuals and for the health care system.

The doctor-patient relationship requires mutual trust. In this sense, CME has the role of promoting the necessary transformations in physician performance without denying the autonomy of the patient. One who is given the attention and medical care shall have the right to refuse or to choose his treatment. Here, it is the correction of an historic failure of Brazilian medical deontology, which attributed to the doctor too much paternalism and authority, now replaced by cooperation, agreement

and constant search among the beneficence of the medical act and the interests of patient [26].

The principle of freedom of the individual (patient) is one of the pillars of the current code. In the ideal scenario, the patient is free to choose his doctor and accept or reject what is offered, such as examinations, consultations, hospitalizations, attendance of any kind, patient records, participation in clinical research, data transfer etc. The exercise of freedom, in order to reduce the asymmetry of information depends on the patient receiving fair, clear and appropriate communication. It results in the the importance of informed, free and clear consent. Therefore, according to article 31 of the CME, chapter V (relationship with patients and family members), it is forbidden to the doctor *to disrespect the patient's or is legal representative's right to decide freely on the diagnostic or therapeutic practices, except in cases of imminent risk of death* [27].

The CME extends the duty of the doctor to inform [28] and ensures that the patient is heard about diagnostic and therapeutic practices, but with one caveat: since *there is no imminent danger of death* [27]. The conflict of values established by the code only has a solution in specific cases, provided the patient has ensured the right to decide about himself. With caution and common sense, a greater or lesser weight can be given to patient's self-determination in the face of the benefit indicated by the doctor.

The physician must exercise his profession without being discriminated and without practicing discrimination of any kind. In addition, he must practice solidarity among doctors, be personally responsible for their deeds and preserve their professional independence. In other words, he should act getting rid, for the benefit of patients, of personal or material influences of employers, paying agencies, institutions, industry and other interests. On the basis of free acting, CME, in its article 68, Chapter VIII (professional remuneration), bans to the doctor *the exercise of the profession with dependency or interaction of pharmacy, pharmaceutical industry, optics or any organization devoted to the manufacture, handling, promotion or marketing of prescription products, whatever their nature* [29].

Currently, excessive restrictions are imposed to doctors, putting in danger the essential trust in the doctor-patient relationship. Public policies are defective, private practices are exclusive, available resources are scarce, and health has been reduced to the condition of merchandise, with the rampant incorporation of new technologies. CEN takes into account such reality, yet respecting the changes of society into which medicine is practiced and the collective will of the population, to whom doctors should always serve.

## Knowledge and consultation of CME

Almost all (98%) of the 644 doctors in the State of São Paulo interviewed between February and March, 2011 declared they knew the new Code of Medical Ethics that had entered into force one year before the survey (Table 1). Among those who declared to know the CME, 74% had consulted the document (Table 2).

**Table 1**. Aware of the existence of the new Code of Medical Ethics according to gender, age group and region of residence of doctors, State of Sao Paulo, 2011

| | **Know the existence of CME** | Do not know the existence of CME | **No. of doctors/answers** |
|---|---|---|---|
| **Gender** | | | |
| Male | 98 | 2 | 382 |
| Female | 96 | 4 | 262 |
| **Age group** | | | |
| 25-34 | 96 | 4 | 182 |
| 35-44 | 99 | 1 | 140 |
| 45-59 | 98 | 2 | 208 |
| 60-80 | 97 | 3 | 114 |
| **Region in the State of SP** | | | |
| Capital | 98 | 2 | 327 |
| SP Metropolitan | 94 | 6 | 47 |
| Interior | 97 | 3 | 270 |
| **Total** | **98** | **3** | **644** |

**Table 2.** Consultation to the Code of Medical Ethics, according to gender, age group and region of domicile of doctors, State of Sao Paulo, 2011

| | Consulted CME | Did not consult CME | No. of doctors/answers |
|---|---|---|---|
| **Gender** | | | |
| Male | 77 | 23 | 375 |
| Female | 69 | 31 | 253 |
| **Age group** | | | |
| 25-34 | 74 | 26 | 177 |
| 35-44 | 76 | 24 | 138 |
| 45-59 | 74 | 27 | 204 |
| 60-80 | 71 | 29 | 109 |
| **Region in the State of SP** | | | |
| Capital | 75 | 25 | 319 |
| SP Metropolitan | 68 | 32 | 45 |
| Interior | 73 | 27 | 263 |
| **Total** | **74** | **26** | **628** |

***Source: Cremesp: 2011***

Among the doctors who consulted the CME, six out of ten did so between one and two times (Table 3). It is worth noting that 9% of doctors, one year after CME had been in force, consulted it more than ten times, with slight emphasis on respondents with more than 60 years (14%). A small trend was noted to increase the number of times the CME was consulted as the age of the respondent increases. On average, CME was consulted three times.

**Table 3**. Number of times the doctors consulted the Code of Medical Ethics, according to gender, age group and region, in the State of Sao Paulo, 2011

| Nº of times | 1-2 | 3-4 | 5-6 | 7-9 | 10 or + | Average | No of doctors/ answers |
|---|---|---|---|---|---|---|---|
| **Gender** | | | | | | | |
| Male | 56 | 27 | 7 | 1 | 9 | 3,1 | 291 |
| Female | 66 | 21 | 4 | 0 | 9 | 2,8 | 173 |
| **Age Group** | | | | | | | |
| 25-34 | 69 | 22 | 3 | 2 | 5 | 2,6 | 130 |
| 35-44 | 61 | 28 | 5 | 0 | 7 | 2,8 | 105 |
| 45-59 | 51 | 29 | 8 | 1 | 11 | 3,4 | 150 |
| 60-80 | 61 | 17 | 8 | 1 | 14 | 3,4 | 79 |
| **Region in the State** | | | | | | | |
| Capital | 62 | 23 | 5 | 1 | 10 | 3,0 | 242 |
| SP Metropolitan | 43 | 33 | 10 | 3 | 10 | 3,6 | 30 |
| Interior | 60 | 26 | 6 | 1 | 7 | 2,9 | 192 |
| **Total** | **60** | **25** | **6** | **1** | **9** | **3,0** | **464** |

***Fonte:*** Cremesp: 2011.

It was possible to identify three groups of doctors: those who knew the existence of the new code and had already consulted it (72%); those who knew the existence and did not consult it (25%); and the minority of doctors who did not know the existence of the new CME (3%). No significant difference was found in the degree of knowledge of the existence and use of the code between gender, age groups and areas of expertise or domicile of doctors.

It is concluded that, one year after entry into force, the new Code of Ethics was included in the routine of doctors, because all were aware of its

publication and the majority had already consulted it. The main limiter of the study, however, is its geographic restriction to the State of Sao Paulo.

## Final considerations

The wide acceptance of CME by doctors and its usefulness as a permanent source of consultation can be partly attributed to the comprehensiveness of its text, which considers the scientific and technological progress, the evolution of professional practices, the more and more remunerated exercise of the profession, the expansion of the role of the doctor, their multiple forms of work and the possibilities of professional insertion in the clinical area, research, teaching or administration.

Such acceptance has the contribution of the option of its policy makers by a CME that was not exhaustive, but rather of easy consultation, whose statements were of a general nature, so that they could be interpreted and applied in particular situations. Even in the face of ethical, legal or regulatory requirements principles, physicians may experience conflicts when they come with their own ethical convictions, with the demands of patients, of decision makers, managers, employers and other health professionals. After all, the capabilities of doctors are not only their technical knowledge. Professional capital also includes defining the obligations, representations of convictions and of the doctor's relationship with society.

Brazilian CME, although generalizing in various aspects, did not left to position itself in relation to large contemporary dilemmas and challenges in the field of bioethics, as the issue of organ transplantation, clinical trials, euthanasia, assisted reproduction and genetic engineering. It did not decrease, however, the imperative of the principle of freedom of the doctor, now connected to the patient's freedom. This is the tacit and implicit contract of any medical act, which permeates the current CME.

In clinical practice, the bioethical reflection is always dynamic, and solutions of ethical dilemmas are based on truths often transitory. Thus, the periodic and systematic updating of CME becomes necessary, because the society expects from doctors precisely responsible dynamism and public commitment, in time, with the preservation of life and medical ethics. Today's society expects that doctors continue making their decisions with humility and tolerance to moral pluralism [30, 31]. There is, thus, a move towards ethical guidelines defined not only by doctors, but established by society [1].

Not by chance, one of the categories of principles emphasized by the new code regarding the skills and qualities required from doctors, because that is the mission that society gives him. To fulfill his task, the doctor should be competent and capable. That justifies the relevance of professional skill and the physician's commitment to science, obviously recognizing its limits, striving, in disgrace and deterioration in the quality of undergraduate education in medicine, to be permanently up to date on the best means of diagnosis and treatment.

The doctor has in CME the preservation of his professional independence; therefore, the ethical concern of eliminating conflicts and stave off unreasonable influences of professional employers, industry and business and commercial interests. In order to complete the CME, ethical rules shared between doctors and other health professionals would be welcome, as the multidisciplinary partnership is essential to the services and the health system.

Finally, it is worth noting that the intention, surely well succeed when verifying the high degree of knowledge and consultation of CME by doctors, was to draw up a code just because the medicine should always be balanced between the service rendered to the patient and to public health, between the individual welfare and the welfare of society.

*The authors are thankful to the Regional Council of Medicine of the State of Sao Paulo*

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Received: 6.11.2012
Revised: 8.7.2012
Approved: 11.19.2012

**Authors' participation**

The main author participated, in the firm contracted by Cremesp, in the undertaking of field survey, in the follow up of the designing of sampling plan, questionnaire, pre-testing, supply of the bank for the sample previously selected in a probabilistic way with necessary information to contact selected physicians, in interviewers' work, and in analysis of collected and tabulated data. Both authors jointly participated in writing the article.

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