

The experience of the Bioethics Committee from a public hospital

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Abstract

The objective of this study was to analyze and systematize the experience of the bioethics committee from the Hospital Geral de São Mateus (General Hospital of São Mateus), which is a public hospital in the State of São Paulo, Brazil. We adopted the qualitative research method, with the case study strategy. Two research techniques were applied: record analysis and an open ended questionnaire answered by the bioethics committee participants. Four categories were established after analyzing the material: history and evolution of the bioethics committee; motivation to participate in the bioethics committee; memorable cases discussed by the committee; suggestions for the improvement of the bioethics committee. It was noted that besides discussing and deliberating, the bioethics committee also developed an educational role for the involved professionals and teams. This role was also expanded to the institution as a whole, by means of symposia with topics related to bioethics. This study reveals the importance of stimulating the creations of such forums in Brazilian healthcare institutions.

Keywords: Bioethics. Hospitals, general. Hospitals, public. Ethics committees, clinical.

Resumo

A experiência do comitê de bioética de um hospital público

O objetivo deste estudo foi analisar e sistematizar a experiência do comitê de bioética do Hospital Geral de São Mateus, hospital público estadual de São Paulo. Foi adotada metodologia qualitativa de pesquisa, com estratégia de estudo de caso. Duas técnicas de pesquisa foram utilizadas: análise documental e questionário com perguntas abertas aplicado aos participantes do comitê de bioética. Por meio da análise do material obtido foram constituídas quatro categorias: histórico e evolução do comitê; motivação para participar dele; casos marcantes ali discutidos; sugestões para aperfeiçoamento do comitê. Verificou-se que, além de discutir e deliberar, o comitê de bioética desenvolveu também papel educativo em relação aos profissionais e equipes envolvidos. Esse papel foi expandido para a instituição como um todo, por meio de simpósios com temas ligados à bioética. O estudo revela a importância de estimular a criação de instâncias desse tipo nas instituições de saúde do Brasil.

Palavras-chave: Bioética. Hospitais gerais. Hospitais públicos. Comitês de ética clínica.

Resumen

La experiencia del Comité de Bioética de un hospital público

El objetivo de este estudio fue analizar y sistematizar la experiencia del Comité de Bioética del Hospital Geral de São Mateus (Hospital General de San Mateo), hospital público del estado de São Paulo, Brasil. Se adoptó la metodología de investigación cualitativa, con la estrategia de estudio de caso. Se utilizaron dos técnicas de investigación: análisis de documentos y cuestionarios con preguntas abiertas aplicadas a los participantes del Comité de Bioética. A través del análisis del material obtenido se constituyeron cuatro categorías: historia y evolución del Comité; motivación para participar de éste; casos importantes discutidos en el Comité de Bioética; sugerencias para la mejora del mismo. Se encontró que, además de discutir y decidir, el Comité de Bioética también ha desempeñado un papel educativo en relación a los profesionales y a los equipos involucrados. Esta función también se amplió a la institución en su conjunto por medio de simposios sobre temas relacionados con la bioética. El estudio pone de manifiesto la importancia de estimular la creación de tales organismos en las instituciones de salud en Brasil.

Palabras clave: Bioética. Hospitales generales. Hospitales públicos. Comités de ética clínica.

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Bioethics Committees (BC) are independent bodies based in hospitals, clinics, research institutes or laboratories, in which professionals from different areas of knowledge come together to discuss and work on/with several aspects related to the sectors of activities regarding the life and health of people¹.

The main objective is to reflect on the different issues involved in the ethical conflicts that present themselves in the clinical practice of the health institution, since the analysis of these situations may exceed the codes of professional ethics². For Gracia³, the BC is an organ of deliberation and consensus; its role is not therefore to inform or convince others of its ideas, or to change their beliefs and values.

The duties of the BC can be advisory, regulatory and educational⁴. They are: 1) to advise, as an advisory body, health professionals, patients and/or their legal representatives, and the institution's management about moral conflicts, or provide assistance and/or clarify situations that require difficult decisions from a moral perspective; 2) to draft guidelines and standards regarding the protection of persons (patients, professionals and community members) and submit these to the institution's management; 3) to educate internal and external communities regarding the moral dimension in the exercise of the health professions⁵.

The BC must have a multidisciplinary composition, with members who have a sensitivity and interest in ethical issues, a capacity and a willingness to dialogue, and a readiness to reflect and study human behaviour, as it is a plural and dialogical space^{6,7}. Participants of a BC can be health professionals and professionals from other fields - such as theology, law and philosophy - as well as representatives of health service users and the community⁷.

In Brazil, there is still little tradition in the constitution of these structures in health units. The first bioethics commissions were implemented in the 1990s, with special emphasis on the experiences of the following hospitals: Hospital de Clínicas de Porto Alegre - UFRS (Porto Alegre Clinical Hospital - Rio Grande do Sul Federal University), Hospital das Clínicas de São Paulo - USP (São Paulo Clinical Hospital - University of São Paulo), Hospital São Lucas da PUC- RS (Saint Lucas Hospital - Rio Grande do Sul Pontifical Catholic University) and the Instituto Nacional de Câncer (National Cancer Institute) in Rio de Janeiro⁷. Recently, the Conselho Federal de Medicina - CFM (Brazilian Federal Council of Medicine) issued CFM Recommendation 8/2015, which deals with the creation and functioning

of bioethics committees and the participation of physicians within them⁸.

In state public hospitals in São Paulo, at time of writing the Hospital Geral de São Mateus - HGSM (Saint Matthew General Hospital) was the only institution that maintained an operating bioethics committee. The history of the hospital is unique, since it was the result of a major popular mobilization between the late 1970s and the 1980s, known as the Movimento de Saúde de São Mateus (Saint Matthew Health Movement), part of the Movimento de Saúde da Zona Leste (East Zone Health Movement)^{9,10}. This region suffered from a lack of public services common to areas geographically distant from the political, administrative, economic and social centre of the capital.

The movement was initiated by residents who began the mobilization through the ecclesial communities, resident associations, friends of neighbourhood societies and the trade union movement. They were mostly metallurgists from the São Paulo capital or ABCD region in the state of São Paulo, a region bordering the São Mateus neighbourhood, where most of the workers resided. One of the principal banners of the Movement was the construction of a general hospital with a maternity unit and an emergency room that could serve the entire region, which at the time had about 200,000 inhabitants, whose closest reference hospital was in the neighbourhood of Tatuapé.

In the 1980s, the movement created a network of health facilities and the long-sought public hospital, inaugurated in March 1991, initially with an emergency room and a number of beds for hospitalization. Over time, clinics and services have been organized, and today it is a general hospital, with emergency care, a medical clinic, general surgery, paediatrics, maternity unit and a specialized burns clinic. It has in its structure four intensive care units (ICU): neonatal, paediatrics, adult and burn care.

In 2003, the hospital's board of directors was renewed for the third time, a change that was observed and closely monitored by the community, which demanded more participation and improvements in the operation of the hospital, especially regarding human relations within the hospital. It was in this context that, in October 2003, the Programa de Humanização (Humanization Program) and the *Humanizar é preciso* (Humanization is needed) manifest, which described the path to be followed in order to bring about changes in interpersonal and institutional relations, were launched¹¹.

A Humanization Meeting has been held each year since then. In these meetings, bioethics has been a recurring topic, based on the problems that arise in the relationship between patients and professionals or the relationship between the professionals themselves, as these conflicts often go beyond the scope of the ethics commissions of each profession. The reading of texts and participation in congresses and lectures with professionals from the field outlined how to introduce the ideas from this sector into the hospital. The 2007 Humanization Meeting was totally dedicated to bioethics.

Extended meetings of the board of directors defined steps for the constitution of a bioethics commission that, in order not to be confused with existing commissions, was called a "bioethics committee". In 2008, the HGSM BC began its activities.

Now that the BC has existed for a number of years, it is useful to study its path, so that the experience can be analysed and systematized in a way that contributes to improving the committee itself and disseminates the experience.

Methodology

Study outline

The qualitative research approach was adopted, using a qualitative case study strategy, which consists of the investigation of a specific unit using multiple data sources, in order to provide a holistic view of the studied phenomenon^{12,13}.

Two techniques were used: documentary analysis and a questionnaire. Written documents are recorded manifestations of aspects of the social life of a given group, generating information that helps to understand the facts and the relationships and actions of this group. For this study, the documentary analysis covered the committee minutes, as well as its internal regulation.

A questionnaire was used to provide additional information. This featured open questions, allowing participants the freedom to respond and use their own language¹⁴. This type of technique was chosen to guarantee the anonymity of the participants, so that, without the presence of the researcher, participants could freely write their opinions and considerations. The open questions addressed the following topics: participation in the committee; discussion of theoretical topics; the conduct of the BC in the cases presented; educational function of the BC; improvement of the committee.

The members of the HGSM bioethics committee, who were taken from its current and previous compositions and had kept some connection with the hospital, totalling 35 participants, were invited to answer the questionnaire. It is, therefore, an intentional sample, composed of individuals most appropriate to provide useful information for the research¹⁵.

The participants were asked to respond to the questionnaire without identifying themselves using a computer and printer. The answers were delivered in an envelope provided with the questionnaire, which was to be sealed and placed in a box.

The time required to answer the questionnaire was estimated to be between 20 and 30 minutes. A period of 15 days was allowed for the return of the questionnaires, following which data analysis began. It was not possible to deliver the questionnaire to a professional who was on maternity leave, and so 34 questionnaires were delivered. The professionals participated with free and informed consent, in accordance with CNS Resolution 466/2012¹⁶.

Data analysis

The material obtained through documentary analysis and questionnaires was divided into parts, which were later correlated, aiming to identify relevant trends and patterns¹⁷, which did not obey an *a priori* theoretical framework. Therefore, we opted for broad targeting¹⁸, so that the categories emerged from the material itself, some of which were influenced by the scripts used in the research.

Results

The questionnaires were answered by 21 professionals, and included areas of medicine (6), psychology (5), nursing (3), dentistry (1), social service (1) and law (1). They were also answered by priests (2), a minister (1) and a nursing assistant (1). The number of committee compositions that respondents participated in was one administration (6); two administrations (6), three administrations (3), four administrations (6).

The analysis of the documents and the questionnaires led to four topic categories related to the committee: history and evolution; motivation to participate; noteworthy cases discussed by the committee; suggestions for improvement.

History and evolution

In 2008, after promoting the committee to the institution and establishing a deadline for registration, the first team, called the “founding committee”, was formed with a one-year mandate (July 2008 to July 2009) and was made responsible for organizing the committee’s work. Internal rules, schedule and conduct of the meetings were defined. The following assumed BC attributes are emphasized: multidisciplinary; renewable composition; voluntary participation; and non-regulatory forum - a forum to assist in the evaluation of the complex issues generated by the demands.

Its specific objectives were defined as follows: to advise, as an advisory body, any HGSM professional who encountered ethical problems and conflicts in the exercise of their profession; to continuously educate the community of professionals, clients and family members on bioethical issues; to develop, whenever necessary, recommendations for the HGSM administration.

The following compositions had two-year mandates and a multidisciplinary character, comprising professionals of the institution and invited members. The last composition analysed in this study began in 2013, with a mandate until August 2015. It was comprised of doctors, psychologists, nurses, social workers, a dentist, a lawyer, a nursing assistant, a representative of the Associação Brasil Soka Gakkai Internacional (Brazilian Soka Gakkai International Association), a representative of the Iniciativa Religiões Unidas (United Religions Initiative) and a representative of the Igreja Batista de São Mateus (St. Matthew Baptist Church). Each management group begins its work with discussions regarding the internal regulations and the Universal Declaration of Bioethics and Human Rights¹⁹.

The committee meetings were held monthly, with a minimum quorum of one third of the participants and an average duration of two and a half hours. There were 75 regular meetings, with an average of 14 participants. Extraordinary meetings were held in case of events or discussion of urgent cases.

In these seven years of existence, several topics were discussed by the committee, based on articles and lectures with guest speakers. These topics covered bioethics and human rights; patient autonomy; bioethics and public health; free and informed consent; principlist bioethics; virtue bioethics; and bioethics of daily life. In addition, the following topics were also discussed: the autonomy of the psychiatric patient; anencephaly;

abortion; the social situation of homeless people; palliative care; methods of deliberation regarding the situations presented to the committee, and anticipated directives of will.

In partnership with the Conselho Regional de Medicina do Estado de São Paulo - CREMESP (Regional Council of Medicine for the State of São Paulo), two symposia were held for the entire institution, with the topics “Patient autonomy and hospital routine” in 2010, and “Approach to violence from the perspective of ethical care and confidentiality” in 2012. Also in 2012, awareness-raising lectures on sexual diversity were held in order to improve care according to current legislation and human rights ethics.

The BC was present at the eighth, ninth and tenth Brazilian congresses of bioethics, which took place in 2009 (Búzios, in the state of Rio de Janeiro), 2011 (Brasília, in the Federal District) and 2013 (Florianópolis, in the state of Santa Catarina), and presented papers²⁰⁻²³ that described the accomplishments and advances of the committee during those periods.

Motivation to participate

Respondents cited a wide range of reasons that led them to participate in the committee. Some referred to interests linked to life values and philosophical aspects, such as a debate about human values, a search for common sense and the defence of life, a search for new horizons:

“To deepen the knowledge of the sensitive issues related to human beings, with a view to taking a stand regarding critical and borderline situations” (S11);

“Search for the integration of knowledge between disciplines: biomedical, moral, religious, philosophical and legal” (S4).

The answers to the questionnaires also revealed interest in professional and/or institutional improvement:

“[Desire to] rethink routines consolidated among professionals, reflect on controversial issues related to the hospital environment” (S2);

“Desire to transform the hospital into a reference institution for quality care and humanization” (S20).

Another type of incentive was the good relationship with the hospital management, which

motivated the acceptance of invitations received to participate in the committee:

“Due to the good relationship and dialogue with the hospital’s board” (S5);

“The commitment of the hospital board to the BC motivated me” (S21).

Previous activities carried out by some respondents also motivated the interest in participating:

“Because it falls within a territory where I act pastorally and because I understand that it is an action of the Church to engage in this city’s public forums” (S5);

“As I was engaged in the Humanization Commission, the Bioethics meeting was an additional door to learning and finding answers to my questions” (S10).

The lectures held in the hospital before 2008 were described as a motivation for some participants:

“After a lecture given in the lecture hall of the hospital, I became very interested in bioethical topics” (S15);

“The lectures held at the hospital opened my mind to many new issues and, as a result, I wanted to participate in the committee” (S17).

In general, the answers to the questionnaires reveal reasons of an altruistic and benevolent nature related to the institution and to the committee.

Noteworthy cases discussed by the committee

Among the various cases discussed by the committee, some are worth mentioning because they were cited by professionals in their responses to the questionnaire:

- **Case A**

The family of a patient with bowel cancer objected to how the news that “there was nothing to be done” regarding the patient’s condition was given by the surgeon responsible for the case. The family members claimed that the doctor communicated this information hastily and without due care. In the BC, discussions intensified regarding the training of medical professionals and the need for multiprofessional teams to contribute to similar situations. BC members followed up with the doctor, the patient and the family.

- **Case B**

Pregnant women using illicit drugs were a topic of discussion at several meetings, based on specific situations reported by the doctor responsible for the neonatology unit. It was verified that, in some situations, the team’s actions had positive results: were welcomed by the pregnant women/mother and had the support of the family, prompted the search for treatment and detoxification, and fostered the maintenance of the bond with the child and the care he or she required. In others, it did not succeed: the baby was abandoned by the mother and the family, and the placement of the baby was judicially determined.

In the BC, the importance of the team’s performance was clarified, as was the legal complexity that involved these situations. An action protocol was developed for these cases, with the intervention of the Conselho Tutelar e Juizado da Infância (Guardianship Council and Juvenile Court), as well as other bodies, such as the Centro de Atenção Psicossocial Álcool e Drogas - CAPS AD (Psychosocial Care Centre for Alcohol and Drugs) and the Centro de Referência de Assistência Social – CRAS (Reference Centre for Social Assistance), when necessary.

- **Case C**

A 33-year-old pregnant woman, diagnosed with mild mental retardation, housed in a institution run by an order of nuns, went into labour at the hospital. The nuns did not want the mother to have contact with her baby and said that the baby should be immediately delivered to them. The pregnant woman expressed a desire to keep the baby. The maternity and neonatology teams worked to protect the child. The BC discussed and followed the case, dealt the legal and emotional aspects, as well as being involved in the search for the patient’s family members. In the end, the mother kept her baby and was able to find her family of origin, who welcomed them.

- **Case D**

An adult chronic renal patient admitted to the ICU did not accept the recommended dialysis, preferring to follow the natural course of the disease. This position caused conflict in the care team, with regard to complying with the patient’s decision or performing the treatment prescribed by the specialist. The case was monitored directly by the BC, as requested by the ICU team. A commission with BC members was created, who talked with the family (in this case, constituted by the children of

the patient), and reached the conclusion that the patient's wishes should be respected. This decision was presented to the medical staff and to the nephrologist who cared for the patient.

- **Case E**

Based on a conflict between two professionals (a physician and a social worker) from a general ward regarding attitudes to be taken in the care of transvestite patients, the situation was taken to the BC for consideration. No direct action was taken concerning the conflict that had occurred; however, based on the discussions held in more than one meeting, the multiprofessional team's lack of preparedness to provide services in cases involving sexual diversity was identified. Lectures on the subject were given, and a recommendation was made to the hospital's board of directors with legal and ethical clarifications on the subject, in order to support a protocol in which the patient's autonomy and his/her right to use his/her social identity prevailed.

Suggestions for improvement

Several suggestions were given by the respondents to improve the activities: promoting the committee within the institution, expansion of the actions related to bioethics and further discussions of topics already covered.

The respondents suggested several measures for the promotion of the committee within the institution: holding a regular panel on the intranet covering bioethical topics; publication on the intranet of texts written by the members of the committee, which can be commented on by the employees of the hospital; dissemination of the committee activities in scientific journals; and distribution of meeting minutes as well as texts via institutional e-mail.

The following measures were suggested to expand the activities related to bioethics in the hospital: creating a specific bioethics library; encouraging employees to take a specialization or university extension course in bioethics; promoting meetings with other committees, such as committees on medical ethics, nursing ethics, death, and palliative care; establishing a BC presence in clinics, the work place of professional teams; ensure continuity of open symposia for the whole institution; conducting an active search to assess how cases of conflicts have been conducted in the institution, providing elements for discussion and action by the committee.

The further analysis of several topics already discussed, due to their complexity and the need to resolve doubts, was also suggested. The topics cited were: patient autonomy - *"professionals often feel that they own the patient"* (S2); autonomy with regard to discharge on request - *"patient's rights and risks; can the family make that decision?"* (S3); confidentiality - *"it is still not respected by many professionals"* (S8); directives of will - *"it is a very recent subject; I still have many doubts"* (S10); and methods of deliberation regarding the situations presented to the committee - *"we need to study Diego Gracia's method more closely"* (S20).

In addition to these, the following topics were also mentioned: drug users → *"it is a growing situation that professionals do not know how to deal with"* (S21); bioethics and religions → *"a complex topic for all of us"* (S5); public health problems in Brazil → *"to enhance our knowledge and to better deal with the region where the hospital is located"* (S11); suicide attempts dealt with in the hospital emergency unit → *"there are many cases and they involve complex situations"* (S6); possibility of a lack of beds in the emergency room or in the ICU → *"many times the demand is very high, how to act in case of a lack of beds"* (S14); issues related to sexual diversity → *"these are patients who we don't know how to deal with"* (S8); care of the health teams → *"the teams get worn out, especially in cases of death and grief"* (S9).

Discussion

The history of the BC of the HGSM reflects the course initiated and constructed based on the needs and growth of institutional concerns regarding the quality of care provided. The diversity of the members of the committee and the renewal of these members with each mandate reflect the idea of not allowing the BC to become a closed group, disconnected from the reality of everyday life. The diverse training of hospital members and the presence of participants from outside the institution enrich and allow for better reflection and criticism arising from different fields of knowledge (health, religion, law). The encouragement and support of the hospital's board of directors favours the development of the BC.

The BC profile is focused on education in the institution, carrying out initiatives of a broad nature within the hospital, such as bioethics symposia, as well as specific actions with professionals and teams, when there is demand and/or need. This profile is in

accordance with the one recommended by Loch and Gauer¹, who consider the BC's educational role as very important.

The report of the noteworthy cases discussed and the topics listed as suggestions for improving the BC reveal the pertinence and importance of its existence in a hospital. This is because many complex and problematic situations require a forum that can accommodate the doubts and anxieties that arise in the assistance sphere.

The need to intensify the promotion of the BC in the hospital was mentioned by the participants of the research, which coincides with the findings of Kawamura et al.², who refer to this same demand in a study regarding successes and difficulties in the operation of the BC of a university hospital.

Although the Gracia³ method is already used in the BC practice, the participants considered that the knowledge regarding this method needs to be enhanced. The author³ recommends that the deliberations be based on a detailed analysis of the circumstances and consequences that characterize the given situation, as well as the identification of possibilities for action, followed by the selection of what seems best.

For the author³, the deliberation is compatible with the plurality of solutions, which must arise from dialogue, practical reasoning, emotions, values and beliefs. Therefore, the decision to be taken is the prudent decision, coming from the creative process of knowledge (and not from the mere application of universal principles to particular situations). In the noteworthy cases cited by the research participants, the BC followed this orientation.

According to the responses to the questionnaires, it is observed that the committee has followed the guideline of assisting and not judging the professionals involved in the demands, as advocated by Loch and Gauer¹. In addition, these authors warn that if, in the case discussions, the committee members are not receptive or even overbearing, trust and the search for future help will be undermined.

The importance of the professional-patient relationship was cited, especially in Case A, which deals with the complaint of a patient's family about the form of the surgeon's communication. Melnik and Goldim²⁴, in a study regarding consulting services provided to hospital BCs, emphasize that diagnostic communications are frequent motives for patient and/or family complaints. Delicate situations, as are most of those related to illness

and hospitalization, require preparation from professionals to understand the possible reactions of patients and family to their communications. Marques and Hossne²⁵ point out that the professional/patient relationship has always been, and will always be fundamental for care activities.

However, it is known that in these situations, in addition to the suffering of the patient and/or the family, there is also the psychological suffering inherent in the task of caring, which can lead professionals to adopt negative mechanisms of adaptation, such as emotional dullness, coldness, distancing, irony and irritability²⁶. By supporting and allowing the sharing of anguish, doubts and conflicts arising from the care task, the BC plays an important role. From the perspective of care aimed at professionals, the participants of the research suggest that the committee also be a forum that can reflect on the topic and suggest proposals, taking into account, especially, those who often experience end-of-life situations.

The issue of drug users has been cited as a serious problem that has arisen frequently in the hospital and has been exemplified in Case B. The Brazilian Ministry of Health²⁷ considers the issue of public health and affirms its commitment to address problems associated with the consumption of alcohol and other drugs, enabling the development of a policy less focused on control and repression. The Ministry of Health considers the presence of drugs in contemporary societies as a complex phenomenon, and seeks to inaugurate practices aimed at overcoming moralist conceptions, still very present in Brazil when it comes to addressing issues related to the use of alcohol and other drugs²⁸. However, despite this advancement in the field of public policies, the problem persists, assuming major proportions, which demands from all, including the HGSM, reflection and creative solutions, for which the BC is the appropriate *locus*.

Case C reveals the BC using an approach that takes into account the voice of a person – an institutionalized pregnant woman with slight intellectual limitation – who is part of a vulnerable population or, adopting the expression of Schramm²⁹, of a population that has been violated. That is, those who cannot face their vulnerable existential condition through their own means or with those means usually offered by institutions. The BC was proactive in preventing the decision of the institution's nuns (to separate the mother from her baby) and in seeking the mother's family, thus assuming a protective strategy. This form of behaviour is in agreement with Kipper⁵, who

considers that, in the development and improvement of the BC, the function of protection and defence of the violated should be exercised.

Case D leads to a reflection regarding the principle of patient autonomy, according to which it is not up to the health professional to decide for the patient without consulting him or her about issues that directly involve him or her³⁰. It is important to emphasize that defending the principle of patient autonomy does not mean to defend self-determination pure and simple, which would represent a simple inversion in the hegemonic relationship that we have today. It means defending the strengthening of relationships between patients, family members and health professionals, recognizing that subjects should have space and a voice in the process, respecting the differences between them in relation to values, expectations, demands and goals, always taking as a basis that the subject of the therapeutic process is the sick person^{30,31}. It is, therefore, an issue that, within the scope of the BC, leads to the improvement of the attitudes of professionals based on discussions originated in concrete cases, texts or lectures.

A relevant aspect observed in the research concerns the lesbian, gay, bisexual, transvestite and transsexual (LGBTT) groups, as in Case E, and suggestions for topics to improve the BC. The Ministry of Health, in 2013, presented the National Policy on Integral Health for Lesbian, Gay, Bisexual, Transvestite and Transsexuals, which establishes guidelines and standards for the integral care of these groups.³² One of the guidelines relates to the awareness of professionals regarding LGBTT rights. Although this guideline from the Ministry already exists, it is known that the change in attitude in relation to topics susceptible to prejudice has been very slow. Thus, the controversy that can occur in the BC meetings is a great opportunity to air the topic, understand and/or review the aforementioned policy, and create appropriate forms of care.

The issue of suicide was cited as an important subject to be contemplated in the BC. It is worth noting that suicide is considered a relevant public health problem throughout the world. Vidal and Gontijo³⁴ point out the importance of quality of care in cases of attempted suicide, since most suicidal people are assisted by some type of health service, especially in the emergency units, before a fatal suicide attempt. For the authors, this first contact is an excellent opportunity for health professionals to identify the potential level of risk, which enables intervention actions to reduce it.

However, it is precisely during this contact that negative reactions can occur, such as hostility and rejection on the part of the professionals, who may feel that their time is being wasted, since they could be dedicating themselves to more serious patients who, in fact, want to live. This interpretation tends to decrease tolerance towards the patient and increases the possibility of them not receiving adequate care. The BC's role, both in internal discussions and in educational activities directed to other sectors of the institution, as well as in the monitoring of suicide attempts, is fundamental to transmit values, perceptions and feelings in relation to these cases, which helps the quality of the care offered.

As for the lack of vacancies in the emergency room and ICU - which was cited by one of the respondents as a possible topic to be explored - Fortes, Zoboli and Spinetti³⁵, when studying literature specialized in bioethics regarding the selection of candidates for scarce health resources, found several criteria: scientific objectivity, screening, waiting lists, social criteria and randomization. The authors report that most of the criteria found are based on the principle of social utility.

Some of the aspects highlighted were the patient's cooperation with professionals; age; gender; potentially affected and rehabilitated workforce; potential and life expectancy; adjusted years of quality life, and the support environment for follow-up treatment. The authors also point out that for the support needed, social and economic conditions, social merit, social responsibility and lifestyle can also be considered. The reading of texts and discussions in the BC can provide elements of reference to face situations of this type.

Regarding the Advance Directives or Living Will, the answers to the questionnaires reveal it to be a provocative and current topic, although controversial and full of uncertainties. Thus, it is suggested that it should be widely discussed at the committee meetings. The concept of a Living Will emerged as a response to technological advances and aggressive medical treatment, used in ambiguous situations, often referred to as therapeutic obstinacy³⁶. As of CFM Resolution 1995/2012³⁷, opinions for and against were presented by doctors and other professionals in the media.

The Resolution sets out criteria for anyone to be able to define with their doctor the therapeutic limits at the terminal stage - as long as they are of legal age and fully aware. The Living Will is considered a way to protect autonomy and respect values and choices of the patient^{36,38}. However, it should be taken into

consideration that competent people may not always be able to make decisions about their future, since these decisions can be based on an imaginary concept of how the future would be³⁸. Thus, taking into account the considerations of these authors, the answers to the questionnaires show a balanced position on the topic, taking into account the progress that the Advance Directives represent, but also the associated risks.

The reality in the region where the hospital is located has prompted some respondents to suggest further studies on public health in order to detail the needs of the local population. This suggestion is in line with what Troster³⁹ points out, when he considered it desirable for committee members to understand the health system and health policies. Porto and Garrafa⁴⁰, when reflecting on the relationship of Brazilian bioethics with public health, consider that there has been agreement in this field. This has been verified since 2005, when national bioethicists and sanitarians played an important role in the formulation of the UNESCO Universal Declaration on Bioethics and Human Rights¹⁹. In its article 14, the declaration deals with social responsibility and health by including public health in the bioethics references, strengthening the fundamental rights of human beings, including access to quality health care.

Final considerations

In agreement with other reports about the experience of bioethics committees mentioned in this study, the path followed by the BC of the HGSM reveals the importance of encouraging the creation of such forums in Brazilian health institutions. These forums should focus on the analysis of both the complex situations arising from scientific progress in the field and the day-to-day situations of health care.

Some basic principles for the functioning of bioethics committees are highlighted based on this research: professional diversity of members; presence of external participants; educational role; assistance in assessing the complex issues generated by the demands; receptive and non-punitive attitude; the reading and discussion of issues related to care practice.

It is recommended that reports of the experience of other BCs are disseminated, with the objective of enhancing this important institutional resource, which greatly contributes to the improvement of professionals, of the hospital and of the quality of care provided to patients.

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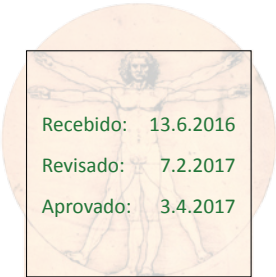
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Participation of the authors

Maridite Cristóvão Gomes de Oliveira was responsible for designing the study, collecting data and preparing the article. Maria Cezira Fantini Nogueira-Martins supervised the project. Reinaldo Ayer de Oliveira was responsible for the review of the article.



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