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Medical ethics in medical training

Thays Helena Barbosa Sanchez [1], *Ipojucan Calixto Fraiz* [1]

1. Universidade Federal do Paraná, Curitiba/PR, Brasil.

Abstract

The new Medical Code of Ethics entered into force in 2019, with the Resolution CFM 2.217/2018. This article focusses on the directives of this document, seeking to identify if they reflect changes in the Society and how the ethical concepts taught during training impact the professional practice. Of qualitative character of primary and secondary data, the sample comprised 15 semi-structured interviews selected with by snowball sampling. The participants are doctors of the residency program of the Complex of the Clinical Hospital of the Federal University of Paraná. We understood that the precepts of the code adhere to human rights and to bioethics. Furthermore, the ethics taught during training was insufficient for the professionals. We concluded that, for having force of law and being based on moral principles, the Medical Code of Ethics fosters the normalization of the medical action; however, a medical conduct based on the ethical directives requires a professional update.

Keywords: Codes of Ethics. Ethics, medical. Education, medical.

Resumo

Ética médica e formação do médico

O novo Código de Ética Médica entrou em vigor em 2019, por meio da Resolução CFM 2.217/2018. Este artigo aborta as orientações desse documento, buscando identificar se elas refletem mudanças ocorridas na sociedade e como conceitos éticos ensinados durante a formação médica impactam a prática profissional. Com caráter qualitativo de dados primários e secundários, a amostra compôs-se de 15 entrevistas com roteiro semiestruturado selecionadas pelo critério "bola de neve". Os participantes são médicos do Programa de Residência Médica do Complexo Hospital de Clínicas da Universidade Federal do Paraná. Compreendeu-se que os preceitos do código são consonantes aos direitos humanos e à bioética. Ademais, a ética ministrada durante a formação mostrou-se insuficiente para os profissionais. Conclui-se que, por ter força de lei e ser respaldado por princípios morais, o Código de Ética Médica propicia a normatização da atuação médica, no entanto uma conduta médica pautada nas diretrizes éticas requer atualização profissional.

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

Resumen

Ética médica y formación de médicos

El nuevo Código de Ética Médica entró en vigor en 2019 mediante la Resolución CFM 2.217/2018. Este artículo aborda los lineamientos de este documento, buscando identificar si reflejan cambios en la sociedad y cómo los conceptos éticos tratados durante la formación médica impactan la práctica profesional médica. La muestra cualitativa con datos primarios y secundarios constó de 15 entrevistas semiestructuradas, seleccionadas por el criterio "bola de nieve". Los participantes fueron los médicos del Programa de Residencia Médica del Complejo Hospital de Clínicas de la Universidad Federal de Paraná. Los preceptos del código resultaron estar acordes con los derechos humanos y la bioética. Pero es insuficiente la ética que se aborda en la formación. Así, por tener fuerza de ley y fundamentarse en principios morales, el Código de Ética Médica dispone de la regulación de la práctica médica, sin embargo, una conducta médica basada en lineamientos éticos requiere actualización profesional.

Palabras clave: Códigos de ética. Ética médica. Educación médica.

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Medical practice comprises the physician-patient relationship, clinical-surgical competence and continuous improvement of learning to ensure quality care based on hippocratic ethics, normative ethics, and deontological ethics [1]. Thus, medical improvement, both practical and theoretical, is indispensable for timely holistic care.

Therefore, the merit of evidence-based medicine as a parameter for guidance of medical conduct today is notorious, since the guidelines explain the most appropriate management in health care from an ethical point of view. Thus, in line with scientific guidelines based on ethical principles, the Federal Council of Medicine (CFM) published the latest update of the Code of Medical Ethics (CEM) in Brazil.

The new CEM (2018) [2-4] came into force on May 1, 2019, consolidating itself as the most up to date document of its kind. The CEM elucidates and regulates the attested rights and duties stipulated to physicians, protecting both physicians and patients. Thus, it is noted that professional ethical principles are continuously stimulated to update themselves to safeguard professional rights and duties in the social context [5]. The CEM ensures legal coherence and commitment to health, human rights, and bioethics [6].

It is worth noting that the Regional Councils of Medicine (CRM) are responsible for supervising professional ethics, so that medical conduct, without due ethical regulatory compliance, is subject to punitive liability provided for in Law 3,268/57 [7]. Such accountability ranges from warnings to revocation of professional practice. For clarification purposes only, ethical-professional processes are subject to CRM, although liabilities subject to civil and criminal sanctions are subject to the courts of Justice [8].

Regarding the new edition of the CEM (CFM Resolution 2,217/2018) [9] approved based on the consensus among the most influential experts and representatives of medical associations and managers of national councils, it is worth mentioning a subtle but substantial progress in relation to the previous code (CFM Resolution 1.931/2009) [10], insofar as the new code was intentionally drafted in a clearer, more precise and assertive way, providing a reduction of interpretative bias [11].

Given the medical-legal relevance brought by the publication of CEM/2018, this research intends to discuss the impact of knowledge of ethical guidelines in the context of medical training and performance [3,4]. Thus, we seek to reflect on the quality of medical training within the scope of ethical discipline. As well, we discuss whether the precepts present in CEM/2018 are in accordance with the demands of current society. Therefore, this study analyzes the importance that newly graduated physicians attribute to the knowledge of medical ethics for good professional practice, based on the physician-patient relationship [3,4].

This study, of qualitative nature, addresses medical ethics and the training of physicians through semi-structured interviews with first-year physicians of the Medical Residency Program of the Hospital de Clínicas Complex of the Federal University of Paraná (CHC/UFPR). *A priori*, the select group researched is justified by the uniqueness of being physicians formed by different Brazilian# universities, in addition to configuring the portion "closest" to medical graduation. Thus, the verisimilitude of the theoretical ethical learning constructed over the undergraduate course is more clearly opposed to the ethical domain of professional practice.

Objective

The objective of this article is to qualitatively evaluate the level of knowledge of first-year residents of the medical clinic (MC) and Family and Community Medicine (MFC) specialties of the Medical Residency Program of the CHC/UFPR regarding the CEM. In addition, from a literature review of scientific articles on medical ethics, it is intended to broaden the analysis of the results found in the context of medical training.

Method

The study consists of applied research of a qualitative nature, with a cross-sectional, exploratory and descriptive character of primary and secondary data. The core of the study material was extracted from interviews guided

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by a semi-structured script [12] consisting of three topics, namely: 1) identification; 2) perception of the teaching of medical ethics; and 3) knowledge of the CEM.

All research was carried out from the participants signing the informed consent form. The semi-structured script and the consent forms were compiled so that the first directed the interviews to a specific data collection, comprising the central analysis, and the second safeguarded the rights of the interviewees.

Given that the qualitative study is *sui generis* in its conclusions, the results present a current, unprecedented, innovative character and, therefore, adequate to the objective of the research, insofar as it is not intended to seek or identify the phenomenon, but rather to capture and understand the individual and/or collective meaning of this for the lives of people [13]. Thus, the research interprets the phenomenon based on its meaning for the interviewees [14].

Therefore, the qualitative model explores and enables greater thematic openness to the interviewee, deepening the subject by exploring items that are normally involved in quantitative research. This study is in line with the latest publications on the theme of ethics and adds unpublished content, by promoting discussion about the new guidelines, bringing reports, experiences, conflicts and ethical challenges of CHC/UFPR residents.

The participants of the research were necessarily in the first year in the specialties of MC or MFC of the Medical Residency Program of the CHC/UFPR. The list of those eligible to participate in the study was made available by the Medical Residency Commission (Coreme) of the CHC/UFPR. The selection of the first participant occurred from the random choice of a resident effectively enrolled in one of these two medical careers.

Subsequently, the sampling scope followed the "snowball" method [15]. From a semi-structured script, the interviews were conducted in person and, *a posteriori*, the telephone was used as a means of communication for possible clarification, totaling an individual informational exchange of, on average, 40 minutes. In a second moment, the information collected was subdivided by content addressed and identified by codes, to then perform a targeted and optimized analysis. The most relevant contents and the most incident responses of the participants were transcribed literally. From a semi-directive conduction and a comprehensive interview [16], greater depth of content was extracted from the nuances of the dialogue, minimizing superficial responses.

It should be noted that the sample was defined according to the theoretical saturation for qualitative methods [17]. Thus, from the moment the interviews allowed obtaining repetitive answers, the theoretical saturation of the sample was inferred, timely interrupting the participation of more respondents.

The documentary sample consisted of 15 interviews in total, and participation in the research was voluntary and optional. However, given the existence of an inconsistent and contradictory discourse in relation to the theme and two other formal withdrawals (of consent), the final compilation of this work consists of 12 validated interviews with content consistent with the theme. Although, in absolute numbers, the sample is small, the scientific gain is based on the qualitative character, since it resides in the depth, and not in the extension [16].

The bibliographic review of scientific articles with comparative purpose, to analyze the results found, was carried out in the electronic databases SciELO, Medline, PubMed, Lilacs and Cochrane, using keywords "Code of Ethics," "*Medical Ethics*" and "Medical Education" and their respective synonyms.

After a critical and systematic evaluation of the consistency of scientific evidence, articles were selected that contained discussions about medical education and the respective professional ethical knowledge based on the CEM, concomitantly with the use of a conceptual and argumentative basis of books published in the area of medical education.

Evolution of ethical dictates

In the classical Agora of ancient Greece, Socrates (5th century BC) inaugurated the concept of ethics publicly. Due to the maieutic method

based on questions, the philosopher encouraged the process of reflection on individual values and the moral dictates in force – virtue and goodness – because he understood that the ethical man does not subvert his morals, either by circumstances or by the whim of others, because he has mastery of its foundations and its purpose. Therefore, the individual who enjoys genuine moral values has the awareness and ability to think actively, to question and re-evaluate their own actions. In short, they are the master of their decision-making process [18].

Furthermore, as Neves points out, according to Plato (428 BC), Ethics *is a habit, art, of doing good, which makes good what is done and who did it* [1]. In detail, it is understood that the moral precepts are innate to the individual; and the habit, in turn, allows to perfect them. In his writings, Plato assumes that an ideal civilization would provide happiness to every individual, as it would constitute a social environment in which each citizen would exercise professional activity according to their inherent virtues and aptitudes. Thus, ethical aptitude is broad, but specific and inseparable from the individual.

In this sense, the idiosyncratic characteristic of ethics has an intrinsic correlation with moral virtue, honor and character. Notably, warriors and politicians were endowed with the noblest moral attributes and, on the other hand, slaves were not even worthy of civic law. It is therefore essential not to untie the philosophical concepts of the political-social dogma of the time.

Ultimately, the notion of Greek social justice is satisfied, precisely, when one reaches the *status* of harmony between the different social classes – in which each human ethical attribute is expressed in favor of society. Thus, a skilled and upright professional behaved correctly and then without any need for recommendations of conduct. Therefore, ethics was not understood as it is currently understood – dependent on specific prior agreements and compiled as normative in a code of ethics [18-21].

Hippocrates, a Greek physician and contemporary to the same philosophers, is universally recognized as the father of medicine [1]. However, it was Percival, an 18th-century English physician, who published the first code of medical ethics [3,22]. At this juncture, it is noteworthy that ethics is a broad concept, referring to the moral behavior of the individual in society, and medical ethics, in turn, restricts the focus of attention only to the moral behavior of physicians in their professional practice.

However, it was only from the second half of the twentieth century that the medical career disengaged from classical ethics, while both the exercise of citizenship and the awareness of the right to shared decision in the disease process required no longer a virtuous professional, but rather skillful and competent for the proper exercise of the profession [23].

In the global context, human rights have gradually established themselves as the core for building a more universal concept of medical ethics because, due to the pluralism of nations, the innumerable cultural references and the various moral traditions, a convergence of the ethical conception is necessary to safeguard the common medical principles and consistent with human integrity and dignity.

Another highlight is the *Geneva Declaration* [24], dated 1948, one of the most consistent policies of the World Medical Association (WMA), considered one of the central documents of medical ethics, insofar as it aims at the structure of the medical oath in entering the profession. It is therefore based on the principles of the Hippocratic Oath and is currently known as the modern version of doctors' commitment to the humanitarian principles of medicine.

In 2017, the WMA Council approved a draft revision version for public consultation, to edit the next update of internationally recognized ethical precepts. In addition, the *Geneva Declaration* is often incorporated into the CEM of different nations or used as a reference for compiling such codes.

It is also worth mentioning that the last International Code of Ethics, entitled *57th WMA General Assembly*, brings items on ethical medical conduct, consisting of three major topics: 1) the duties of physicians in general; 2) the duties of physicians with patients; and 3) the duties of physicians with their colleagues [25].

Briefly, it is inferred that the CEM validates and ensures the quality of health care, since, as a force of law and supported by moral principles, it provides the standardization of medical practice.

However, the permanence of a medical conduct based on modern ethical guidelines requires that, from time to time, the CEM be updated.

At the national level, in 2016, an intense discussion began between members of the CFM, the CRM, specialists and representatives of the Brazilian Medical Associations, then participants of the III National Conference of Medical Ethics (Conem), which culminated in the approval of the new CEM in 2018 [3,4]. This update came into force on May 1, 2019, through CFM Resolution 2,217/2018 [9], thus revoking the previous code (CFM Resolution 1,931/2009) [10].

It should be noted that there are nine CEM published in Brazil [3,11,23]. Therefore, the medical ethical foundations are continuously reviewed, based on evidence, reinforcing the notorious relevance of the physician-patient relationship for society.

Occasionally, some of the main changes in CEM/2018 [3,4] refer to the explicit incorporation of protection to society; respect for the patient even after his death, ensuring greater protection of the dignity and integrity of the human being; determination of the use of the best technical and scientific means available in the workplace, both for health promotion and prevention; inclusion of the doctor with some disability in relation to the full right to practice medicine without prejudice to patient safety.

In addition, CEM/2018 [3,4] determined that it is the duty of the physician, when it is his obligation, to attend in urgency and emergency sectors. There was also express inclusion of the medical duty with their professional colleagues, ensuring respect, consideration and solidarity. Finally, the code brought the obligation to pay attention to the specific rules of the CFM regarding the use of digital communication channels [9-11].

Thus, this section is built to support the objective of this study, which deals, in the first analysis, with the CEM and, *a posteriori*, with the correlation with the medical formative aspect before the study of ethics throughout the undergraduate course. The singular aspects of the thematic conceptualization are complementary to the result of the study and, therefore, historical clarification is crucial to effectively direct the efforts of specific analysis of medical ethics in today's society.

Ethical study

Context of medical undergraduate studies

On the global scene, with regard to medical training, the WMA recommended the universal inclusion of medical ethics and human rights as mandatory content for medical undergraduate studies [26] since the association intends to promote the highest standards and ethical behavior in the medical profession. WMA and its committees continually review emerging ethical issues, regulating and updating existing policies. Therefore, it institutes global policies focused on ethical issues concerning medical professionalism, patient care, research on human beings and public health.

Meeting the international dictates, the Ministry of Education (MEC), an agency of the Federal Government of Brazil founded in 1930 [27], during the Getúlio Vargas Government, released Resolution CNE/CES 3/2014 [28], which establishes the National Curriculum Guidelines of the Undergraduate Course in Medicine. Thus, among the determinations of the training of the general practitioner, we highlight the professional performance based on ethical principles from the perspective of integrality of health promotion assistance, based, then, on the sense of social responsibility and commitment to citizenship.

It is noteworthy that Brazilian# universities have the discretion to set up their own pedagogical project; however, they must respect general guidelines issued by the MEC, which are in line with the dictates of the WMA.

From the aforementioned literary scope, the discussions about the main resolutions and decrees that underlie medical education in Brazil, based on the quality of health care, notably in relation to the field of professional ethics, were closed. Although the study of ethics is present in undergraduate courses, ethical infractions permeate the reality of the medical career.

Medical Residency Program

Regarding medical residency, regulated by Decree 80,281/1977 [29], it is presented as a postgraduate teaching modality for physicians in the form of a specialization course. In addition

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to the decree, the National Medical Residency Commission (CNRM) was created to supervise medical residences in Brazil.

According to the CNRM, in 2018, according to data from the System of the National Medical Residency Commission (SisCNRM), there were 26,094 vacancies authorized for entry into the first year of medical residency (R1) in Brazil, considering all medical specialties [30]. Of these, in the state of Paraná, there were 1,511 vacancies [31].

In the context of CHC/UFPR, Coreme, as an auxiliary instance of CNRM, supervises and evaluates the institution's medical residency programs (PRM), whose management is supported by norms of CNRM, CHC/UFPR and its internal regulations. Therefore, as the responsible body, Coreme, through the PRM Notice of CHC/UFPR 2019, ensures 24 vacancies for R1 in the specialty of CM and 20 vacancies for R1 in MFC [32]. Therefore, the total number of possibilities of the research sample was 44 physicians R1 of the PRM of the CHC/UFPR.

Thus, after finishing the process of basic contextualization in which the selected group of participants of this study is inserted, it is possible to discuss more thoroughly the points notably relevant to the analysis.

Results

The field study of this scientific proposal consisted of interviews, with a semi-structured script, of 15 resident physicians effectively enrolled in the first year of the PRM of the CHC/UFPR, divided between two medical specialties, medical clinic and family and community medicine. However, given the presence of an inconsistent and contradictory discourse in relation to the theme and two formal withdrawals of consent, still during the elaboration phase of this study, the number of validated interviews with content consistent with the theme was reduced to 12 participants, identified with codenames R01 to R12. Of these, seven physicians belonged to the MC specialty, and five to the MFC specialty.

It is noteworthy that the focus of the study is prior knowledge, whether acquired during the course or in professional practice immediately after it (before the 1st year of medical residency of the CHC/UFPR), about the CEM and its updates. Therefore, it is not sought here to disclose data such as gender, age or the institution of acquisition of the medical title of the participants involved, in order to preserve their identity.

From the content extraction of the participants, the orientation of the descriptive analysis for explanatory analysis [33,34] was conceived by dividing into five categories, elected based on the highest patterns of key expressions and correlates between the exposed responses. They are: C1) ethical teaching throughout medical undergraduate course; C2) outdated on the subject CEM/2018 [3,4]; C3) practical opportunity to use the principles of CEM thanks to prior knowledge; C4) need for the participation of more experienced preceptors or doctors to conduct an ethical case; and C5) ability to comment on an update of CEM/2018 [3,4] (Table 1).

Table 1. Categorization of the responses of the first-year resident physicians of the Hospital de Clínicas Complex of Federal University of Paraná of the two specialties surveyed

SPECIALTY	CM	MFC	TOTAL
CATEGORY	Attendance No. of items present %	Attendance No. of items present %	Resulting No. of items present %
C1 **Medical training** *"Little knowledge"* *"The importance of ethics (...) is subdued"*	42.8	20	33.4
C2 **Outdated on CEM/2018** *"I really don't remember"* *"I don't know"*	28.6	20	25

continues...

Table 1. Continuation

SPECIALTY	CM	MFC	TOTAL
CATEGORY	Attendance No. of items present %	Attendance No. of items present %	Resulting No. of items present %
C3 **Domain of CEM in practice** *"I explained the case, (...) I respected the patient's decision"* *"I took a contrary position (...), because I knew the ethical principles"* *"The patient's confidentiality was respected"* *"I have charged the proper fees"*	57.1	40	50
C4 **Presence of others in decision making** *"I went to discuss the case to ensure the most appropriate conduct"* *"I didn't decide alone"* *"I needed the help of a more experienced professional"*	14.3	60	33.4
C5 **Ability to comment on a CEM/2018 update** *"According to the latest edition (...), one of the fundamental principles"* *"Specific item that cites the use of social media"* *"Reinforces the need for respect and consideration with colleagues"* *"Inclusion of the right to professional practice by the disabled physician"*	57.1	80	66.7

MC: medical clinic; MFC: Family and Community Medicine

The percentages in Table 1 were calculated from the frequency of occurrence of explicit content/number of residents interviewed. Subsequently, they were recorded in the categories created (with their respective meanings), also observing the distribution by specialties. Therefore, the focus of the analysis is on prior and formative knowledge about the CEM and its domain for the practice of the medical act. Thus, we opted for the key analysis of medical training, added to the exclusionary categories, namely: updated *versus* outdated on CEM/2018 [3,4]; and domain of CEM for clinical management *versus* need for others to conduct an ethical case.

After presenting the main results regarding the domain of ethical knowledge by the R1 interviewee group of the CHC/UFPR and regarding the issue under analysis of familiarity with the CEM/2018 [3,4], we then proceed to discuss the highlighted results.

Discussion

Ethical knowledge in the medical scenario of CHC/UFPR

In this topic, the core of the analysis is ethical teaching throughout medical undergraduate studies (categorization C1), including thematic outdating (categorization C2) and, finally, the need for the presence of a more experienced physician to conduct an ethically focused clinical case (categorization C4). Therefore, from the analysis of co-occurrences [34], the issue of medical ethics in the context of physician training is highlighted.

To begin the analysis of the results, it is noteworthy that, according to the Regional Council of Medicine of the State of São Paulo (Cremesp), between 2001 and 2011, the totality of ethical-professional processes in that state increased by 302%. In the first analysis, this fact

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is associated with penalties, more specifically those resulting from bad practice and precarious medical training [35]. The results presented by the CFM in the survey Profile of Doctors in Brazil corroborate the discredit with Brazilian education and medical training. The most significant data published are: 16.5% of Brazilian physicians are unaware of the existence of the CEM and 81.5% of professionals show skepticism about the direction of medical practice [36].

In this context, the field research carried out presents converging information, such as: a prevalence of 25% of responses that point to the outdated regulations of CEM/2018 [3,4]. These young physicians, with similar propositions, in their entirety, point to the fact as a consequence to the limited learning of ethics throughout medical undergraduate studies.

"It's... I don't know the year of the last update of the Code of Ethics. (...) the ethical study was not a priority, it certainly was not the most discussed topic during the years of my undergraduate studies. There were subjects that I needed to master before, but in the end, I forgot the ethical issues that involve medical practice" (Resident R04/C2 categorization).

In a confluent way, a total of 33.4% of discourses mention the insufficiency of formative ethical teaching, despite the high conceptual relevance to professional life.

"Since graduation, I feel a lack of confidence to discuss medical ethics. I think because of the little knowledge in the area. Even today, with a greater perception of the importance of a good theoretical training, I have no broad mastery over professional rights and duties, but the basic secrecy. My time is directed to other updates" (Resident R01/categorization C1).

"The importance of ethics in medical school is subjugated by students and not so valued, as other disciplines, by teachers. But this failure in teaching we only realize at the time of practical life, when we have that anxiety for not knowing how to proceed" (Resident R12/categorization C1).

The two previous categories under analysis corroborate the frequency of 50% of discourses that show the need for the presence of others to finalize their own conduct, as shown below:

"Not only did I experience it (...), but I had to ask for help from medical colleagues to guide me at the time. "I didn't decide alone" The doctors who are older in the service end up helping a lot, especially in these moments of doubt" (Resident R05/categorization C4).

"Look, it's not even been a long time... I went to discuss the case to ensure the most appropriate conduct. I had to learn in practice how to protect myself. Because, of course, it is not the medical area that I know most" (Resident R08/categorization C4).

Based on the above, it is possible to note that medical unpreparedness in the ethical field is a reflection of years of undergraduate studies with reduced use of time dedicated to the discussion and study of the discipline. The teaching-learning deficit in question obviously goes beyond the academic environment and affects the quality of professional performance. In this sense, Neves [1] and Schuh [37] discuss, historically and scientifically, the need for a new methodological intervention to boost the quality of medical training, within the scope, of the ethical area and its aspect physician-patient relationship.

Use of the precepts of the Code of Medical Ethics

This topic focuses on discussing practical professional experiences that required the use of the EMC precepts (categorization C3), in addition to the main references to the present updates of EMC/2018 [3,4] (categorization C5). Such an approach is necessary to understand the reflections of ethical dictates in the medical routine.

To continue the analysis of the results, it is worth emphasizing the solid jurisprudence that understands medical services (hospitals/doctors and patients) as a consumer relationship, which are, therefore, governed by the Consumer Protection Code (Law 8,078/1990 [38]). Thus, according to data published in the newspaper *O Estado de S. Paulo* cited by Macedo [39], the number of cases in the Supreme Court related only to medical error rose 140% from 2010 to 2014.

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In this context, it is important to highlight the existence of the "indemnity industry" [8], in which, on the other hand, physicians adopt "defensive medicine" [40,41]. This affects both the acquisition of professional liability insurance for physicians and the request for examinations, referrals, procedures or therapies without specific indication, as a means of protection against possible liability. According to Woodward [41], according to data from the American Medical Association (AMA), it is estimated that the protective medical resource of requests for examinations, procedures and therapy is responsible for 10% of the entire cost of internal medical services in the United States.

In view of the above, it is possible to note that poor medical performance can reflect both in an administrative process (ethical-professional process), within the scope of the Regional Councils of Medicine, and in a judicial process (in the civil or criminal spheres). Therefore, the domain of medical law and medicine enables a more cautious, timely conduct with normative support for an unblemished professional performance. CEM/2018 [3,4], then, is presented in accordance with the daily demands and exigences of medicine and today's society.

At this juncture, conducts dependent on ethical *expertise* point to conceptual importance that are in line with the correct professional practice.

"I explained the case, gave the information and all necessary clarifications (...), including the options of procedure, consequences and risks. After clarifying the doubts, I respected the patient's decision" (Resident R02/categorization C3).

"I positioned myself against the patient's request not to tell the sexual partner (...), for knowing the ethical principles of fair reason for breach of confidentiality. I was confident in the conduct of disclosing the diagnosis to the partner, with written consent, in defense of the health risk of a third party" (Resident R03/categorization C3).

"It was a situation of beginning of sexual life (...). Finally, the patient did not want her parents to know. As my adolescent patient had the ability to discern to understand her health situation, then the confidentiality of my patient was respected" (Resident R07/categorization C3).

Category C3 under discussion underlies the need for medical updating regarding the EMC precepts to safeguard the horizontal relationship between physicians and patients, as well as to ensure the technical authority of the professional. Regarding CEM/2018 [3,4], references to the updates are as follows:

"According to the latest edition (...), one of the fundamental principles I remember is about using the means that are available to achieve the best results. The intention is to do what is best for the patient, however, recognizing that the conditions that exist at the moment may limit our performance. Hence, we fall into the reality of the profession, in which the ideal is not always the possible, but we are aware and supported" (Resident R06/categorization C5).

"There is a specific item that cites the use of social media, which must respect the CFM standards. For example, as it is happening today in the country. The CFM released an exceptional regulation for telemedicine that was given by specific resolution" (Resident R9/categorization C5).

"(...) one point I remember is that the new code reinforces the need for respect and consideration with colleagues" (Resident R10/categorization C5).

"I read about the inclusion of the right to professional practice by the disabled physician, respecting, of course, their limitations. This shows the isonomy of treatment with medical professionals" (Resident R11/categorization C5).

It is noteworthy that the excerpts provided in this topic are from resident physicians who stated to delve into the subject after school. Thus, the ability to explore the theme is closely linked to the dedication to ethical study after standard medical training. In this context, different sources for updating were mentioned, such as the re-reading of CEM/2009 [10], the reading of CEM/2018 [3,4] and the realization of face-to-face medical ethics courses made available by CRM in 2019.

That said, from an analytical perspective of the facts, there is again a low ethical learning during medical training, as already documented by Camargo [42] in a similar study. In addition, there is a common need for knowledge of medical

ethics to assertively deal with conflicts and challenges present in medical practice. Therefore, residents with greater capacity to discuss the theme represented a group of professionals who devoted time to ethical study, in addition to academic training.

Thus, the C3 categorization presents a perspective that ethical knowledge brings legal certainty to the exercise of the medical profession. Therefore, it is inferred that the Code of Ethics incorporates the material *status* of the medical routine. Furthermore, França [40] reiterates the value of medical ethics, as it recognizes the formative deficiency of medicine in Brazil, highlighting the decline in the quality of the professional class.

Thus, it is possible to notice a convergence of the results with the scientific literature, and the medical reality demonstrates, therefore, an academic scenario of didactic stagnation in the ethical disciplinary field. In this context, D'Avila [43] proposes new, less rigid and more dynamic ways of integrating ethics with medical practice over the six years of school.

In short, from the discussion of the content and the commitment to good medical training, it is intended that the subject is no longer neglected, so that the recognition and appreciation of the medical profession is no longer a privilege, but a guaranteed right [44].

Analysis correlations and limitations

In this last topic, from a "structural" analysis [34], it is understood that the ease in discussing the topic of medical ethics is closely related to the priority of the ethical study required in the different stages of medical life. Thus, understanding and thematic domain are lower during medical school and, gradually, greater throughout professional life. Still with regard to CEM/2018 [3,4], its precepts are in line with human rights and the principles of bioethics [6], reflecting in essence the current society.

The study has some limitations due to the inability of all categories under analysis to be addressed by all respondents, as many are supported by the right not to opine. The explanation is due to the embarrassment faced by the interviewees in the absence of articulation on the subject or to the purposeful escape from the context, in this case individuals who are sometimes more prolix. This data reinforces the difficulty of the interviewees in transposing the academic study and, thus, expanding the theme, either in a discussion or in medical practice.

Another limiting factor lies in the sample choice itself by the "snowball" technique [15], in which the participants were restricted to groups of physicians closer to each other. On the other hand, the connection between them facilitated the researcher's contact and the interviewees' commitment to the study. In addition, physicians represent academic origin and, thus, distinct influences of undergraduate studies, which corroborates the verisimilitude of the results with the education and health literature on formative ethics.

This study, then, is oriented in line with the commitment expressed in the *Geneva Declaration* [24], whose text emphasizes the principle of sharing medical knowledge, whether for the benefit of the patient or for the advancement of health care. Therefore, the scientific benefit of the research lies in the dissemination of an updated compilation of the new ethical precepts of medicine and in the correlation of these norms with the reality of the clinical practice of first-year residents of the CHC/UFPR.

Final considerations

The CFM, through CEM/2018 [3,4], published the new standards and principles of professional medical conduct, broadly discussing the latest ethical perspectives in the medical area. In this context, this article shows, locally, that the new guidelines are in line with the current demands and needs of medicine and society.

In addition, this research, in the university context, carried out with a portion of first-year residents of the CHC/UFPR, allows us to verify that, although the Brazilian medical degree allocates exclusive time to ethical study, there is still a *lack* of mastery and security of the subject by the resident in the professional environment. This is due to the short time dedicated exclusively to understanding and updating the concepts of medical ethics. Moreover, comparatively, the perspectives indicate that

the years of profession are inversely related to the unpreparedness to discuss the nuances of ethical concepts in current medicine.

From the understanding of the thematic relevance, there is, then, motivation for updating and for the engagement of other scientific studies and pedagogical improvements in the training area. The global tendency to value the physician-patient relationship in the various specialties of modern medicine is gradually highlighted. Therefore, this study is a promising focus for new perspectives in the area of medical education.

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Research

Thays Helena Barbosa Sanchez – Graduate (specialist) – thays.sanchez@edu.pucrs.br
0000-0002-0206-6180

Ipojucan Calixto Fraiz – PhD – fraiz@uol.com.br
0000-0002-0366-4297

Correspondence
Thays Helena Barbosa Sanchez – Rua Quinze de Novembro, 1290, ap. 12, Centro CEP 79002-141. Campo Grande/MS, Brasil.

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