

Government of the public: physician-patient relationship within medical expert advice for social security

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Introduction

Bioethics can be conceptualized as a discipline in the ethics family¹. Pegoraro² reminds us of the etymology of the word “ethics” with two complementary aspects, *ethos* as a way of existing and *ethos* as a place which one inhabits. Thus, the attempt to understand the conflicts that emerge in the daily working routines, in the professional exercise of the medical experts of the Brazilian Social Security System, is related to understanding the subject as an ethical being, a “political animal” of individual action, with interface/repercussion on collectivity. In addition, it means adopting an approach that overcomes the limits of a bioethics that is a subsidiary of the biomedical field³⁻⁵.

In modern and contemporary states, the social welfare policies, remarkably social security, show the State’s leading role in the task of preserving life, in its management. In the form of agreements and contracts, they aim at the population as a whole, and they ensure rights to and demand duties from the individuals in their basic needs for supporting themselves and their families.

In Brazil, social security is a constitutional right that integrates the Social Security System together with the health sector and social assistance, guaranteeing coverage for vital events like birth, illness/disability, disablement, old age and death. The resources for these guarantees come from mandatory contributions payable on the economic activity. The administration and operationalization of social security benefits are the responsibility of the *Instituto Nacional do Seguro Social* (INSS – National Institute of Social Security), an autonomous agency of the Social Security Ministry.

The disability benefits integrate the range of benefits and aim to guarantee income to Social Security insured workers whose disability prevent them from working. The recognition of the disability, of its onset, the maintenance and cessation are legal competences of the Medical-Legal

Examination Activity of the INSS or of the Medical-Legal Examination Activity of the Social Security System^{6,7}. The disability assessment, a medical-legal task, occurs in the interface with the insured worker. It is through the exercise of this technical task, in this space, that the distinction between able and disabled individuals occurs.

The application for the disability benefit derives from the perception of the Social Security insured worker, or of his/her legal representative, that he/she has an organic and/or psychic condition recognized by the medical rationality as an illness. In theory, this biopsychic condition alters involuntarily the worker's capacity for guaranteeing his/her economic support (and that of the family) through the income earned in the work he/she used to exercise or could exercise.

Therefore, the existence of the normality disorder needs to undergo, firstly, an operation of recognition, by the medical power-knowledge, of the existence and designation of a clinical diagnosis. The second operation of this power-knowledge is to recognize the illness as disabling, that is, the regulatory framework. In this activity, the rationality of medicine is put at the service of the rationality of law, in a double reasoning that is called social security reasoning⁸.

The disability benefits can have their causality related to work - accident benefits - or not, when they are called social security benefits. The disability benefit is the most frequent among all the benefits granted by the Social Security System. In 2011, the Social Security System granted 4.8 million benefits. Disability benefit, age pension and maternity pay were the most frequent, corresponding to, respectively, 42.4%, 12.2% and 11.9%.

According to the Manual of Medical-Legal Procedures of the Social Security System, "the medical-legal examination aims at performing a labor assessment of the examinee for the purpose of framing in the pertinent legal situation"¹⁰. In 2011, 7,396,562 medical-legal examinations were conducted, with 68.9% of favorable conclusions. This arbitration, however, is frequently a subject of controversy¹¹.

We consider that the doctor-patient relationship in the Social Security System adds conflicts that are typical of the situation of medical-legal examination (its inclusion/exclusion scrutiny operation) to elements of the assistance field, influencing expectations and results. We work with the hypothesis that the conflicts that emerge in the expert-insured worker interface are expressions of the medical-legal activity included in the social security management calculation. In this sense, the medical-legal examination would be part of a security device, an expression of the biopolitics of social security, of government functioning¹²⁻¹⁵.

What is the doctor-patient relationship?

The doctor-patient relationship has been the theme of several studies with different focuses¹⁶⁻¹⁹. In this paper, we understand it in the perspective of the approach to the medical worker in relation to his/her object, the ill body, and in the perspective of health practices as

organized around two large axes: control of the occurrence of the disease and patients' recovery²⁰. In addition, we divide the medical activity into the type that provides care and the type that does not, and we include the medical-legal examination in the latter.

Concerning the medical activity that provides care, we believe that the characterization of medical work in the terms of Nascimento Sobrinho, Nascimento and Carvalho²¹ is significant: work developed towards an object/subject utilizing specific instruments to obtain results such as prevention, relief, healing, and rehabilitation. In this perspective, centered on the medical authority, the doctor-patient relationship is conceived as an instrument that favors the collection of information that would guide the definition of the diagnosis and therapy, or adherence to the prescribed conducts.

We believe that the activity related to performing medical-legal examinations is different, in nature, from the medical activity that provides care⁸. The purpose of the former is confounded neither with handling the occurrence of diseases, nor with patients' recovery. In the social security medical-legal activity, the purpose is financial redress, the instrumentalization of the knowledge of medicine by the legal value of the insurance that replaces income in the presence of a debilitating disease.

Paul²² defines medical-legal procedures or forensic medicine as a specialty in which the principles and practices of Medicine are applied to the elucidation of questions in the course of legal procedures. Vilela and Ephifânio²³ add that this medical act occurs as a consequence of a formal request made by the administrative or legal authority when it needs to form belief in the execution of its functions.

Almeida understands medical-legal examination procedures as the medical act of greatest power asymmetry between doctor and patient, in which "the manifestations of distance and authoritarianism present in propaedeutic doctor-patient relationships are potentialized"²⁴.

On the other hand, in a study that evaluated the performance of the program of disability benefits at an INSS Management, Marasciulo²⁵ established as a hypothesis to explain the high volume that was found of benefit receipt the non-observance, by the expert doctors, of the expected behavior of gatekeepers of the system.

The inspiration in Foucault

Michel Foucault, in his works, approached the issue of power from a perspective that analyzed power mechanisms expressed in daily exercises and practices. According to Candiotti²⁶, "his analysis [of the question of power] focuses on the relations of forces that act over social practices" to the detriment of generic or totalizing approaches. In his research, power emerges from commands and confrontations, from affirmations and resistances, through procedures that are made known in the relations as part of them.

The categories biopower and biopolitics, developed by Foucault in research that focused on sexuality, designate power techniques and forms resulting from society transformations that have been occurring from the 17th and 18th centuries to the present day.

Until then, power could be summarized in the formula of sovereignty. Sovereign-subject relationship. The right to cause death or let live, an asymmetric right in essence, which was imposed through the sovereign's violence and his legal system. It was characterized by the sovereign state's strength to assert its interests in the form of confiscation and extortion, through the removal of properties, of labor, of bodies and of life¹².

From the 17th century onwards, the expression of power mechanisms undergoes significant changes: with the emergence of new relationships deriving from the nascent industrial capitalism, with its specific society conformation and mode of reproduction – with the exploitation of bodies for labor -, “another power economy [...] that must, at the same time, increase the subjected forces and the efficacy of what subjects them”¹⁵, which Foucault calls disciplinary power, emerges.

Sovereignty as a form of power that was structured according to control over land ownership continued to be a paradigm to the conformation of laws and codes. Disciplinary expression, in turn, with its techniques centered on visibility and examination of bodies, has the norm as its typical enunciation and normalization as its operational format. Foucault shows that medicine started to develop in this period, and that the medicalization of society, of behaviors and conducts are effects of a register that joins the sovereign power of laws and the normalizing disciplinary power in a discourse that is apparently neutral – the discourse of science.

Throughout the second half of the 18th century, another power technology emerges, the “non-disciplinary power technology [...] that does not exclude the disciplinary technique [...] but is not directed at the man-body [...] it is in another scale [...] it is directed at the living man”¹⁵, addressed to the biological characteristics of the human species and their occurrences as a set, as population mass.

In this modality, the biological characteristics become objects of calculations and policies through techniques and institutions ruled not only by the “anatomy-politics of the human body”¹⁵, but also by managerial technologies.

This management power over life and living, biopower targeted at the man species, has the population and its phenomena as object. Phenomena that are forged by the constitution of specific knowledge that ascribed to them a peculiar identity formed through parameters such as natality, fecundity, mortality, life expectation, among others, constituting what Foucault would call “a biopolicy of the human species”¹⁵.

It will be over these phenomena that another type of medicine knowledge will act, with the introduction of new techniques of coordination and intervention in the collectivity; medicalization of society; intervention in the consequences of labor, of old age, of accidents, of labor capacity¹⁵:

It is the population, therefore, [...] that emerges as the goal and the instrument of the government: subject of needs, of aspirations, but also object in the government's hands. [It emerges] as conscious, before the government, of what it wants, and also unconscious of what it is made to do¹³.

The State will be responsible for "guaranteeing the security of the economic processes and of processes that are intrinsic to the population"¹³, exercising over it a regulation that assumes, mainly, the form of arrangements of security, of preservation of indicators, of cost regulation and of incentives to control preferences and ways of managing life¹⁴.

Managing the population and the phenomena deriving from its existence will be the responsibility of this State which, all the time, will resort to knowledge in accumulated series, to calculations and adjustments to maintain it, and to its processes "within limits that are socially and economically acceptable and around an [...] optimal average for a given social functioning"¹³.

In this sense, Stepanes²⁷ reminds us that the conditions for the emergence of the Social Security System are linked to social tensions and unbalances deriving from economic liberalism and from the process of development of industrial capitalism in Europe, between the end of the 18th century and the 19th century. The concern about the social issue, or rather, the need for the State's intervention in order to mitigate the dysfunctions of the economic development process, was translated as protection for workers against diseases, disability and unemployment.

However, managing life – administrating and regulating the population's conducts, fulfilling the welfare state – implies, in the terms proposed by Foucault, that the government must "help to live and let die"¹⁵. Such command places us before the paradox of biopolitics²⁸, which imposes the exclusion of parts of its population body as a form of harmonization. Racism as a State policy, in this perspective, is not restricted to the known aspects of the elimination of ethnicities; rather, it implies the systematic juxtaposition of exclusion of / inclusion in the very social body²⁹.

Methodological approach

The path of investigation and analysis that was adopted was constructed based on the understanding that "the methodological characteristic must correspond to the need of knowledge about the object"³⁰. In this sense, we conducted a qualitative study of empirical material constituted by a sample (n = 79), selected by convenience, of records of the Social Security Ombudsman containing complaints about the medical-legal examination work, dated 2008.

The record file was categorized into thematic nuclei, and for the analysis, we started from the principle that there was a narrative of the insured citizen to be observed, recognized in its characteristics, but especially in its content. Taken at face value, the records were considered as evidences of what was claimed in relation to complaints that involved the medical-legal

examination work. We analyzed the content of these narratives and how they articulated with the premises of this study, in a comprehensive movement of meaning extraction and production, as proposed by Minayo³⁰.

According to Schramm³¹, the Bioethical analysis occurs in two basic movements, one that is descriptive and analytical, and the other, of moral decision. The “applicability” of Bioethics would imply two tasks: “the description and understanding of the conflicts of values involved in human acts and the prescription of morally correct behaviors”³¹. In this study, due to the characteristics of our object, we did not intend to complete the entire cycle, arriving at the prescriptions. Our aim was to contribute to expand the understanding of the problem, signaling a bioethics in which understanding becomes an essential dimension of bioethics itself³².

Ethical considerations

The decisions about the study's design, approach and theoretical framework derive partly from reflections and questionings of the author that arose during her work in the Social Security System. The authorized use of the database was guided by the commitment to confidentiality, and secrecy regarding the identity of complainants, defendants and social security administration units was preserved.

The research project that originated this paper was analyzed and approved by the Research Ethics Committee of the Social Medicine Institute of *Universidade do Estado do Rio de Janeiro*.

Complaints about the medical-legal examination procedures in the Social Security Ombudsman^(b)

The Ombudsman is an institution that has recently integrated the history of consumption relations in Brazil³³. A space for the harmonization of conflicts, even in its public version, it frequently assumes the approach of the citizen as a client, a notion that is related to the individual viewed in his condition of economic subject^{14,34,35}.

The *Ouvidoria Geral da Previdência Social* (OUGPS^(c) - Social Security Ombudsman) provides the citizen that uses the services of the Social Security System with a post-service interface. It receives and answers criticisms, suggestions, praises, complaints and accusations regarding social security services.

^(b) Information on flows, assistance data and coding of records were obtained by the author with the Social Security Ombudsman.

^(c) OUGPS. Available from: < <http://www.previdencia.gov.br/conteudoDinamico.php?id=424>>. Accessed on: 20 May 2013.

The Ombudsman can be contacted through the following modalities of access: self-assistance in the website of the Social Security Ministry; a call to the telephone exchange of the Social Security System; correspondence to the post office box of the Social Security System; and face-to-face contact, at the Social Security Ministry headquarters in Brasília. In 2011, 57% of all the recorded manifestations were received through the telephone exchange and 41% through the internet.

Considering the period 2008 to 2012, 79% of the manifestations recorded at OUGPS corresponded to the type Complaints, subdivided into complaints related to benefits, banking service, social security service and collection/inspection. In this period, 48% of the complaints were related to benefits, 26% to banking service, 23% to social security service and 3% to the collection/inspection area.

The complaints about the medical-legal examination procedures are included in the category complaints related to the social security service, in a subcategory called *alleged inadequate assistance provided by expert doctor* (code 03008.01). In 2012, 142,838 complaints were recorded at the OUGPS, and 34,224 of them were of the type social security service. Of these, 4,119 were recorded under code 03008.01 - 2.8% of all the complaints, or 12% of the complaints about the social security service. Within the scope of this study, we analyzed a sample (n = 79) of complaints of the type *alleged inadequate assistance provided by expert doctor* recorded at OUGPS in 2008.

It is important to clarify that we did not analyze the communication process between the citizen and OUGPS, nor did we investigate possible epidemiological issues regarding the complainants' characteristics. Moreover, we did not focus on the process of investigation of the complaints undertaken by the INSS, nor on the results or solutions given to the complainants, nor on the impacts of the Ombudsman's actions.

Results of the records analysis and discussion

We found that it was possible to group the complaints around six thematic nuclei: "expert does not check/follow the report or the examination result brought by the insured worker"; "expert acts with excess of power"; "expert does not act as a doctor"; "expert has no knowledge/qualification"; "other complaints: material conditions"; and "other complaints: the medical-legal examination recognizes the existence of disability, but the benefit is not granted due to administrative requirements". This disposition aimed to highlight what was most significant and frequent, and it also took into consideration that a record could be broken down/included in more than one thematic nucleus.

a) The expert does not check/follow the report or the examination result brought by the insured worker

In this nucleus, we identified two typical records. The first and most frequent was: "reports and examinations were not checked". This complaint was manifested in different forms, such as: "the doctor refused to check the reports"; "the doctor not even looked at the examination results" and even "he tore the report". The questioning of the result of the medical-legal examinations emerges, in this type of record, in an indignant form: "The doctor did not check the examination results. He just noted down the insured worker's data. He denied the benefit. How can this be if he did not check the examination results?" It seems clear that examination results, the reports issued by assistant doctors and other documents are considered proof of the insured worker's health status, of his/her disability.

When the documents are not checked/analyzed by the medical expert, a space of incredulity about the expert's decision and its criteria is opened, as in the following record: "the doctor did not check the documents that the insured worker presented, and due to this the insured worker wants to know what criterion was used to deny his benefit".

Such records highlight the lack of examination of the insured worker's medical-care documentation, one of the essential elements of the medical-legal examination task. This documentation aims to corroborate the submitted complaints and, added to the other elements (clinical examination, knowledge about the insured worker's professional activity and legal framework), it supports the medical-legal decision³⁶. In addition, the insured worker's obligation to provide evidence of his/her health status is mentioned in many institutional-normative orientations related to the medical-legal procedures of disability assessment.

In the website of the Social Security System we found: "to receive the benefit^(d), the existence of disability must be proved through an examination performed by a medical expert of the Social Security System". The Technical Manual of Medical-Legal Procedures explains that the necessity of presenting burden of proof of the existence of disability lies with the insured worker, including information on the diagnosis, treatments and complementary examinations. It also mentions that the documental information must be noted down on the medical-legal report¹⁰. In this sense, the normative instruction INSS/PRES 45 states that the onset of the disease and of the disability must be recorded on the medical-legal examination, based on objective data, on complementary examinations, on proof of hospitalization; in short, on documental elements³⁷.

A second pattern of this thematic nucleus is characterized by the fact that the reports and complementary examinations are checked by the expert, but the decision is not in accordance with them: "I presented reports issued by the occupational doctor and by other doctors proving the disability to exercise my profession. If the doctors who treat me prove that I cannot work and exercise my profession, how can an expert doctor discharge me after having checked all the medical reports and the results of my examinations?".

^(d) Disability benefit. Available from: <<http://www.previdencia.gov.br/conteudoDinamico.php?id=21>>. Accessed on: 20 May 2013.

Complementary examinations and medical reports are considered by the insured worker as proof of disability; however, from the legal and normative standpoint, they do not grant access to the benefit. The model of control adopted over disability benefits requires submission of the applicant/insured worker to the medical-legal examination.

Another relevant aspect in this complaint is the reference to the occupational doctor. Mendes and Dias³⁸ discuss the evolution of the concepts and practices of occupational medicine and argue that its classic function is the selection and preservation of the workforce in operational conditions. Maeno³⁹ states that when the occupational doctors work in the selection of employees, they become elements of exclusion of workers in companies. This exclusion can occur through a refusal to adapt the environment, jobs and tasks to the working capacity of the insured workers after they are discharged by the medical-legal examination.

In addition, we found medical examinations and reports indicating conducts that, because they are not considered, followed or discussed with the insured worker, become reason for conflict, as in the following record: "the insured worker brought an ultrasonography showing a lesion on shoulders and hands, taken one day before the medical-legal examination, and a medical report indicating that he can no longer exercise the same activity, which is totally performed on a computer, and he is discharged to return to work without being assisted by PR? Is it because PR does not have doctors at the moment?"

Professional rehabilitation (PR) is a social security service directed at the promotion of the return to work. Referral to this service occurs when the medical expert concludes that the insured worker can return to work, but in a different activity or in an activity that is adapted to his labor potential. Many times, the professional rehabilitation process implies providing the insured worker with a new professional qualification, and this means higher institutional investment in human resources, including medical experts and material resources.

The *Tribunal de Contas da União* (TCU – Federal Audit Court), in its operational audit report about the grant and maintenance of disability benefits⁴⁰, verified the low effectiveness of the rehabilitation service, with waiting lists for admission, long periods of permanence in the rehabilitation program, inefficient offer of professionalizing training, insufficient personnel, among other problems. The Court concluded that there is an increase in the expenditures on disability benefits due to this scenario, as the payment of the benefit is maintained during the entire period in which the insured worker is undergoing professional rehabilitation.

Another aspect in the theme of proof requirements is when the medical experts demand documentation, as in the following complaint: "the Experts are requesting a computed tomography. There is a lot of bureaucracy to do this kind of examination, it is very complicated, it is necessary to wait for a vacancy, with no projected date". The high cost of these examinations and the fact that the INSS must perform them reveal an additional onus of the health sector concerning the requirements and conducts related to disability benefits.

b) The expert acts with excess of power

The characteristic record of this thematic nucleus is: "The expert said that, with the power that comes from Brasília, he can do whatever he wants". Here, to the medical authority, derived from the professionalized exclusiveness of the knowledge about bodies, which is the basis of medicine, is added the authority of the administration over the administrated. An administrative discretionary power that, in the concrete case, integrates its will or judgment into the legal norm. A power that tensions the so-called supremacy of the public interest over individual interests⁴¹, which adds the sovereignty of law to a disciplinary functioning that is typical of clinical knowledge¹⁵. A power that has the force of law, as the legislative and executive branches are mixed in an act, in the apparent anomy enunciated in the complaint record: "he can do whatever he wants"⁴².

The records are full of words naming feelings like "humiliation" and "embarrassment"; or of adjectives like "rude" and "prepotent", to designate the approach during the medical-legal examination. The following complaint synthesizes these findings: "The expert was very rude, impatient, very ironical, arrogant and prejudiced; he told the insured worker that he should be ashamed, that the Social Security would not support him, and that he should return to work".

In a national audit program developed in 2009, the Internal Audit Department of INSS analyzed a sample of records of the Social Security Ombudsman related to the Medical-Legal Examination Procedures and identified that 69% of these records were complaints due to poor assistance. The great majority of them was composed of complaints classified as rudeness and neglect/negligence. Only 19.4% of the records were related by the Audit to the denial of the requested benefit.

On the other hand, in the same study, interviews performed with a national sample of medical experts showed 85.4% of positive answers to the occurrence of verbal aggression and 34.1% of positive answers to physical aggression during the assistance. Feelings of insecurity, coercion and/or threat during the medical-legal examination were reported by 80% of the interviewees, with effects on the decision for 14.5% of the respondents⁴³.

The medical-legal examination situation or setting shows a load of violence that makes us reflect on the meaning of such violence. Would this question the very condition of representation of the State's power over its citizens? Would the inclusion/exclusion operation include the paradoxical violence of politics over life, as, when politics manages the population, it leaves out a part of this very population²⁸?

c) The expert does not act as a doctor

"He was poorly assisted, without any ethics due and ensured by the disease". Here, what is at stake is the expectation of conformity with what one expects from medical assistance, from care provided for the other in a disease situation. Being ill is a necessary condition for requesting and obtaining the benefit, but it is not a sufficient condition. In addition to it, there must be disability, and this condition must be recognized by the medical-legal examination.

Excessive quickness: "He treated the insured worker very badly and he concluded the medical-legal examination in only one minute". Absence of empathy: "he refused to check my pressure and said that he was there to judge me; that it was not medical assistance. If I wanted it, I should go to a hospital". Lack of physical examination: "during the medical-legal examination the expert doctor did not even examine me". All of these result in the antithesis of what is expected from medical action: "the attitudes of these expert doctors are making the worker's health status become worse". More than ever, the meaning of the medical activity is questioned, as this modality of access to benefits due to a disabling disease defines medicine as a place of control.

As Schraiber⁴⁴ states, the social expectation regarding medicine is that it is responsible, through its agents, for treating and caring. However, the social need met by medical work is not always the same; therefore, it will not be only and always about care, even if this is the image of comparison.

The following record seems to order and justify, to provide a question/explanation that strengthens the reverse role that the medical-legal activity assumes compared to the medical-care activity: "The oath of the doctors who graduate and work in the INSS: do they only comply with the government's orders or do they assist their patients with respect, justice, ethics and seriousness?"

The Hippocratic oath, the mythical record of the origins of medicine, is part of the doctors' graduation ritual. In essence, it is a reduced set of rules to govern the doctor's action over patients, masters, etc. What we believe to be relevant in this record is the fact that the oath is taken as a commitment to the patient. The values "respect, justice, ethics and seriousness" would be ideal principles of an ethical action or expectations about this action.

d) The expert has no knowledge/qualification

Here, the legitimacy of the medical expert's action is questioned: "if her problem is orthopedic, how can she be judged by a doctor specialized in cardiology?". The commonplace is to give importance to a more legitimate knowledge, as it is fractionated and compartmentalized.

This theme also emerges in the form of a questioning concerning knowledge about conducts and organization flows of care services - knowledge that is seen as part of a necessary repertoire: "how can a doctor who allegedly is an INSS expert not know that the waiting list for kidney transplantation is not organized by numeration, but by compatibility?" Or in the form of recognition, although in a critical fashion, of the complexity required by the task: "she has no qualification to be an INSS expert".

The fragmentation of the medical work in terms of specialties and sub-specialties is part of an ongoing process characterized by transformations in the medical activity resulting from the expansion of scientific knowledge and from the advance and exploration of technologies applied to the working processes in the area of health, with a disaggregating impact on the doctor-patient relationship⁴⁴.

As far as the medical-legal examination is concerned, the space that knowledge occupies in the composition of medical authority is reiterated through the dimension of the complaint about a qualification that seems to be insufficient. The complainant does not question the knowledge-power; in fact, he demands it.

e) Other complaints: material conditions

The complaints also inform deficiencies in the material conditions for the performance of the examination: “there was neither stethoscope nor a device to measure pressure”. Lack of equipment is added to the perception of inadequacy of spaces, environments and practices during medical-legal examinations, as in the following record: “the doctors assist the insured workers with open doors and they do not have privacy”.

These complaints are coherent with the results obtained by the INSS Audit when it detected, after evaluating 196 medical offices across Brazil, an index of 84.1% of inadequacy⁴³. The parameter was non-compliance with an internal norm of the social security institution that standardizes the necessary structure and equipment to the medical-legal examination offices in the Social Security Agencies. The norm includes equipment for the clinical examination itself, material resources such as computers, beds for examinations, chairs, etc. In addition, it establishes spatial dimensions.

Furthermore, the privacy that would be expected during medical assistance is negatively affected by an atmosphere of apprehension regarding occurrences that show the explosive nature of the tensions that are present⁴⁵. In this environment, the visibility of the examination procedure, as the doctors do not ignore the apparent hassle and inadequacy, can be perceived as a defensive element that integrates a strategic search for safety.

f) Other complaints: the medical-legal examination recognizes the existence of disability, but the benefit is not granted due to administrative requirements

“The result of the medical-legal examination grants the benefit, but the administrative area denies it due to the loss of the quality of insured worker. The insured worker informs that she is a formal employee; so, how can the benefit be denied due to lack of the quality of insured worker?” The record, a typical example in this thematic nucleus, reflects a mismatch between the medical-legal decision and the recognition of the right to the benefit. The enrolment and the contributions to the Social Security System are requirements that are not always fulfilled, with the necessary regularity, throughout the worker’s productive life. The inclusion in the informal productive activity – therefore, without social security protection – is a recognized reality that is constantly monitored⁴⁶.

In this sense, there may be situations in which the existence of disability is recognized, but the worker has no administrative right to the benefit. Such situations show that the grant of the social security benefit results from a macroprocess in which the medical-legal examination,

although essential, is one of the elements. This macroprocess involves economic variables such as the labor market and level of economic activity, among others, as well as administrative norms and procedures of recognition and maintenance of benefits, in which the medical-legal examination is included.

The complaint authorizes us to ask what has been the answer, in the social security field, to the adversity constituted by disability, and to question the effectiveness of such answers in the situations of highest vulnerability, in which disease, disability and lack of coverage of the social security are present.

Final remarks

Based on a vast normative set targeted at the preservation of social order, the social insurance, a security mechanism, and especially insurance against work disability, informs a biopolitics exercised through medical-legal examination practices. The regulating character of the entrance of the medical-legal examination activity into the social security system occurs through the individualizing and disciplinary knowledge of the medical rationality penetrated by the legal-administrative rationality of the norms^{8,36}, in an "intertwining of the medical knowledge-power with the legal knowledge-power"²⁹.

Through this instrument - the medical-legal examination -, those who have the right are distinguished from those who have not; the disabled are distinguished from able individuals. In this way, a balance is achieved (or is sought to be achieved) in the system. In other words, the sustainability of the system depends on the protection to the population of social security insured workers. This protection includes its imminent discontinuation, a paradox of this power – biopower - over the administered life. Therefore, the social security biopolitics aims at the population but, concerning the disability benefit program, it shows its individualizing face and counts on the adjustment operation that is performed by its medical experts in the interface with the insured workers, a doctor-patient relationship transformed by the medical-legal examination situation.

In this field, there are bureaucratic controls over the mass of benefit grants; denials; administrative processes for the management of medical-legal examinations; institutional procedures to handle dissatisfactions with the results of such examinations; analyses of the labor market and of the demographic trends of the population, among other types of managerial machinery.

The tensions and dysfunctions of the extreme situations of control over the population, such as those that were revealed through the analyses of the Ombudsman records, inform the doctor-patient interface in the social security medical-legal examination. We believe that these situations need to be recognized as predictable and possibly inevitable to the practice of these limits, in the form in which they are placed. The asymmetry that is present and intensified by the

medical-legal examination situation integrates the control operation, serving the social security biopolitics.

Finally, we believe that it is necessary to bear in mind the arbitrary nature of the norm and focus on these practices so that we do not provide explanations that reduce facts to the agents' arbitrariness. Discussing the doctor-patient relationship in the social security medical-legal examination includes the analysis of the conditions of the exercise and the teleology of the activity, as we tried to do here. That is, between the current social expectation of the medical activity and the medical-legal work of control over the receipt and permanence in the social security benefit, *there is a displacement, a non-place, the place of "no", to be questioned.*

This study attempted, within its limits, to provide elements that enable to better understand and approach the medical-legal examination in the Social Security System, favoring further research into present challenges, in the wake of studies on biopolitics. The society's debate about the public social security policy is not limited to econometric aspects; therefore, it is necessary to problematize daily routines and practices, creating spaces to reflect on such practices, and making the society's choices and its members' action become more responsible. In this sense, is it possible to act differently, to govern conducts in another way that is not associated with medical inspection? We bet it is. The social practices, including the security ones, can be enhanced with inclusive and unfinished debates that take into account the need of limits and of choices regarding the form of these limits⁴⁷.

Beyond the results of this investigation, we think that it is necessary to discuss the current Social Security model, with the aim of clarifying its presuppositions of economic safety of all in relation to all, and it is also necessary to promote reforms that prioritize people's autonomy and dignity, among other aspects. We all live in the scope of these security policies, included in the economic and political calculation. To discuss this event – perhaps this is one of the inescapable tasks of a bioethics that is open to the collective dimension.

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