

Bioethics and professional identity – the healthcare worker's construction of the experience of him/herself¹

Bioética e identidade profissional: a construção de uma experiência de si do trabalhador da saúde

Bio-ética e identidad profesional - la construcción de una experiencia propia del trabajador de la salud

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ABSTRACT

This study approaches bioethics as discourse inside broad cultural changes and also in its growing impacts on the constitution of the healthcare professional's identity. Two theses, based on Giddens' theoretical framework, are presented. The first is that bioethics potentially is an abstract system that is capable of producing reflection and of organizing the experience and the subjective identity project of the healthcare worker; the second states that the ethical/bioethical education of the healthcare worker is inseparable from a set of pedagogical devices that relate work and formal education in "modes of being professional". Professional identity is discussed in the context of the decentralization of the modern subject and new notions of personal identities, as well as within pedagogical devices that are strongly aligned with the political and technical demands and configurations of concrete work scenarios, capable of defining the moral/ethical potential of the formal education offered.

Keywords: Identity. Health personnel. Education and work. Bioethics.

RESUMO

O estudo aborda a bioética como discurso no interior de amplas mudanças culturais e em seus crescentes impactos sobre a constituição da identidade do profissional da saúde. São apresentadas duas teses, fundamentadas no referencial de Giddens: 1. A bioética é, potencialmente, um sistema abstrato capaz de produzir reflexividade, ordenando a experiência e o projeto de identidade subjetiva do trabalhador da saúde; 2. A formação ética/bioética do trabalhador da saúde é indissociável de um conjunto de dispositivos pedagógicos que relacionam o trabalho e a escola em

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"modos de ser profissional". A identidade profissional é problematizada no contexto de descentramento do sujeito moderno e novas noções de identidades pessoais, bem como no interior de dispositivos pedagógicos fortemente alinhados às exigências e conformações políticas e técnicas dos cenários concretos de trabalho, capazes de definir a potencialidade moral/ética da formação.

Palavras-chave: Identidade. Pessoal de saúde. Educação e trabalho. Bioética.

RESUMEN

El estudio aborda la bio-ética como discurso em el interior de amplios câmbios culturales y em sus crecientes impactos sobre la constitución de la identidad del profesional de la salud. Se presentan dos tesis fundamentadas em el referencial de Giddens: 1 La bio-ética es, potencialmente, um sistema abstracto capaz de producir reflexividad, ordenando la experiencia y el proyecto de identidad subjetiva del trabajador de la salud; 2 La formación ética/bio-ética del trabajador de la salud es indisoluble de um conjunto de dispositivos pedagógicos que relacionan el trabajo y la escuela em "modos de ser profesional". La identidad profesional se problematiza em el contexto de descentralización del sujeto moderno y nuevas nociones de identidades personales, así como em el interior de dispositivos pedagógicos fuertemente alineados a las exigências y conformaciones políticas y técnicas de los espacios concretos de trabajo capaces de definir la potencialidad moral/ética de la formación.

Palabras clave: Identidad. Personal de salud. Educación y trabajo. Bioética.

INTRODUCTION

This study is part of a theoretical investigation that is based on an object delimited by fundamental references: - the focus on the **healthcare worker**; - the focus on one dimension of this education, which is called "**ethical education**", defined in terms of a discourse that acts within professional education, identified as a new field of interdisciplinary knowledge or discussion – **bioethics**. Ethics/bioethics was viewed through a double bias: - as a discourse that penetrates and produces reflexivity, participating in the healthcare worker's relationship with his/her work and with him/herself; - as a discourse that is penetrated by and produced inside certain technologies (of professional practice and education), in complex scenarios of education-work integration. The study was mainly based on Foucault, due to the productive character of his concern about the subject as a historically and culturally contingent and singular experience.

The reflections focus on the first bias and the intention is to approach bioethics as a discourse that manifests an interesting productivity in the field of health, in a varied and multidirectional way. If it is true that elements of a discourse that started to impose itself with the emergence of bioethics have been increasingly impacting the contexts of health education and work – participating in different definitions about the role, the responsibility and the frontiers of professional action –, it is also true that the thought produced in the health field has not only incorporated but has interacted, modified and given its own shades to bioethics' propositions. It is also a fact that the majority of the issues discussed today in terms of bioethics, both in the area of general science and in that of health intervention, has not been inaugurated by bioethics, as if they were sleeping or ignored problems waiting for a discourse that brought them to light. What bioethics has done is: it has organized within a logic, composed inside a system, equipped a way of looking with concepts, goals and arguments about science and life; ultimately, it has put new fields of vision to function about what existed well before it.

Thinking about the "health sciences" as a typical modern science and, furthermore, typically challenged by the pretension of obtaining maximum trust in its findings and interventions, they do not escape from the doubt and risk that invade social life. "Medical science", which has always confronted the unsafe knowledge of tradition, sometimes fighting it, other times incorporating it under labels of its arsenal, sees that its bases of operation are strongly imbued with a notion of

autonomy founded on the specificity of the case, in the face-to-face relationship and on a supposed trust established in this relationship. Even accumulated specialization, characteristic of the delayed modernity pointed by Giddens (2001), at the same time that it offers the details of specific knowledge, it produces multiple sources of authority, subject to contestations and divergences, regarding supposed results.

One of the angles of the relation between bioethics and healthcare work can be outlined in the dimension of these workers' education and, more specifically, in what had been agreed as healthcare workers' "ethical education". The path of approach is constituted around two theses about the healthcare worker's experience of him/herself in the context of ethical/bioethical education.

On the theses about the healthcare worker's experience of him/herself in the context of ethical/bioethical education

THESIS I: Bioethics potentially is an "abstract system" that is capable of producing reflexivity and of organizing the experience and the subjective identity project of the healthcare worker.

Here, another pole of bioethics is emphasized, when it is viewed as the necessary basis for morally responsible professional exercise in the field of health. The idea, already common, of ethical principles² that regulate behaviors and actions in the scope of research and practices into human health has, as one of its principles, the notion of protection against abuses, iatrogenesis and errors of judgment and acts performed by some over others, or with direct or indirect consequences over others. In simple terms, it is the idea of protection against malpractice, based on an idea of good practice or good science. In the position of protected, the other is usually placed: the patient, client, user, from the individual to populations. On the other hand, the professionals' protection is also highlighted, due to the fact that the use of good instruments increases the possibility of success and, therefore, reduces the chances of mistakes. As a tool to handle the problems and dilemmas of practice, essentially willing to promote moral reasoning in decision-making processes, bioethics strengthens the notion of protection also under this perspective.

If this is the known pole, another possible one would be thinking of bioethics as being connected with the constitution of the healthcare professional's identity. More than tools that enable a qualified action, it can also provide conditions so that a worker thinks s/he is qualified to such action. More than this, so that a type of worker is differentiated from many others (and knows s/he is differentiated) because: s/he recognizes in her/himself certain attributes, s/he identifies in her/his operations certain logics and values; in short, it establishes "self-identities" that are related, in relative coherence, to the institution that houses and maintains them.

An apparent inconsistency needs to be clarified concerning Foucault's perspective and the application of some of Giddens' ideas. At first sight, Giddens' term "self-identity" seems to be in opposition to Foucault, but it does not mean an identity that is *self*-produced or a reference that is constructed based on oneself, as in an encounter with an essence that has already been placed in the individual. On the contrary, based on diverse languages and objects of study, the authors converge on the socially constructed character of "identities" or subjectivities, or of forms of being subject in this time. The Foucauldian synthesis that correlates fields of knowledge (discourses) + types of normativeness (regulatory practices) + forms of subjectivity is, perhaps, more easily apprehended

² Although we are aware of the classic differentiation between morals and ethics – the former is connected with social life practices in their regulations or in the way principles and values guide choices, judgments and conducts in social relations; and the latter is the very reflection on these conducts and practices, the study or branch of philosophy that has morals as its object – in this text this differentiation is not relevant. Ethics, in Foucault, is recognized as one of the axes of subject problematization; ethics connected with the idea of subjectivation, as a way of becoming the moral subject of one's actions. To achieve this, in many studies, he focused on historical examples of morals, and used them to propose a notion of ethics as the esthetics of existence, which links the individual with rules and values (technologies of him/herself) and makes him/her place himself/herself as the object of moral practice. In a general way, the author employs, as equivalent terms, "moral subject" and "ethical subject".

when bioethics is thought of as discourse, abstract or prescribing system (which integrates discourses and practices) – here articulating again other concepts of these two authors, despite their differences. It is believed that Giddens' conception of identity cannot be connected with any kind of destination, but with critical thought about contemporary society and, in this, it is possible to recognize the similarity of projects in contributions from different authors.

The question that is put to the philosopher today is no longer knowing [...] how the world can be lived, experimented, crossed by the subject. The central problem is, nowadays, knowing what conditions are imposed on a subject so that s/he can introduce her/himself, function, be a knot in the systematic network of what surrounds us.

Returning to this second pole, which links bioethics to identity, but not being indifferent to the other pole mentioned above (of bioethics as a base for morally correct action), protection moves to the very identity of being-a-doctor, being-a-nurse, or what medicine and nursing are. We do not consider that bioethics would have been an invention to function as a mechanism to protect these agents and their practices, but just that it is efficient also in this area. To argue in this direction, support was searched in notions proposed by Giddens (2001), especially those of “abstract systems”, “reflexivity of the self”, “ontological security”, as well as the concept of “delayed modernity”³.

Abstract systems function as filters through which the choices and revisions that reflexively organize the enterprise of self-identity occur. The author deals with the way in which self-identity has become a reflexive enterprise, a “reflexive project of the self” or a search for the “maintenance of coherent biographical narratives”, in the “post-traditional order” of modernity and of the new experiences that it opens. When one talks about the efficacy of bioethics as an abstract system that produces links between problems and solutions, values and alternatives – mediated by the experience that the subject makes of him/herself in concrete situations – such efficacy is considered as a potentiality to be studied in the form that it unfolds in diversified subjective manifestations.

The commitment to the professional one wants to be is signed and stimulated since school, in the same logic of subjectivities extensively connected with a project of society, with desirable attributes and sensible choices, with ways of conducting life. But this commitment is also re-elaborated as life is conducted, in disparate forms of links between intimate, professional and collective personal life, or other names that it is possible to give. The meaning of identity and belonging to a job or career is still strong in health, even in times of fragility (and rupture?) of the centrality of work in subjective life. To professionals prepared in intensive processes (long or concentrated, with intense use of practical exercise and insertion in concrete working scenarios) and to whom the permanence in the profession is the keynote, the strong link with the meaning of belonging and the commitment to this identity project is recurrent. Thus, it would not be difficult to understand that, in this project, bioethics is included as staff and instrument, end and means, even if diluted, disguised or coated with diverse matters. Simply because it arose and occupied this place? Probably not. Perhaps because some of these matters have been there for some time, not immutable, but restored, and others are aggregating and transforming themselves, but now they can be linked and connected to knowledge, to a term: bioethics.

As Giddens (2001) reminds us, abstract systems are connected and interact with individual experience, affecting both the body and the psyche, in the way they start to be mobilized to construct and fulfill the projects of life and of person defined in this relationship. One of the effects is the triggering of “requalification” processes, in which individuals are pushed to the reacquisition of knowledge and diverse competencies, related to a range of matters, from intimate aspects of

³ There are many motivations to think of bioethics as an “abstract system”, although not all of them are anchored on a faithful translation of the author's propositions, but on interpretations that are more or less free, or inspired by them. We decided to highlight, in quotation marks, expressions and terms used by the above-mentioned author, even when no literal quotation of the work's excerpts is made, to signal themes that recur in it and are employed here.

personal life to amplified social relations. Such requalifications are always partial, they vary in depth, especially due to the reasons and questions being focused here, and are affected by the “revisable character of specialized knowledge”. About this “expert” characteristic, he states that specialization is one of the keys to understand the modern abstract systems, and that “everybody living in conditions of modernity is affected by multiple abstract systems and, in the best hypothesis, they may incorporate just a superficial knowledge of their complexity” (Giddens, 2001, p.20).

Many questions unfold from these references when one turns to bioethics. One difference that it is important to stress concerns the way in which bioethics starts to affect everyday life, without exempting the layman, and the way in which it affects particularly those who have become, or are in the process to become, experts. Here, particular aspects emerge, like the fact that a widely disseminated discourse, although controversial and fragmented, has made a series of themes become common - themes that not always are named bioethical themes. Themes that existed long before the neologism itself, together with other emerging ones, are no longer distant from the forms in which everybody represent themselves and their world. It is coherent to think that all this really impacts the reflexivity of the subjects of a culture, of a period of time.

If people’s interaction with abstract systems produces such effects, what can we say about the effects on the healthcare workers’ reflexivity, when bioethics is viewed as an abstract system? Saying that bioethics interacts, mediating the subject’s experience with his/her work and with him/herself still does not explain much. It is reasonable that this worker mobilizes his/her personal resources, and other available ones, to carry out a personal/professional project that was elaborated and continues to be in the convergence of disparate influences and authorities. But why and how is this relation different from that of any individual that shares this culture?

Thinking about a reflexivity that is institutionalized (along the lines of a profession) by the regular application of knowledge about the circumstances that justify its existence, it would be possible to talk about a reflexivity that is, in itself, self-justifying, self-reflexivity, like a judge of itself. This is implied in the fact that this reflexivity tells the subject and the others that a profession is useful, necessary and pertinent; and that the circumstances that justify it are the very knowledge they mobilize and to which they resort. In healthcare, bioethics expresses more vigor as an abstract system that constitutes reflexivity, and it possible to argue based on two specificities that may be involved in this vigor or efficiency.

The first argument about this reflexivity can be related to what Giddens (2001) refers as the great importance of the expert systems (specialized knowledge and its products) in the abstract systems. From explanation to intervention and from there to the conquest of monopolies, the path that is common to so many professions is known and, in it, it is possible to recognize the establishment of safe margins so that only accredited and qualified people can enjoy and handle the available arsenal. The defense of frontiers under permanent surveillance, the conflicts in arenas taken by different parties, as well as the increasing specialization of knowledge and practices become common in this scenario. Therefore, the relation between such practices and their systems of experts or “communities of thought”⁴ is obvious. But where would bioethics – an interdisciplinary movement not accustomed to seclusion – play in this arena of experts?

As a movement that permeates a culture and crosses distinct branches of knowledge, would bioethics have imposed itself as a necessary “matter” in this task of ensuring legitimacy? Would the adherence to the movement or the incorporation of this language as an inevitable process to its sustainability have been caused by an intentionality of the professionals themselves? If this artifice was not so clearly put as an intention, would it have been materialized in the gradual process of connections and junctions between specialized knowledge and its cultural and scientific surroundings, in a manifestation of how contingent and negotiable their frontiers are?

In fact, not only the idea of contingent and negotiable frontiers can be borrowed from Fleck (1986). With him, we can also think of “translations” of knowledge into a style of thought, not as a simple

⁴ In reference to Fleck (1986).

act of “importing”, but as an act of assimilating, enriching, molding and designating new properties to the “translated”. Thus, bioethics, offering “frontier objects”, would mobilize these movements between the rigidity and flexibility of the “styles of thinking” of these disciplines, sharing not only problems (that escape and defy their limits), but also instruments. Dealing with frontier objects would result in zones of agreement between the groups that interact (rigid nuclei?), and “diffuse and peripheral zones” of translation and recreation by each group or discipline, more strongly structured for approach and specific use.

It is possible to reflect on the bioethics that is translated and captured in the frontiers of healthcare work, without losing itself as an abstract system of broad repercussions, but acquiring more penetration potential, new clothing and new contents. With this, Giddens’ argument about the importance of the expert systems (communities of thought?) for the constitution and propagation of the abstract systems is confirmed and amplified. Not only do these professionals, when they use bioethics, strengthen its penetration as an abstract system (since they function as experts and their discourse is recognized as legitimate), but they also deliver a discourse that virtually transforms them. Not only do the expert systems penetrate many spheres of daily life, but, at the same time, they are penetrated by other systems.

Another argument in favor of the vigor of bioethics as an abstract system that participates in the constitution of reflexivity and identity in the specificity of healthcare work refers to a much subtler efficacy, entangled in the professionals’ traditional references, to such an extent that they are the basic substratum of their subjective identification. In the mark of delayed modernity, Giddens (2001) mentioned the “isolation of experience” based on which the modern institutions create action scenarios organized according to their own terms and dynamics, free from external criteria, in an “internal referentiality” that disconnects them from general and morality existential experiences and problems. Science, technology and the “expert knowledge” would have a fundamental role in this isolation.

Medicine, for example: it is possible to recognize an ambivalent position – that of being stabilized in social life as a practice that is protected in the interior of a relationship of intimacy and trust among subjects and that, therefore, in this encounter, is guarded from the others’ look; and, at the same time, as a practice that is forced to extract, from this unique experience of the encounter, a thought that can be generalized and applied to multiplicity. In other words, the specificity of the case has something to say that has less to do with such specificity, and more with systems of nominations and descriptions, in order to continually feed a language, codifications and normalizations, and to continually amplify the archive of records about the human multiplicity that feels pain, becomes ill and dies.

What is guarded in the particularity of the encounter is what discomforts and destabilizes the safety of the patterns. Inside the “solid” knowledge of clinical language, the objectivity and detail of specialization and expertise are a strong currency, valued to the point that they are seen as a sufficient resource to attend the encounter with the other person. But if now this other person can be a presence that is no longer dissolved in codes, calculations and prescriptions, he/she can also claim for more than expert actions and techniques; he/she can demand abstract systems that are not entirely identified with the clinic, its diagnostic and therapeutic insights. Here bioethics acquires the efficacy of an abstract system that tacks, composes these positions of ambiguity, giving them a kind of finish. Seen from within, from the worker’s angle, the power of isolating and protecting his/her experience, as much as the power of expanding it to the margins of the public, can be viewed as a virtue of practice and of its practitioners, as a condition of fortress by its practitioners and those who are favored by it.

Bioethics proves to be capable of strengthening the value of what is already legitimated (knowledge and clinical practice) as a product not only desirable and useful, but also qualifiable and distributable – not only important due to the effects it may have on people’s lives, but for being an asset that should be competently applied and justly distributed among all who need it. In this sense, it attributes value and conditions of value to a traditional knowledge and practice, somehow relativizing the “isolation of experience”, the “internal referentiality”, or the intimacy of the

encounter. If they exist, they must account for themselves in some way. Effective and comprehensive ways? Not so much. But relative protection.

Even running the risk of reducing the argument to the example, it is possible to finalize this thesis with an illustration based on the idea of beneficence. As a bioethical principle, beneficence was widely disseminated by the work authored by Beauchamp and Childress, published in 1977, "Biomedical Ethics". The intention to "show how ethical theory can illuminate problems referring to health" (Beauchamp, Childress, 2002, p.17), in the sense of an applied ethics, ended up producing the main reference (the best known reference in the academic and scientific environment), to the point of "making bioethics become principlist". To Pessini and Barchifontaine (2002), it provided the language to speak to a specific public (healthcare professionals) and was the safe harbor of these professionals.

Language to give meaning to ethics in this context of subjects and practices, "so that ethics can speak"? Yes. But also language that has integrated and has given meaning (theoretical-philosophical) to a set of experiences of these subjects, that is, "so that technicians are able to speak".

Even before the connection of the care practices with science, the fact of seeking the benefit of the person who received them was the basis of trust in the action of taking care/curing and of its legitimacy as a social practice. Welfare, as a goal, sustains the relation both of the person who provides care and of the person who receives it. The professional needs to believe that his/her decision is moved by interest in the other person – and this will be a distinctive mark of the way in which he/she sees and judges him/herself, with as much or greater consistence than the instruments he/she employs or the results he/she obtains in his/her actions. Even mistakes are admissible, but the absence of this purpose is inconceivable. Beneficence is a constituent of self-identity, and its absence is disaggregating in this same level.

So, what has bioethics brought that is new? As Beauchamp and Childress (2002) state, common morality is considered as the correct point-of-departure for ethical theory, despite its incompleteness and imperfections. Seeking, in tradition, the raw material for ethical reflection is an elementary resource so that, from this, consistent and valid repertoires of objective solutions are built, as well as firm, articulated and expansible moral convictions; in short, "judicious judgments" must be "self-evident norms" and "plausible intuitions" (acceptable without argumentative support or without resorting to other judgments), as they serve as reliable premises, independently of their origin, upon which a solid structure is erected, enriched by a broad body of experience.

Beneficence was already a component of a morality, or of an abstract system connected with moral notions of a culture that, in the interactions with the new configurations and requirements of the practices, was organized in a different way, or inside a new abstract system. Or else, contents were organized in another way and acquired the configuration of an abstract system that was more unitary, elaborated or highlighted. Thus, bioethical theory viewed beneficence as this judicious judgment or self-evident norm, and gave to it a systematized body, in a network of connections between principles and casuistry, ideas and practical problems.

In this way, the bioethical model highlighted the links that articulate individual experience with the thought of a period, aggregating solutions and alternatives which used to be fragmented into a logic and guiding framework in relation to what recurs and, perhaps, what is unexpected in these practices; in short, connecting the service to the other and the service to itself, in the same requirement. From this, the use, or the obligatory presence of beneficence in the ways of thinking and talking about healthcare, was responsible for amplifying its utility, with increasing problems to respond to and integrate.

THESIS II: The ethical/bioethical education of the healthcare worker is inseparable from a set of pedagogical devices that relate work and formal education⁵ in "modes of being professional". Or:

⁵ Far from a separation between work and school, the intention is to highlight their overlapping (or the impossibility of thinking about them in isolation), taking into account certain specificities in terms of regulations, political-institutional dynamics, or even social representations, which end up configuring references to think about these two formal spaces

The worker's ethical education is processed inside certain technologies (of practice and of education) in complexified scenarios of education-work integration.

Once bioethics has been constituted as discourse inside broad cultural changes, especially those generated in the relations of this culture to science; once it has been appropriated as a set of tools that is adequate and necessary to the health practices and the "good" professional exercise in this field, a pertinent, even inevitable question was asked to doctors and nurses – what ethical being are you?⁶

But what was new about this question, since the "ethical" education of doctors and nurses has always been present in the pedagogical agendas of professional education? At least in the sense that we can circumscribe as institutionalized professional education, independently of the place it occupied or the conception that justified it, there was a notion of morality applied to these professionals' practice. In spite of this, there is a huge emptiness regarding moral education in historical studies about these professions. The majority of these studies is organized around spatial-temporal historical axes which privilege the practices' relation to great transformations of the Western thought and society. The professional's moral education or ethical education is usually confounded with and limited to the teaching of ethics and, even in this perspective, studies are scarce (Rego, 2003; Dallari, 1996; Germano, 1993).

What this thesis points to, in relation to the reported focuses, can be synthesized in **some problematizations**: - this "professional identity", which the educational processes intend to "construct", can only be thought of in the context of broad changes in personal identities, in the "sense of self" and in the very idea of what identity can be today; - the question about the "ethical being" is not separate from the question about the "professional or technical being"; - the pedagogical devices define any moral/ethical potential of education; and – such devices are strongly aligned with political and technical requirements and configurations of the work scenarios.

Initially, it is important to discuss what was referred as changes in the notion of identity, of personal identities or subject. It is what Hall (1997) approaches as crisis or collapse of modern identities, or the death of the modern subject, in which the idea of death or collapse refers to a process of decentering, fragmentation or displacement, or, better still, double displacement, as it "decenters the individuals both from their place in the social and cultural world and from themselves" (Hall, 1997, p.9). This crisis affects the idea people have of themselves as integrated subjects – with solid localizations as social beings, like those provided by means of their positions of gender, class, ethnicity, race, nationality, among others – disarticulating stable identities from the past, and also, enabling new articulations, the production of new subjects, or "positions of subject" in societies marked by difference.

In the last years, identity has been placed as object of study on the part of these workers, in different theoretical insertions, mobilized by ideas such as: today's professional could only be understood by the critical analysis of historical transformations of work in society and cultural heritages that shaped these professionals' identity; professional education used to be decisive in the formation of professional identities; political projects for healthcare work and for specific professions used to undergo the criticism of their workers' cultural identities, among others.

According to Rose (2001, p. 45), despite such heterogeneity, there is a "blotting" of the differences in our present, in such a way that humans still conceive themselves in a situation of familiarity with "humans considered as selfs that have autonomy, choice and self-responsibility, equipped with a

(which justifies referring to them as "world of school" and "world of work", especially in fields of research that focus on transformations processed in elected scenarios and under the influence of impacts that are also eligible, both in macro or microanalyses). Thus, the criticism according to which this type of reference might neglect, for example, educational work or education as social work is limited.

⁶ In reference to Foucault's comment on the establishment of sexuality precepts (set of practices, institutions and knowledge), from the 17th century onwards, which made the following question become inevitable: what sexual being are you? (Foucault, 2002).

psychology that aspires to self-fulfillment, effectively or potentially living their lives as if they were an enterprise of themselves”.

In a second point, which raises the articulation of the “ethical being” and the “professional or technical being” in these workers’ education processes, the temporary and contingent character of any supposed “unity” is highlighted. The relation between “ethical being” and “technical being” is presumed or approached by the pedagogical devices, indicating the always precarious and mobile nature of the answers that workers have about themselves. When a large part of the statement of “what ethical being I am” is based on “how good a technician I am” or on “how I perform my professional role”, the circumstances of the performance, the predicates and evaluation criteria of this role are less solid, more mobile and provisional, exactly due to their contingency.

If we consider that an interesting ethical position would emerge from this lack of solidness (of the references and circumstances of professional practice), as it would confront the worker with the reflection on him/herself in other bases (not those of tradition and fixed identities), could we think that the more solid and cohesive (culturally and subjectively) these professional identities, the more difficult the ethical disruptions would become? So, the enterprise of being a professional, also for this reason, would be connected (would access in multiple ways) with the enterprise of being ethical.

But when one states this articulation, it does not mean that this is reflected in the entire apparatus of professional education. A kind of ambiguous crossing seems to be revealed: on the one hand, the emergence and increasing valuation of the “ethical being”, or of the being with ethical competences, as inalienable to the professional practice; on the other hand, a disposition and functioning of these apparatuses that make the “ethical” be subsumed under the “technical”, incorporated, phagocytosed and encapsulated inside it, as if an automatic, infallible and long-lasting relationship took place and, based on this, the good technique were able to answer for the ethical action, were able to represent the ethical subject.

Through this thought we arrive at the third and fourth points – that the pedagogical devices also act in the definition of the moral/ethical potential of education and, on their turn, such devices are strongly aligned with the political and technical requirements and configurations of the work scenarios.

The idea of pedagogical devices, in a certain way, already emerges in opposition to any notion that may view the large arsenal of pedagogical instruments (places, methods, practices, knowledge, resources) as simple means to achieve an end that directs the entire process and, therefore, a set of tools that is almost lifeless, manipulable and cold. On the contrary, devices function, move, expand themselves, incorporate and produce things through the interaction of many hot and cold elements; things like discourses and practices (knowledge and institutions, propositions and normativeness of many distinct types, from the scientific to the moral ones) strategically joined. Thus, device refers to the network of relations between heterogeneous elements (discourses, laws, institutions, enunciations, administrative measures, etc.), in which the type of link established between these elements is of a special nature, according to a function that is always strategic, which responds to a historically given need (Castro, 2004). “In short, what was said and what was not said are the elements of the device. The device is the network that can be weaved between these elements” (Foucault, 2000, p.244).

With this idea, the previous statement becomes obvious. If what we are calling ethical/moral education enters into, participates in, or is one of the elements of the device of professional education, it is obvious that this device is decisive in this dimension. But how does it penetrate this device, or how is it captured in it? What relationship does it establish with other elements of this device, this ethical education that is no longer thought of as being isolated?

At this moment three relations will be revisited, or three other elements that participate in this network or device, among many that could be chosen, by reference to professional identities, to a political situation of the sector and a logic of the healthcare services, and also, to a university dynamics of knowledge framed in disciplines.

The first reference, to professional identities, leads to some highlights that are worth being revisited: - professional identity (being a doctor, being a nurse), in its historical and cultural aspects, has been learned as an important object of reflection by those who are or who are preparing themselves to be professionals; - the education processes try to capture, understand and/or criticize the modes of being professional, as expressions of social representations or of the thought that workers have of themselves; - these attentions focused on identities bring a linear and spontaneous fusion between subjectivity and work, identity and action, or modes of being and modes of doing the work, in which what I do speaks about me, or in which the professional is identified by the content, characteristics and values that are attributed, socially and subjectively, to his/her work (acts and results), as “a being that is constructed in time, space and in the daily relations” of work (Araújo Netto, Ramos, 2004, p.56); - the educational processes assume to themselves the task of: accessing identities that are built at work, translating them into contents that can be assimilated, constituting intelligibilities and, without giving up the pretention of making their criticism and promoting their transformation, to maintain a unity that ensures the consolidation of professional identification structures that are sufficient to this socialization; - the readings and translations in the school-work relation are not free from theorizations and models that mediate these relations and, thus, certain reading channels, or access roads, are opened (and others, hindered); the ethical element of work is, through these roads, accessed and starts to constitute a (bigger or smaller) component of work and, afterwards, a component of education.

The second reference points to another complex set of elements, some vectors that rival, configure a situation and a logic of functioning of the Brazilian health services. Just the analysis of this theme, reduced here to an element, would already need a very broad study, as it leads to branches in countless interfaces, typical of political and technical processes undergoing intense transformations. In the impossibility of distinguishing a single and coherent flow of transformations in the field of health, it is possible to recognize some directions, which can be more or less generalized, like those that focus on labor organization models, worker profile and complexification and expansion of the health practice fields.

Each one of these trends, deriving from sociological and technological changes in the world of work or from political changes in the health system, has repercussions on the ways of working and teaching in health, representing or imposing technological changes without single and self-evident meanings, but which demonstrate the complexification of the concrete scenarios of work and, also, of the alternatives of education-work integration. In a very brief representation, we could talk about a health system that shapes a profile of worker (wage earner in public services and, extensively, in primary care services) who increasingly becomes the target of particular political interventions. In short, the State is not only the largest employer, it is also the largest regulator of labor relations, of labor organization and division, of the technological models and even of the job market and of the healthcare worker's education in Brazil.

As the engine of this set of mobilizations which are relatively comprehensive and simultaneous, we have not only the requirements of *Sistema Único de Saúde* (SUS – National Health System) and its model of care, but also the intense reformulation of the courses' legal mark, with the implementation of the New National Curricular Guidelines, aligned with the common and specific professional competencies demanded by this model of care and fostered by interministry policies (Health and Education).

Even considering a relative success in constructing a “uniform” legal and theoretical basis to the processes of change in undergraduate health courses, a series of choices and operationalizations impels schools and courses to paths and contingencies that are never uniform. On the one hand, we could talk about shared circumstances, trends and movements; on the other hand, contingencies that hinder any supposed common condition. In short, the moment “aggregates” around a reevaluation of the teaching-service integration, as both share integrality as the guiding axis, as the strong currency with the supposed capacity of negotiating differences in roles and positions in favor of common bases and objectives. But to what extent are they common? And under what conditions of adherence to this new statute of integrality? (Who elected it? Under what arguments and references? What

constructions are possible in this mark? How is it imposed on the players?). On the side that constrains and limits this unifying logic, relativizing its potential of being a hegemonic and solid movement, there are contingencies that cannot be solved in the scope of this kind of intervention, because they are typical of the structure and situation of these courses. These contingencies refer to: institutional differences (courses in public or private universities) that imply discrepancies in terms of qualification and perspective of a teaching career, inclusion and valuation of research, management logics, teaching and teachers' work conditions (infrastructure, support, resources), teaching, research and extension resources, among others; regional disparities; capacities of interlocution between health services managers and schools and courses.

In the third and last relation, we intend to focus a little more on this university dynamics or knowledge framed in disciplines. What we would like to highlight is that, besides everything that may be problematic in the current context of healthcare workers' education, there are aspects that have been delimiting for a long time the possibilities of development of knowledge and techniques in the mark of modern science.

From the organization of knowledge in disciplines, from their intercommunications and hierarchizations inside a global field, it is possible to talk about "science" (as opposed to multiple, independent, heterogeneous and secret knowledge that existed before the great enterprise of generalization and annexation, typical of the development of technological knowledge that happened in the 18th century) (Foucault, 2005). The interest in this reference is that of emphasizing a consequence, pointed by Foucault, of this control that is internally exercised in the discipline of knowledge, which was the possibility of renouncing to the "onerous orthodoxy" about enunciations, in the form of an "epistemological unlock". That is, "liberalism" concerning the content of enunciations replaces orthodoxy by an infinitely more rigorous and more comprehensive control over the enunciation procedures. The problem moves to the investigation of "who spoke" and whether he was qualified to speak, in what level and set this enunciation is situated, in conformity with which knowledge typology. Thus, beyond the contemporary constraints that weigh on the university, it is important to recognize that some of the criticisms and proposals for institutional restructuring and knowledge reorganization would imply a lot more than administrative reforms or the adoption of theoretical assumptions for teaching. Relations between knowledge and power are at stake, as well as the rules of the great scientific enterprise. Staying outside these rules imposes speaking from outside or perhaps not speaking at all. Loosing, moving and displacing rules, without ever ceasing to create others, is nothing more than the characteristic movement of the university dynamics or of the dynamics of disciplines, academic and professional, in their institutional forms, in their mobile and uncertain frontiers.

Professions like nursing and medicine also have different experiences of coping with the tensions of their situations as fields of knowledge and practice. One of the reasons is that, although they have frontier objects, they are established as disciplines with very diverse statutes and histories.

Due to all these considerations, the possibility of an identity that fulfilled the illusion of unity and coherence would be hopelessly broken – an identity that articulated without conflicts the movements: of expansion and retraction, normalization and innovation, self-criticism and sustainability, exposure and preservation, of customs control of borders, and a detachment that is only imagined, in short, of professionalization, discipline formation and scientification, on one side, and of ethical reflection, on the other side.

Maybe the recognition that, besides our multiple and decentered identities, also the subjective relation with our work cannot happen over a calm and clean surface, under an integrated and ideal subject, but it can be the condition we have of new criticisms, new looks over the institutions in which this professional subject understands him/herself as such. Thus, the few elements approached here – professional identities, relation to politics and health services and university scenario – are only representative of the complexity of the education-work relation. A relation that is mediated by technologies with direct repercussions, not only on the modes of working, but on the modes of perceiving and constituting oneself as a working subject and, as such (not only, but also), an ethical subject.

The analysis difficulties that derive from the complexity of these relations (education-work) cannot reduce work demands to market demands. Even in times of employability and “competencies to the world of work”, it is not possible to simplify the positions of the market and of the school, presupposing absolute autonomy or submission; but perhaps, exactly due to this, the resource of thinking about devices that interact strategically is feasible. Thus, pedagogical devices and healthcare work devices (therapeutic, care, management devices) are interactive and co-functional, if not, for some moments, identical or absolutely fastened together.

The different work modalities or the different ways in which work can be organized technologically allow thinking in the constitution of technology-mediated working subjects, subjectivities or identities. Instrumentality both from the point of view of the operation of knowledge (it should be useful/applicable or it should be put into action for certain purposes), of the need to exercise skills in the action, and from the point of view that the “purposes” of this work are apprehended in a commitment to reality and by the sensibility to perceive problems in it.

We have attempted to situate what is being called ethical/moral education inside a device of professional education, and this in relation to other devices, to design a network in which reflection on ethics/bioethics can be triggered from different points or crossings. More than finding a fixed point where ethical education would be entangled, “captured” in this device (as was asked previously), this is about seeing multiple connections and mobile points, crossings with several elements. Thus, we reaffirm that this ethical education is not isolated in traditionally standardized contents and experiences, but it is essentially implied in scenarios and modes of teaching and working, complexified by political and technological processes that cross this and other networks and which could also be viewed as specific devices.

COLLABORATORS

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