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Doctor-patient relationship in consultation reports sent to the Regional Medicine Council

José Marques Filho¹, William Saad Hossne²

Abstract

This study aimed to evaluate, in the context of bioethics, the frequency and characteristics of the opinion-consultations of the Conselho Regional de Medicina (Regional Medicine Council) of the state of São Paulo concerning the doctor-patient relationship. The sample was based on the opinion-consultations published on the Regional Council website relating to the descriptors “doctor-patient relationship”, “bioethics – bioethic – bioethical” and “medical ethics”. The total number of opinion-consultations identified was 5,012, of which 2,717 (54.2%) were related to the descriptor “medical ethics”, 111 (2.21%) were related to the descriptors “bioethics – bioethic – bioethical” and 163 (3.25%) were related to the descriptor “doctor-patient relationship”. It was concluded that the frequency of opinion-consultations related to bioethics and the doctor-patient relationship is relatively small when compared to the number of opinion-consultations related to medical ethics, and that there is a predominance of deontological and administrative aspects in the opinion-consultations focused on the doctor-patient relationship, in comparison with bioethic aspects. In addition, the opinion-consultations and publications of this Regional Council influenced Conselho Federal de Medicina (Federal Council of Medicine) resolutions and the updating of the Code of Medical Ethics.

Keywords: Doctor-patients relationship. Medical ethics. Bioethics. Legislation as topic.

Resumo

Relação médico-paciente nos pareceres-consultas enviados ao Cremesp

Este estudo teve como objetivo avaliar, à luz da bioética, a frequência e as características dos pareceres-consultas do Conselho Regional de Medicina do Estado de São Paulo atinentes à relação médico-paciente. A amostra baseou-se nos pareceres-consultas publicados no site do conselho regional relativos aos descritores “relação médico-paciente”, “bioética”, “bioéticas”, “bioético”, “bioéticos” e “ética médica”. Foram encontrados 5.012, sendo 2.717 (54,2%) relativos ao descritor “ética médica”, 111 (2,21%) aos descritores “bioética”, “bioéticas”, “bioético”, “bioéticos” e 163 (3,25%) ao descritor “relação médico-paciente”. Conclui-se que a frequência dos relacionados à bioética e à relação médico-paciente é pequena quando comparada aos relacionados à ética médica, e que há predomínio de aspectos deontológicos e administrativos nos pareceres-consultas centrados na relação médico-paciente quando comparados aos aspectos bioéticos. Além disso, os pareceres-consultas e publicações desse conselho regional influenciaram resoluções do Conselho Federal de Medicina e a atualização do Código de Ética Médica.

Palavras-chave: Relação médico-pacientes. Ética médica. Bioética. Legislação como assunto.

Resumen

Relación médico-paciente en los dictámenes-consultas enviados al Consejo Regional de Medicina

Este estudio tuvo como objetivo evaluar, a la luz de la Bioética, la frecuencia y las características de los dictámenes-consultas del Consejo Regional de Medicina (Consejo Regional de Medicina) del Estado de São Paulo atinentes a la relación médico-paciente. La muestra se basó en los dictámenes-consultas publicados en el sitio del Consejo Regional relativos a los descriptores “relación médico-paciente”, “bioética”, “bioéticas”, “bioético”, “bioéticos” y “ética médica”. Se encontraron 5.012 dictámenes-consultas, siendo 2.717 (54,2%) relativos al descriptor “ética médica”, 111 (2,21%) relativos a los descriptores “bioética-bioéticas-bioético-bioéticos” y 163 (3,25%) relativos al descriptor “relación médico-paciente”. Se concluye que la frecuencia de dictámenes-consultas relacionados con la bioética y con la relación médico-paciente es relativamente pequeña cuando se la compara con los relativos a la Ética Médica, y que existe un predominio de aspectos deontológicos y administrativos en los dictámenes-consultas centrados en la relación médico-paciente en comparación con los aspectos bioéticos. Por otra parte, los dictámenes-consultas y las publicaciones de este Consejo Regional tuvieron influencia en las resoluciones del Conselho Federal de Medicina (Consejo Federal de Medicina) y en la actualización del Código de Ética Médica.

Palabras clave: Relación médico-pacientes. Ética médica. Bioética. Legislación como asunto.

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Declararam não haver conflito de interesse.

In addition to being exclusively responsible for supervising the medical profession in Brazil, subject to Federal Law 3.268 of 1957¹, the regional medical councils and the Conselho Federal de Medicina - CFM (the Federal Council of Medicine) publish resolutions, the exclusive normative acts of the plenary sessions of these federal autarchies, with the aim of regularizing subjects of the exclusive competence of these entities in their areas of operation. Additionally, since the beginning of their activities, the Federal Council and the regional councils of medicine have published opinion-consultations arising from the growing ethical conflicts relating to both new diagnostic and therapeutic techniques, the evolution of the rights of patients and advances in the areas of humanities.

At the federal level, this activity was regulated by CFM Resolution 1.335/1989², while in the state of São Paulo it was governed by the resolution of the Conselho Regional de Medicina do Estado de São Paulo - Cremesp (the São Paulo State Regional Council of Medicine) - Cremesp Resolution 223/2010³ - the distribution of consultations on which opinions could be formed has followed practically the same system since the creation of the councils: the regional president, by means of a specific resolution, delegates the function of distributing the consultations to secretaries, who, in turn, pass them on to the regional councilors or to the coordinator of the technical chamber related to the central theme.

Once elaborated, the opinion-consultations are submitted for the approval of the technical chamber, composed of at least five members (delegates and advisers). Approvals must take place by unanimous vote. If unanimity is not reached, the consultation-opinion is re-presented and discussed at the plenary session of Cremesp by the reporting councilor, and is voted on and approved by a simple majority of votes.

Although only officially regulated by a resolution published in 2010, the opinion-consultations system has been used by Cremesp since its creation, as shown in the work "Medical Ethics" published in 1988⁴, and the 1996 version of the same text⁵, in addition to opinions published on the Cremesp website since 1995⁶.

In Brazil, the Federal Council of Medicine and the regional councils have played an important role in the transition from medical ethics to bioethics. In recent decades, several CFM initiatives have been extremely important for the dissemination of bioethics in Brazil, notably "Revista Bioética"

(Bioethics Magazine), published regularly since 1993, and which is today the main journal of bioethical texts and research in Brazil⁷.

As for the regional councils, Cremesp was the first to create an Interdisciplinary Technical Chamber of Bioethics⁸. Unlike the other Cremesp technical chambers, the bioethics chamber is made up of professionals from a range of areas, such as nurses, philosophers, theologians, lawyers, among others. The chamber was approved at plenary session 2.473 in July 2000, with the first meeting held at the end of the following month. This collegiate structure, a true model for bioethics committees in Brazil, has as its main functions the consideration of the consultations dispatched by the secretaries, the issuing of opinions, and the divulging of bioethics-related topics at events and in publications in the field.

The role of the Cremesp Technical Chamber of Bioethics in the publication of Resolution CFM 1,805/2006⁹, on the termination of life, deserves special mention. After the "Forum on the Terminally Ill" organized and hosted by the Technical Chamber of Bioethics at the Cremesp offices in May 2001, the theme was discussed at the meetings of the chamber for around three years, and included the participation of jurists, theologians, philosophers and other professionals with recognized knowledge on the subject.

This activity contributed until the elaboration of the project, which was then sent to CFM, and culminated in the aforementioned CFM Resolution 1,805/2006⁹, being published with minor modifications from the version of the Cremesp Interdisciplinary Technical Chamber. Another notable event was the publication of "Palliative Care", a pioneering work in Brazil, organized by Professor Reynaldo Ayer de Oliveira, as the coordinator of the chamber¹⁰. This was the first technical publication on the subject in Brazil and was influential in the official inclusion of palliative medicine as an area of medical practice by the CFM¹¹.

In the discussions about termination of life, several ethical conflicts arose in relation to palliative care, a new area of practice for doctors. After several meetings to discuss this topic in the Technical Chamber of Bioethics, it was decided to create a committee called "the Cremesp Working Group on Palliative Care", the purpose of which was to deepen discussions about the care offered to terminally ill patients with serious and incurable diseases.

At the end of the work of the committee, it was observed that the volume of technical data

and literature researched, as well as the knowledge of the members of the group - professionals from various areas with experience relating to patients who were beyond therapeutic possibilities - merited the publication of a book that encompassed both the technical and ethical aspects of this new area of medical practice. Finally, the dissemination of bioethics in Brazil by Cremesp also involved the creation of the Bioethics Center¹².

In view of this dissemination and construction of Bioethics by Cremesp in the state of São Paulo and Brazil, through events, publications, and the pioneering creation of an Interdisciplinary Technical Chamber of Bioethics and the Bioethics Center, it is opportune to study the frequency and the characteristics of the consultations sent to and the opinions issued by the organization, with the aim of evaluating the impact of Cremesp's actions on the medical profession and society in general, as well as on bioethics as a whole, and especially on the doctor-patient relationship.

Thus, the present study sought to evaluate, from a bioethical point of view, the characteristics of the consultations submitted to Cremesp, as well as the frequency of these documents, considering specifically the doctor-patient relationship and highlighting those with historical or doctrinal value or which had a possible influence on the CFM or the updating of the Código de Ética Médica – CME (Code of Medical Ethics).

Method

A retrospective study with a descriptive and exploratory technique and a quantitative and qualitative approach was carried out. The period chosen was between February 4, 2002 and April 15, 2015, the date of the publication of the opinion-consultations on the Cremesp website and the date of the data collection of this study, respectively.

The research was carried out on the Cremesp website in the section "legislation", using the link "search for opinions". The following descriptors were searched for in the consultation-opinion texts: "medical ethics", "doctor-patient relationship", "bioethical", "bioethic" and "bioethics". The universe of this study refers to the total of opinion-consultations published on the Cremesp website concerning the doctor-patient relationship, which were analyzed and classified into three categories:

- 1) deontological: where most of the content of the consultation and opinion has aspects and questions which are predominantly deontological, or in other words, which refer to the fulfillment of moral questions related to articles of the CME;
- 2) bioethics: where most of the content of the consultation and opinion features aspects related to conflicts of values, involving patients and their families and demanding a more reflexive analysis, with the possibility of adopting diverse positions and with the potential for a wider discussion;
- 3) administrative: where most of the content of the consultation and opinion is predominantly administrative or bureaucratic.

Ten opinion-consultations concerning the doctor-patient relationship and classified as "bioethics" were selected, using the criteria of historical value, doctrinal importance in relation to the subject in question, and possible influence on the resolutions published by CFM or their importance to the updating of the CME in 2009.

Results

The total number of opinion-consultations published on the Cremesp website during the period of the study was 5,012. There were 2,717 (54.2%) opinion-consultations relating to the descriptor "medical ethics", 111 (2.21%) related to the descriptors "bioethics", "bioethical" and "bioethic" and 163 (3.25%) related to the descriptor "doctor-patient relationship".

The opinion-consultations with the descriptor "doctor-patient relationship" (total of 163) were thus classified: deontological → 129 opinion-consultations (79.1%); Bioethics → 30 opinion-consultations (18.4%); administrative → 4 opinion-consultations (2.4%).

Among the 30 opinion-consultations of the sample classified as "bioethics", the first author selected the following documents, in chronological order of publication, taking into account historical value, the doctrinal scope for the subject in question, and the possible influence on the resolutions published by the CFM and the updating of the current CEM: 1) Cremesp Opinion 29299/1996 – Blood transfusion of Jehovah's Witness; 2) Cremesp Opinion 37267/1999 – Dysthanasia; 3) Cremesp Opinion 105715/2004 – Patient autonomy; 4)

Cremesp Opinion 82406/2004 – Professional confidentiality; 5) Cremesp Opinion 84368/2007 – Limiting of procedures to treat diseases in final phase; 6) Cremesp Opinion 90198/2010 – Communication of death to families; 7) Cremesp Opinion 124460/2010 – Free and Informed Consent Form in clinical practice; 8) Cremesp Opinion 155608/2011 – Medical conduct regarding post-operative patient follow-up; 9) Cremesp Opinion 138679/2012 – Confidentiality of medical records; 10) Cremesp Opinion 18688/2012 – Living will. There is a description of each opinion at the end of this document.

Discussion

In the last five decades, traditional medical ethics has undergone extraordinary changes due to several factors, but the emergence and development of bioethics can be considered as having the greatest impact of all. Discussing human rights in Brazilian medical codes of ethics, Martin²³ discussed the profound transformation brought about by the use of new concepts heavily influenced by bioethics. The tendency is now to train health professionals capable of adopting a much more embracing position, seeking an opening to new challenges, to become more responsible and supportive in the construction of a more conscientious medical ethics of bioethics and human rights.

This transformation is reflected in the doctor-patient relationship, which in this period became much more complex due to the impact of a number of factors. This transformation influences disparate aspects such as the increase of consultations attributed to each professional in the health systems, the consequent acceleration of the pace of anamnesis and clinical examinations, and the increasing importance of laboratory tests and diagnostic imaging.

To these factors is added the advent of the internet, which can “inform” a patient about their possible diagnosis, in some cases raising unfounded doubts and anxiety. Finally, it can be considered that the incorporation of the bioethical referential of autonomy has contributed to this transformation, giving the patient the right to decide about their body and the therapeutic approach to be adopted²⁴.

The Federal and regional councils of medicine, institutions that until a few decades ago had assumed paternalistic and conservative positions, have also been transformed. While some regional councils maintain more conservative positions, others, such

as Cremesp, act in a manner more in keeping with a professional stance based on bioethics.

Despite this recognition, the practical impact of the actions of Cremesp on professionals who practice medicine in the state of São Paulo must be evaluated. We believe that the impact of the council's actions - in relation to bioethics in medical practice - in the state can be evaluated indirectly, for example, through the content of the accusations it receives, postulated on the basis of a strong bioethical connotation, or by the analysis of the actions of the public prosecutor, which seek to adapt the practice of medical actions to the opinion-consultations published by Cremesp.

Another way to understand this situation would be to study the quantity and content of the consultations sent to Cremesp by doctors practicing medicine in the state, especially when evaluating aspects related to bioethical connotations, such as the doctor-patient relationship. Our data show that, despite Cremesp's investment in bioethics, with consequent recognition from society and public institutions, and an impact on medicine and medical education, the demand for consultations from the medical class is relatively small, both in the area of bioethics as a whole, and particularly with regard to the doctor-patient relationship.

In this complex, constantly changing relationship, bioethical conflicts have increased, as demonstrated by specialized literature, which could theoretically lead to a significant increase in the demand for consultations sent to Cremesp. However, the results found in this study do not confirm this expectation.

It is worth noting the large number of opinion-consultations published on the Cremesp website - 5,012 in total – which demonstrate that this instrument is widely used by professionals who practice medicine in the state of São Paulo, but also by authorities and by society in general. It is expected that approximately half of these consultations will be related to medical ethics (54.2%), since the scope of the federal and regional councils is precisely to supervise the professional exercise and ensure compliance with the code of professional ethics.

However, it is surprising to note the small number of opinion-consultations in which the words “bioethical” and “bioethics” appear - only 2.1% of the total, which suggests that despite the bioethical discussion having been assimilated, it is still not identified as related to this field. Obviously, when searching for opinion-consultations on various topics

or subjects - for example, abortion, palliative care, transplants - we find questions and questions that are compatible with bioethical reflection. However, these conflicts are in the majority much more deontological and administrative than bioethical.

Similarly, attention is drawn to the few opinion-consultations featuring the descriptor "doctor-patient relationship", which represent only 3.25% of the total opinion-consultations. In addition, of the opinion-consultations regarding this doctor-patient relationship, only 18.4% have content compatible with bioethical reflections regarding conflicts of values, while the majority dealt more with deontological and administrative issues.

The comparison of these data with those of other regional councils and those of the CFM itself could not be performed in this analysis, given the inexistence of systematic research or publications with the same characteristics as this study in Brazil. Not even in non-Brazilian literature do we find publications regarding this type of comparison, as most countries have different institutional systems that oversee professional practice. Although the CFM regularly publishes works with opinion-consultations, they do not have a detailed analysis of the frequency of subjects or topics²⁵.

Some of the actions and opinion-consultations of Cremesp have influenced, to a certain extent, the resolutions published by the CFM, and some have had a great impact on medical practice in Brazil. A frequent theme identified in the consultations sent to Cremesp is related to the terminality of life and to critical patients beyond the possibility of cure. In this area, in particular, the influence of Cremesp deserves to be highlighted, both in relation to the position of the entity in the opinion-consultations and its attitude of promoting events and discussions on concepts such as "therapeutic obstinacy" and "palliative care".

There have been remarkable changes in the area of medical care for serious and incurable diseases in the last decade in Brazil. CFM Resolution 1.805/2006⁹ significantly influenced the reflections and discussions carried out by the Cremesp Interdisciplinary Technical Chamber of Bioethics. On this subject, it is worth mentioning an excerpt from Cremesp Opinion 37.267/ 1999, by Professor Marco Segre, regarding Cremesp's position on "therapeutic obstinacy":

The situation described by the consultant clearly fits with cases in which the doctor, intervening in the case of the patient, more often than not in the

absence of or even against his will and that of his family, begins to assume a posture more of torturer than of doctor¹⁴.

It should be noted that this Cremesp position was published seven years before the publication of the aforementioned CFM resolution⁹. And even after the publication of the CFM Resolution, the Cremesp opinions maintain a doctrinal position along the same lines of conduct, as demonstrated by Cremesp opinion 84.368/2007:

As it appears in the consultation, in fact, the adoption of measures to limit procedures and treatments that prolong the life of the patient in the terminal stage of severe and incurable disease, respecting the will of the person or their legal representative, "has all the ethical, moral and legal support in Brazil"¹⁷.

These Cremesp opinions contributed to the implementation of palliative medicine in Brazil, including the inclusion in the current CME of the ethical permission for non-diagnostic and therapeutic investment in severe cases which are beyond therapeutic possibilities and the inclusion of the ethical obligation of palliative care. There is no doubt among doctors working in the area of palliative medicine that the Cremesp initiative to create a specific commission to study the issue, with the consequent publication of the book "Palliative Care",¹⁰ was the main factor behind the CFM officially recognizing this medicine as an area of medical practice in Brazil.

Following this line of thinking, it is important to mention the contribution of Cremesp Opinion 18.688/2012 to CFM Resolution 1.995/2012²⁶:

Recognizing that the patient has a right to a dignified death, and to choose how and where to die, and refuse or request certain treatments, medications and interventions, as well as to interrupt them, it is legally possible for a document to exist that ensures the constitutional guarantee of his freedom, including of consciousness. But while there is no legal model, formula or legal prediction of the contours to guide the same in the legal order of the country, there is also nothing to the contrary, preventing its preparation to the extent of predicting the traits that should be observed. But fundamentally, more than a document that appeals to formality (...)²².

In the area of advance directives of will in Brazil, we can mention, for example, the studies of Dadalto, Tupinambás and Greco²⁷ and Nunes and Anjos²⁸, although the conflicts of values related to this subject

are still little discussed and published. One aspect that has caused repercussions in recent reflection on the subject in Brazil, specifically in a legal context, is the necessity of the publication of a federal law that formalizes the living will, as it has already occurred in several countries, including Portugal and Spain. The posture of Cremesp²² is to treat an advance directive of will as an essentially ethical document and as a consequence of medical-patient law.

Although it contains important legal aspects, it should not be seen as a mere document, but an ethical construction of respect for the patient's will in each situation and, especially, in more advanced stages of serious illnesses which are beyond the possibility of cure. The position adopted by Cremesp has been to provide a suitable framework to CFM Resolution 1,995/2012²⁶, in keeping with the Brazilian reality, including when recommending that the patient's advance directives are recorded in medical records.

In addition, this resolution has directed the attention of health professionals towards the importance of addressing the issue in medical consultations and treatments. Patients diagnosed with serious and progressive diseases should be encouraged to discuss their values and preferences, especially in the early stages of the disease, since its progression and the progressive aggravation of their mental functions can seriously limit their autonomy.

Some Cremesp opinions have doctrinal value, with a strong bioethical connotation, such as those that refer to the defense of the broad autonomy of both physicians and patients. Cremesp Opinion 29.299/1996, a pioneering position for medical conduct when dealing with the refusal of Jehovah's Witness patients regarding blood transfusion, clearly positions itself in favor of patient autonomy. This opinion emphasizes that it is *undeniable, and increasingly accepted by Brazilian law, the right of the individual to decide for themselves, meaning that a person cannot be constrained to accept any therapeutic conduct, even if, in the view of third parties, this conduct will be of benefit*¹³.

Another opinion that may be considered paradigmatic for the defense of patient autonomy is Cremesp 10.5715/2004, whose content defines *a prison inmate patient who refuses the dialysis treatment offered, requesting the transfer of the service. Poor adherence to treatment. Refusal of hospitalization. Right of choice must be observed*¹⁵.

It also highlights the doctrinal position regarding the importance of the doctor-patient

relationship: *Firstly, it is necessary to mention that the individual who is arrested as a result of criminal conviction has part of his rights suspended, such as the automatic consequence of deprivation of freedom*¹⁵. However, the patient's right to choose a doctor or medical staff who will assist him or her, even if in prison, must be observed, since the doctor-patient relationship cannot be established compulsorily. *It should also be emphasized that the doctor's autonomy in accepting the choice of the patient must also be guaranteed*¹⁵.

The broad autonomy of the patient and the doctor also has a bioethical aspect, as shown in Cremesp Opinion 155.608/2011, in which a plastic surgeon asks how to proceed when faced with a patient abandoning postoperative follow up. The opinion states: *the surgeon has the duty to use all the means available to achieve his objectives, using his expertise, prudence, technique and respect for all the ethical dictates of our profession*²⁰. Every medical note should be duly affixed to the medical record, with all the details, including the fact that a patient has abandoned postoperative follow-up.

It should be considered, however, that abandoning treatment is the right of any patient. The strategy of summoning a patient by letter with an "acknowledgment of receipt" notice seems absurd to us. Setting a deadline for abandonment would also be inconsistent, since *it is clear that, if the patient abandons follow-up, the surgeon will no longer be responsible for him or her, especially due to the logical impossibility of continuing medical attention*²⁰.

Professional confidentiality and the protection of patient privacy are also frequent themes in consultations with Cremesp. In Cremesp Opinion 82406/2004, in response to a question about the use of colored stickers on the cover of medical records, according to the patient's pathology, to facilitate the localization of the document, Cremesp's position is firm and objective: *professional confidentiality and the preservation of patient privacy are the pillars that support the unique doctor-patient professional relationship. Thus, it seems to us absolutely inappropriate, from any perspective, to use 'colored stickers' to identify patients with a certain diagnosis*¹⁶.

This same doctrinal stance on the protection of medical confidentiality is maintained in Cremesp Opinion 138.679/2012, which refers to the access to a patient's medical records by members of his or her family: *the family can and should be informed, but the commitment of the doctor and the medical team is to the patient, including in terms of protecting*

*the patient's privacy. The family should be informed of the bioethical referential of confidentiality to which the patient is entitled and that they may have restricted access to the medical records if the patient wishes. If authorized by the patient, this access must be given to the family members*²¹.

The role and responsibilities of the doctor as the coordinator of the multidisciplinary team appear in various consultations sent to Cremesp. The attitude of the São Paulo regional body has been to ensure the importance of the doctor as the coordinator of the team and his or her responsibility over the quality of medical care, as demonstrated by Cremesp Opinion 90.198/2010. In response to the question of who is responsible for communicating a diagnosis or reporting death, the opinion clearly establishes the role of the medical coordinator of the health team:

*We understand that explaining the results of an examination, or informing a diagnosis, or clarifying and satisfying all the doubts of the patient or family member are actions within the competence of the physician, the coordinator of the health team, and the individual who is most responsible for the quality of care given to the patient's illness. Particularly in relation to the information given to relatives regarding the death of a certain patient, it seems fundamental to us that it is given by the person in charge of the health team, the doctor; except in those cases where another professional is more suitable, from a professional point of view, to perform this challenging function. These exceptions will always take into account the best conduct for the particular situation*¹⁸.

In relation to the Free and Informed Consent Form (FICF) in medical practice, Cremesp's opinion-consultations recommend – a decision that has been accepted by the regional councils and the CFM – that such documents should not be mandatory in diagnostic or therapeutic procedures. In this case, Cremesp Opinion 124.460/2010 defines the position adopted:

*It is obligatory that the medical record should include the clarifications provided and the consent of the patient. We do not find it reasonable or necessary to obtain the patient's signature for any and all medical procedures. On the other hand, nothing prevents the FICF from being used in certain departments or medical departments to perform invasive diagnostic exams, surgeries and more aggressive therapies. It is not possible for a clinical director to alter the guidelines by requiring that the FICF is used in all procedures or determined procedures*¹⁹.

Finally, in relation to the opinion-consultations that deal with the doctor-patient relationship, the guidelines of the documents analyzed by Cremesp demonstrate absolute respect for the physician's and the patient's autonomy, encouraging the practice of benevolent paternalism²⁹ and shared decisions³⁰. These precepts make the relationship more symmetrical, that is, the doctor and patient assume their due responsibilities, against the backdrop of the classic hippocratic *philia*.

It is clear from the present study that concepts such as "the just distance"³¹ - the ideal point between patient autonomy and physician paternalism in the doctor-patient relationship - narrative medicine³², based on the patient's autobiographical account, and assumptions of contemporary philosophers such as Paul Ricoeur³³ ("Suffering is, like pleasure, the last stronghold of singularity") and Ortega y Gasset³⁴ ("I am myself and my circumstance") should be more publicized in Brazilian bioethical literature, so that they are incorporated in curricula and vocational training, and assimilated in the guidelines and resolutions of institutions of the medical profession.

Final considerations

At the beginning of these considerations, it is important to mention an issue that is not a subject of the study, but that arose from the data collection process used in it, demonstrating that the methodological approach adopted for the carrying out of the study transcends the simple application of a certain methodology. By systematizing the information, it can be seen that the opinion-consultations indicate a valuable method of providing information regarding the main questions of the professionals, illustrating the issues that should be debated in the forums of medical councils and organizations.

Considering the historical facts discussed here, Cremesp's pioneering work in the creation of the Interdisciplinary Technical Chamber of Bioethics, the Center for Bioethics and publications in the area of bioethics, and the content of the questions raised in this study, demonstrate that the council has participated in the construction and implementation of this new field of human knowledge in Brazil, more precisely in the state of São Paulo. The data collected in this study, on the other hand, demonstrate that deontological and administrative issues still predominate in consultation requests.

The most diverse factors and causes are those that relate to normative and operational aspects. However, one cannot fail to mention at least two of the main issues - the Brazilian tradition, from the second half of the last century, of the discipline of medical deontology being taught by professors connected with legal medicine and, perhaps most importantly, the lack at the present time of disciplines of bioethics in undergraduate and postgraduate courses in our medical schools. Even in cases of courses and institutions in which the discipline is taught, there is a clear deontological bias, which distorts the content of bioethical reflection and weakens the possibilities of formation and criticism aroused by this field of knowledge.

The absence of the bioethical discipline in degree courses in the area of health, especially medicine, is a relevant issue that must be tackled in the coming years. The maintenance of the *lato* and *stricto sensu* postgraduate programs in bioethics is

a fundamental aim if the number of professionals with adequate training in this new field of human knowledge is to be increased. In this sense, implementing bioethics committees in hospital institutions can expand the importance of bioethical reflection among professionals who work in patient care, even if not linked to the academic area.

Finally, it should be considered that the creation of Bioethics Centers in other regional councils of medicine, as well as the implementation of Interdisciplinary Technical Chambers of Bioethics, will also contribute to increase the critical mass of professionals prepared to employ and diffuse bioethics among different areas of knowledge. In addition to promoting training and constant professional development, these bodies can contribute to the dissemination of bioethics, consolidating the reflections proposed by this field and thus stimulating the conquest of citizenship throughout Brazilian society.

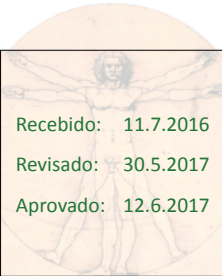
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Participation of the authors

The authors participated jointly in the preparation of this work.



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Annex

Site of search	
www.cremesp.org.br	
1) Cremesp Opinion 29.299/1996¹³ – Blood transfusion in Jehovah's Witness	
Consultation: <i>Doctors VDVF and PIF requested the opinion of Cremesp in relation to the following questions:</i>	
1) <i>Is there any obstacle to the transfusion of blood products in a Jehovah's Witness patient?;</i>	
2) <i>What is the responsibility of the attending doctor and the hemotherapy physician when the administration of a transfusion is the only method of emergency treatment of the anemia of the patient in the presented case?</i>	
Opinion: <i>it is undeniable, and increasingly accepted by Brazilian law, the right of the individual to decide for themselves, meaning that a person cannot be constrained to accept any therapeutic conduct, even if, in the view of third parties, this conduct will be of benefit</i>	
2) Cremesp Opinion 37.267/1999¹⁴ – Dysthanasia	
Consultation: <i>The approach a doctor should take in the case of a 78-year-old patient with metastatic malignant neoplasm who did not respond to the usual treatment, following verbal authorization of relatives not to intubate, in a clear course of respiratory failure.</i>	
Opinion: <i>The situation described by the consultant clearly fits with cases in which the doctor, intervening in the case of the patient, more often than not in the absence of or even against his will and that of his family, begins to assume a posture more of torturer than of doctor.</i>	
3) Cremesp Opinion 105.715/2004¹⁵ – Patient autonomy	
Consultation: <i>Doctor SBS., in her capacity as the medical technician responsible for the nephrology and dialysis service, requests an opinion on the possible measures to be taken, in response to the manifestation of a prisoner, reporting his dissatisfaction with the treatment offered, as well as requesting the transfer of the respective medical service. After a brief presentation of the facts, including the refusal of hospitalization by the patient and poor adherence to treatment, the querent questions Cremesp about the position that should be adopted.</i>	
Opinion: <i>a prison inmate patient who refuses the dialysis treatment offered, requiring the transfer of service. Poor adherence to treatment. Refusal of hospitalization. Right of choice must be observed.</i>	
4) Cremesp Opinion 82.406/04¹⁶ – Professional confidentiality	
Consultation: <i>If it is permissible to use colored stickers on the cover of medical records, based on the pathology of the patient, in order to facilitate the localization of such records; and if the Medical Record Review Commission has the authority to interfere in this situation or if it is merely a consultative organ.</i>	
Opinion: <i>professional confidentiality and the preservation of patient privacy are the pillars that support the unique doctor-patient professional relationship. Thus, it seems to us absolutely inappropriate, from any perspective, to use 'colored stickers' to identify patients with a certain diagnosis.</i>	
5) Cremesp Opinion 84.368/2007¹⁷ – Limiting of procedures to treat diseases in final phase	
Consultation: <i>the mother of a child patient, through an express request, states that she is against any type of resuscitation of her daughter by the medical team, in the case of complications. The child suffers irreversible neurological damage related to her disease, with dependence on mechanical pulmonary ventilation a possibility.</i>	
Opinion: <i>As it appears in the consultation, in fact, the adoption of measures to limit procedures and treatments that prolong the life of the patient in the terminal stage of severe and incurable disease, respecting the will of the person or their legal representative, "has all the ethical, moral and legal support in Brazil".</i>	
6) Cremesp Opinion 90.198/2010¹⁸ – Communicating death to family members	
Consultation: <i>the communication to the patient of a newly concluded diagnosis or even in the case of death is the responsibility of which professional: the doctor, the psychologist or the nurse?</i>	
Opinion: <i>We understand that explaining the results of an examination, or informing a diagnosis, or clarifying and satisfying all the doubts of the patient or family member are actions within the competence of the physician, the coordinator of the health team, and the individual who is most responsible for the quality of care given to the patient's illness. Particularly in relation to the information given to relatives regarding the death of a certain patient, it seems fundamental to us that it is given by the person in charge of the health team, the doctor; except in those cases where another professional is more suitable, from a professional point of view, to perform this challenging function. These exceptions will always take into account the best conduct for the particular situation.</i>	

7) Cremesp Opinion 124.460/2010¹⁹ – Free and Informed Consent Form in clinical practice

Consultation: if the clinical director can make the completion of an informed consent form compulsory for the institution's medical professionals.

Opinion: It is obligatory that the medical record should include the clarifications provided and the consent of the patient. We do not find it reasonable or necessary to obtain the patient's signature for any and all medical procedures. On the other hand, nothing prevents the FICF from being used in certain departments or medical departments to perform invasive diagnostic exams, surgeries and more aggressive therapies. It is not possible for a clinical director to alter the guidelines by requiring that the FICF is used in all procedures or determined procedures.

8) Cremesp Opinion 155.608/2011²⁰ – Medical conduct in the case of abandonment of post-operative follow-up treatment by patient

Consultation: On how to prove, in a legal and ethical manner, the abandonment of treatment by the patient.

Opinion: In complying with all the duties listed, in addition to maintaining a respectful and polite relationship with his or her patients, the doctor will hardly be the victim of any unethical maneuver on the part of the patient. If, even if acting correctly, the doctor is the victim of an artificial and immoral maneuver on the part of the patient, our courts, in the full state of law, will certainly punish the guilty parties in the inevitable ethical and judicial litigation to which all who practice the Hippocratic art are subject.

9) Cremesp Opinion 138.679/2012²¹ – Confidentiality of medical records

Consultation: a family frequently questions the treatment given to a hospitalized patient with a serious health condition. The medical team wants guidance on how to proceed in the case, and to know whether if the patient dies, the attending physician should sign the death certificate or refer it to the Death Verification Service (DVS).

Opinion: The attending doctor, responsible for the patient and the leader of the multidisciplinary team, should be responsible for communicating with the patient, and should always seek his or her best interests. This doctor has the commitment and the duty of vigilance, of information and of obtaining consent for all the acts practiced. The family can and should be informed, but the commitment of the doctor and the medical team is to the patient, including in terms of protecting the patient's privacy. The family should be informed of the bioethical referential of confidentiality to which the patient is entitled and that they may have restricted access to the medical records if the patient wishes. If authorized by the patient, this access must be given to the family members. If the patient, for whatever reason, loses all or part of their autonomy, and the attending physician considers them incapable of making autonomous decisions, the medical professional must then verify who can represent the patient when communicating with the team and inform and discuss the therapeutic proposals with that person.

10) Cremesp Opinion 18.688/2012²² – Living will

Consultation: Regarding the non-obligation of doctors to prolong the life of terminal patients.

Opinion: Recognizing that the patient has a right to a dignified death, and to choose how and where to die, and refuse or request certain treatments, medications and interventions, as well as to interrupt them, it is legally possible for a document to exist that ensures the constitutional guarantee of his freedom, including of consciousness. But while there is no legal model, formula or legal prediction of the contours to guide the same in the legal order of the country, there is also nothing to the contrary that prevents its preparation to the extent of predicting the behavior that should be observed. But fundamentally, more than a document that appeals to formality, this should be the result of a process involving patient, family, medical assistants, religious faith, constructed with the awareness of everything that surrounds our will and desires, with respect to individualities, and matured with the understanding of our finitude.