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CONSERVADURISMO VERSUS LIBERALISMO. IDENTIDAD VERSUS SITUACIONISMO
EL LEGADO DE JAMES DRANE

Fernando Lolas Stepke[1]

La reflexión ética sobre el comportamiento humano no tiene por finalidad describir, explicar, comprender o interpretar. Su finalidad es *justificar y legitimar* comportamientos considerados “morales” o apropiados por una sociedad según tradición, costumbre o leyes.

La ética es a la moral como la musicología a la música. Es una elaboración secundaria, lingüística, de las razones o fundamentos por los cuales lo bueno es bueno y lo malo es malo.

El principal problema cuando se justifica o legitima una conducta reside en la autoridad que lo hace. De allí que no sea posible discutir temas de ética sin reflexionar sobre el poder, recordando que autoridad es poder legítimo.

De este modo, la religión, la costumbre, la razón suelen invocarse para sustentar la legitimación ética que puede provenir de convicciones o usos sociales que concitan adhesión o respeto.

Es sabido que Max Weber sintetizó las formas de razonamiento ético en Occidente en dos grandes corrientes. Llamó a una “*Gesinnungsethik*” (ética de las convicciones) y “*Verantwortungsethik*” (ética de la responsabilidad) a la otra. La primera suele asociarse al raciocinio deontológico, destacando deberes que emanan de creencias. La segunda con el efecto de decisiones y acciones sobre el bienestar y la convivencia.

Muchas personas creen en dogmas religiosos, otras en dogmas científicos, algunas en “leyes naturales” enunciadas por alguna autoridad con apego a la razón o la creencia. Enfrentan los inevitables dilemas de la vida humana recurriendo a las prescripciones de su fe. “La voluntad de creer”, como escribía William James, es consubstancial a la especie humana. Incluso quienes creen no creer abrigan convicciones de las que no se percatan. Ortega y Gasset decía “las ideas se tienen, en las creencias se está”. Se *está* en ellas aún sin saberlo. Una arqueología o un “desenmascaramiento” de las creencias sirven para abordar el estudio de grupos y sociedades.

Frente a esa postura, razonar según las consecuencias de los actos para la convivencia o el bien común produce formas diversas de ética de la responsabilidad. Conocido es el utilitarismo, que proclama buena una decisión cuando produce el mayor bien para el mayor número de personas.

Al tomar decisiones suele mezclarse ambas formas de justificación moral. Las personas suelen sopesar los pros y los contras, maximizando sus posibilidades, respetando ciertos principios o apoyándose en creencias explícitas o inconscientes.

Por qué las personas tienen algunas creencias y no otras depende de muchos factores. No se escoge ni el lugar ni el momento del nacimiento. Tampoco la familia, los ancestros o el régimen político en que se llega al mundo. Las creencias pueden mutar en el curso de la vida pero las personas sienten, pese a los cambios, una suerte de continuidad biográfica a la que guardan lealtad. Esta *ipseidad*, individualidad persistente pero mudable, puede ser llamada también “identidad”. Muchas decisiones se toman para proteger y resguardar la identidad debida a la nación, la historia, las instituciones. Especialmente expresivo es el caso de quienes creen representar el tipo ideal de una institución o grupo humano. Sus creencias les impulsan a conservar inmutable esa identidad, a defenderla de influencias foráneas. En suma, a preservar.

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Esta postura conservadora fue la que James Drane (1930-2023) expuso y criticó en relación a la Iglesia Católica Romana. Después del Concilio Vaticano Segundo se avizoraba un "*aggiornamento*" de la doctrina católica en relación a temas vitales, entre otros, la reproducción humana y la anticoncepción. Así lo dejaba entrever el resultado de una comisión instalada por Juan XXIII. Pero fue desatendida y desechada por Paulo VI en su encíclica "*Humanae Vitae*". Las fuerzas conservadoras predominaron en la jerarquía eclesiástica, a fin de sostener la "identidad" de la Iglesia.

Drane fue expulsado de la condición sacerdotal no solamente por escribir artículos de prensa en que reafirmaba las conclusiones razonables de la comisión conciliar. Al término de uno de ellos, en forma algo críptica pero manifiesta, objetó el dogma de la infalibilidad papal, aquella doctrina de Pio IX que se impuso en el siglo XIX. Los Papas, en materias doctrinales, no pueden errar.

Largo sería explicar o pretender entender situaciones históricas que exigen versación y competencias. Lo central es preguntarse qué demuestra el caso de James Drane cuando, en sucesivos escritos, confronta lo que llama "postura católica liberal" con el conservadurismo de la curia y la jerarquía. El nunca abandonó la iglesia y siempre abogó por el diálogo con otras confesiones cristianas. Pero objetó la rigidez en la mantención de una identidad eclesial que no se encontraría en los orígenes del cristianismo ni tampoco en muchos de sus textos canónicos.

Quienes le conocimos en la época liminar del nacimiento del discurso bioético en Iberoamérica, del cual fue promotor y precursor, podíamos concordar con sus planteamientos e incluso aceptar su catolicidad post sacerdotal como una decisión encomiable. La pregunta que nunca respondimos es hasta qué punto puede o debe una institución más espiritual que política adaptarse a los avatares del tiempo y cambiar según preferencias de las multitudes. Algo frecuente en la política contingente, especialmente en algunas pseudo democracias latinoamericanas que devienen en dictaduras populistas. Bien sabemos que en el seno de una institución compleja y antigua conviven distintas orientaciones y persuasiones, pero sus modos de ejercer influencia no pasan por la consulta popular, que no es la fuente de su autoridad. La "ortodoxia" es un concepto escurridizo, especialmente en una época como la actual en que predomina el laicismo, preconizado como antídoto contra supersticiones. Es probable que la popularidad de la iglesia romana creciera con posturas más aceptantes de los usos en boga, pero ello está en contra de la noción de "identidad transhistórica" que se autoatribuye.

Lo relevante del caso, y oportuno de recordar ahora que Drane ha muerto, es en qué medida la Ley Natural y los derechos humanos inalienables, núcleo de toda discusión actual sobre dilemas bioéticos, pueden ser invocados en forma exclusiva por una corriente doctrinal o política. Está en juego la fidelidad a la propia historia, los intereses de quienes transitoriamente la dominan, la esfera de influencia que gana o pierde y, finalmente, el sentido de las ideologías. Por más que se intente desacreditar a algunas por los efectos que su aplicación tuvo o tiene en el cuerpo social, la tensión entre conservadurismo y liberalismo (en el sentido que les dio Drane) es parte de la vida social. Frente a eso, las minucias del discurso bioético y su utilización con espurios fines son solamente parte de una historia en desarrollo, en la que cabe discernir tendencias pero nunca verdades.

En este número de *Acta Bioethica* incluimos un homenaje a James Drane y una recensión de su último libro, con referencias a otras obras suyas.

Hans-Martin Sass

También ha fallecido otro importante bioeticista, Hans-Martin Sass, representante de una forma europea de este discurso, quien dedicó parte de sus esfuerzos a la exposición de una "ética diferencial", a la integración transcultural de los problemas y trabajos y al redescubrimiento de las aportaciones del pastor luterano Fritz Jahr, un precursor que creó el vocablo *Bio-Ethik* en la década de los años 20 del siglo pasado. En este número, el profesor Amir Muzur, de Rijeka, Croacia, le tributa un merecido homenaje *in memoriam.*

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RELIGIOUS MORALITY, SECULAR MORALITY AND THE SEARCH FOR MORAL RELATIVISM IN THE WEST

Gilvana de Jesus do Vale Campos[1], Alessandre Gomes de Lima[2], Stela Marcos de Almeida Neves Barbas[3]

Abstract: This work aims to characterize religious and secular moralities in the West from a critical-diachronic point of view, seeking to identify spaces that cover moral relativism in solving complex bioethics issues. Concerns such as the destination of surplus embryos, for instance, usually raise polarized positionings without consensual solutions. With the presuppositions introduced on western culture through several events, mainly the principle of laicity, the view of morality widened. This work is reflexive, meta-ethical, with an interdisciplinary approach. It is a national and international literature review regarding the main points on religious and secular morality. We concluded that the present moral overview certainly includes moral relativism based on essential morality, one which can be represented by moral strangers and moral friends.

Keywords: moral codes, religious morality, secular morality.

Moral religiosa, moral laica y la búsqueda del relativismo moral en Occidente

Resumen: Este trabajo pretende caracterizar las moralidades religiosa y laica en Occidente desde un punto de vista crítico-diacrónico, buscando identificar espacios que abarquen el relativismo moral en la resolución de cuestiones complejas de bioética. Preocupaciones como el destino de los embriones sobrantes, por ejemplo, suelen suscitar posiciones polarizadas, sin soluciones consensuadas. Con los presupuestos introducidos en la cultura occidental a través de diversos acontecimientos, principalmente el principio de laicidad, se amplió la visión de la moral. Este trabajo es reflexivo, meta-ético, con abordaje interdisciplinario. Se trata de una revisión bibliográfica nacional e internacional sobre los principales puntos de la moral religiosa y laica. Concluimos que el panorama moral actual ciertamente incluye el relativismo moral basado en la moralidad esencial, que puede ser representada por extraños morales y amigos morales.

Palabras clave: códigos morales, moral religiosa, moral secular

Moralidade religiosa, moralidade secular e a busca por um relativismo moral no Ocidente

Resumo: Esse trabalha objetiva caracterizar moralidades religiosas e secular no Ocidente desde um ponto de vista crítico-diacrônico, buscando identificar espaços que cubram o relativismo moral ao solucionar temas bioéticos complexos. Preocupações tais como a destinação de embriões excedentes, por exemplo, habitualmente levantam posicionamentos polarizados sem soluções consensuais. Com os pressupostos introduzidos na cultura ocidental através de diversos acontecimentos, principalmente o princípio da laicidade, a visão da moralidade foi ampliada. Esse trabalho é reflexivo, meta-ético, com uma abordagem interdisciplinar. É uma revisão da literatura nacional e internacional a respeito dos pontos principais sobre a moralidade religiosa e secular. Nós concluímos que a atual visão geral da moral certamente inclui o relativismo moral baseado na moralidade essencial, que pode ser representada por estranhos morais e amigos morais.

Palavras chave: códigos morais, moralidade religiosa, moralidade secular

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Introduction

The debate over what is from nature and what is a result of social conventions in humankind's life is old and involves, to a large extent, the understanding of *physis* and *nomos*, which meanings were used in different ways through classical antiquity, including an idea of an opposition between them*(1)*. The *physis* was acknowledged as the "nature, human nature. . . . a source of values and, therefore, in itself, somehow prescriptive." And through *nomos*, "people believed in gods and recognized a distinction between things that are right and things that are wrong. . . .*Nomos* would be the law, the convention or the usual"*(2:189-191)*.

From the perspective of this "opposition", the sophists investigated the morality as to its origin: would it be a subject of nature (*physis*) or convention (*nomos*)?*(1)*. It is still occasionally questioned if: is the moral born with humankind or is it acquired? Does it integrate their mental/emotional structure, or do humans become aware of themselves as moral beings through learning?*(3)*.

The interest in the subject is broad and some of the answers, more formally or not, are denotative of how it has been understood over time: "The moral is acquired as a result of habit, whence its name came to be through a small modification of this same word [habit]"*(4:27)*. "The moral (…) has influence over actions and affections, it follows that [it] alone cannot be derived from reason because the reason alone (…) can never have such influence. The moral awakens passions and either produces or prevents actions. Reason, by itself, is entirely powerless in this regard"*(5:497)*. "The moral is something historical and psychological, not the attribute of some innate essence of humankind as the categorical imperative"*(3:8)*. The moral is compared to language, which is also regarded as both innate and acquired. Innate are the inner mechanisms of one's processing or the field to its development. Acquired are the unfolding of one's assimilation on a process of construction, reform and adaptation, demolition and retouching ever continuous*(6)*.

With its *physis* alongside the *nomos*, humankind discovers themselves and builds themselves while interacting with the world. That happens due to their perception ability, which is broader and more valuable than the five senses. The perception organizes the "raw data of the hetero-consciousness", modifies the cognitive structure gradually, and develops self-consciousness. In the organization, in face of the multiform of the outside of one's body, their perceptive relation highlights itself through reciprocity with living objects: "I act on the living world, and the living world acts on me; I affect the world's ways of living, and the world affects my way of living, being, and staying in life"*(7:2)*. Cognitively, one involves themselves in this outside culture whose symbols are representations set up by intelligence. Such involvement activates the brain and generates internal stimuli that produces diverse and complex answers to facts. In the self-consciousness, a field of reflexivity, evaluations are elaborated and personal decisions that lead to actions are made*(7)*. The self-consciousness is the human way to represent the dual aspect that constitutes their nature, simultaneously, individual and social*(8)*.

When it comes to shared life, it is possible to recognize a social structure within it. Society only sets itself when it enters the individual consciousness, shaping them*(10)*. All of it is justified because society is only constituted when it permeates the individual consciences, shaping them. Therefore, from a conservative point of view, it is possible to argue that some of the various mental states of an individual, principally the most essential ones, have a "social origin". Here is the whole that constitutes the part, being impossible to explain the whole "without explaining the part", even as an aftereffect*(10)*.

The continuity of social structure, like that of organizational structure, does not fall apart with the changes in units (or individuals). It is possible due to the process of social living, represented by the interactions between individuals and groups alongside their activities. So much so that some can exclude themselves from social life for any reason just as others can enter it, but the structure remains. Thus, life in society can be perceived as the "functioning of social structure", which contributes to the respective continuity through recurring functions and activities, such as punishment of crimes, for instance*(9)*.

In the relationship between the individual and this structure, their intelligence and actions are presented differently: respectively, on one hand there is conceptual thoughts and selfish desires that are directed only to oneself; on the other hand, there are moral actions with impersonal purpose, recognized "through the signal that all rules of behavior to which one obeys, are probably universalizing"*(10:36)*. The moral is one of the maintaining functions of the social structure and a regulating force of behavior by means of codes. Whenever a behavioral problem arises, its judgment is made in the light of the prescriptions regulated in the moral code embraced by the society in which it occurs. It is the case of problems that are related to the Bioethics field and that also bring to light the discussion between moral and morality.

The objective of this work is to characterize the religious and secular moralities in the West from a critical-diachronic point of view, seeking to identify spaces that cover moral relativism in solving complex bioethics issues, such as the destination of supernumerary embryos. It is a meta-ethical study in which morality evaluations can focus on other means, according to the problem's nature and its social implications, many of which arise polarized positionings. To Durkheim*(11)*, morality rules set a "fundamental notion" that applies to specific conditions of life and can be diversified according to the situation and the circumstances that involve it. Aristotle*(4:53)* explains that "the exercise of virtue concerns the means" or finding a path that reaches the most appropriate solution without losing sight of the guiding principle. The proposed criticality does not refer to the deconstruction of images or moral prescriptions but rather the examination of the founding conditions of occidental morality. According to Silva*(12)*, practical considerations must have moral objectivity as its central point and always require illuminating references in areas that involve human life.

Methodologically, it was made a literature review with an interdisciplinary approach, given that this theme is common to a plurality of disciplines (Bioethics, Anthropology, Theology, Philosophy, Psychology, and Sociology). With the approximation of the respective contents, one escapes from the "casual abbreviation" of the moral aspects of the problem, usually limited to the view of their environment, class, and beliefs*(13)*. The disciplines were sorted by intersection practice, that is, when there is no "central discipline" that uses "elements of other disciplines in its favor, but rather problems that, having its origin in a discipline [bioethical problems], radiate to others"*(14:9)*. Relevant authors and classical texts of each area were consulted at a national and international level and amongst them, the inspiring text of the philosopher and historian Antonio Ferreira Paim.

Humankind: the individual, the collective and the moral building

The moral is something constituent of society, the result of evaluations about the acceptance and disapproval of customs reflected in actions. It is a necessary institution, for it is impossible to have life in society without leading rules of behavior to be followed by its members*(15)*, which are its fundamental units. Since the human being becomes historical insofar as self-produces, the moral also permeates this process, becoming equally historical*(16)*.

The moral emerged with the change from ways of living in nature to a life of social living. Over the centuries, factors such as work and its social division, the increase of productivity, and the emergence of private property allowed the rise of new organizations of the production activities and, with them, the rise of other relationships. In this broad context of culture, with the historical and social progress and its resulting change in the production methods, with the preponderance of the labor relationships and the collective sense in culture, the moral became essential to ensure the correspondence between the individual behavior and the collective interests. If on one hand the historical and social progress was neither free nor conscious, on the other hand, the moral progress must be evaluated regarding the criteria: an extension to situations without a solution yet, contribution to the consciousness related to individual and group behavior, and the level of harmonization between personal and collective interests*(16)*.

Two observational focuses of moral emerge from this: as an institution and as behaviors resulted from it. The first one lies on the normative, ideal plan and forms the set of values, principles, and requirements valid for a given society; it is the moral as a code. The second one lies on the fact-based plan and represents the behaviors that materialize these principles and prescriptions in social relationships; it is the morality*(17)*. In fact, the moral is often referred to as ethic due to their shared axiological basis. However, the moral distinguishes itself form ethic as a study of "morality within its essence, as an individual and social venture (…) Unlike the practic-moral problems, the ethical ones are characterized by their generality"*(16:10-17)*.

From the pragmatic point of view, rules are established as borders between what one must do and what one must not do. They form the "founding roots of human expression" in its finiteness and do not restrict to codes; "they transcend the scope of human life on the individual dimension, demarcating in time the spaces and forms of relationships between the members of a group"*(18:110)* and the search for solutions to morally complex problems that extrapolates those codes.

On the individual dimension and in the fact-based plan, the moral has an important function in the formation of humans, especially in the development of the notion of justice, concern with one another, and observation of cultural norms that lead the social behavior*(19)*. Therefore, works about the moral and its development cover multiples areas and associations.

The researches of Kohlberg*(20)*, for instance, associated the moral to cognition, having as its central point the idea that the development provides changes in the cognitive structures. The moral of an individual develops through stages just like their cognition: on the first and second stages, pre-conventional, their judgment over what is right or wrong relies only on one's interests; on the third and fourth stages, their moral actions rely on conventional social norms; on the fifth and sixth stages, their actions rely on moral principles of universal value, especially equality and reciprocity. Moral principles are more important than social norms.

Psychology researches, for its part, have been using moral judgments to evaluate the relationship between cognitive and emotional processes and decision-making in morally complex topics. Affirmative answers to complex and difficult-to-solve problems may be considered functional, that is, as having some usefulness to the majority. They can be viewed according to the utilitarian principle of Stuart Mill's moral philosophy. In parallel, negative answers may be considered non-utilitarian upon evaluation of an action's characteristics instead of its effects. They can be associated with Kant's principle of deontology*(19)*.

Under Mill's philosophy, according to his utilitarianism (scope of positive answers), "every properly raised human being shows that, in varying degrees, both genuine private affections and a sincere interest for the public good are possible"*(21:198)*. However, to have a correspondence between individual interest and collective interest it is necessary that the social and legal instruments stimulate the harmony between them and that opinion and education seek to create in each individual an indissociable bond between one's happiness and the collective good. Mill explains that human actions have a purpose, an interest, which must be explicitly identified and the first thing to be pursued. The rules that regulate these actions must be based on what is aimed to be achieved, obeying its character. The actions will be good if aimed to the largest number of people and seek their well-being*(21)*. In summary, the individual absorbs values from the environment in which they live and act according to them, reflecting their morality. However, when their values are not in accordance to a specific situation, moral problems set and personal moral judgment arises. The individual reflects about the acquired values and sorts them in another hierarchy, enabling the development of different reasonings about norms and imposed moral explanations*(20)*.

About the Kantian deontology (scope of negative answers), its principle relies on the notion of rational individual and the motivation of moral attitude. The actions must attend to what is morally necessary, avoiding deductions based on empirical demonstrations. They must not depend on how its effects will be perceived nor on whether its legitimacy will be confirmed or not*(22)*. Kant highlights moral's metaphysics, which investigates the principles of pure desire and not the actions and the conditions of the desire in general. The moral's metaphysic is essential not only to the investigation of practical principles which rule the reasons for acting and are found, *a priori*, on the individual judgment. They are also essential because the moral principles themselves are subjected to corruption if "the thread and the supreme norm of a correct judgment" are lacking to the guidance of the action (Kant, 1785/2002: 5). It is not enough that an action follows the moral rule; it also needs to be performed because of this rule at the risk of becoming only contingent and precarious. "The non-moral field produces legal actions, but also produces, more frequently, actions against the rule"*(23:6)*.

Based on both Mill's utilitarianism and Kant's deontology, we concluded that the "conscious self" is not indifferent to any perception because ever since "the first stages of development (…) all contents archived have nuances between the absolute positive or negative"*(7:2)*. We also concluded that between the normative and the empirical, both fact-based, it is possible to inquire behavior proposals based solely on studies about normative morals, set on beliefs or codes relative to a given culture*(24)*.

The justification of moral principles must be made based on reason, whose exercise regards the ends and its respective questions, in addition to the phenomena classifications and the explanations based on beliefs and norms previously established. Examining the core of principles can assure fairer and more adequate moral judgments*(24)*.

The problem with moral judgment is not on the formulation of judgment itself but on the elements that ground it*(15)*. Moral judgments often focus on the notions of good or bad, which implies a value judgment*(3)*. In the relationship between good/bad, Nietzsche*(25)* criticizes the association between the concept of good (and of bad) to moral genealogy, explaining that the concept meaning of evaluating actions had grown apart from its origin. At first, non-selfish actions were judged good by their beneficiaries. Afterwards, this recognition was forgotten and these same actions, for they have always been perceived as good, began to be considered as good within themselves, in a judgment that came from its doers, greater in power and thought. "There we have 'the utility,' 'the oblivion,' 'the habit,' and, lastly, 'the error,' everything serving as a basis to an evaluation"*(25:18-19)*. The habit (repetition) makes many actions or ways of acting acquire "a consistency which precipitates and isolate them from particular events that reflect them. . . .They not only are on us but also, as a product of repeated experiences, obtain, from repetition. . . .a kind of rise and authority"*(11:19)*.

The codes of behavior have an important role in the acquisition of moral habits. Knowing from its origins to its systematization is essential to visualize the basis and conditions of its creation and comprehend its evolution and what it represents as the final result of the individual and social moral life.

Moral Codes: development and prospects

The effort to set norms that could contribute to the survival of the human groups in a cohesive manner was "unimaginable", as the codification of customs was a late event in humankind's evolution. Before the written codes, the transmission and maintenance of knowledge and customs were widely made through oral tradition*(15:158)* in societies without any written language.

The societies without a written language are characterized by having been numerous and considered the customs as a normative source. All that was lived traditionally became a rule and should be followed by everyone. According to Lima*(26)*, these societies held just the memory as a resource to retain and transmit the representation of what was important to them. Amid dramatization and multiples narratives, the spoken messages were emitted and received at the same time and in the same place. Both emitter and receiver lived in the same historical-political-geographic context, sharing semantical meanings and significances alike.

In these societies, the moral and juridical rules were part of religion in a highly tangled way, so much that it was hard to dissociate one from the other*(27)*. The solely oral system of transmission of these customs remained in force until writing arrived in its multiple forms. When these societies started to count with symbols to express their ideas and norms—like the Sumerian's cuneiform script (around 3.000 B.C.)—these norms and ideas were adopted by people of different linguistic families and different semantics. Between 4,000 and 2,000 B.C., due to the social, technical and political advancements in different parts of the world, writing came into being with Phoenician's alphabet representation and Greek supplementation*(28)*. As a result, there was the creation of comprehensive legal systems and norms – known as codes: Urukagina Code, from 2,380 to 2,360 b.C.; The Code of Ur-Nammu, from 2,050 b.C.; Laws of Eshnunna, from 1,930 b.C. and some others, which had influences amongst one another. The Ur-Nammu code, for instance, influenced the Laws of Eshnunna, and them both influenced the Hammurabi Code (from 1,790 b.C.), that is one of the most well-knowns in present days. Wolkmer summarizes: "In ancient societies, boths codes and laws were expressions of the divine will, disclosed through the imposition of a legislator – administrators, who had dynastic privileges and a legitimacy guaranteed by the priestly house" (29:4). Hammurabi's Code mystical model of elaboration "can also be ascertained in the Old Testament"*(18:109)*.

This notions lead us to reflect on the origin of written moral codes, in regard to the costumes that would arise in each society and the ones that were adopted when the oral form of transmission was replaced by the written one. The influences amidst the codes may have led to choices, amplification or overlapping of the rules of conduct that commenced to guide societies by means of written codes. There is also the semantic matter, which leads to different interpretations of the norms according to the linguistic branch each society has and without the appropriate diachronic perspective. Durkheim*(10)* explains that concepts are represented by refined feelings and words and address a "plurality of men". But since the particular vocabulary and grammar represent a collectivity of those who adopt it, usually the images suggested by them are not likely to find correspondence outside this community.

These aspects can represent part of the difficulties in reassembling the course of morality, especially when there are no religious references, according to Paim*(15)*. Science materials, such as anthropology (about the human especies and heredity) and archeology (about languages et cetera), work as evidence about peoples' past and can be as important as writing in this retrieval. However, one of the most difficult aspects is to identify "where to start the story (…) There are deep continuities between western mythification of remote populations and that of distant ancestors"*(30:15)*.

As literate societies succeeded each other, they distanced themselves from the illiterate ones, also because they recognized the necessity of maintaining rules of conduct for their intergenerational reproduction. They have established the understanding that it was not enough for mankind to know about wrong and right and decide how to act. It was necessary to establish limits and punishments to coordinate the relations between them. It was necessary to develop codes "to improve the relationship between the individuals of collectivity"*(18:109)*.

Simultaneously, the characteristics of morality and its principles acquired different directions and features from East to West. The first one developed more theorizations than the second, which facilitated a clearer observation of theoretical problems. The second one has had the determination of Judeo-Christian Morality as its final historical destination. In the West, as a rule, morality is composed of "a basic nucleus" which hs been enriched since the appearance of the Decalogue: the ideal human being*(15)*.

Theoretically, morality represents a set of rules of conduct that applies to a specific period. From the praxis perspective, morality can be understood as an "agreement between the conscience, a judge, and established precepts"*(15:163)*, but it does not imply the possibility of another morality being developed. From a sociological point of view, morality is important for religious reasons as well as for convention. Religious reasons are explained by the holy, and convention, which concerns traditions, represents whether they are approved or not by the closest social circles. Traditions are developed from the behavioural regularity and by the lack of consideration regarding them, and they are kept and ratified by tradition*(15)*.

Religious Morality in the West

The homo religiosus

The encyclical letter *Fides et ratio(31:5)* from John Paul II about the relationship between faith and reason, asserts that "Man seeks, by nature, for the truth. And this seeking does not concern only the achievement of partial truths, whether physic or scientific; it does not only seek for true goodness in each of their decisions. But their seeking leads to a superior truth, a truth that is able to explain the meaning of life; it is, therefore, something that can reach no other thing but the resolute (…) The ability and decision to trust their own being and existence to somebody else implies, undoubtedly, one of the most anthropologically meaningful and expressive acts".

From this perspective, in regard to the general seeking for truth, knowledge is the main way through which humankind tries to understand reality and build it in their minds, using images and ideas. Since reality is made up by different structures and levels, knowledge will be acquired, cognitively, in different forms and by different degrees, through diversed experiences. For instance: scientific knowledge provides a rational perspective of facts, and an objective and careful analysis of its causes; it is systematized. Philosophical knowledge aims to identify meaning in an implied reality, not perceptible through senses and beyond experience; it is systematized. Theological knowledge has God as the focus and perceives beings to the divine light; it is systematized. And popular or empirical knowledge comes from experience, it encompasses everyone and is not systematized*(32)*. As for the particular search of a truth that explains the meaning of life, which leads to the resolute, we infer that the theological and empirical knowledges are responsible for the creation and establishment of the religious man, as well as the representations they absorb or embrace. That happens, respectively, due to its foundation and the ancient way in which knowledge is transmitted.

In their being in the world as a human organism, an individual's condition per se is characterized by a "congenital instability", and their relation with the world is not previously established as well. This makes their existence a persistent search for balance in face of the inherent instability and cultural imperative of stability. "They produce language and therefrom [create] a series of symbols that pervade every single aspect of their life"*(33:19)*. From there arises the notion of sacred, which is understood as something different from mankind and perceived by them as an "immensely powerful reality". Even though it is different from them, it refers and relates to them in a distinct manner from the one that is developed with other phenomena. The sacred guides their reality, establishing a certain order to their life and bestowing it with purpose. The sacred can be expressed in different ways, but it is possible to notice some cross-cultural uniformities*(33)*. According to Eliade*(34)*, sacredness revelations are quintessential to address a remote religious past as well as to resist the historical innovations.

Theoretically, it can be understood as a category *a priori* from the human experience, which is to say, it is placed in the human spirit as its primary origin and it is prompted from that experience. It has a specific element that goes beyond rationality (the unmentionable) and a conceptual designation (the unspeakable). In general, the term "sacred" is seen as an essentially moral and completely good attribute, but, in its etymological meaning, *heilig* (sacred/holy) means "saint" and, in many languages, it was learnt as "something else". Since it is an entirely *sui generis* category, it cannot be strictly defined as primary and fundamental datum*(35)*. "Saint (or sacred/holy) is an explanatory and evaluative category that comes from, and presents itself, *exclusively* in the religious scope (…) as its basis and medulla", explain Borau*(36:35)*, from Comunidade Ecumênica Horeb - Barcelona (Spain). (*emphasis added*).

Sacred/Holy can only be explained by the feeling provided by the psyche, which can be "proposed" from descriptions of similar or opposite feelings or by means of symbolic terms. There is a primary feeling, related to a certain object, which arouses a "feeling of creature" –of nullity before what is above it–, as if the second one was a reflection of the first*(35)*. Matos*(37)* explains that the empirical knowledge comes from the censorial experiences, because there's a subjective ability already.

Not only mankind is “naturally religious”, but the relationships develop from religion’s interference. Society’s culture works as the interlocutor of these relationships through values, symbolisms and norms that are socially shared*(32)*. Society is a construction, and religion takes a prominent position in it*(33)*. As a system of traditional and systematized symbols, religion contributes to the development of religious individual attitudes. Every culture, at any level and in different degrees, at different times and geographical spaces, have kept forms of religion and were strongly affected by them (32). The religious belief and experience of sacred are not exclusive to primitive religions, nor to the exotic ones. According to Christianism, this experience presents itself in different forms, both in the individual and collective spheres, and fosters twists and “institutional simplifications”*(38)*. According to Turner*(39:185)* “the holy canopies provide a *nomos* to the communities, a feeling of order, a chain of significances where specific moral norms are intertwined by the cosmos’ fabric itself”.

To sum up, mankind wanted to evolve from the natural level that they were at, striving to reach a religious ideal of humanity in which it is possible to identify the multiple ethics that evolved societies have developed over the centuries. Regardless of the historical period and its context, this individual, the *homo religiosus*, is the one from traditional societies, the one that is maintained by religious values and beliefs. It believes in the existence of an “absolute reality”, in the holy origin of life and in the idea that their existence, being a religious one, enables them to fulfill their potentialities. “Embraces a specific way of existing in the world, and, besides the great amount of historic-religious forms, this specific way is always recognizable”*(34:97)*. Great part of the attitudes they have taken in archaic societies have contributed to the individual becoming what it is today and has not disappeared entirely. There are lots of historical ways of being religious, and all of them are recognizable.

From this point of view, *homo religiosus* would not accept any level of moral relativism in the seek for resolution to complex moral questions, supported by Christian theology that not only sponsored (and still sponsors) human cultural composition, but also transposed to the Judeo-Christian code the Jewish notions of God, the Creator and Father or Jesus, and their wisdom*(40)*.

The Judeo-Christian Code

Many codes contemplating diverse cultural traditions arose, and among them the Judeo-Christian code. Moses presented the Decalogue of God’s Law, which served as the basis for the first moment of building the Christian morality, an essential dimension to human life, side-by-side with religion. The fundamental text is Deuteronomy, one of Moses’ five books that compose the Old Testament, the Torah for the Jews. The way in which Deuteronomy is known was only passed along in the 5th century BC. In Christian tradition, one important text is the Sermon on the Mount, part of the first gospel in the New Testament*(15)*.

The second moment of building of the Judeo-Christian morality was that of the Greek intervention. In the Jewish tradition, based on the Old Testament, the moral was represented by normatives dictated directly by the deities. The Greeks, on the other hand, had an autonomous idea about one’s moral conduct, worrying about the limits of the areas in one’s life. They called ethics the concepts of morality*(15)* and philosophers gave their contributions in this sense. Aristotle*(4)*, for example, defined ethics as the “science of praxis” and virtue as an achievement, not an obligation. Humans’ actions should be analyzed based on its principles, means and purposes.

Christianism brought closer these traditions previously known as Jewish and Greek. Christian preachings were based on the notion of the ideal person, represented by the ideas of perfection (responsibility, love of neighbor, and others) that made mankind virtuous. Despite some of these ideas being present also among the Greek, they were centered on mankind as citizens, verifying what made them stand out. The approaching of these traditions demanded a theoretical construction that eliminated chiefly the autonomy of the moral and the naturalistic and hedonistic aspects of the Greek tradition. Moral should completely submit to religious principles, linked to the ideal of the human person or ideal person or virtuous person. Reaching virtue was essential to the salvation after death*(15)*.

The Christian theology that based the Judeo-Christian code has its origins directly linked to Jewish and Christian testimonial texts from many sources: Christian reworks/modifications in Jewish texts or "deuterocanonical books"; Christian apocryphal texts with a sort of Judeo-Christian syncretism of evangelical knowledge; works that described "the life of the Judeo-Christian Church in worship, in morals, in ascesis, in catechetical teaching"*(40:88)*; testimonies concerning the Judeo-Christian Church, such as the Epistle of Barnabas; letters from Ignatius of Antioch and Clement of Rome and, to a lesser extent, some oral traditions considered presbyters. This theology also made the link between the Christian testament in formation and the Greek theology, which had pagan contrapositions to Christianity. "The historic circumstance of Christian theologists. . . .having their schools in the vicinity of the Hellenistic philosophers created conditions for a more accurate elaboration of Christian theology from the point of view of the reciprocal implication between biblical faith and Greek reason"*(40:89)*.

From the theoretical point of view, the Judeo-Christian code is objective, while moral is subjective, and these conditions produce tension for the human existance. The objective condition constitutes the precepts that apply to everyone, and the subjective condition represents the adoption of these concepts as law and their personal coercion*(15)*. Coercion is explained as an obstacle to the realization of will. If the use of personal freedom goes against the freedom established by the universal law, coercion will oppose the former in backing of the latter*(22)*. The continuous coercion ends up going unnoticed, meaning that, little by little, the habit (of what was coerced) was installed, rendering inefficient the inner tendency*(11)*. The ideal of the human person is the basic core for both conditions, and its vision may diverge only regarding the ways of fundamentation, that is, if the ideal will limit itself to the Christian revelations or if rational features can be added to it. Eventual negation of the morality relative to these conditions does not mean disregarding the ideal of the human person, as their benefits are relatively known*(15)*.

The human person ideal that serves as a "prototype" in the Code was not immediately formulated, having evolved in different moments, such as: the presentation of the Decalogue of Moses and the human person in the image and likeness of God; Middle Ages and the concept of the person based on Greek rationality; end of the 18th century*(15)* and the notion of the human person centered on the social ethics, on the idea of Kant's second formulation, summarized in "act as to treat humanity, in your own person and everyone else's person, always at the same time as an end and never as only a means"*(23:18)*.

The notion of the ideal of the human person was object of formulations by various cultures in different periods of time*(15)*. Theoretically and philosophically, this expression on itself harbors an analysis of its meanings. The word "ideal" represents something faraway from the objective reality, a "singular thing that can be or is absolutely determined by the idea" (Kant, 1981/2001:498). The ideal does not have a "creator force", but does have a "practical force", arising from the principles that regulate and on which resides the notion of perfection of some actions*(41)*. On "human person", its concept is debated since the Ancient Greeks, who did not understand its universal nature. One of the ideas is the one that the human person is a being integrated by body and psychism, conscious and with the power to self-determine, but is not limited to this set. One is capable of overcoming oneself and transcending. The idea understood by religions, on the other hand, comes from Christianity, derived from the biblical declaration that God created men in his image and likeness. However, the Christian Church "already accepts as integrating factors of the person the psychic and cultural data that they acquire after birth"*(42:221)*.

The notions that currently configure the ideal of the human person are not all originated from the Judeo-Christian code. Do not derive from senses nor experience and do not contribute to organizing the experience of sciences, being composed only of ideals. But the discussions in this sense should only go on if to revive the archetype created by the tradition in light of the current times and social transformations. Paim*(15)* concludes that the ideal of the human person, fueled on the Western culture, did not change as time passed and in fact extended its original notion from Christian to citizen.

Precisely because of this great basis, the Judeo-Christian moral code can be considered a non-rational creation. But it "hoards a rational interpretation, because it is not constituted in a simple element of faith"*(15:133)*. This interpretation is not meant to diminish its substance, but to understand it as a way for the secular aspect of society to recover elements of the Western culture that remain in it.

The preponderance of the ideas of the Judeo-Christian code and its influence in the moral life of the West has suffered much criticism. The centrality of the ideal of the human person, preserved in the code, ended up mistakenly associating, maybe in the perspective of good and evil, the notion of poverty to the ideal of moral. "It is easier for a camel to pass through the eye of a needle than for a rich man to enter the kingdom of God"*(15:137)* was a popular saying in the Christian tradition. Bayle*(43)*, quoted by Primo*(44)*, defended morality separated from religion. He stated that historical facts could prove that human evilness has always been side by side with belief in divinity and if there had not been "virtuous atheists" there were also not "depraved atheists". These verifications ended up deconstructing ideas of moral associated with religion, crystallized in time and space.

But the reality is that the Judeo-Christian code was the basis for the biggest part of the relations permeated by morality, although moral is not restricted to the ideal of the human person it has its focus on*(15)*. Reaffirming this, Serrão*(7)* explains that the Decalogue presented by Moses and other "repositories of written values" exemplify the values of morality in the external symbolic culture since the ancient times from nowadays.

Linking the theoretical aspects raised and the historical basis described, we can infer that one important element to the preservation of the strength of the Judeo-Christian code can be the repetition of the conducts. Durkheim*(11)* explains that the "collective habit" is not something *immanent* to the repeated acts, but instead something expressed in a determined way by formulations (such as the oral tradition) and education, also being fixed by writings (the codes). He justifies that repetition happens because the human conscience does not perceive all the peculiarities of social life with enough force as to understand the reality of each fact. Therefore, instead of analyzing the facts, the things, there is only the analysis of the ideology that coats them. On this 'horizon of understanding", Turner*(39)* explains that scholars of the value load implicit in observation and information collection have concluded that the barrier lies in the distinction between the "is", as things really are, and the "should", "as things should be". This distinctive line is usually not distinguished by the followers of the most religious morality.

But parallel to the validity of the Judeo-Christian code and the possibility of other interpretations of it, events occurred over the centuries, and the respective values brought forth another view of morality. Such values were understood as secular.

Secular morality in the west

Presuppositions to the understanding of homo saecularis

A review of history or the world shows that it the phenomenon of secularization is not rare in itself, but rather, the knowledge that one has of it*(45)*. According to Weber*(46)*, quoted by Swatos and Christiano*(47)*, he stated that, since the 16th century, a process occurred in the West that resulted from the gradual understanding of social spheres that facts could be explained by experiences in the world and the applicability of reason. The rationalization of actions or "specific form of social change" made it possible for the emergence of the "modern world".

Some basic events motivated other views of life in general and, as a consequence, brought a new perspective of morality. Some of them were: religious reform and the emergence of Protestantism, distinguishing religious life from moral life*(15)*; replacement of monarchist liberalism by republican and socialist alternatives of material, positivist and laicizing bases, with defense of the opposition between science and religion; foundation of the secular state with republican bases, guaranteeing freedom of religion and conscience, among others; emergence of scientific methods and theories, with demystification of some religious explanations; emergence of knowledge and discoveries, based on rationality and experiment*(48)*.

The changes promoted by these events contributed to the search for the distinction also gradual between the centuries and the institutional religious dogmatics*(49)* that until then is watched. This broad movement became known as secularization which, from this point of view, can be understood as "a gradual distinction between the century and the dogmatic and institutional objectivations of the religious as church"*(49:21)* the basic idea was that "the world would have its own causal link". And its consequence (more immediate) was to leave aside explanations that had as reference the forces external to this world*(47)* the reduction of the ascendancy of the institutionalized religious powers over social life has resulted in a different way of understanding and judging the things of the world, forms this more autonomous and emancipated in the face of religious issues*(48)*.

Secularism, which mainly marked the separation between religion and the State, played an important role in the new worldview. This principle promoted, in parallel, a set of beliefs, internalizing values and socializing expectations and ideas. This can perhaps be called "secular faith", based on the need for "reproduction of the social contract and justification of the historical role of the nation"*(49:143)*, that is, of the natural freedom of Man and of a pact of association with society, not of submission.

Theoretically, several assumptions that seek to explain secularization as a mark of modernity have influence of Judeo-Christian theology on the basis of movements of "departure from religion". This is because the idea of creation, far from the divine origin, potentiated the process of desacralizing the facts of life. The insertion of the rationality of capitalism and the consequent promotion of the structure of society and its way of life also focused on individual and collective consciences in relation to religious traditions*(48)*. An example of this is that, in effect, doctors, economists, psychologists, and other professionals have become more in demand to assist in solving the world's problems than ministers, priests, and other religious authorities*(47)*.

The concept of secularization is much discussed and controversial, but its approach is important to scale the process. In the English sense, secularization means the generations, the epoch or the span of a century. It arrived in the 19th century associated with the search for a more just world order and a moral program that would analyze human problems without religious or sacred explanations*(50)*. In the social perspective, Berger (33) defines secularization as a process by which areas of society and sectors of culture have escaped the dominance of religious institutions and their symbols.

The concept is also inconclusive as to whether it is an ideology, a process or a theory, respectively because it has served ideological functions, because it is not inevitable and because there are no criteria that can support empirical investigations*(51)*. Berger*(45)* disagrees with a "theory of secularization" because the central idea that modernization causes a religious decline in the individual and social context is mistaken, which does not correspond to what is observed in the changes brought about by modern events.

Shiner*(50)* analyzed and summarized some concepts of secularization and its empirical effects, allowing a view of the respective changes: 1. "decline of the religion" or loss of prestige and influence of religion before society. In this case, from secularization would remain a society without religion; 2. "conformity with this world", in which society transferred its former attention to the religious to the interest in the things of the world. With this, society would become completely involved with the current pragmatic activities, and religious groups would not distinguish themselves at all; 3. disaffection of society from the religious order, that is, society undertook an autonomous way of knowing reality and limited religion to private life. Thus, the character of religion would be solely internal and would not influence collective actions or institutions; 4. transposition of beliefs in religion to institutions of human creation, that is, institutions and social arrangements have become something disassociated from religion. In this case, religion would be an anthropologized process, and society would perform all the institutional functions before religious; 5. desacralization of the world, that is, the world was losing its natural and sacred character and became the object and cause of manipulation and exploitation. Then there would be the total rationality of society in relation to the world, and supernatural phenomena would have no place in it; 6. "movement of a sacred society to a secular one" or change of society in multiple variables and at different stages. With this, decisions would be made on the basis of utilitarian and rational aspects, and there would be "complete acceptance of the changes"*(50:217)*.

Swatos and Christiano*(47)* justify that there is no doubt that the separation of state and church was sufficient, in much of the West, for people to develop the ability to live without religious interference. They could choose between different religions without harming their civilian life. The transcendental could not be compatible with the whole humanity as before, but what was real in fact would remain, always facing interpretation. Existential problems are eternal and their solutions go beyond rational vision. The authors define secularization as a part of the healthy cycle of growth of humanity and the development of religious vision.

As far as secularization and morality are concerned, just as the thesis of secularization of the modern world is not universal, so the assertion of moral decay in highly secularized countries is not true. The misconception may be due to the fact that partial loss of faith, or a change in the view of religious domination, is mistaken as a cause of abuse and crime. Therefore, one must understand what faith really is and examine the relationship between religion and morality. This one cannot be an echo of that one*(52)*.

This understanding is what best suits the objective of this work, arguing that secularization was a non-universal, non-unidirectional, non-unitary and, necessarily, non-anti-religious process*(53)*. The association of its elements with religion is due in part to the fact that "anti-religion often paradoxically involves elements normally based on religion"*(54:54)*.

From what was described, we cannot conclude that the secular world is profane, nor that the view of the *homo saecularis* is that of an irreligious man. Respectively, what can be called profane is the abolition of memories and religious behaviors in relation to some rituals. And irreligious men, despite their probable existence in archaic societies, it is in modern European societies that they are most fully identified. The irreligious is only fully constituted if it is all demystified, if it desecrates itself and the world is desacralized. He "recognizes himself as the only subject and agent of history and rejects every call to transcendence"*(34:97)*. Yet the *homo saecularis* it has the secularity characterized by its ability to decide on its fate with freedom. And this capacity was achieved due to ideas arising from rationalism and religious and political confrontations that brought other nuances to traditional values*(48)*.

The irreligious man would certainly not need to resort to moral relativism to solve complex moral/bioethical problems, because for him, according to Eliade*(34:89)*, all situations "mean nothing more than what the concrete act shows". Yet the *homo saecular* could rely on moral relativism, needing to distinguish the values of its individual consciousness and the common interest as social utility. "There is a pluralism of different versions of modernity, with different delineations of the coexistence of religion and secularity, which must be administered politically"*(55 cited by 56:78)*

Social morality and morality of consensus

Unlike the ontological way, its invariable foundation of being and duty-being (mainly from the religious point of view) and the perspective directed to moral principles, there is the pragmatic way, whose positioning always aims to identify practical solutions to concrete complex problems; it always seeks the most convenient and harmonious solution to such problems*(12)*.

In the case of morality separate from religion, its pragmatic path, on one hand, may have indications from the other interpretation of the Bible in the Renaissance, which had quite significant adherents in Europe. The new interpretation shattered the religious tradition of Christian morality, which virtually prevailed in the West, and led to the emergence of Protestantism. With the Reformation, by disassociating the earthly course from eternal salvation, mankind of that time should only fulfill the moral precepts with no view to salvation through them*(15)*. On the other hand, the separation may have been reinforced by the introduction of secularism, as a principle of social and broad moral philosophy and consisting of a complex set of commitments and ideas that include neutrality, autonomy and community. In general terms, neutrality concerns the guarantee of religious freedom in the private sphere and the adoption of State actions without religious reference. Autonomy corresponds to "human emancipation", aiming to separate the identity of the human/citizen from their vision as a believer. The community's scope is to extend the understanding of morality more secular than political*(57)*.

Regarding the moral path to follow, the challenge would be to define moral options that are not religious, but accepted by religions. Secular morality should be able to grasp the truths of each moral, religious and non-religious view – as in the conception of the person–, based on the consensus among the "reasonable moral doctrines". There could be no compatibility between secularism (moral) and religion just for the sake of "stability"*(57)*.

The resulting notion was the probability of a moral distanced from the ideas of good and evil, as understood by tradition, and characterized mainly by the legitimate need to maintain the "collective existence". It was called social morality, distinguishing itself from individual morality that can be associated with religious beliefs and their precepts. It would also be a consensual moral, due to the aspects of political representation involved*(15)*.

These characteristics can be visualized in the understanding that the facts underpinning morality often constitute duties that are accepted by everyone involved in problems. But morality is not only an action that "can be universalized". Even though moral practices have not been created to be useful to society (or to contribute to the cohesive survival of human groups), they can be of common utility and a source of social/moral evolution if they have a significant representation that makes a specific conduct clear. The sense of utility comes from the value of numerous elements and the tangle of their relations, considering the various conditions and circumstances, in order to achieve the most adequate possible notion of utility. Its most accurate assessment results from the "combinations of ideas", kept consciously and in order (hierarchical), without anything remaining obscure as to the issues involved. It is still necessary to foresee and combine not only the immediate effects, but also repercussions on all lines and strands "of the social organism". Regardless of the path, one should be aware that the solution that is being undertaken is conjectural since there are always open spaces and inherent risks. "In such matters, certainty is impossible"*(58:11)*.

In another perspective, but with an equally important connotation, reflecting on the two origins of morality – values and their constitutive experiences and the conditions of cooperativity – Joas*(52)* argues that the systems of norms have their concreteness based on these two sources. Within this, according to the specificity of the situations, the agents must consider the good and the just. "The reduction [from perspective] to the just is as one-sided as the reduction to the good; inadmissible, too, is a reduction of the good to religious imperatives"*(52:244)*.

In short, whether from the point of view of Durkheim morality or the notion of Joas, social morality represents an attempt at morality established by consensus, based on secular foundations of equal validity for all, including non-believers. From Durkheim's explanations, we learn that this validity for all can precisely represent the interest in solving a problem that is common and enveloped in social values. On the other hand, the possibility of consensus may correspond to the intervention of other agents who assume assertive postures before the generalized formulations of individuals. From Joas' point of view, we infer a sense of good that holds within itself the clear idea of good, not just as something abstract, but as "that in whose interest all other things are done"*(4:11)*. The just, intrinsically associated with the good, refers to the legitimacy of the acts, to the preservation of the moral elements used and not to exceed the respective measures.

But secularization is recent in a way, in terms of substantially changing cultures and values. Therefore, one cannot yet affirm the effects of their multiple arms on the moral directions between the various generations in the long term. Affirmations about relevant changes between generations would still be at the superficial level of the definition of rules for issues of individual life, with striking differences between the religious and the view of contemporary consensual morality and relatively easy to distinguish. To some extent (secularization is not unidirectional), "one can [even] dismiss the hypothesis that new generations of people of faith exhibit change in fundamental values so that their attitudes are not nourished by the fundamental imaginaries, deeply rooted in their religious worldview"*(52:234)*. Without them being aware, this view influences even those who have moved away from the confessional orientations with which they were formed. This indicates that the confessional imaginary is inherent in secular worldviews, insofar as there is a legacy of religious certainties to the process of secularization. Similarly, there are decisive rejections of confessional aspects because they seem a "counter-identification" to the secular view. There are as many secularisms as there are varieties of religions*(52)*.

However, when the interest focuses on moral judgments, one must deviate from the individual life and analyze the structures that underlie moral judgments, identifying what persists, over time, as confessional religious specificities, for example. The notions of individuality and sociability, which can be conflicting, tend to elicit different attitudes regarding the function of "institutionalized religion" and the role of ethics/moral. Therefore, one must understand the intention when assessing the moral quality of an action and the fact that the content of moral norms are interpreted distinctly, either by the confessional aspects, either as a norm or as an ideal to be followed*(52)*.

We deduce from the changes promoted by the events cited two important points: first, the faculty of the individual to integrate moral precepts to their religious precepts, from which one can conclude a personal position in the context of collective positions; second, the social morality that contemplates moral relativism, assuming a reflection on moral rules that take into account the interests of the collective over the individual. According to Durkheim*(11)*, the tendencies of the collective, as much as their representations, are not generated by individual consciences but by the conditions or state in which the whole "social body" is found. He agrees that individual natures, refractory to new trends or to other representations, may impede the realization of collective interests. He resumes his notion (already mentioned) of individuals as essential elements of society, which enters their consciences and transforms them, and says that their contribution would represent "vague predispositions" and that these could only achieve a defined form through the intervention of other agents.

The notion of collective morality then developed may mark the third moment of the constitution of Western morality, although, according to Espínola*(48)*, much of the old mentality still remains.

Final considerations

What was found from the descriptions was that secular morality, so far, does not circumscribe a line of action, but rather indicates a broad openness (not political or religious) to individual autonomy, the search for neutrality and the vision of community. In the latter, we consider mainly the commitments derived from secularism, subsidized by a morality backed by the universality of duty, in the sense of common utility, good and just, invoking social values and cooperativity.

Moral relativism is implicit in the very opening of the representativeness of social and consensual morality, which substantially separates personal religious belief from common/collective interest. From the point of view of secularism, the autonomy that enables individuals to be guided by a morality that they prefer to associate with their beliefs is the same that supports others to act on behalf of the collective and according to the majority, in the face of complex problems. These distinguish the personal values, which they keep for themselves, from the larger and explicit social interests.

In this perspective, contemporary Bioethics now deals with secular Western societies, the result of historical dissociations and with strong traditional and pluralistic remnants, because they involve a great diversity of moral beliefs and feelings. With this, it remains for bioethicists, faced with complex problems, to identify an essence in this morality that reaches different communities of beliefs and ideologies. "Essential morality would be compared to a continuist morality, in which people convey to common efforts the moral authority of their consent"*(59:32)*. This essential morality can substantially guide the distinction between the right and the not right, between good and bad. The essence, at this time, may be the notion that subsidizes and ensues the figures of moral strangers and moral friends.

Tristam Engelhardt, identifier and disseminator of the ideas around this figure, "advocated secularity in bioethical dialogues, being himself a practicing Orthodox Christian – thus carrying 'conservative' ideas" on complex topics*(60:3)*. Engelhardt justifies this notion with the fact that each one understands and experiences reality in a distinct way, fundamentally, in the same way, that there are several structures of meaning and meaning. Then conflicts will always and inevitably arise between traditional Christian beliefs and secular understanding of the world as to proper conduct and bioethics*(61)*. He defines moral strangers as "people who do not share moral premises or rules of evidence and inference sufficient to resolve moral controversies through rational argumentation"*(59:32)*. Moral strangers, which does not mean strangers to each other, can resolve moral issues through common agreements. In contrast, there are moral friends who share (only) one morality in essence and can contribute to the resolution of controversies by resorting to sound moral arguments of recognized authority, for example*(59)*.

The notion of moral strangers appears as a representation of moral relativism for judgment and solution of complex bioethical problems.

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EQUITY IN HEALTH AND JUSTICE: A LOOK AT THE BRAZILIAN UNIFIED HEALTH SYSTEM (SUS) FROM THE PERSPECTIVE OF JOHN RAWLS

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Abstract: This study addresses the issue of equity in health and justice from the perspective of public health bioethics, describing the Brazilian Unified Health System (SUS), equating legitimate interests for essential goods, such as health. The conception of John Rawls' theory of justice is "justice as fairness" and has a seventeenth century contractualism tenor. Although it was not conceived specifically for health and marked by the "difference principle", it promoted, in the field of health care, the institution of health systems created on the basis of universal access and equity in the distribution of scarce resources. The principles of the Brazilian Unified Health System (SUS) guarantee access to all levels of care, equality in health care, without distinctions or privileges of any kind, integrity in health care, free of charge, community participation and decentralization, regionalization and hierarchization of health actions and services, which gives the SUS a strong Rawlsian bias. The Brazilian model was built on the principle that health is a right of all and a duty of the State, therefore, it is based on the assumption of universal and equal access to health actions and services for its promotion and recovery.

Keywords: equity, vulnerability, bioethics, public health, social justice, unified health system.

Equidad en salud y justicia: una mirada al Sistema Único de Salud (SUS) brasileño desde la perspectiva de John Rawls

Resumen: Este estudio aborda el tema equidad en salud y justicia desde la perspectiva de la bioética de la salud pública, describiendo el Sistema Único de Salud (SUS) brasileño, equiparando intereses legítimos por los bienes esenciales, como la salud. La concepción de la teoría de justicia de John Rawls es la "justicia como equidad" y tiene un tenor de contractualismo del siglo XVII. Aunque no fue concebida específicamente para la salud y marcada por el "principio de la diferencia", impulsó, en el ámbito de la atención sanitaria, la institución de sistemas de salud creados sobre la base del acceso universal y la equidad en la distribución de recursos escasos. Los principios del Sistema Único de Salud (SUS) brasileño garantizan el acceso para todos los niveles asistenciales, igualdad en la atención a la salud, sin distinciones ni privilegios de ningún tipo, integridad en la asistencia a la salud, gratuidad, participación comunitaria y una descentralización, regionalización y jerarquización de las acciones y servicios de salud, lo que da al SUS un fuerte sesgo rawlsiano. El modelo brasileño se construyó sobre el principio de que la salud es un derecho de todos y un deber del Estado, por lo tanto, se basa en el supuesto del acceso universal e igualitario a las acciones y servicios de salud para su promoción y recuperación.

Palabras clave: equidad, vulnerabilidad, bioética, salud pública, justicia social, sistema unificado de salud

Equidade em saúde e justiça: um olhar sobre o Sistema Único de Saúde (SUS) sob a perspectiva de John Rawls

Resumo: Este estudo aborda a questão da equidade em saúde e da justiça sob a perspectiva da bioética da saúde pública, descrevendo o Sistema Único de Saúde (SUS), equiparando interesses legítimos para bens essenciais, como a saúde. A concepção da teoria da justiça de John Rawls é "justiça como equidade" e tem um teor contratualista do século XVII. Embora não tenha sido concebida especificamente para a saúde e marcada pelo "princípio da diferença", ela promoveu, no campo da assistência à saúde, a instituição de sistemas de saúde criados com base no acesso universal e na equidade na distribuição de recursos escassos. Os princípios do Sistema Único de Saúde (SUS) garantem o acesso a todos os níveis de atenção, a igualdade na assistência à saúde, sem distinções ou privilégios de qualquer espécie, a integralidade na assistência à saúde, a gratuidade, a participação da comunidade e a descentralização, regionalização e hierarquização das ações e serviços de saúde, o que confere ao SUS um forte viés rawlsiano. O modelo brasileiro foi construído com base no princípio de que a saúde é um direito de todos e um dever do Estado, portanto, parte do pressuposto do acesso universal e igualitário às ações e serviços de saúde para sua promoção e recuperação.

Palavras-chave: equidade, vulnerabilidade, bioética, saúde pública, justiça social, sistema único de saúde

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Introduction

Public Health Bioethics has faced challenges such as equating legitimate interests for the essential goods, such as health and other goods. The scarcity of resources in the face of increasing demands, such as the aging of the population, the continuous increase in chronic-degenerative diseases, new infectious diseases, and other emerging diseases, makes it hard to equate expenditure and resource management. Frequently, all existing public health systems suffer from the same problem, and going against this problem requires some public policy formulations that cover all the different segments involved and some better ways to execute them. Bioethics is an important tool to assist in the management of public services.

Looking at the Brazilians' situation, the struggle is pointed out on the debate between the plurality of interests and related values to different segments of society, expressing conflicts between different rights, duties, access modalities, and by solving their health problems*(1)*.

The bioethics field progress over the past 40 years allows that its tenets can be applied to debates about social and political problems, related to the people's well-being, on peoples and nations, and more specific issues that affect citizens knowledge and practices in their routines, not only in public health but in other essential sectors*(2)*.

According to Aristotle, Justice has the legal stands on equality, but equality occurs on both distributions and exchanges. Treating equal ones equally and unequal ones unequally is fair. Just as it is unfair to treat equal ones unequally and unequal ones equally*(3)*.

John Bordley Rawls, so-called "Jack", was born on February 21^{st}, 1921, in Baltimore, Maryland. He is the most famous American philosopher, who died at the age of81, in 2002. After teaching for a while at Cornell University and the Massachusetts Institute of Technology, Rawls joined the Department of Philosophy at Harvard University in 1962 and remained there for the rest of his career. His most important work, "A Theory of Justice", is a philosophy and ethics work and is considered one of the most important works in the political philosophy of the 20th century. In "A Theory of Justice", Rawls declares that justice is the "first virtue of social institutions", individuals are free to pursue their goals as they wish, only limited by the restrictions agreed by all, corresponding to the"basic structure" of society and also that it is inadmissible to sacrifice freedom for equality*(4)*.

Addressing the issue of justice in contemporary democratic societies, John Rawls establishes that, liberal democracies are unfair, therefore the individual pursuit prevails selfishness and individualism to the detriment of the interests of others.

Wealth inequalities and income inequalities are present in contemporary society, marked by an excessive human and State selfishness that, in many cases, omits to promote public policies that are denominated as social abyss*(5)*.

Rawls' conception of justice is "justice as equity" and with a tenor of 17th-century contractualism. Therefore, he proposed a theory of justice in response to classical Utilitarianism (1971): a theory of justice based on equity, understood from an initial hypothetical situation, in which there is a position of equality between all individuals, ignoring knowledge about contingencies that results in disparities among men, such as social position, class status, and natural attributes and talents. Those situations are called by Rawls*(4)* the "veil of ignorance" and will ensure that all participants are in the same situation, preventing individuals from being guided by their prejudices and establishing principles that benefit their particular situation.

"The veil of ignorance is such a natural condition that something like it must have occurred to many. The formulation in the text is implicit, I believe, in Kant's doctrine of the categorical imperative, both in the way this procedural criterion is defined and the use Kant makes of it"*(4)*.

At the moment of the initial pact, there is nothing left to choose but the fundamental structures of a society and its foundations. The principles of justice are the result of a consensus or equitable adjustment in the words of Rawls*(4:21)* "I have said that the original position is the appropriate initial status quo which insures that the fundamentalagreements reached in it are fair. This fact yields the name ‘’justice as fairness”.

Through a thought experiment he seeks these answers through an original position and for this he was a contractualist thinker, but by elaborating this new model of social contract he differs from the classical contractualist thinkers such as Thomas Hobbes, John Locke, and Jean Jacques Rousseau, which a social contract with limited freedom to protect some goods such as life and property would justify imposing rules.

The original position is a hypothetical situation in which the contracting parties are under a “veil of ignorance” and extract their principles of justice from there. The reasonableness and rationality between the parts must prevail, without personal influences, biases, and prejudices. The structuring of this society would happen through this veil where we do not know about our abilities, gender, professional training, race, economic situation, health, or sickness. In this position, we would hardly choose an unfairsociety because we would be there. The impartiality (impartial and fair rules for all) makes an important mark in Rawls’ distributive justice trajectory.

For a fair society’s desire, it will only be possible if it is guided by principles that will outline the economic inequalities are truly fair, so everyone will have opportunities. The principles that will guide the foundation construction of a truly just society:

a) A minimum collection of individual freedoms (equal freedom), a wide range of basic freedoms of an individual, citizen who is a member of the rule of law - freedom to come and go, religious freedom, political freedomto vote and to be voted, of expression, of meeting, of private property. And these freedoms must be equal to all belonging.

b) The “difference principle” stands for income and wealth distribution and social and economic disparity. There would be no problems regarding those differences, in fact, those differences would even be desirable, as long as they established the two main conditions. The positions and burdens in society would have to cover equality of opportunity that would have to be occupied by everyone, and the existing differences between them must provide the greatest sort of benefits in favor of the less fortunate.

Below, there are some ways to do distributive justice and some questions to answer:

Are the careers opened for all the talents? Under what conditions is the distribution of liberties, opportunities, and goods that society makes available to persons just or morally fair?

A libertarian would say that a fair distribution system must be a free exchange system into formal equality, which means that jobs and careers are available to everyone. Rawls*(4)* strongly agrees that this theory represents a noticeable improvement compared to aristocratic and caste systems, besides that, he also asserts that a fair distribution is the onlyone that stems from free exchanges and voluntary transactions as available jobs to all, adjusting a system of fair equality of opportunity and adoption from meritocracy will be the outcome. A more egalitarian conception of distributive justice will only be possible by the “difference principle”.

Rawls*(4)* does not state that one way to compensate for differences in natural talents or abilities is to have an equal leveling and thus a guarantee of results. On the other hand, the “difference principle” allows people to have different gains, which can benefit from their good fortune, only on terms that improve the situation of those who have lost out. So, it is fair to be able to earn more in a system where everyone is taxed and as a result, there areinvestments for the benefit of the less fortunate.

Therefore, there is no unfairness in the benefits obtained by a few, provided that thesituation of the less fortunate is improved as a result. Thus it is worth pointing out that the beginning of justice as equity, like any other contractualist point of view, consists of two parts, the first being an interpretation of an initial situation and the problem of choice posed at that time, and the second seeks to demonstrate that they would be accepted by consensus. The word contract suggests this plurality, as well as the condition of proper sharing of benefits that takes place by principles acceptable to both parties*(6)*.

In conclusion, the two basic principles are chosen in a situation of initial equitable agreement and in Rawls' words*(4:712)*: "Thus, a well-ordered society satisfies the principles of justice which are collectively rational from the perspective of the original position; and from the standpoint of the individual, the desire to affirm the public conception of justice as regulative of one's plan oflife accords with the principles of rational choice. These conclusions support the values of the community, and in reaching them my account of justice as fairness is completed."

The themes to be analyzed below are Rawlsian Maximin, justice as equity and health, determining and conditioning factors of health, the Unified Health System (SUS), andfinal considerations.

The Rawlsian Maximin

Rawls*(4)* first principle of fair equality of opportunity must be supplemented by the so-called "difference principle". Once the first principle is guaranteed, if inequalities still remain between the subjects participating in the initial contract, the needs of the less privileged must be prioritized. The minimum condition should be maximized so that present inequalities, whether economic or social, must be distributed simultaneously in the fairest possible way, in such a way that they always result in greater benefits for the less fortunate. So, the economic inequalities are only justifiable if they are established for the maximum benefit possible for those who are in the lowest position on the distribution of income and wealth, and then, Rawls expresses himself as the condition of "democratic equality"*(4)*.

Thomas Piketty*(7)* says that modern theories of social justice have expressed this idea in the form of the "maximin" principle, according to which a fair society should maximize opportunities and living conditions provided by the social system.

Rawls' main idea is to generate conditions for equal opportunities, not only for the present days but also for the future, that is why he presents a safe standard level and is quite satisfactory because it consists in the situation of the least advantaged in a well-ordered society, which results in the full realization of the two principles of justice*(8)*.

Rawls*(9)* states that we must extract the maximum from the minimum, that is, maximizing what you would achieve if you ended up in the minimum position and had considered an equal division of wealth, allowing social or economic inequalities, only when they were intended to benefit the less favored. In this way, there would be a maximization of the *minimum* and thus equity would be guaranteed.

Equity in Health and Justice

Among the philosophers, it was Aristotle, Plato's disciple, who dealt more systematically with ethics and especially about justice and equity. He aimed for equality among people, with each person meeting their needs. According to the philosopher, the fair must necessarily be, at the same time, intermediate between excess and defect; as an intermediary, he must avoid certain extremes; since equal involves two equal parties. If people are not equal, they should not receive equal things*(3)*.

John Rawls, a great author of political theory, states that justice is not obtained as a result of everyone's interest, nor from the majority, but as a fundamental ontological assumption to perceive collective anxieties*(4)*. For Rawls*(4)*, the first issue of justice is facing inequities, as well as determining principles to regulate social, natural, and historical inequalities, adjusting their deep and long-lasting effects, because when left to themselves, such inequalities would threaten the necessary freedom to a well-ordered society*(9)*.

Although it was not primarily designed for health, Rawls's Theory of Justice, markedby the difference principle, led in the field of health care to the institution of health systems created based on universal access and equity in the distribution of scarce resources*(10)*.

Most public health systems in different nations serve as an example by that, including SUS, which has an egalitarian and democratic base by Rawlsian thoughts.

Amartya Sen criticizes Rawls' theory by introducing the concept of justice as an expansion of effective freedoms and that primary goods do not guarantee these effective freedoms that would make people equal in their capacities for the simple reason that people are different, therefore having needs and different priorities*(11)*.

Sen also criticizes Rawls because he does not mention directly the term health in his Distributive Theory and the primary goods, but that was refuted when Rawls emphasizes that health is a natural good, not requiring an explicit mention*(11)*.

Another critic of Rawls whose theory inspired SUS was Nozick in Anarchy, State and Utopia, when he argued that the principle of difference would require constant and invasive government intervention in activities to maintain distribution, conflicting with the first principle of freedom*(12)*.

The concept of health equity began to be debated in the Ottawa Charter in 1986, promoted by the World Health Organization. This document was the result of the First International Conference on Health Promotion.

Nowadays, equity in health is understood not as equality, because it takes into account the differences between people in their social and health conditions. Reinforcing these concepts, Margaret Whitehead, Duncan Chair in Public Health at the University of Liverpool writes that "health equity involves minimizing all health differences that are unnecessary and avoidable, as well as unfair*(13)*.

Whitehead*(13)* discusses equity and health based on two assumptions: less fortunate people have lower chances of survival and there are large differences in people's experiences of getting sick.

Considering that there are differences in the health profile between nations and between groups within a nation, inequity refers to a specific difference: the unnecessary, avoidable, and unfair. This term takes on a moral and ethical perspective as, while biological factors and the effects of sick people moving to lower social classes are partly responsible for differences in health, socioeconomic and environmental factors are the protagonists in this scenario*(14)*.

In Brazil, equity with a strong Rawlsian bias constitutes one of the doctrinal principles of the SUS, although the term is not included in the main legal provisions that regulate it.

Rawls includes health services as a social good and thus embraces the idea that institutions should protect health as a social good, focusing his theory of justice as equity, demonstrating a concern for the healthy practice of social policies more committed to the less fortunate.

Paranhos et al.*(15)* describe Norman Daniels' theory of health justice from an extensive interpretation of Rawls' thought, emphasizing that health care has the moral role of guaranteeing health itself and thus protecting people's freedoms and ensuring the possibility of seizing life opportunities. For Daniels, John Rawls' theory of justice has the necessary elements to establish an equitable distribution of health.

Determining and Conditioning Factors of Health

The determining and conditioning factors for health are implicit in Article 3 of Law n. 8080, of September 19, 1990. Given by Law n. 12,864 of September 24, 2013, which amended the caput of Article 3 of Law n. 8080/90, including physical activity as a determining and conditioning factor of health.

For the World Health Organization (WHO) health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", a concept adopted in 1948 but far from being a reality.

Social Determinants of Health – SDH and to WHO, are the social conditions in which people live and work. Article 3. by Law 8080/90 states that health has as determining and conditioning factors, among others, food, housing, basic sanitation, the environment, work, income, education, physical activity, transport, recreation, and access to essential goods andservices.

Also as determining factors of health condition, biological conditions such as age, gender, and physical environments such as geographic conditions, food quality, and water sources for human consumption must be included.

Several models have been proposed to study the social determinants and the web of relationships between the different factors studied through these different approaches. One adopted by the National Commission on Social Determinants of Health (CNDSS in Portuguese) is the Dahlgren and Whitehead model, which includes the Social Determinants of Health arranged in different layers, from a layer closer to the individual determinants to a distal layer, where the macro-determinants are located. Individuals are at the base of the model, with their individual characteristics such as age, gender, and genetic factors. In the immediately outer layer, individual behavior and lifestyles appear. The next layer highlights the influence of community and support networks. The next level represents factors related to living and working conditions, food availability, and access to essential environments and services, such as health and education. Finally, at the last level are the macro-determinants related to the economic, cultural, and environmental conditions of society and that has a great influence on the other layers*(16)*.

Figure 1 - Dahlgren and Whitehead diagram

In Brazil, knowledge, and implementation of health policies aimed at promoting health through its determinants had a great boost in the creation of the National Commission on Social Determinants of Health (CSDH). This Commission was established on March 13, 2006, through a Presidential Decree, a two-year term. The creation of the CSDH is a response to the global movement around the SDH triggered by WHO, which in March 2005 created the Commission on Social Determinants of Health (CSDH), intending to promote, at the international level, awareness of the importance of social determinants in the health situation of individuals and populations and the need to combat the health inequities they generate. The actions and activities carried out by the CSDH have been a valuable contribution to building a more humane and just society.

The Unique Health, Equity, and Vulnerability System

Considered one of the largest and best public health systems in the world, SUS benefits more than 200 million Brazilians and performs around 2.8 billion services per year, from simple outpatient procedures to highly complex care, such as organ transplants. The blood center system, the successful emergency rescue policy, the treatment of AIDS (Acquired Immunodeficiency Syndrome - AIDS), the distribution of medications related to chronic diseases such as diabetes and arterial hypertension, the expansion of The Family Health Strategy, and the largest vaccine distribution network in the world: these are all SUS achievements and examples to the world. The consequence of these actions is expressed in the significant improvement in health indicators, highlighted are [SS2] the continuous increase in life expectancy at birth, as well as maternal and infant mortality rates according to the IBGE*(17)*, seen in Figure 2 and Figure 3 and it was this unified, free and organized system that was responsible for so many achievements.

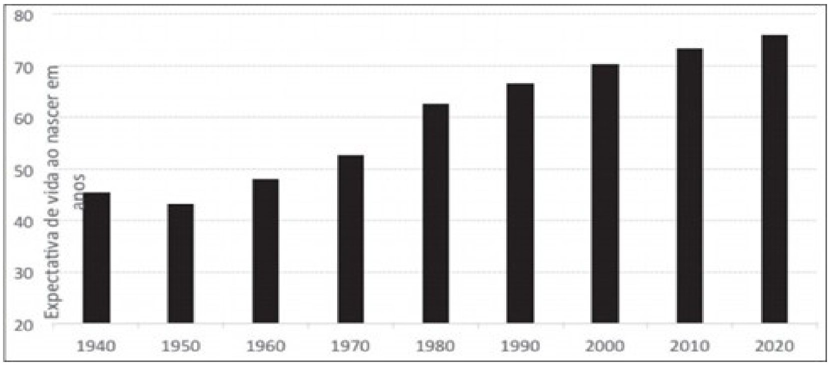

Figure 2 – Variation in life expectancy at birth of Brazilians, from the 1940s onwards and its projection for 2020.

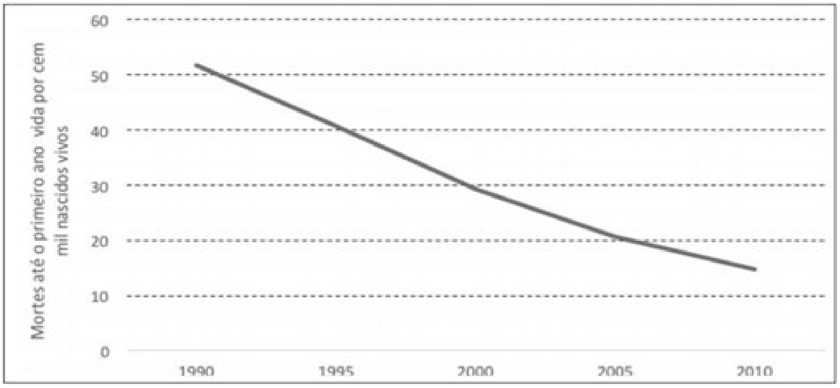

Figure 3 – Time variation of the infant mortality coefficient in Brazil – deaths up to one year of life per 100,000 live births.

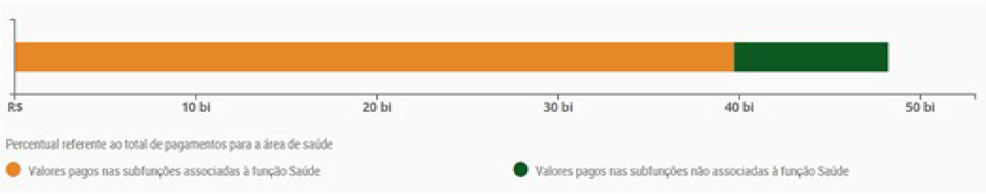

Figure 4 - Percentage of total payments to the health area.

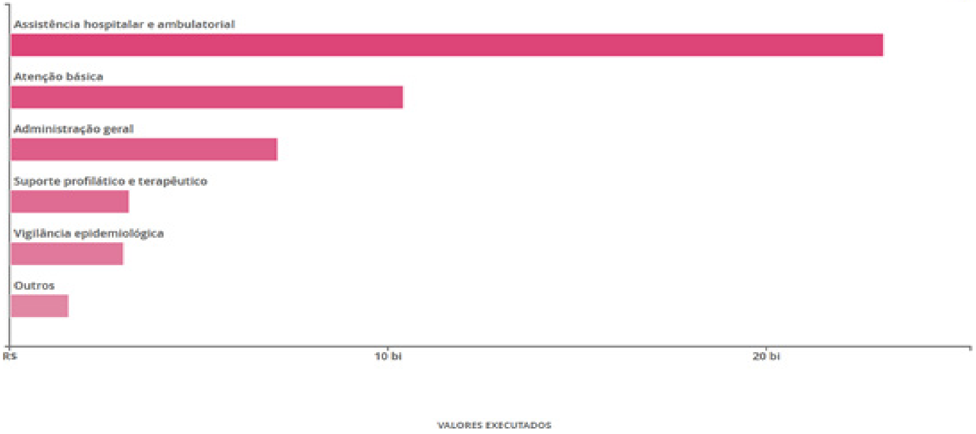

Figure 5 - Expenses by subareas (total).

Celebrating 33 years in 2021, SUS is considered one of the largest public health systems in the world and conquers everyday advances for the health of Brazilians, and is a world reference regarding public health care.

The Federal Constitution of 1988 in its article 196, through Law n. 8080 of 19/9/90 guaranteed one of the greatest achievements of the Brazilians, SUS. SUS ensures care for approximately 190 million people, 80% of whom are fully dependent on it for any health care.

The financing of SUS is carried out with citizens' taxes, encompassing the Union, States, and Municipalities' resources, as well as other supplementary sources of financing, all duly included in the social security budget. The Federal Constitution defines that municipalities must allocate 15% of what they collect, in health actions. While state governments contribute 12% and the federal government has its contribution defined based on a more complex calculation: the amount that was spent in the previous year is added to the nominal variation of the Gross Domestic Product (GDP), this variation is added to what was spent in the previous year to define the minimum investment amount in that year*(17)*.

SUS can be considered one of the greatest social achievements of the 1988 Constitution. SUS acquired a universalist type of legislation from the Organic Health Law based on political-administrative decentralization and has important guidelines such as universal access, the comprehensiveness and care equality, as well as the usage of epidemiological data to establish priorities in public policies for the allocation of health resources, aiming to establish universal coverage and care combined with decentralized administrative management and community participation. Accordingly, the original concept of the SUS aimed to eliminate any discrimination strategy, even temporarily, between socially distinct clienteles.

Nowadays, health financing in Brazil has fluctuated around 8% of its GDP. Countries with notorious excellence in their health systems finance expenditures with amounts slightly higher than in Brazil, such as the United Kingdom (9.9% of GDP) and Canada (10.4% of GDP) Piola et al.*(18)* and the ailment of SUS reveals that it has spending inefficiency instead of underfunding. Sufficient funding combined with proper resource management is the key to orderly and effective functioning for most countries.

A universal and equal access, which later became a constitutional precept, had the meaning of including everyone for equality. And equity in SUS is usually referred to as a triad with the principles of universality and integrality*(19)*.

Aith and Scalco*(20)* add that, to face the challenge of guaranteeing the universal right to health and, at the same time, effectively protect the special needs of people in vulnerable conditions, the structuring of SUS follows two complementary strategies: first, organizing a general network of actions and public health services, aimed at offering universal health care, comprehensive and equal access, as well as to organize, within this general network, special health care networks of specific population groups, according to biological, social, economic, or cultural.

The equity principle is present when the State organizes its public network and treats unequal ones unequally. More than promoting this requirement, SUS, on behalf of equity, organizes its attention to children, the elderly, indigenous peoples, and pregnant women.

In a country with continental dimensions, the verification of local and regional needs is of great importance and, therefore, public policies have been developed for the most vulnerable groups, whether in vulnerability due to health conditions, socioeconomic, or cultural vulnerabilities.

Saldiva and Veras*(21)* states that in addition to organizing the system, it is SUS's responsibility to plan health conditions, health care, and inter-federative articulation. Health conditions planning is mandatory for public entities, it must consider the specific problems of each region and must induce policies for the private sector in order to address the gaps in the SUS.

Therefore, the discussion of distributive justice health in Brazil is concerned with identifying the precepts of equity and how it should support the orientation given to health policies, focusing on the ones in need, referencing Rawls's theory of justice.

In Rawls's Theory of Justice, neither health nor the rest of welfare policies occupy a relevant place, as demonstrated previously in this article[4]. To Rawls, health is a natural primary good, thus responding to Sen's criticisms. It is a natural good desired by all and influenced by the basic structure of society*(4)*.

However, there is a tension between the conception of justice that is understood as equality and justice that is understood as equity both in Rawls' theory and in the content of the law that regulates SUS. Equal distribution of primary goods for all and the defense of justice in favoring those in most need. The report made by the National Health Council even highlights this situation and considers it a challenge to serve groups that already have defined access and those that have insufficient access*(1)*.

Final Considerations

Rawls asserts that justice is the way that the most important social institutions distribute fundamental rights and duties and determine the division of advantages arising from social *cooperation(4)*. Several factors forced the need for transformation in health systems, especially organization issues, costs, and financing form such as Public-Private Partnerships (PPP), where based on contracts as the main premise, relationships must be supported in mutual benefits and extreme trust. Perhaps, based on good results already measured, it'll come to pass in a way to contribute to the improvement of the system.

The World Health Organization proposes equitable guidance of health systems and highlights that differences must be reduced in people's conditions. SUS principles are constituted by 1-universality of access at all levels of care 2-equality in health care, without distinctions or privileges of any kind 3-completeness in health care assistance 4-gratuitously 5-community participation 6-decentralization, regionalization, and hierarchization of health actions and services give the SUS a strong Rawlsian bias*(22)*. Rawls' theory of justice was the one that most influenced theorists at the end of the last century and also the one where equity was consolidated.

The main idea is that the principles of justice for the basic structuring of society are the object of the original consensus, emanating from free and rational people, concerned with promoting their own interests, who would accept an original position of equality*(23)*.

This text is not intended to discuss the legal-administrative organization of SUS, however, it is intended to show the trajectory of this grandiose health system in a country ofcontinental dimensions with enormous cultural, social, economic, and geographic diversity. Despite the fiscal crisis, lack of funding to find a balance between the general services provided by the system and the ones to vulnerable groups, it is verified that in fact, public health policies organized by the State have been working on behalf of groups in vulnerable conditions with the usual difficulties of a low budget.

The Brazilian model was built on the principle that health is a right for all and a duty of the State, therefore based on the universal and equal assumption of health actions and services for its promotion and recovery. (Art. 196 of the Federal Constitution of 1988). With the fiscal crisis of recent years and without a better definition of other sources of funding, the deficiency of health care in the public sector regarding universalization was shown clearly and progressively. How to build a health system with qualities and technologies demanded by the current medicine in an environment of fiscal restrictions? The current allocation of resources is impractical in terms of providing comprehensive health care for the entire population. The scarcity of resources still maintained satisfactory service for goods considered public: the eradication of endemic diseases and vaccination campaigns. This form of health provision by SUS, in this context, no longer meets the criteria of justice and equity as in the past. Utopian thinking? The desire to reduce inequalities cannot be forgotten and the best strategy would be to rethink the country's health model without losing the Rawlsian bias and then, in this context, maintain the issue of equity as a basic postulated by the principle of social justice. What kind of equality/equity is sought in SUS?

Agreeing with Nunes*(23)* Rawls' equity is the equity in the delivery of the primary good. There will be Rawlsian equity if all citizens receive health care according to their needs. Non-equal resource redistributions, the product of adjustments made due to biological, social, and political-organizational factors that determine existing inequalities, would be guaranteed successes.

Lastly, the correct way to provide basic services to millions of Brazilians in a greaterdegree of vulnerability by the Family Health Strategy (ESF) is already in most municipalities in Brazil. According to Carneiro Junior et al.*(24)* "Organization of equitable health practices in primary care in a metropolitan region in the context of social inclusion and exclusion processes. The ESF's distributive criteria and norms are links to urban or rural areas characterized by situations of poverty. Those criteria and norms are not based on a simple cut by income level. This selective inclusion alludes to the foundation of John Rawls'theory of justice, as it grants priority to the "less privileged members of society".

Training local managers and qualification for professionals, aiming at efficiency in management processes, having a more adequate distribution of the health workforce that is now concentrated in large centers. Continuous and consistent policies with technical planning and society participation will bring hope for better days.

There will be more equity in SUS when there is less expenditure on high-complexity services and when resources are shifted to better coverage of basic and medium-complexity services. All this, added to greater incentives for the ESF, which is the main and most effective current model of primary care, covering around 60% of the population. This way, equity becomes more tangible and, like this, we will be closer to Rawls. The ESF program focuses its attention on the most deprived, and that is a clear reference to John Rawls' theory of distributive justice with equity.

Author Contributions

Writing-review & editing, L.O.M.M., M.F.R., A.C. and G.R. All authors designed the manuscript and contributed to the writing, review, and final approval of the final version. All authors have read and agreed to the published version of the manuscript.

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Conflicts of Interest

The authors declare no conflict of interest.

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COMPETENCIAS INTERCULTURALES DESDE UN ENFOQUE ÉTICO INTERCULTURAL EN LA FORMACIÓN INICIAL DE PROFESIONALES EN CIENCIAS DE LA SALUD. UN DESAFÍO INELUDIBLE

Juan Beltrán-Véliz[1], Julio Tereucán Angulo[2], Ana María Alarcón[3], José Luis Gálvez-Nieto[4], Nathaly Vera-Gajardo[5]

Resumen: Chile es un país culturalmente diverso cuya población debe enfrentar dificultades relacionadas con la salud. Este ensayo tiene por objetivo reflexionar en torno a las competencias interculturales desde un enfoque ético intercultural, en la formación inicial de profesionales en ciencias de la salud. Se constata una salud carente y descontextualizada de la realidad cultural en la formación inicial en ciencias de la salud. Para evolucionar en esta área, se requiere imperiosamente formar a los profesionales en competencias interculturales desde un enfoque ético intercultural. Ello contribuirá al reconocimiento y comprensión de la otredad desde su propia cultura, a partir de la relación e intercambio de experiencias, conocimientos, saberes, entre otros. Para ello se requiere del diálogo intercultural entre profesionales y expertos pertenecientes a distintos sistemas de salud, con el fin de coconstruir desde la salud y enfermedad, para responder de forma oportuna y adecuada a las demandas de salud, y brindar un cuidado en salud digno y de calidad. En efecto, mitigará las desigualdades e injusticias, a la vez que proporcionará una vida más plena a las personas que conviven en una sociedad culturalmente diversa.

Palabras clave: educación intercultural, salud intercultural, competencia intercultural, ética intercultural.

Intercultural competences from an intercultural ethical approach in the initial training of professionals in health sciences. An inescapable challenge

Abstract: Chile is a culturally diverse country, and this population must face difficulties related to health. This essay aims to reflect on intercultural competencies from an intercultural ethical approach, in the initial training of professionals in health sciences. The initial training in health sciences shows that health is lacking and decontextualized from the cultural reality. In order to evolve in this area, it is imperative to train professionals in intercultural competencies from an intercultural ethical approach. This will contribute to the recognition and understanding of otherness from their own culture, based on the relationship and exchange of experiences, knowledge, wisdom, among others. This requires intercultural dialogue between professionals and experts belonging to different health systems, in order to co-construct from health and disease. This will allow a timely and adequate response to health demands. It will also provide quality and dignified health care and attention. In effect, it will mitigate inequalities and injustices, while providing a fuller life to people living in a culturally diverse society.

Keywords: Intercultural education, intercultural health, intercultural competence, intercultural ethics.

Competências interculturais a partir de uma abordagem ética intercultural na formação inicial de profissionais em ciências da saúde. Um desafio inevitável

Resumo: O Chile é um país culturalmente diverso, essa população deve enfrentar dificuldades relacionadas à saúde. Este ensaio tem como objetivo refletir sobre as competências interculturais a partir de uma abordagem ética intercultural, na formação inicial de profissionais em ciências da saúde. A saúde carente e descontextualizada da realidade cultural é verificada na formação inicial em ciências da saúde. Para evoluir nesta área, é imperativo formar profissionais em competências interculturais a partir de uma abordagem ética intercultural. Isso contribuirá para o reconhecimento e compreensão da alteridade a partir da própria cultura, do relacionamento e troca de experiências, saberes, saberes, entre outros. Para isso, é necessário o diálogo intercultural entre profissionais e especialistas pertencentes a diferentes sistemas de saúde; a fim de co-construir a partir da saúde e da doença. Isso permitirá uma resposta oportuna e adequada às demandas de saúde. Da mesma forma, prestará cuidados e atenção à saúde dignos e de qualidade. Com efeito, atenuará as desigualdades e as injustiças, ao mesmo tempo que proporcionará uma vida mais plena às pessoas que vivem numa sociedade culturalmente diversa.

Palavras-chave: Educação intercultural, saúde intercultural, competência intercultural, ética intercultural.

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Introducción

Actualmente en Chile la población de los pueblos originarios sobrepasa el 12,2% del total de la población chilena*(1)* y la población inmigrante ha aumentado de manera significativa y permanente, representando actualmente un 7,8% de la población total del país*(2).* Al respecto, Chile se posiciona como un país culturalmente diverso, no solo por la cantidad de personas pertenecientes a culturas originarias, sino que también por migrantes establecidos en el país*(3,4).*

En este escenario, tanto los pueblos originarios como los inmigrantes deben enfrentar dificultades relacionadas con la salud en el país donde habitan. Lo expuesto está vinculado con las prácticas de los profesionales de ciencias de la salud, las que se reducen a una racionalidad instrumental y tecnocrática(5), fragmentando así la realidad y por tanto, eclipsando la forma de atender y comprender los fenómenos vinculados con la salud desde la diversidad cultural. En este sentido, no consideran que el contexto social y cultural está mediado por las actividades y experiencias humanas*(6,7)* situadas. Ello resulta preocupante, toda vez que, en el contexto chileno, los profesionales en ciencias de la salud se desempeñan en contextos culturales diversos. En efecto, la construcción del derecho a la salud intercultural en Chile es sustancialmente limitada *(8).*

Contrario a lo mencionado, el ser humano tiene derecho al goce máximo de salud, sin distinción de raza, cultura y condición económica o social*(9),* pues se consideran inadmisibles las desigualdades respecto del estado de salud de las poblaciones que interactúan en una sociedad culturalmente diversa*(10).*

En este contexto, en Chile se han realizados esfuerzos por construir un sistema de salud para a atender a la diversidad cultural, lo cual ha derivado en la publicación de marcos legales: la Ley 19.937*(11)* indica que se debe incorporar un enfoque de salud intercultural en los programas de salud en comunas con alta concentración indígena. La Norma General Administrativa N.°16 sobre Interculturalidad en los Servicios de Salud*(12)* señala la necesidad de avanzar en la pertinencia cultural, intercultural y complementara en los establecimientos que dependan de los servicios de salud. Asimismo, la Ley 20.584 *(13)* establece que se debe garantizar el derecho de las personas que pertenecen a los pueblos originarios a recibir una atención de salud con pertinencia cultural. Sumado a la Ley 21.094 *(14)*, que prescribe que las universidades del Estado deberán promover, durante la formación profesional del estudiantado, una vinculación necesaria con los requerimientos y desafíos del país y sus regiones desde una perspectiva intercultural.

No obstante, dichas políticas públicas han sido insuficientes, dado que, desde el área de salud, se legitiman prácticas monoculturales, hegemónicas y colonizadoras*(15)*. Ello se refleja particularmente en la formación inicial de los profesionales en ciencias de la salud, en la que se aprecia desconocimiento y exclusión de otras cosmovisiones, lenguas, conocimientos, formas de conocer, pensar, sentir, hacer, enseñar, aprender y comprender el mundo*(16,17,8,18).* En correspondencia, otros estudios revelan carencia en la formación inicial de dichos profesionales en torno a la salud intercultural, así como también respecto de la vinculación con la diversidad cultural*(19,20,4).* Tales antecedentes son motivo de preocupación para todos los países*(10)*, particularmente para las instituciones universitarias que forman a los profesionales en el área de salud, toda vez que la ética, bioética, la interculturalidad y el ser humano están inherentemente relacionados con la vida y la salud; sin embargo, esta relación no se aprecia en la práctica de estos profesionales, desde una perspectiva amplia y profunda, sustentada en la diversidad cultural y en los procesos sociales*(21,22).*

Ante esto, y dada la creciente diversidad cultural que se constituye en un proceso transformador y dinámico, los profesionales en ciencias de la salud necesitan ser formados en “competencias interculturales” desde un “enfoque ético intercultural”. Por una parte, las competencias interculturales, permitirán al sujeto tomar conciencia respecto de su forma de pensar y actuar con todo su entorno, de tal manera de comprender la otredad desde su propia cultura*(23,7,24)*. Además, tanto desde el plano de comunicación como desde la práctica, el profesional de la salud respetará y valorará la cultura de las personas pertenecientes a las minorías, comunidades y pueblos*(8).* Por otra, el enfoque ético intercultural, promoverá la reducción de las desigualdades y garantizará el derecho a una salud digna*(25)*, a partir del diálogo de las relaciones intersubjetivas y del reconocimiento de la identidad del otro*(26)*. Además, permitirá que los profesionales se vinculen e interactúen con personas de distintas comunidades, considerando aspectos sociales, culturales*(21)*, históricos y geográficos, que configuran formas de ser, sentir, percibir, pensar y hacer, para coconstruir desde el plano de salud y enfermedad.

En atención a lo expuesto, este ensayo tiene por objetivo reflexionar acerca de las competencias interculturales, desde un enfoque ético intercultural, en la formación inicial de profesionales en ciencias de la salud.

Educación y salud intercultural

Para aproximarse a la acepción de educación intercultural, primero se precisa abordar la interculturalidad, la cual hace referencia a un conjunto de interrelaciones y articulación entre sujetos pertenecientes a culturas distintas, que se da en términos de mayoría-minoría y que a menudo se encuentran en constante cambio, lo cual estructura una sociedad*(27)*. En dicha concepción de interculturalidad las relaciones entre sujetos de culturas diversas se dan desde la desigualdad, aspecto que ha ocurrido históricamente en las distintas sociedades en el mundo, y en el contexto chileno no es la excepción. La interculturalidad involucra además una forma de posicionarnos en el mundo, de mirar la realidad que nos envuelve a través de la diversidad y la complejidad que está presente en las personas. Ello implica considerar la diversidad como una condición inseparable del ser humano*(28)*.

La interculturalidad está estrechamente vinculada con la educación, y se posiciona la educación intercultural como una dimensión que permite y beneficia la relación de conocimientos y saberes*(29)*, considerando para ello los fundamentos epistemológicos, éticos, bioéticos, morales y teleológicos que subyacen a cada cultura. A partir de este posicionamiento, la educación intercultural permite conocer, reconocer y comprender la cultura propia y la de otros sujetos en constante interacción, respetando saberes y experiencias. Para ello, es necesario reconocer que cada sujeto tiene un razonamiento para comprender el mundo, desde una perspectiva propia*(30)*. La educación intercultural, entonces, implica construir un saber diverso, con el fin de comprender al otro*(31)* desde la diversidad y complejidad.

Desde esta perspectiva, la educación intercultural permite la apertura de una serie de acciones que conllevan un flujo de conocimientos, saberes y experiencias, lo que hace posible construir espacios para una salud intercultural. Dicho constructo hace referencia a distintas percepciones y prácticas de interacción que se dan en el proceso salud, enfermedad y atención, y que operan y se articulan en acciones de cuidado, prevención y solución a las enfermedades*(32)* en contextos culturalmente diversos. Además, la salud intercultural promueve una interacción entre culturas de forma respetuosa, sinérgica y horizontal. Asimismo, un trato humano y eficiente orientado a los miembros que forman parte de culturas distintas, al tiempo que evita la exclusión de los conocimientos, experiencias y prácticas de salud*(33,34)* arraigadas culturalmente. En tal sentido, posibilita un entendimiento y comprensión mutua entre culturas, sobre la base del respeto por las experiencias, conocimientos, saberes, valores, prácticas, tradiciones y creencias de los sujetos involucrados en un plano sociocultural e histórico diverso. Sumado a ello, promueve la complementariedad, reciprocidad y equilibrio fundados en el diálogo*(35,18)* y la colaboración constante. Ello contribuye a la reflexión e innovación, lo que a su vez moviliza acciones para mejorar la pertinencia de la salud y, por tanto, el cuidado y bienestar de todas las personas pertenecientes a una sociedad culturalmente diversa.

Competencias interculturales desde un enfoque ético intercultural en la formación inicial de profesionales en ciencias de la salud

La competencia intercultural hace referencia a un adecuado y relevante conocimiento sobre culturas particulares y diversas, cuando miembros de estas culturas interactúan. Así como también se caracteriza por conservar actitudes receptivas y portar las habilidades requeridas para establecer y mantener el contacto con personas diversas*(36)*. En correspondencia, Deardorff*(37)* indica que la expresión alude a las habilidades, actitudes y comportamientos necesarios para mejorar y fortalecer las interacciones que se generan entre la diversidad de culturas, ya sea al interior de una sociedad o a través del cruce de fronteras. En el ámbito de la salud intercultural, las competencias interculturales hacen referencia a las habilidades que debiesen portar o llegar a desarrollar los profesionales de todas las áreas de la salud para comprender, considerar e incorporar la cultura de la otra persona como un componente relevante al momento de interactuar en un espacio terapéutico*(38).*

En este sentido, las competencias interculturales en la formación inicial de profesionales en ciencias de la salud revisten importancia a partir de relaciones adecuadas entre miembros de culturas distintas, lo cual despliega un *corpus* de conocimientos, habilidades, situaciones, experiencias y acciones que contribuyen a estrechar las brechas de desigualdad. Todo ello con la finalidad de garantizar la equidad, el cuidado, la atención digna y de calidad en la salud para todas las comunidades y personas*(39).*

Lo expuesto, implica necesariamente que el profesional de la salud desarrolle sus prácticas y se relacione con la otredad a partir de la ética intercultural, dado que ésta provee de sentido a la reflexión desde una mirada diversa, aunque sin desconocer lo propio, y está abierta al diálogo en las relaciones intersubjetivas orientadas al reconocimiento*(26)* y valorización del otro. Al respecto, Todorov*(40)* indica que las culturas siempre han estado en contacto sobre la base del diálogo*(41).* Desde esta perspectiva, el diálogo intercultural *s*e posiciona como un elemento clave que subyace a la ética intercultural, puesto que busca la comprensión y el reconocimiento*(42,18)* de las diversas racionalidades; así como también, la fecundación recíproca y el encuentro de sensibilidades*(43)*, al tiempo que posibilita la apertura intelectual de la otredad*(42).* En este sentido, es de vital importancia que los profesionales en ciencias de la salud dispongan de la capacidad para dialogar con otros expertos*(44)* que pertenecen a un sistema de salud distinto, de modo de acceder a conocimientos, saberes y prácticas experienciales que enriquezcan y optimicen el servicio de salud. La ética intercultural moviliza transformaciones socioculturales a partir de los ámbitos valorativos y normativos propios de las sociedades culturalmente diversas*(45).* Entonces, incorporar las competencias interculturales —sustentadas en un enfoque ético intercultural— en la formación inicial de profesionales en ciencias de la salud, permitirá transformar positivamente la realidad a través del reconocimiento de la diferencia y de la dignidad, lo cual favorecerá la comprensión del otro, dado que el diálogo intercultural posibilita una mirada emancipadora, a fin de superar las injusticias y desigualdades*(46)* en el área de salud, en términos individuales, colectivos y comunitarios, y en distintos espacios culturales.

Lo anterior aportaría a mejorar y avanzar en la construcción de procesos educativos interculturales en la formación inicial de profesionales en ciencias de la salud. Junto con ello, permitiría a estos profesionales desarrollar prácticas de salud integrales e inclusivas, desde un enfoque ético intercultural, en territorios de pueblos originarios y en los contextos que emergen por la inmigración*(47).* Todo ello apuntaría a generar transformaciones en el campo de la salud intercultural para concebir el bienestar integral*(5)* y alcanzar el buen vivir*(48,18)* de todas las personas, considerando para ello el equilibrio físico, cognitivo, espiritual, emocional*(49)* y social como un todo articulado y armónico.

Conclusiones

En la formación inicial de profesionales en ciencias de la salud se aprecia carencias respecto de un enfoque intercultural, debido a prácticas centradas en una racionalidad instrumental y tecnocrática, así como también a la legitimización de prácticas monoculturales propias de la cultura occidental eurocéntrica. Ello provoca un desconocimiento y exclusión mayoritaria de otros conocimientos y experiencias en el campo de la salud, lo que, a su vez, obstaculiza la vinculación de estos profesionales con la diversidad cultural.

Para superar lo anterior, la formación en ciencias de la salud debe realizarse con base en competencias interculturales, considerando aspectos cognitivos, comportamentales, valóricos, afectivos, sociales, culturales, históricos y geográficos. Junto con ello, dicha formación requiere desarrollarse desde un enfoque ético intercultural, lo cual les posibilitará tomar conciencia de sus acciones y reconocer y valorar la diversidad y dignidad del otro, de manera de comprenderlo desde su propia cultura, a partir de la relación e interacción de conocimientos, saberes, experiencias, formas de vida, de pensar, hacer y vivir en el campo de la salud. Para ello, se debe disponer de un diálogo intercultural que permita movilizar el respeto y colaboración mutua entre profesionales en ciencias de la salud y otros expertos que pertenecen a un sistema de salud culturalmente distinto. Ello favorecerá a la coconstrucción desde la salud y enfermedad en la que esté presente la apertura intelectual, de manera de promover la reflexión e innovación constante para enriquecer y optimizar el servicio de salud. Del mismo modo, avanzar en el conocimiento desde la complementariedad y reciprocidad.

Respecto de lo anterior, las universidades, en colaboración con el Estado y la población situada en distintos territorios culturales, deben promover y generar políticas públicas educativas orientadas al desarrollo de currículos y prácticas pedagógicas contextualizadas. Este aspecto, aportará a la formación de profesionales en ciencias de la salud, pertinencia cultural, responsabilidad ética y bioética. Lo expuesto permitirá responder de forma eficaz y eficiente, mediante prácticas integrales e inclusivas, a las demandas y problemáticas de salud que emanan de contextos culturales diversos. Ello, a su vez, mejorará la prevención, el cuidado y atención en salud de todas y cada una de las personas, desde lo físico, cognitivo, emocional, espiritual y social, como un todo armónico. Además, contribuirá a mitigar las injusticias y estrechar las brechas de desigualdad y, por tanto, garantizará una salud digna y de calidad desde una perspectiva individual y comunitaria. Al tiempo que permitirá a las personas alcanzar el bienestar común y, en consecuencia, proporcionar una vida más plena.

Conflicto de intereses

Lo autores no tienen conflictos de interés

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POST-MODERN BIOETHICAL STRESSES DESTINATION OF SURPLUS EMBRYOS: BRAZILIAN ANALYSIS AND BRIEF COMPARISONS

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Abstract: The objective of the present study is to point out tensions of the theoretical/practical universe that Bioethics is facing in Brazil, in the search for a praxis for the destination of surplus embryos. We consider that Bioethics analyzes the implications of such practices in society and in relationships between individuals. Brief data from other countries were presented to compare the Brazilian situation progressively from the conceptual point of view and the adoption of measures. The research is a scoping review on the main points that have been hindering the progress of discussions on the subject and consequently the respective solution. The legal status of the embryo was described from several perspectives and theories, with the resulting proposals for the destination of surplus embryos in their positive and negative aspects. The tensions of Bioethics were presented in the context of post-modernity and the consequent social and moral plurality, together with the difficulties of identifying a secular bioethical morality. In the end, we conclude the possibility of proclaiming a consensus on the destination of surplus embryos based on secular morality, supported by the figure of the “moral strangers”.

Keywords: embryo status, excess embryos, bioethics

La bioética posmoderna tensiona el destino de los embriones sobrantes: análisis brasileño y breves comparaciones

Resumen: El objetivo del presente estudio es señalar las tensiones del universo teórico/práctico que la bioética enfrenta en Brasil, en la búsqueda de una praxis para el destino de los embriones sobrantes. Consideramos que la bioética analiza las implicaciones de tales prácticas en la sociedad y en las relaciones entre los individuos. Se presentaron breves datos de otros países para comparar progresivamente la situación brasileña desde el punto de vista conceptual y de la adopción de medidas. La investigación es una revisión del alcance de los principales puntos que han obstaculizado el avance de las discusiones sobre el tema y, en consecuencia, la respectiva solución. Se describió el estatuto jurídico del embrión desde diversas perspectivas y teorías, con las consiguientes propuestas para el destino de los embriones sobrantes en sus aspectos positivos y negativos. Se presentaron las tensiones de la bioética en el contexto de la posmodernidad y la consecuente pluralidad social y moral, junto con las dificultades de identificar una moral bioética laica. Al final, se concluye la posibilidad de proclamar un consenso sobre el destino de los embriones sobrantes basado en una moral laica, apoyada en la figura de los “extraños morales”.

Palabras clave: estatuto embrionario, embriones sobrantes, bioética

Bioética pós-moderna enfatiza o destino de embriões excedentes: análise brasileira e comparações breves

Resumo: O objetivo do presente estudo é destacar as tensões do universo teórico/prático que a Bioética está enfrentando no Brasil, na busca de uma praxis para a destinação de embriões excedentes. Nós consideramos que a Bioética analisa as implicações de tais práticas na sociedade e nas relações entre indivíduos. Dados resumidos de outros países são apresentados para comparar a situação brasileira progressivamente de um ponto de vista conceitual para a adoção de medidas. A pesquisa é uma revisão de escopo sobre os pontos principais que vem atrapalhando o andamento das discussões sobre o assunto e consequentemente a solução respectiva. O status legal do embrião foi descrito a partir de diversas perspectivas e teorias, com as propostas resultantes para a destinação dos embriões excedentes em seus aspectos positivos e negativos. As tensões da Bioética foram apresentadas no contexto da pós-modernidade e a consequente pluralidade social e moral, juntamente com as dificuldades de identificar uma moralidade bioética secular. Ao final, nós concluímos pela possibilidade de proclamar um consenso sobre a destinação de embriões excedentes baseado na moralidade secular, apoiado pela figura dos “estranhos morais”.

Palavras-chave: status do embrião, embriões excedentes, bioética

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Introduction

The use of assisted fertilization, which has existed since the 70's (20th century), is also increasingly growing in Brazil demonstrating that the answers given by science for many problems that are difficult to solve have been accepted worldwide.

However, "sciences are not aware of how they imprint themselves in culture, society in history"*(1:3)*. They do not always consider the problems that their answers may cause, and how its effects may be resolved. Such effects are merely considered "secondary drawbacks or minor by-products", in a simplification of complexity.

About these aspects, Morin*(1)* explains that the substantial concepts of man, individual, and society exist in several disciplines and are usually scrutinized by them, making their interdisciplinary reconstitution difficult. There seems to be a dispute for concepts among disciplines, each one with its certainties, while the problems arising from them continue.

Another example is the encapsulation or fragmentation of knowledge, meaning the following: either the knowledge that is set aside from the empirical reality or science would be above the problems it triggers or the science that brings the solution, while the other areas take care of its effects respectively.

In this context, assisted fertilization has raised questions, especially regarding the fate of surplus embryos. These are human embryos that were obtained through hormonal hyperstimulation in women, were not implanted in the maternal uterus for whatever reason*(2)* and have been cryopreserved.

The destiny of these embryos can be seen as the inscription of assisted fertilization in culture, society, and history. This inscription has generated religious, ethical, and legal questions for society, confirming the negative effects of the progress in science which Morin referred. Far from appearing secondary or minor, this line of questioning has aroused discussions from various points of view because it involves values that integrate the culture and history of society.

While, on the one hand, it is true that the subject lacks a legal standardization that provides viable solutions for the fate of surplus embryos, on the other, it is logical that this standardization involves quite controversial points, such as the fundamental concept of an embryo and the fundamental right to life, among others, making the possibility of a socially satisfactory solution difficult.

For the time being, there are no general statutes that ensure a destination for surplus embryos within a secular ethic that allows the sharing of ideas or solutions by "moral strangers". These people who do not share the same premises or moral rules, but who manage to solve social obstacles through healthy arguments. There are many legitimate moral perspectives, but "moral strangers" can share some ethical solutions that benefit society as a whole, although holding different scales of values*(3)*.

For Casabona*(4)*, the problems arising with the new technologies are not only wide-ranging, but also multidisciplinary in nature, especially those affecting the ethical sciences, due to their relationship with the protection of human life and dignity. The search for solutions for science's answers to empirical problems represents a harmonious search to living contentedly with the inevitable and beneficial advancement of science. The benefits brought by techno-sciences demonstrate the need for a new epistemology that aims to break the determinism and simplification with which the facts have been treated. It is an epistemology that "incorporates chance, probability and uncertainty as necessary parameters for the understanding of reality"*(5:3)*.

Thus, it is necessary for disciplines to seek, each in its own way and with its own competence, solutions to the questions that arise. In addition to more personal or group interests and beliefs, it is also important to observe solutions that serve more people and solve more problems.

A illuminating study on the subject shows that there are three fundamental positions today on the destination of surplus embryos. The perspectives basically focus on the notion of embryo: two radical/extreme views and one advanced one. The first one considers the human embryo a person from conception. The second one considers the embryo to be "just a bunch of cells", without the status of a person. The third one is in between the two previous ones and considers the embryo a "real potentiality", destined to become a person in its development*(6:123)*.

Respectively, the positions cited correspond to the following theories: "conceptionism," which prioritizes the maximum protection of the embryo as a human person and recipient of rights (6); the "genetic-development" perspective, which considers the human embryo to be a heap of cells that, as such, has no rights, because there is no person properly said (Meirelles, 2000);and the "potentiality of the human person" perspective, which views the embryo as a potential human being*(6)*. From the concept of the embryo, other aspects also arise, including guardianship.

In this context, and in search of a praxis, the objective of this work is to point out, through a scoping review, tensions of the theoretical/practical universe that Bioethics faces in Brazil, in the search for a praxis for the destination of surplus embryos. The scope review is indicated when the subject has been little explored or has a heterogeneous and complex character. A mapping of important aspects of the topic is made in the literature, and its volume, nature and characteristics should correspond to a primary research*(7)*.

In the course of the research for this paper, national and international research by researchers/authors who are prominent in this topic was consulted.

Embryo status

Lepienne claims that discussing the moral *status* of the human embryo is perhaps one of the "most thorny tasks of Bioethics"*(8:12)*. This difficulty is inferred from the fact that the theme includes definitions of an embryo and limits of the human person, in addition to the respective ethical and legal implications. Depending on the ethical and legal points of view, the embryo is defined based on different conditions, generating negative and positive positions, depending on individual or group beliefs.

For Blumberg-Mokri*(9:31)*, when it comes to the basic construction of the human embryo, the recurring question is: "the human embryo is ... human?" Furthermore, the supreme principle that underpins this issue is respect for the human nature of the embryo, in vivo or in vitro Bernard et al. cite other questions in this sense that are raised by biomedical technoscience: "Is the embryo human from fertilization or from a later stage? […] Does this apply to the human embryo and from when?"*(10:179)*. These questions arise from the identification of the embryo as human or not, and here come its consequences: when do life and personality begin?

Currently, the paradigm resulting da large and steady great and steady scientific-technological evolution has brought other representations of the world, other problems, and different solutions to old issues, such as assisted reproduction for couples facing difficulty regarding fertilization. Society has become plural due to these representations (among others), broadening its view of concepts and morality. In most cases, problems are seen within the perspective of openness to new understanding. In others, more traditional points of view persist, especially on issues involving religious principles, common sense, and group ethics.

Given the advanced possibilities of scientific answers to general problems of reality, and amid current discussions on the subject, it is worth reflecting philosophically on the concept of the embryo in order to understand how it is defended in the context of the current paradigm.

In ancient Greece and Rome, people were not seen as they are today. One's right came from social recognition and paternal acceptance. In the Christian community, the conception was that of man as a being created in the light of the divine image, and this idea greatly influenced the notion of the embryo. The Pythagoreans, who considered soul a divine and immortal essence, argued that the embryo would have spirit from conception. Supposedly, it was commanded by exclusive functions of growth and nutrition, and the ascent to human status was progressive, because intelligence, a human trait, only arrived at a certain moment. The Stoics, on the other hand, for whom the soul was a material principle and part of the divine that extended to the body, understood that the embryo would be animated at birth, in its first breath. The vital breath would turn into life and make it grow*(10)*.

This description clarifies two important points in relation to what is being discussed today: the preservation of the strong Christian conception around the embryo and its representation associated with the phenomenon of animation, with origin and stages of development until it acquires human characteristics. The former reflects group positions, but the latter can contribute to decisions about the fate of the surplus.

In the general sense, the word "embryo" refers to a stage of human development in which the fertilized cell, the egg, is transformed into a collection of tissues and cells, which is the fetus. This takes place in the first eight weeks of fertilization*(8)*.

In sexual reproduction, conception occurs when a spermatozoon (male gamete) joins an oocyte (female gamete) and its elements will compose a different organism, the zygote. The new organism then begins to develop into an embryo by means of differentiated cell division into two cells, into four cells and so on. A "stable body" is formed, whose cells act in a coordinated manner in a regular, predictable, and human evolution-oriented process*(11:304)*.

The period of formation the largest growth of the embryo occurs, which increases it to about 10 thousand times the size of the zygote and the main systems are developed. It is a very vulnerable stage, so much so that only between 10% and 20% of the fertilized eggs become embryos. At the embryo stage, about 50% of pregnancies do not go ahead due to several factors, including inadequate attachment of the blastocyst in the mother's uterus*(12)*.

In *in vitro* fertilization, the encounter of the sperm with the egg (fertilization) takes place in the laboratory, and the formed embryo is placed in the female uterus later. In this process, the development of the embryos is interrupted before cell differentiation, will all cells pluripotent. "It is the moment when (the embryos) are evaluated for their viability of implantation in the uterus"*(12:20,21)*. If the embryo is healthy and in the right environment and with the right nutrition, its development will be active, according to the process of the species. There is only difference in the degree of maturation, not in the type, at any stage of the embryo, fetus, or even the baby*(11)*.

According to these authors, based on embryological evidence, the human embryo is not just a part, but a complete human being immature. Their constituents are human from the genetic point of view, but they are not whole human organisms, because none of them have an active disposition for development. Since fertilization, the human embryo is completely programmed for active development towards the next stage of human evolution.

Lucas*(13)* states that medicine has entered into the discussion about the status of the human embryo and has defined it as "a potential being," because it understands that, concretely, it only reaches some meaning at the beginning of life (a being in action).

To a certain extent, in Brazil, when the Federal Supreme Court (SFT) judged the constitutionality of Law no. 11.105/2005 and adopted the notion of embryo as a potential human being, which, in itself, already deserves legal support. It highlighted the distinct realities of the embryo, the fetus and the human person, and stated that there is no embryonic human person, but the embryo of a human person*(14)* (*emphasis added*).

In Portugal, the reasoning prior to the legislation considers the embryo "a living human being," with a right to life and protection*(15:4)*. In the UK, the status of the embryo is debated differently by law, morality and ethics, without much depth as to the concept*(16:13)*. In China, the recognition of the legal status of the human embryo is under renegotiation due to various causes and developments*(17)*.

Thus, while arguments —from religious beliefs to biological definitions— create impasses for the solution, the number of surplus embryos continues to grow and have an uncertain destination. Palliative measures can reduce this number through legal determinations, for example, regarding the number of embryos to be implanted in the maternal womb. It is also important to review the process since the hormonal stimulation, as a surplus, results from something that started well before.

About the destiny of embryos, the authors made a link to the Biodirect by using the term "embryonicide" to refer to the destruction of surplus embryos and expressions as "human guinea pig" to portray the use of surplus embryos in research (2). There is also a tendency to see the embryo in a "coisified" form, only as research material, disregarding the ethical and ontological issues that exist in parallel with its scientific purpose.

Speaking of the idea of "thingification," Mürkovic, in a *summa divisio,* explains that there are "people and the rest" that are things and that "thing" is not to be understood pejoratively, but as that which is not a person: "There is no intermediary between the person and the thing, half-person or person (…). Therefore, to qualify the embryo as a human person, (...) it is necessary to treat it as a person or not"*(18:1)*.

This is one of the points on which the definition of the embryo's status and the fate of surplus embryos depends.

Destination of surplus embryos in Brazil and other examples

The concern for the fate of these embryos is universal. Santos*(19)* states that, in Portugal, this issue was discussed in several legislative projects, several committees were created, but no bill became law. In Brazil, the discussion of this issue was somewhat neglected. The Federal Council of Medicine's has endeavored to make ethical standards possible, but they refer to physicians.

Surplus embryos may not have the appropriate environment and nutrition for their active development because they remain in the laboratory and cryopreserved. Through the theory of nidation, the uterus is the appropriate environment, and is prepared for the development of the embryo, because it provides the necessary conditions for its growth. "*In vitro* embryos do not have conditions of development outside the womb until they are implanted and nested"*(19:31)*. Semião*(20)* states that there is no extrauterine life. Therefore, *in vitro* fertilized embryos cannot be considered human.

There is an impasse: what initially exists (the embryo) is not only a "bundle of homogeneous cells," as is biologically proven, but it needs an adequate environment and nutrition to exercise its active disposition. The point of this impasse is: what to do with the preserved embryos, when there is no stipulated time for its cryoconservation?

In China in 2014, a study of over 3,000 embryos frozen between 12 months and 48 months found no difference in thaw survival rates, implantation rates, pregnancy rates, live birth babies, nor birth weight*(21)*. In the United States in 2017, the media reported on a pregnancy with an embryo frozen for 24 years, and the baby was born well*(22)*.

As there is uncertainty regarding the viability of each of the embryos conceived, several eggs are fertilized and the most suitable ones are implanted in the uterus. The others remain cryopreserved. The rest remain cryopreserved*(23)* are surplus. A brief example shows the following: in Australia and New Zealand in 2000 the total was over 71,000 frozen embryos*(24)*; in the United States in 2002 about 400,000 cryopreserved embryos were in storage: 88% for future use by patients, 3% for research and 9% "unwanted", possibly abandoned. More recent data from that country estimates that there are over 1 million cryopreserved human embryos, and at least about 90,000 may have been abandoned*(25)*. In Spain, in 2012, the number of cryoconserved embryos was over 200,000 and, worldwide, this figure was over 1,500,000, highlighting the great loss that the process of *in vitro* fertilization causes*(26)*.

However, some measures started to be adopted. For example, as recently as 1988 in Spain, Law 35 established that surplus embryos could only be kept for six years. In 1990 in Germany Law 745 prohibited the intentional creation of surplus embryos, with a penalty for violation*(27)*. In Brazil, in 2005, art. 5, *caput*, of Law nº 11.105/2005, the

Biosafety Law states that: "Art. 5 The use of embryonic stem cells obtained from human embryos produced by in vitro fertilization and not used in the respective procedure is allowed for research and therapy purposes". It established the conditions for such (Brazil, 2005). In Portugal, until 2000, there were no regulations in this sense*(27)*.

In 2013, the Brazilian Federal Council of Medicine (CFM), through the Resolution 2013/2013, established ethical standards for assisted reproduction techniques, determining in Section I – General Principles: "6– The maximum number of oocytes and embryos to be transferred to the receptor cannot exceed four", rang from 2 to 4, depending on the age of the woman. ranging from 2 to 4, depending on the woman age. In Section V, this resolution, indicated: "4- Cryopreserved embryos more than 5 (five) years old may be discarded if this is the will of the patients, and not only for stem cell research, as provided in the Biosafety Law"*(28:3)*.

The estimate was that 108,000 cryoconserved embryos were discarded under this Resolution*(29)*. Resolution no. 2,121/2015 kept the above criteria and innovated in others*(30:1)*. The lack of protection on the part of the State causes controversial situations to be disciplined only by this Resolution.

Specifically, Theories about the beginning of life, based on the concept of the embryo, end up positioning their supporters in relation to the fate of surplus embryos.

Surplus embryos destination

Several theories about the status of the embryo can be cited. The main ones, based on the definition of the embryo as a human person, as an accumulation of cells, and as a potential human being, respectively, advocate the following:

- Conceptionist theory: Life begins at the moment of conception, between 12 and 24 hours after fertilization. The embryo, the first stage of human development, represents a full condition of the person in question, including their inherent values of being: "the cell formed with its own characteristics (...) from that moment on (...) would be able to develop independently of third-party interference"*(12:26)*. However, there is no consensus among its followers that life begins at the moment of conception. Among the criticisms, it is claimed that human beings are distinguished from other beings by their self-awareness, and that the identification of the human being rests is in the brain, which controls all their vital.

This theory is quite radical, does not allow other interpretations, and seems to influence the legal world a lot in Brazil. Their supporters do not even consider the existence of surplus embryos, since they disapprove of all forms of artificial fertilization. This because this resource affects the personal dignity of the embryo by reducing it to an "object of technology," exposing it to unacceptable conditions, such as cryoconservation*(6)*.

- Genetic-developmental theory: Based on the Report of the Committee of Inquiry into Human Fertilization and Embryology, the Warnock Report, of 1984, which upholds "the moral status of the embryo only after birth"*(31:20)* and limits the embryo intended for research to 14 days after fertilization. Thereafter, it is possible to have cell division into identical embryos and generate the notion of individuality*(32)*.

According to this theory, before birth, the human being goes through specific stages essential to his development: pre-embryo, embryo, and fetus. Thus, the use of cryoconserved embryos should occur until the 14th day after fertilization, a phase in which they are still pre-embryos*(12)*. For their advocates, the absence of rights of the embryo does not mean ignoring them in all their ethical dimensions*(6)*.

According to the same Warnock Report, the destruction or disposal of surplus embryos as hospital waste, an option adopted in some countries, can only be the responsibility of human reproduction clinics in case of simultaneous death of both parents or if the cryoconservation period exceeds ten years*(33)*.

- Potential development theory: Advocates of this theory recognize "aspects of truth" in the two previous positions. However, they also consider that their statements are not sufficient in isolation. In an eclectic view, this trend seeks to complement points that “seem contradictory” in them, avoiding serious misunderstandings.

For this theory, the embryo is a category that cannot be confused with having human characteristics, but also not only with being a heaps of cells. In this way, the embryo is not human, but its capacity to become human is not denied. Therefore, there must be a special and irreducible status for him*(6)*.

The discussions regarding this involve quite controversial aspects. More recently, insights arising from advances in cell biology have brought more questions about the potentiality of the embryo that can be seen in various perspectives and reasoning*(34:3)*.

Potentiality is a concept originated from the principles of potency and act, defined by Aristotle in the 4th century B.C. Such principles go beyond the meanings of motion: potency is the “principle of change in another thing or in the same thing” and act is principle that results from motion. “It seems that act is primarily motion*(35:396,403)*. Potencialidade —potential adjective plus the Latin suffix “dade”, indicating quality or state— it involves the principle of *dynamis*, position or capacity, force of achievement, and updating to produce the being. Kottow*(36)*; Nunes*(37)* explains that potentiality is the ultimate expression of humanity, given that each human being is only in fact a person if he/she has the potential to express and modify his/her personality. Its inner dynamism is endowed with great power or possibility of development.

In bioethics, potency plays an important role in debates about the embryo. Conservatives attribute an ethical meaning to “the potential of the human organism,” and liberals do not admit the coherence between the concept of embryo and its ethical meaning. But both sides agree on its natural potentiality*(38:1)*. The embryo can become human because it contains the necessary codification for the formation of a complete human being; it needs only the specific conditions for its evolution*(12)*. The properties inherent to the human person are already present in the embryo in a state of latency*(39)*.

Incidentally, Nunes opposes the idea that the concept of what constitutes a person is basically philosophical, not biological. For this reason, it is admitted that what is understood by the human person is “a virtuality that is slowly being defined in reality”*(37:1)* resorting to a potential for development that also evolves over time.

From the perspective of the embryo as a potential human person, three proposals regarding the fate of surplus embryos can be seen: disposal/destruction, use in scientific research, and storage in human reproductive clinics for possible donation to third parties. Discarding is a simplistic way to get rid of embryos and faces strong opposition. Use in scientific research has been found to contribute to the therapeutics of several diseases, mainly the degenerative ones. Donation to third parties is the least criticized option facing the absolute impossibility of procreating by natural means*(40)*. For Semião*(41)*, surplus embryos can be donated free of charge —as occurs legally with human organs— provided that the purpose is morally accepted according to the current consciousness of the human being. Leite*(6)* believes that the donation of embryos for research can bring two answers: with defined goals, it can promote the evolution of diagnostics and therapeutics, a positive answer; without defined goals, it can go against deotonlogy, a negative answer.

Teixeira and Oliveira*(42)* also take a position in favor of research, including with surplus embryos, in these situations: if it is demonstrated that the research will significantly increase scientific knowledge; if the knowledge cannot be obtained by other means; if the results will contribute to ensuring the life and health of other people; and if the projects are ethically approved and monitored according to bioethical principles. This is the case if the designers do not intend to use them, if there is no adoption project, or if the cryopreservation time does not exceed the expected time for uterine implantation.

Addressing the challenges facing the contemporary bioethics environment

The destination of surplus embryos also forms part of the Bioethics area, whose principles and aspects can subsidize the elaboration of the embryo's status model. In this perspective, Nunes refers to Reisse*(43)* and states that, for Bioethics, "life is that property of matter resulting from the cyclic reactions of bioelements, and human life would be an isolated human cell, a cultivation of human cells, an organ to be implanted, a spermatozoon to be transferred *in vitro* (...)"*(44:29)*. This complex context of opposing thoughts, which demands from society new positions in the face of culture, but traditional in the face of history, is the "material" of contemporary Bioethics that tries to solve its challenges.

Bioethical concerns stem from problems relating to human interactions and biotechnological advances, and solutions must be based on "immanent" principles that are negotiated between moral agents*(45)*. In its work, Bioethics develops, in a rational and specific way, a particular practice that simultaneously moves experience, knowledge, and competence in a context of particular action. It is a "second order practice, which operates on first order practices"*(46:202)* in direct contact with determinants of the action of the bases of human existence.

At this moment, a new paradigm installed, scientific advances and the problems resulting from them indicate the emergence of "a new ontology of life accompanied by an epistemological change… It started with interventions in the blood, organ, then in the elements of reproduction"*(47:1690)* and other advances.

Bioethics is aware of this new ontology that involves either the most general properties of being without determinations that impair its full nature by qualifying it (Aristotelian sense) or the comprehensive sense of being and the possibilities of multiple existences, as opposed to the orientation of a common being with divine attributes (heiddergeriano sense)*(48)*, which also separates it from the difficulties of reaching, based on this, a consensus on the theme of surplus embryos.

If there are two ontological ways of being *homo sapiens* (as human beings and as people), questions arise concerning the moral *status of* each. With both being members of humanity, they must have a moral *status* that corresponds to all individuals, regardless of the specific characteristics of age, gender, or genetic endowment*(36)*. These two means of being homo sapiens seem to be contained in Heiddeger's definition that being (a category proper to the human) cannot be conceived without being (a presence that is distinguished from others and establishes relations with being itself). "Being is always the being of a being [...] what results as interrogated in the question of being is the being itself"*(49:32,35)*.

The interpretation based on this ontological conception makes life refer to the condition of being-in-the-world and determines the meaning it will objectively have. This makes Bioethics concrete*(50)*.

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The growing interest of Bioethics in the beginning of the lives of human beings as individuals has a very specific reason: human reproduction is not a conscious act, nor is it voluntary; it is a natural event, with its causalities, its inaccuracies, and, especially, with transcendent influences and metaphysical borders. The beginning of life has little importance for ethics and morality; the latter is perhaps attached to its beginning peripherally in relation to homo sapiens as a species. Bioethics considers the individualized beginning of life to be essential*(36)*.

From this perspective, what Bioethics needs, both for this historical moment in the West and for its area of work, is an ethical concept from the beginning of human life. Bioethical morality depends on that concept, as well as the decisions on the subject. However, like any other concept that implies essential decisions about the lives of others, each ethical perspective will be truncated and morally suspect if it does not include and prioritize the values of those who are most directly affected*(36)*.

In times of conflict, morality is guiding the search for solutions, since “the description of reality, is always infected with evaluative and explanatory expectations”*(3:259)*. People therefore see it according to what they have in mind. Bioethics does not have a model of morality and does not aim to elaborate another social morality based on the particular morality. It avoids secular explanations that do not recognize the real diversity of moral perspectives.

In his research on the current paths of Bioethics, Engelhardt*(51)* concluded that the existing 2,500 years of philosophical reflections offer an insufficient basis for reality to maintain a morality that supports a consensual destination for the disposal of surplus embryos.

Conceptual issues and controversies find no solution in rational arguments and always return to the need for principles, to circular arguments, or to endless regressions. This seems to occur with the discussions on the definition of embryo and, consequently, with the solution to the fate of surplus embryos.

Human beings have always adapted to new scientific discoveries. In medicine, patients are now treated as consumers who opt for the treatments that can bring them greater well-being*(47)*. The bases for cultural diagnosis are other, and, therefore, it becomes difficult to understand and defend arguments when there is controversy about what is best and what is most viable for the whole.

Engelhardt*(52)* has identified views of contemporary morality in four aspects: *moral reflection* is characterized by intense disagreement and by conflicts; *moral dispute* is prominent and persistent, based on both old and contemporary moral reflections; *moral controversy* is persistent and impossible to solve y means of secular, rational, and logical arguments; a proclamation of consensus amidst disagreements, which is nothing more than statements in the name of such a morality, disregarding discussions and disputes .

The first three of these characteristics seem to respectively form the basis of discussions regarding the fate of surplus embryos: there are several disagreements regarding the concept of embryo and concepts that depend on it - conceptualist and genetic-developmental theories; the reflections lie between the traditional and the contemporary - conceptualist and potential developmental theories. And the issue does not seem solvable by secular arguments. However, it is logical to argue that embryos cannot go from being potential human beings one moment (to be implanted in the mother’s womb and develop) to disposable leftovers the next (after leftovers from uterine implantation).

Thus, one realizes that Bioethics finds itself in a field of moral pluralism in which, although faith has generally been fragmented, convictions remain rooted. The disagreements are broad and range from issues such as a human reproduction until allocation of resources for research. Stable moral judgments are not shared, and this diversity is strategically ignored in order to try to implement a so-called common morality, which aims to direct policies throughout the world*(51)*.

In summary, in the scope of the plurality of moral views, contemporary Bioethics may have a solution in the figure of the “moral strangers”, at least in relation to the fate of surplus embryos. This figure refers to the possibility of a “peaceful pluralism” in Bioethics. Engelhardt (2008), who coined this expression, defends the discovery of an essential secular morality for Bioethics through the identification of a point of interaction between all the differences, with dialogues capable of generating real contributions in contemporary society.

It would be a non-religious Bioethics, “almost secular, that is, detached from religious dogmas.”Secularism, in turn, is the policy of separation between religion and State. Bioethics is under constant scrutiny and currently faces very different moral visions, obligations, rights and values, each one defending its priority”*(53:3)*. The morality of a secular Bioethics will not guide ways of living, but should be able to unite “moral strangers” in peaceful encounters and collaborations, state the authors.

For Bioethics, it is therefore assumed that finding solutions for the destination of surplus embryos will depend on the identification of a bioethical morality. On the other hand, the "proclamation of consensus" may be referred to using the fourth characteristic cited by Engelhardt*(52)* in contemporary morality as statements in the name of a certain morality, disregarding discussions and disputes. Until then, they are not verified in terms of the problem of the fate of surplus embryos.

Closing remarks

The effects of the changes that have been occurring over the last 40 years have been extensive, irreversible, and continuous, and have both destabilized certainties that guided theories and knowledge and modified the practical reality. A plural society has developed in several ways: cultural, religious, identity, ethnic, and morality, among others, that arise every day whenever science and technology advance. Society is also plural because it combines both the introduction of the new and the maintenance of the traditional.

With this, the area of interest of Bioethics has been extended, largely because general concerns involving humanity or large groups have also begun. Along with situations of specific conflicts, Bioethics, as a "practical ethics" that is initially focused on health and life sciences, has started to focus on conflicts and controversies resulting from the attempt to solve problems that refer to all, especially moral ones. If, on the one hand, its field has increased - by encompassing others - on the other hand, it has had to deepen through the need to understand the values and beliefs of plural society.

Discussions on the destination of surplus embryos is one of the issues involving values and beliefs regarding the new and the traditional, aspects that must be respected in the examination of solutions because they should not pass through the disregard of plurality in its different forms.

Therefore, the field of Bioethics encounters tensions in the search for answers that satisfy society as a whole. Therefore, the search of contemporary Bioethics for a secular morality can also represent a practical solution. The question is, what research is being conducted to achieve this?

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CODE OF ETHICS FOR BRAZILIAN MEDICAL STUDENTS. A LITERATURE REVIEW

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Abstract: In August 2018, the Federal Council of Medicine (CFM), the body responsible for the supervision and standardization of medical professional practice in Brazil, published a national code of ethics for medical students (CEMS), which standardizes and suggests behaviors, based on the best moral and ethical values, for medical students, supporting the humanization of medicine and indirectly helping teachers and managers of medical courses. The purpose of the study was to evaluate the dissemination and awareness of scientific publications on the Brazilian CEMS code and consisted of an integrative literature review of all publications related to the Brazilian CEMS published from 2005 to the present. We found 4 studies related to regional and university codes of ethics for medical students published from 2005 to 2022, and regarding the CEMS elaborated by the FCM, we found a single study from its launch in 2018 to 2022. A CEMS has universal importance, facilitating the ethical and human development of future physicians, and despite its importance in the training of physicians, there is a lack of published research on the subject in Brazil.

Keywords: Bioethics, Medical Ethics Code, Ethic, motivation, Code of Ethics for Medical Students, Teaching.

Código de ética para estudiantes de medicina brasileños. Una revisión de la literatura

Resumen: En agosto de 2018, el Consejo Federal de Medicina (CFM), órgano responsable de la supervisión y normalización de la práctica profesional médica en Brasil, publicó un código nacional de ética para estudiantes de medicina (CEMS), que normaliza y sugiere conductas, basadas en los mejores valores morales y éticos, para los estudiantes de medicina, apoyando la humanización de la medicina y ayudando indirectamente a los profesores y gestores de los cursos de medicina. El propósito del estudio fue evaluar la difusión y el conocimiento de las publicaciones científicas sobre el código de la CEMS brasileña, y consistió en una revisión bibliográfica integradora de las publicaciones relacionadas con la CEMS brasileña publicadas desde 2005 hasta la actualidad. Encontramos 4 estudios relacionados con códigos de ética regionales y universitarios para estudiantes de medicina publicados desde 2005 hasta 2022, y, respecto de los CEMS elaborados por la FCM, encontramos un único estudio desde su lanzamiento en 2018 hasta 2022. Un CEMS tiene importancia universal, facilitando el desarrollo ético y humano de los futuros médicos, y, a pesar de su importancia en la formación de los médicos, falta investigación publicada sobre el tema en Brasil.

Palabras clave: bioética, código de ética médica, principio moral, motivación, código de ética para estudiantes de medicina, facultad

Código de ética para estudantes de medicina brasileiros. Revisão bibliográfica

Resumo: Em agosto de 2018, o Conselho Federal de Medicina (CFM), órgão responsável pela fiscalização e normatização do exercício profissional médico no Brasil, publicou um código nacional de ética do estudante de medicina (CEMS), que padroniza e sugere condutas, com base nos melhores valores morais e éticos, para os estudantes de medicina, apoiando a humanização da medicina e auxiliando indiretamente os professores e gestores dos cursos de medicina. O objetivo do estudo foi avaliar a disseminação e a conscientização das publicações científicas sobre o código CEMS brasileiro, e consistiu em uma revisão integrativa da literatura de todas as publicações relacionadas ao CEMS brasileiro publicadas de 2005 até o presente. Encontramos 4 estudos relacionados a códigos de ética regionais e universitários para estudantes de medicina publicados de 2005 a 2022 e, com relação ao CEMS elaborado pela FCM, encontramos um único estudo desde seu lançamento em 2018 até 2022. Um CEMS tem importância universal, facilitando o desenvolvimento ético e humano dos futuros médicos, e, apesar de sua importância na formação dos médicos, há uma carência de pesquisas publicadas sobre o assunto no Brasil.

Palavras-chave: bioética, código de ética médica, ética médica, motivação, estudantes de medicina, ensino.

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Introduction

Different authors defend the idea that a medical course integrated with humanities subjects would result in a professional trained based on respect and compassion for others. Andin a similar context, in Brazil, at the end of the 19th century, the teaching of ethics was introduced, associated with the existing discipline of legal medicine and deontology*(1-4)*.

Since the mid-twentieth century, medical treatments have become more effective, and approaches to treatment have become more aggressive, placing the ethical conduct of professionals as a focus of international attention*(5)*. Currently, supported by the biotechnological revolution in recent years, physicians often deal with moral and bioethical dilemmas, situations that require good clinical and ethical judgment. These demands have led many countries to teach bioethics, in addition to medical ethics, in medical courses to provide future physicians with the skills and competencies to manage such situations*(6-8)*.

The medical profession requires a high degree of responsibility in their acts and in the training phase, both practical and theoretical training, are carried out over years of sacrifice, where the medical student, often still a teenager, in search of the ideal of being a doctor, exchanges the leisure time proper to the age for endless hours of studies. This phase often determines physical and psychological suffering, evidenced through depressive and anxious behaviors*(9)*, motivated by concern with the study exclusively of clinics and their updates in digital speed, making the medical course predominantly technical, distancing the academic from human values and critical thinking.

It is recognized by researchers in the field of teaching, the importance and the need for the participation of ethical and bioethical reflections in all years of medical training, for a development within the limits of legality and more humanized of the future physician*(10)*, however the approach of these themes still finds many obstacles to integrate into the curriculum of medical education and in the motivation of students' studies. The teaching of bioethics as a regular subject in its curriculum is not yet found in all countries*(11)*. The introduction of bioethics in the curriculum is a measure that minimizes even the existing conflicts in the doctor-patient relationship, also based on the knowledge of the need for clear and eficient communication and*(12-14)*. Among other facts, critics of the Flexnian teaching model consider it far from the concern of introducing transformative measures in the medical course, which come to contemplate, themes that lead to reflection on humanities*(15,16)*. And from the "Edinburgh Declaration", developed at the World Conference on Medical Education (Scotland, 1988), among other attributions, it brought recommendations regarding the need for integration of medical education with Primary Health Care and thus train a technically competent professional, taking with him, from within the community, the perception and acquisition of social values, resulting from this interaction*(17)*. In accordance with this vision, the Brazilian Curriculum Guidelines for undergraduate medical courses, approved in 200118, also follow the Program for Improvement and Expansion of teaching- educates Brazil (PROMED), created in 1997 where the competence associated with ethical posture with humanistic vision, sense of social responsibility, commitment and citizenship with health protection and prevention of diseases is postulated*(18,19)*.

In Brazil, the organizational structure of the medical profession is determined by the Regional Councils of Medicine (RCMs) that represent and serve the different states of the federation, following a hierarchy, where the Federal Council of Medicine (FCM), with functions governed by the Federal Constitution, is the highest body of oversight and standardizes good professional practice, using a Code of Medical Ethics (CME) for this purpose3. As a rule, it is part of the curriculum of medical courses, the teaching of the Code of Medical Ethics/CME, and its importance is recognized, since they contribute to the ethical training of the doctor but usually the topics addressed, are chosen by the teachers, without the participation of the students, which it has been a reason for criticism because this practice does not motivate students to study and to reflect on moral values and the biopsychosocial dimension of the person and their social networking, in the strict sense*(15)*.

The influences of technological and pharmaceutical progression in modern medicine has generated ethical dilemmas for health professionals and in academics, resulting in the need for a code of ethics for medical students (CEMS)*(20,21)*. In the national scenario, the first versions of CEMS were published at the regional level by the RCM of the State of São Paulo (RCM/SP) and the Federal District (RCM/FD)*(22,23)* among others.

Pragmatically, medical ethics guides practices within the profession, and similarly, the CEM developed by the Federal Council of Medicine (FCM) and published in 2018 establishes behaviors, based on the best moral and ethical values, for medical students, also serving to assist teachers and those responsible for managing medical education institutions in Brazil*(20,21)*.

The CEM of the FCM comprises fundamental principles and is based on six axes that guide the technical and human aspects of the training of medical students, namely, (1) the relationship of the student with the cadaver; (2) the interpersonal relationships of the student; (3) the student's relationship with educational and health institutions; (4) the student's relationship with the professional team; (5) the student's responsibility for his or her studies and training; and (6) the student's relationship with society*(21)*.

Considering the primary objectives of physician training, an understanding of professional values and ethical conduct is essential for the complete training of physicians*(22,12-14)*, including the development of integrity and responsibilities in the future researcher*(24-27)*. According to Lima (2018),"The training of future doctors in undergraduate programs should provide students with incentives to improve their ability to deal with problems in the fields of morals and ethics in synergy with activities related to teaching and professional practice"*(20)*.

The 21st century challenges physicians to present ethical answers to current dilemmas and the Code of Ethics of Medical Students is a trigger to bioethical discussions, allowing reflection beyond deontology and professional ethics*(28)*. The subject of this study is the dissemination of and knowledge regarding the Medical Student Code of Ethics (MSCE) prepared by the RCM, the FCM and some Brazilian universities*(20,22,29)*. This research is justified by the fact that the importance given to physicians maintaining their ethical conduct should also be the same during physician training, familiarizing students with ethical relationships and their obstacles because learning precedes professional behavior. In the context of an accelerated globalization process, social networks on the internet drive the behavior of young people around the world. This approach to medical students, i.e., providing knowledge of the bioethical and ethical principles of the medical profession, is important because it stimulates the development of and reflection on humanized values*(28,29)*, fundamental for empathy, and thus contributes to complete structural training of physicians, familiarizing them with professional dilemmas for which clinical decisions can be based on a moral, ethical and human basis*(5)*.

In recent years, in addition to the known adversities that involve the formation of a physician, the absenteeism of students has occupied a place in the discussions between teachers and researchers*(30)* because it is a deviation from the behavior that has potentiated the entire problem that already exists and this will reflect on the relationship of the doctor with the patient. And the teaching and/or practice of bioethics in medical education has been proposed as a tool for coping with situations involving conflicting moral aspects such as the one mentioned*(22)*. The objective of this study is to evaluate the dissemination of CEMSs in scientific media, such as newspapers and magazines, accessible to medical students, their professors and course directors through an integrative literature review.

Methods

This was a descriptive study, from a literature review, characterizing an integrative review, with a qualitative approach in which the selected studies were analyzed based on the authors' interpretation.

An integrative literature review of CEMSs of different regional institutions and Brazilian universities and the CEMS of the FCM (2018)*(21)* was conducted in two simultaneous stages. The decision to conduct an integrative literature review was based on the fact that it enabled the combination of data from the theoretical and empirical literature and allowed the incorporation of a wide repertoire of topics: definitions of concepts; review of theories and evidence; and analyses of methodological problems of a particular topic. It was thus possible to generate a consistent and understandable overview of the complex concepts, theories and health problems relevant to the present study*(31)*.

Data collection consisted of two searches, mechanical and computerized, of virtual databases, i.e., the BIREME, Latin American Literature in Health Sciences (LILACS) and Scientific Electronic Library Online (SCIELO) databases and scientific articles from CAPES Journals were also reviewed, excluding repeated studies.

The following DeCS descriptors were used in this study as keywords for the searches: bioethics, medical student, code of ethics, medical ethics, motivation and teaching. In searches conducted in the virtual databases, the period from 2005 to 2022 was established for the publication of articles on regional and Brazilian university CEMSs, and the period from 2018 to 2022 was established for the CEMS of the FCM, from the time of its publication.

The inclusion criteria for the selection of articles were as follows: (a) address the CEMS of the FCM or regional and Brazilian university CEMSs; and (b) make reference to students' interest in studying CEMS. The exclusion criteria were as follows: publications that addressed only CME at the professional level. We also excluded articles that did not provide the research setting, those pertaining to a field other than medicine, and those that were graduate theses, letters to the editor, comments, editorial, communications, congresses and symposia.

The results are presented in a descriptive manner, i.e., based on the objectives and results of the selected studies, in chronological order of publication.

Results

The integrative literature review, with the application of the inclusion and exclusion criteria presented in the methodology, included four publications related to regional and university CEMSs.

The oldest publication from this period dated to 2005, and the most recent dated to 2017. Studies on CEMSs were developed in the Federal District (RCM-FD) and in the states of the Brazilian Federation: Bahia, São Paulo (RCM-SP) and Minas Gerais*(21,32)*.

The following provides a description of the studies that investigated regional and Brazilian university CEMSs, identifying the authors, year of publication, location where it was conducted, title, objectives and different methodologies.

Lemos et al. (2005) presented a CEMS proposal for students in the Brazilian state of Bahia titled "Proposed code of ethics for medical students in Bahia," with the objective of developing a code to guide the conduct of medical students in their daily lives. This was a qualitative, cross-sectional, exploratory study. A random sample of 106 undergraduate medical students was studied*(32)*.

Ract and Maia (2012) conducted a study in São Paulo titled "Reflection on four versions of the medical student's code of ethics," with the objective of analyzing 4 versions of CEMSs namely, the CEMS of RCM-SP; the CEMS published by RCM-FD; a proposed code of ethics for medical students from Bahia; and the CEMS of the Academic Center of the State University of Maringá (UEM). This was a comparative document analysis that investigated how ethics are integrated into medical school*(23)*.

Lisboa and Lins (2014) conducted a study in the state of Bahia titled "Code of ethics of medical students: a qualitative analysis," with the objective of comparing the codes of ethics for medical students existing in Brazil at the time of the study33. The codes analyzed were the CEMS of the CRM-FD; the CEMS of the Federal University of Bahia (UFB); the CEMS of the University of the Extreme South of Santa Catarina; and the CEMS of the RCM-SP. This was a qualitative study with an exploratory and descriptive character*(33)*. The analyzed material consisted of all Brazilian CEMSs available in Google Scholar, LILACS, and BIREME.

Menezes et al. (2017) conducted a study in the state of Minas Gerais with the objective of developing a collective code of ethics for medical students. They addressed CEMSs and compared their process of preparing the code with that described in the literature*(29)*.

Digital database searches to identify studies for the integrative literature review resulted in 4 studies that addressed regional and university CEMSs. Regarding the CEMS of the FCM, the results of the literature review, carried out from its publication in 2018, until the occasion of the study, showed that one of the selected authors mentioned the CEEM of the CFM, using it in his research, but there was no reference regarding the knowledge of the students about its content*(34)*.

Discussion

The introduction of a complementary ethical theme, such as the study of CEMS, in medical school programs would allow physicians to better understand the needs of patients and provide a balance in the attention given to academics, which are almost exclusively directed to the study of physical clinical and surgical aspects*(5)*. Even if slow and progressive, the incorporation of an ethical context in the teaching of and learning by medical students encourages ethical discourse in this field(6). Thus, CEMS fill an important gap, not only for students but also for teachers and for the disciplines of ethics and bioethics themselves*(5)*.

Lemos et al. (2005) addressed a CEMS proposal for scholars from the Brazilian state of Bahia, and the authors' argument for developing a CEMS was the need to guide medical students in everyday situations, aiming to prepare these students for the future of medical practice*(32)*.

The aforementioned assertion is implicit in the studies by Lemos et al., (2005) and Menezes et al., (2017) and both highlighted the importance of the contribution of students to the elaboration of CEMSs, as well as that of professors and RCMs.

The selected studies (Lemos et al., 2005; Ract; Maia, 2012; Lisboa; Lins, 2014; Menezes et al., 2017) only analyzed regional CEMSs and did not address students' knowledge about CEMs.

Ract and Maia (2012) and Lisboa and Lins (2014) conducted documentary analyses of four CEMSs from different RCMs and Brazilian universities and warned that the codes mirror codes of professional ethics, inducing to a trend toward the professionalization of medical students*(23,33)*; however, punishments for ethical infractions are not discussed. Therefore, there is a risk of professionalization, which stimulates the concern of exclusively technical training, stifling the existence of ethics in medical practice. The authors highlighted the importance and the need to develop a specific CEMS for the demands of medical students, that is independent of codes of professional ethics. They warned about the difficulty that medical councils have with regard to participating in academia in the context of ethical education as collaborators in sparking interest in the study and application of this human science*(23,33)*.

The study by Freitas et al. published in 2021 analyzed proposals by the Federal Government of Brazil for the inclusion of medical students in the fight against COVID-1934. The study addressed Ordinance 492/2020 enacted by the Ministry of Health as a temporary strategic measure through the program "Brazil Counts with Me" to fight the pandemic, which arrived in Brazil in March 2020; the ordinance allowed medical students to act in the fight against the disease(35).

The aforementioned government program, which allowed the participation of medical students in combating the COVID-19 pandemic(35), was analyzed by the authors from the perspective of the CEMS of the FCM21, the Universal Declaration of Human Rights (UDHR)*(36)* and Universal Declaration on Bioethics and Human Rights (UDBDH)*(37)* and the main regulatory frameworks of research on human beings*(37-39)* the authors concluded that the decision to include medical students in the strategy for coping with COVID-19 was guided by utilitarian ethics aimed at a greater number of collaborators*(34)*. However, this was not a simplistic decision based on a cost–benefit analysis but rather a decision based on ethical principles anchored in risk mitigation measures. Notably, the study by Freitas et al.*(34)*, despite being the only article published to date (2018-2022) on the CEMS of the FCM, did not address students' knowledge of the aforementioned code.

Reiser (1994), as already mentioned, stated that the same attention to physicians' conduct should also be given to guidance in academic training, which precedes professional practice*(15)*. The pedagogical role of the CEMS published by the FCM and its possible greater capillarity is evident because the influence of the responsible body has a national scope*(3)*.

Conclusion

Despite the importance of CEMSs in the training of physicians, the search in digital databases to identify studies for the integrative literature review yielded only 4 publications that addressed the CEMSs of RCMs and Brazilian universities and only 1 study that addressed with the CEM of the FCM*(35)*. However, none of the studies addressed students' knowledge about CEMSs, and despite leading to important ethical reflection*(34)*, there is a dearth of national publications about CEMSs.

The absence of the literature on the CEMS of the FCM is probably partly because the code was recently published*(21)* in August 2018, just prior to the COVID-19 pandemic; the disease led to high morbidity and mortality, and there was very little knowledge regarding its natural history. For these reasons, with the purpose of reducing the impacts of the pandemic on humanity, studies and research involving COVID-19 were prioritized, to the detriment of other topics*(40)*, so that, according to Esquivel-Guadarrama, ideas could be transformed into concrete actions and alleviate damage*(41)*.

We emphasize the didactic importance of the CEMS theme, which strengthens the use of new concepts for the teaching of ethics and bioethics associated with the life of medical students. The CEMS of the FCM fills a gap in the training of Brazilian physicians; that is, it provides medical students with a code of ethics that focuses on their specific demands. It is not a code of professional ethics but a code of ethical conduct for medical students, with a pedagogical role, providing a stimulus for the humanization of medicine through a document of national scope, with broad involvement, encompassing relationships with life and death*(21)*.

Some of the current ethical problems are universal, with common characteristics on all continents*(42-44)*, and cause, as the case may be, the need to develop or improve CEMSs because of their transformative potential nationally, not just in Brazil. This study contributes to stimulating researchers to reflect on the subject of CEMSs, for which wide dissemination will enable medical students to engage in more flexible thinking, focusing on the meaning of moral and ethical values, favoring the formation of ethical behavior in students and facilitating awareness in their current and future roles in society through the doctor−patient relationship and with the other members of the team, contributing to personal maturation in addition to supporting, as we mentioned, more humanized training for new physicians.

The results from this study also contribute to broadening the framework of publications on the CEMS of the FCM and on the CEMSs of RMCs and universities. In addition, it can serve as a source of reference for future studies and as a source of reading for people who are interested in the topic. In future studies, qualitative studies should include interviews with medical students about the importance that they attribute to CEMSs, the results of which would open a channel for the study of human relationships and their consequent interferences in the doctor−patient relationship, supporting the centralization of the human being in the care consequently the humanization of medical care.

Declarations

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ANALYSIS OF ACADEMIC KNOWLEDGE ABOUT THE CODE OF ETHICS FOR MEDICINE STUDENTS DEVELOPED BY THE FEDERAL MEDICINE COUNCIL OF BRAZIL

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Abstract: Introduction: In 2018, the Federal Council of Medicine (FCM), the regulatory body of the medical profession in Brazil, developed the Medical Student Code of Ethics (CEME), with the aim of positively influencing the conduct of future doctors through ethical and humanitarian training. Objective: The objective of this study was to identify whether medical students are aware and knowledgeable of the CEME. Materials and Methods: A field study was carried out with quantitative and cross-sectional approaches. Subjects were medical students in the 1st to the 12th semesters at a Brazilian university. Results: The survey results showed that most medical students (56%) did not know the CEME. Further, when examining individual classes, grouped as first years (M1 to M8) and last years (M9 to M12), only 30% of the students in the first group and 27% of the students in the last group were aware of the CEME. Conclusion: Most medical students, regardless of time in school, are unaware of the CEME.

Keywords: Code of ethics; Medical education; Medicine student; Bioethics; Medical ethics.

Análisis del conocimiento académico sobre el código de ética para estudiantes de medicina desarrollado por el Consejo Federal de Medicina de Brasil

Resumen: Introducción: En 2018, el Consejo Federal de Medicina (FCM), el organismo regulador de la profesión médica en Brasil, desarrolló el Código de Ética del Estudiante de Medicina (CEME), con el objetivo de influir positivamente en la conducta de los futuros médicos a través de la formación ética y humanitaria. Objetivo: El objetivo de este estudio fue identificar si los estudiantes de medicina son conscientes y conocedores del CEME. Materiales y métodos: Se realizó un estudio de campo con enfoques cuantitativos y transversales. Los sujetos fueron estudiantes de medicina en los semestres 1 ° a 12 en una universidad brasileña. Resultados: Los resultados de la encuesta mostraron que la mayoría de los estudiantes de medicina (56%) no conocían el CEME. Además, al examinar las clases individuales, agrupadas como primeros años (M1 a M8) y últimos años (M9 a M12), solo el 30% de los estudiantes del primer grupo y el 27% de los estudiantes del último grupo conocían el CEME. Conclusión: La mayoría de los estudiantes de medicina, independientemente del tiempo en la escuela, desconocen el CEME.

Palabras clave: Código de ética; Educación médica; Estudiante de medicina; Bioética; Ética médica.

Análise do conhecimento acadêmico sobre o código de ética do estudante de medicina elaborado pelo Conselho Federal de Medicina do Brasil

Resumo: Introdução: Em 2018, o Conselho Federal de Medicina (FCM), órgão regulador da profissão médica no Brasil, desenvolveu o Código de Ética do Estudante de Medicina (CEME), com o objetivo de influenciar positivamente a conduta dos futuros médicos por meio de treinamento ético e humanitário. Objetivo: O objetivo deste estudo foi identificar se os estudantes de medicina estão cientes e conhecedores do CEME. Materiais e Métodos: Foi realizado um estudo de campo com abordagens quantitativas e transversais. Os sujeitos foram estudantes de medicina do 1º ao 12º semestre de uma universidade brasileira. Resultados: Os resultados da pesquisa mostraram que a maioria dos estudantes de medicina (56%) não conheciam o CEME. Além disso, ao examinar as turmas individuais, agrupadas em primeiros anos (M1 a M8) e últimos anos (M9 a M12), apenas 30% dos alunos do primeiro grupo e 27% dos alunos do último grupo tinham conhecimento do CEME. Conclusão: A maioria dos estudantes de medicina, independentemente do tempo na escola, desconhece o CEME.

Palavras-chave: Código de ética; Educação médica; Estudante de Medicina; Bioética; Ética médica.

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Introduction

Currently, medical training is dominated by the biomedical model*(1)*, which is defined by rational, objective and scientific evidence. Medicine, which is intrinsically related to technological development, has reached the highest degree of scientific evidence. Medical education, which teaches these traditional aspects of medical practice, has an imperative need to keep up to date regardless of the high speed with which information presents itself in the digital world. Thus, medical students are exposed to a high level of demand on their cognitive*(2)* abilities as they manage and integrate the acquisition of knowledge in the time allotted for medical training.

Faced with this complex integration of skills and competencies, students and professors, as a rule, overvalue studies of clinical and surgical sciences, asymmetrically and disproportionately, limiting and minimizing the period for discussion and study of the ethical and humanitarian aspects of medical practice relationship—activities relevant to the development of reflective and critical thinking of the future physician*(3)*.

In Brazil, the Federal Council of Medicine (Conselho Federal de Medicina - CFM), making use of its regulatory powers conferred by the federal constitution, oversees and regulates professional practice, and this body drafted and disseminated the current Code of Medical Ethics*(4)*, which, in turn, guides the "medical act". In practice, the medical act is the decision-making of the professional, one of the most important moments in the doctor−patient relationship. According to this code, this process should be performed based on respect for the fundamental rights and needs of patients*(3-5)*. Ethical process protects the patient and maintains the integrity of the profession, in addition to acting without deviating from the moral precepts of the community, thus contributing to the development and strengthening of the credibility of the relationship and minimizing human suffering.

The study of the code of professional medical ethics is part of the curriculum of most medical schools, and*(6)* by definition are rules of conduct, with a vision based on mission, principles and moral values, interposed to the legislation in force in the country. Therefore, it is a set of inflexible "right" and "wrong", who thus participate in the process of the best decision during the "medical act" and will be subject to punishments for infractions*(7)*. There is support in the literature and consensus among researchers in the teaching area, regarding the need to go beyond the study of the code of professional ethics and in this context, several authors defend the thesis that the medical student needs to develop a critical and reflective thinking that enables the development of future doctors with capacity for ethical judgment in the face of the current obstacles in the day to day of the professional, Therefore, the involvement of academics and medicine with humanities themes is necessary*(8-12)*. The National Curricular Guidelines/DCN for undergraduate medical courses (BRASIL, 2001)*(13)* are in agreement with the national and international literature, when they stimulate the awakening of responsibilities in academics, with the introduction of social and humanistic values. And this agreement of the DCN continues with a commitment to ethics, culture, and the exercise of citizenship through the promotion of interaction between teaching and the community*(14)*.

Every initiative to make the doctor-patient relationship more humanized contributes to the reduction of frequent conflicts in the health sectors and consequently of men's suffering*(15,16)*. And with this aspect, teaching also favors the development of eticity in research, with the view of new researchers from these courses where there was space for discussion about integrity and responsibility in the execution of scientific projects, from the initial questioning to publication*(17-20)*.

The socioeconomic and cultural transformations caused by globalization have stimulated in the timeline, many controversial debates and currently reached consensus among the authors as to the need to introduce humanities themes in the medical course*(21)*, including in a transversal way*(22)*, involving academics from the first years of the course, thus contemplating all grades, as transformative measures, bringing the medical future closer to these social, cultural and ethical values. And this was the gap to introduce and practice the bioethical precepts that meet these needs to arouse greater interest in human relations and their care. Thus, bioethics emerges as an instrument that goes beyond the limits of deontology and current laws because it relies on moralities and transposes the plural needs of individuals and society*(23,24)* qualifying the physician for ethical responses to emerging dilemmas.

In response to the needs evidenced in the last years of medical training, the CFM, in 2018, implemented a specific Code of Ethics for the Medical Student (CEEM)*(25,26)* to guide the conduct and training of medical students*(3,25,27)*. Due to the scope of the CFM in the entire Brazilian territory, it is assumed that CEEM would be widely known and dispersed in the academic environment. CEEM covers the entire universe of medical students' experiences, such as their relationship with the educational institution, the handling of cadavers, the care of patients, and their relationships with society and their teams, in addition to interpersonal relationship skills and responsibility for their own medical training*(3,25,27,28)*. Therefore, CEEM has a national reach and is organized into six axes that guide the study of medicine, with fundamental principles that regulate the role of medical students, aiming to improve their behavior*(3,25,28)*. The aforementioned guiding structure in the ethical molds of CEEM provides students with a compilation of principles and norms, guided by broad respect for individuals and their rights.

A search in the Virtual Health Library (BVS) showed that beginning in 2018, when the CEEM was published, only one study addressed this code of ethics; however, it does not reference students' knowledge about CEEM and its content. In previous years, before this CFM initiative, some authors*(3,29)* discussed the need for and importance of producing a code of ethics for medical students. In the national literature, we observed that in addition to a lack of information on the existence of the CEEM, there are no studies about the knowledge of medical students regarding this code.

Motivated by this lack of knowledge observed in the literature, we developed this study to identify, quantify and analyze the knowledge of medical students attending a Brazilian university about the CEEM*(25)*. We conducted a field study involving the medical students.

Despite the importance of the subject, there is no requirement for the study of CEEM in the medical curriculum in Brazil, which in part probably justifies the lack of CEEM knowledge among the students. However, the teachings on ethics and bioethics contained in the CEEM apply to the practice of medical students, as already described, can also contribute to the more humanized development of the future physician, as they emphasize respect for the dignity of those around him or her. While the code is designated for students, its principles also have application for professors and managers of medical courses, who teach about the confrontation of contemporary ethical dilemmas.

Undeniably, there is a universal need to modernize the teaching tools of ethics and bioethics in the modern classroom*(12,30)* for a generation that has grown up with digital immediacy and progressive globalization through use of the internet and other technological tools*(31)*.

Thus, this study aims to contribute to the development or improvement of the Code of Ethics for Medical Students and to provide a reference for countries other than Brazil that may be interested in adapting such a code according to their cultures and senses of morality.

Methods

Regarding the methodology, They were carried outin two stages: a bibliographic review, researching the existence and number of publications on the Code of Ethics of the Medical Student of the CFM (2018) and a characterized research as a field study conducted in the medical school of a Brazilian university. It was based, as a research question and in the verified reality, whether the students of this course knew the Code of Ethics of the Medical Student of the Federal Council of Medicine / CEEM-CFM. all those involved in the research were questioned at the same time.

The subjects are students in 12 classes, divided by semesters, ranging from the 1st to the 12th and last period of the course. Each class contained approximately 30 students, and after dropouts, failures and transfers, there were 300 regularly enrolled students in February 2020 at the time of data collection. Invitations to participate in the study were issued to the students. Of these, 203 students met the exclusion and inclusion criteria and signed the informed consent forms. Therefore, the sample of this study comprised a total of 203 participants, whose ages ranged from 17 to 36 (mean 25 years).

In the quantitative approach, the inclusion criteria were (a) being duly enrolled in the medical program; (b) being in the classroom at the time the questionnaire would be administered and agreeing to participate; and (c) not knowing the project in question. The exclusion criteria were as follows: (a) members of the Academic League of Bioethics and (b) students who did not agree to participate or who declined to participate after the clarifications, which included guarantees of privacy and confidentiality. All participants were guaranteed the right to withdraw from participating in the study at any time of its development, without any kind of prejudice.

The study was cross-sectional, with a single data collection, concomitant for all classes, through a structured, closed questionnaire, with the following and only predefined question: “There is a code of ethics for medical students of the CFM? ( ) Yes ( ) No”.

The questionnaires were administered by a team of 12 students from the Academic League of Bioethics, with the permission of the professors responsible for the classes and coordinated by the authors. The team was previously instructed about how to administer the questionnaire in the 12 classes. They did so on the same day, determined in advance by the authors, when the study participants were together and available for questioning.

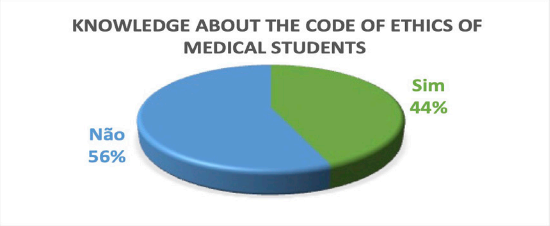
Team members went to the classrooms and explained the research to the medical students, the guiding question, its objectives and the guarantees of research ethics (Resolution no. 446 of December 2012 of the CNS of the Ministry of Health*(32)* that governs research on human beings in Brazil) and subsequently obtained agreements to participate and collected signatures of participants on the Free and Informed Consent Form (ICF).

For the presentation of the results, the classes were assigned according to semesters, ranging from M1 to M8 for the first four years of medical school and from M9 to M12 for the last years of medical.

Results

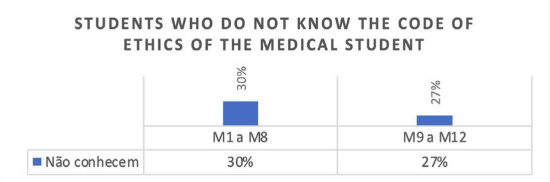
Of the three hundred (300) students enrolled regularly in the medical program, from the 1st to the 12th semester, 68% (n = 203) met the inclusion and exclusion methodological criteria necessary to participate in the study. The results obtained with the responses of the applied questionnaire are presented below by means of graphs.

The results of the questionnaires showed that of the 203 (100%) students who participated in the study, 44% (n = 89) confirmed knowledge of the existence of the CEEM, and 56% (n = 114) reported no knowledge of the code (Graph 1).



Graph 1: Students who know CEEM (Yes); They do not know the CEEM (No).

Considering the results by class, dividing them between students in the first four years of medical school (M1, M2, M3, M4, M5, M6, M7 and M8) and the last years of medical school (M9, M10, M11 and M12), it was observed that 30% (n = 60) of students enrolled in the first years (M1 to M8) and 27% (n = 54) of students in the last years (M9 to M12) were unaware of the CEEM (Graph 2).



Graph 2: Students unaware of the CEEM

When comparing students in the first four years (M1 to M8) with students in the last years (M9 to M12), there was no significant difference in knowledge of the CEEM.

Therefore, the lack of knowledge of the code does not predominate in the first four years of medical school.

Discussion

The results of the study showed that more than half of the medical students studied (56%) were unaware of the CEEM. Further, when classified by time in school, as first years (M1 to M8) and last years (M9 to M12), only 30% of the students in the early years of medical school and 27% of the students in their last years of medical school were familiar with the CEEM.

These findings demonstrate ignorance about the CEEM, unlike the Code of Medical Ethics for professionals, whose teaching is part of the curriculum throughout the Brazilian territory

It is important to note that the lack of scientific publications on the medical students; code of ethics does not occur only at the national level, where only four studies*(3,28,32)* addressed the topic in the past 10 years but also at the international level where studies*(4,27)* involve only the importance of medical students learning about ethics, bioethics and the Code of Medical Ethics, meanwhile without addressing a specific code of ethics for students.

The study by Liu et al.*(5)*. showed that medical students, when participating in a program on bioethics, perceived positive learning experiences that allowed them to appreciate the relevance of bioethics, ethics and humanities in clinical practice. Although this study did not reference a specific code of ethics for academics, the conclusions by Liu et al. highlighted the importance of a reference to present ethical standards for the daily clinical practice of medical students*(5,27)*. Other studies*(3,33,34,28)* also highlighted the importance of teaching ethics and bioethics*(5,35)* in medical programs, as well as the importance of a code of ethics for medical students*(3,28,34)*.

National authors evaluated in a question similar to our study, about the knowledge of medical students about the moral and mandatory importance of medical secrecy in the doctor-patient relationship and also verified the lack of knowledge of most medical students on the subject in question(28). And in another group of studies, in another Brazilian university, the same result was obtained when they evaluated the knowledge of 263 medical and dental students regarding the patient's image rights, where the authors observed that 44% of the students at some point recorded photos, videos or medical records of patients without informed consent and 77% of the students were unaware of the existence of the ethical-legal aspects that involve the patient's right to image*(36)*.

Conclusion

The Medical Professional's Code of Medical Ethics is integrating with other topics involving bioethics taught during medical school, so the student is given the theoretical foundations necessary for professional life, but these lessons lack practical application 27 that could be introduced, in part, through CEEM.

This study showed that the majority (56%) of our subjects did not know the Code of Ethics for the Medical Student. When comparing students in the initial years (30%) of medical school and students in the final years (27%), no significant difference in knowledge of the code was observed. In response to the question presented in the introduction, it is concluded that most medical students do not know about the CEEM, regardless of where they were in their course of study.

Thus, the present study contributes to broadening the bibliographic framework on the subject, highlighting the need to broaden the debate on the code of ethics of medical students and its dissemination among students and professors. For this purpose, it is suggested that the CEEM be presented to students beginning in the first year of medical school and addressed and discussed for the duration of their training to fill this gap in the curricula about CEEM and its importance as an tool for teaching bioethics.

In conclusion, this study, in addition to collaborating with the dissemination of CEEM among academics and professors, also contributed to demonstrate the importance of the need for an interdisciplinary and transversal approach to CEEM so that all students, from the first to the last semester, adopt an ethical stance in clinical practice. Through the discussion of the contents of the EMSF, its application in daily practice and acting as a trigger for the study of bioethical themes and dilemmas, we will observe the ethical growth, simultaneous to the technical, thus valuing the human aspect of medical education. The CEEM study is of fundamental importance as a reference for an ethical stance from the beginning of clinical practice from the university, taking this behavior to their professional life, resulting in the well-being of patients.

Regarding the limitations of the present study, it was conducted in only one university. Thus, for future studies, it is suggested to increase the number of universities and the number of study participants.

Future prospects

The introduction of the regular study of the Code of Ethics of Medical Students /CEME should be encouraged in medical courses from the earliest years, so that it acts as a facilitator in the approach and practical implementation of topics such as bioethical principles, as well as those of medical ethics such as privacy and medical confidentiality, creating a connection of knowledge with the thought and ethical attitudes of the future conducting it beyond diagnostic and therapeutic purposes in addition to familiarizing it with coping with ethical obstacles arising from development, including technologies. The academic training will be reflected in the ethical attitudes of the physician, that is, graduates capable of defending, practicing and respecting the pillar principles of the doctor-patient relationship and in parallel, medical scientists, coming from these schools with more humanized training, will develop integrated and responsible conduct in research, from its genesis and development to publication. This whole context will result in the well-being of the patient, the family and society.

And these recommendations extend to other courses in the area of health that deal closely with man in his moment of greatest fragility, human suffering.

Declarations

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MUERTE DIGNA EN LA UNIDAD DE CUIDADOS INTENSIVOS: ¿CÓMO SE HA LLEVADO A CABO?

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Resumen: El concepto de "muerte digna" o "buena muerte" ha sido muy difundido entre los profesionales de la salud, que lo manejan de manera rutinaria y experimentan el dilema ético sobre lo que realmente se debe hacer ante un enfermo terminal. Ante esto, el presente estudio tiene como objetivo mostrar los conceptos y cómo los casos de pacientes terminales han sido tratados dentro de las Unidad de Cuidados Intensivos (UCI). Para argumentar respecto de la aplicación y funcionalidad de la eutanasia, la ortotanasia y la distanasia en las UCI, se realizó una revisión bibliográfica de 14 artículos. Se concluyó que se debe considerar el conocimiento del profesional con relación a estos temas y distinguir el tema específico que se aborda, sin olvidar enfatizar los derechos previstos en la Constitución y el bienestar del paciente y su familia.

Palabras clave: ortotanasia, distanasia, eutanasia, Unidad de Cuidados Intensivos, cuidados paliativos

Dignified death in the Intensive Care Unit: How has it been conducted?

Abstract: The concept of dignified death or a good death has been widespread among health professionals, who routinely deal with it and experience the ethical dilemma about what should really be done in the face of a terminally ill patient. Given this, the present study aims to show the concepts and how cases of terminally ill patients have been conducted within the Intensive Care Units (ICU). To argue about the application and functionality of euthanasia, orthothanasia and dysthanasia in ICUs, a literature review of 14 articles was carried out. It was concluded that the knowledge that the professional has in relation to these themes needs to be taken into account and to distinguish the specific theme that is addressed, not forgetting to emphasize the rights provided for in the constitution and the well-being of the paciente and his family.

Keywords: orthothanasia, dysthanasia, euthanasia, Intensive Care Unit, palliative care

Morte digna na Unidade de Terapia Intensiva: como ela tem sido conduzida?

Resumo: O conceito de morte digna ou boa morte tem sido difundido entre os profissionais de saúde, os quais lidam com isso rotineiramente e vivem o dilema ético sobre o que realmente deve ser feito diante de um paciente terminal. Visto isso, o presente estudo visa mostrar os conceito e como tem sido conduzido os casos de pacientes em fase terminal dentro das Unidades de Terapia Intensiva (UTI). Para argumentar sobre a aplicação e a funcionalidade da eutanasia, ortotanásia e distanásia nas UTIs foi realizada uma revisão bibliográfica de 14 artigos. Concluiu-se que precisa ser levado em consideração o conhecimento que o profissional tem em relação a esses temas e distinguir a temática específica que é tratado, não esquecendo de salientar os direitos previstos na constituição e o bem-estar do paciente e de sua família.

Palavras-chave: ortotanásia, distanásia, eutanásia, Unidade de Terapia Intensiva, cuidados paliativos

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Introducción

En los inicios de la medicina, 460 a.C. hasta 377 a.C., Hipócrates, considerado el padre de la medicina, escribe en su juramento: "A nadie le daré con gusto un remedio mortal ni un consejo que induzca a la pérdida", para orientar éticamente a los profesionales médicos de la época a no corroborar con medidas que ayuden en la muerte de los pacientes. Este fragmento está presente en la actualidad, en el que se presenta un tema muy debatido y nada concreto, la eutanasia, la ortotanasia, la distanasia y la mistanasia*(1)*.

Los avances de la medicina han proporcionado un marcado aumento en la calidad de vida de las personas, especialmente en áreas desarrolladas, donde la supervivencia es alta y el proceso desde enfermar hasta morir puede prolongarse mediante tratamientos que traen curación o alivio a los enfermos*(2)*. Este aumento de la esperanza de vida trae consigo un problema, el transcurso de la edad avanzada supone un mayor número de individuos con enfermedades crónicas, que muchas veces no disponen de los medios para ser tratados, que inevitablemente llegarán al final de la vida*(3)*.

Evidenciado este proceso, el concepto de muerte digna o buena muerte se ha difundido entre los profesionales de la salud, que lo afrontan de forma rutinaria y experimentan el dilema ético sobre lo que realmente se debe hacer ante un paciente terminal*(4)*. El pensamiento común suele pensar en prolongar siempre, tanto como sea posible, y con todos los esfuerzos para que la persona viva un minuto más. Sin embargo, el proceso de esta puede ser bastante penoso y doloroso para algunos pacientes, con medidas invasivas que hacen de este pasaje entre la vida y la muerte un trauma*(5)*.

Así, en lo que respecta a la eutanasia, hoy es entendida como acortar la vida, para evitar el sufrimiento del enfermo terminal, práctica ilegal en Brasil, según el Código de Ética Médica de 1988, pero aceptada en países como Holanda y Bélgica. Es decir, sería el profesional de la salud, a pedido del paciente en sufrimiento, adelantar el período de enfermedad hasta la muerte, y privarlo de pasar por períodos de sufrimiento*(6)*.

La distanasia, que no es conocida por todos, es algo que se practica en el área de la salud, donde en una muerte dolorosa, se prolonga la vida biológica de los pacientes por medios terapéuticos y farmacológicos, pero sin calidad de vida. Este esfuerzo puede ser a petición de los familiares o del propio personal médico, que trata por todos los medios de mantener con vida a su paciente. A diferencia de la ortotanasia, que descarta medidas para prolongar la vida, y se enfoca en el alivio del dolor, para que la muerte suceda con dignidad*(4)*.

Además de la distanasia, la ortotanasia es la suspensión de actos o métodos artificiales que tienen por objeto prolongar la vida de pacientes sin perspectivas de curación, con el fin de evitar sufrimientos innecesarios y ofrecer una muerte digna. Actualmente, la ortotanasia es el único método avalado por la legislación brasileña, está íntimamente relacionado con los cuidados paliativos, en los cuales el paciente es abordado respetando su demanda espiritual, física, psicológica, social, hasta que la muerte ocurra con dignidad*(7)*.

La Unidad de Cuidados Intensivos (UCI), donde acuden los pacientes graves o potencialmente graves, es donde se vive a diario este dilema. Hay pacientes en extrema agonía, y pacientes sin ningún pronóstico de curación, por lo tanto, todos los días se cuestiona cuál de las medidas anteriores se está llevando a cabo, y cuál sería la mejor para que el enfermo terminal tuviera la mínima calidad de vida. la vida en este proceso*(8)*.

Metodología

El estudio se produjo a partir de una revisión bibliográfica en las bases de datos PubMED, LILACS, UpToDate, Scientific Electronic Library Online (Scielo) y ScienceDirect. Para desarrollar el trabajo se siguieron algunos pasos, a saber: definición del tema, criterios de inclusión y exclusión, posterior a ello, se realizó una búsqueda en las bases de datos con los criterios específicos, para finalizar, análisis e interpretación de los resultados para elaborar la revisión. Cabe mencionar que la temática se limitó a la distanasia, eutanasia, ortotanasia y los aspectos bioéticos dentro de las Unidades de Cuidados Intensivos, para lo cual se utilizaron los descriptores a partir de la combinación de las palabras-clave "eutanasia", "distanasia", "ortotanasia", " Unidad de Cuidados Intensivos" y "cuidados paliativos" asociados a través de los operadores booleanos AND y OR. De esta forma, buscamos artículos que estuvieran escritos en portugués, español e inglés. Tuvo como criterio de inclusión, artículos publicados a partir de 2018 y relacionados con el tema del estudio y como criterio de exclusión, artículos que fueron publicados en períodos inferiores a 2018 y no tenían relación con el tema. Al final del proceso se analizaron 14 artículos, todos publicados entre 2018 y 2022.

Discusión

Profesionales de la salud y conocimientos sobre los conceptos de eutanasia, distanasia y ortotanasia

Con el desarrollo de las tecnologías, se han ampliado las posibilidades de intervenciones que posponen la muerte, lo que plantea interrogantes sobre la ética de los procedimientos si fueran innecesarios o insuficientes, especialmente en las UCI, donde la terminalidad puede tener tres aspectos principales: eutanasia, ortotanasia y distanasia*(4)*. Por eso, es importante saber diferenciar entre lo lícito y lo ilegal, esencialmente, a la hora de tomar la decisión de realizar o suspender la terapia de un paciente con una enfermedad terminal*(6)*.

Actualmente, un número considerable de profesionales médicos no saben diferenciar los tipos de terminales en la vida. En una pesquisa realizada con médicos de las UTI de la ciudad de Campo Grande, Mato Grosso do Sul, Brasil, se preguntó el concepto de eutanasia, ortotanasia y distanasia, el 32% de los entrevistados no sabía diferenciar los conceptos y solo el 46,2% eran conscientes de los tres términos4. Así, se sabe que para abordar a un paciente y tomar decisiones que involucren conflictos de valores, es necesario conocer claramente los conceptos y también diferenciarlos*(6)*.

En la investigación citada anteriormente, algunos médicos respondieron que los procedimientos deberían analizarse críticamente, ya que un número significativo de médicos malinterpretó los conceptos. En consecuencia, es probable que muchos profesionales adopten conductas erróneamente por falta de explicación y conocimiento*(4)*.

Eutanasia y sus conceptos

La eutanasia puede darse de forma activa, en la que el enfermo terminal solicita a un médico que le administre deliberadamente una sustancia o procedimiento para acabar con la vida, o de forma pasiva, en la que el final de la vida es provocado por otra persona que sólo tiene el interés de evitarla prolongando el sufrimiento del paciente al final de la vida, en este tipo de eutanasia el paciente no la desea y la forma de realizar la eutanasia pasiva es la supresión o omisión de la medida que en ese caso sería necesaria*(9)*. Además de esta división, la eutanasia puede subdividirse en tres categorías: muerte intencional, suicidio asistido profesionalmente y homicidio doloso de recién nacidos con anomalías congénitas*(6,10)*. La muerte intencional es la eutanasia activa, mientras que el suicidio asistido profesionalmente es similar al pasivo, pero es activo, es una práctica en la que el médico, a petición del enfermo terminal, prescribe un medicamento letal y el paciente lo toma solo*(11)*.

Es de destacar, que la eutanasia pasiva y la ortotanasia tienen una línea muy fina entre ellas, lo que las diferencia es solo el hecho de que en la eutanasia pasiva la terapia se retira incluso ante la indicación del caso, en cambio, en la ortotanasia la terapia se retira cuando no hay no hay más indicación para el caso. Es importante señalar que en la eutanasia pasiva la muerte es causada por la omisión de la conducta de los profesionales de la salud, sin embargo, en la ortotanasia no hay intención de anticipar la muerte, sino que sucede de forma natural*(12)*.

Practica de la distanasia

Para hablar de distanasia, es importante recordar el concepto: la distanasia es el uso de procedimientos terapéuticos en pacientes que ya no tienen los medios para salvar sus vidas. Estos procedimientos pueden seguir un protocolo, pero si se utilizan sin analizar la situación del paciente, son capaces de tener efectos mucho más perjudiciales que beneficiosos para el paciente*(12)*.

En la mayoría de los casos de distanasia existe un problema de comunicación entre médico, paciente y familia, ya que la falta de información sobre el pronóstico del paciente puede generar una expectativa de mejoría. Esa esperanza hace que los familiares del paciente influyen en las decisiones médicas y tengan el uso de métodos terapéuticos innecesarios, causando más dolor y sufrimiento al paciente*(4)*. Se destaca que el profesional de salud tiene el poder sobre la capacidad de influir en las elecciones del paciente y de la familia, por lo tanto, debe servir de guía para ellos y mostrar cuáles son las mejores decisiones para el moribundo*(5)*.

Otro problema importante en la práctica de la distanasia es la falta de conocimiento que se brinda durante la graduación. En una encuesta con profesionales de la salud, los encuestados afirmaron que durante la graduación no tuvieron formación práctica sobre cómo enfrentar el final de la vida, y la mayoría desconocía la Resolución del Consejo Federal de Medicina (CFM) 1.805/06 que permite el ejercicio de la ortotanasia, por lo que optan por practicar la distanasia y así evitar la muerte*(13)*.

De esta forma, se puede evitar la distanasia si los profesionales tienen formación práctica, dialogan sobre el caso de cada paciente y son francos con los familiares, suspendiendo así el uso de protocolos terapéuticos innecesarios y limitando la propuesta terapéutica sólo para cuando sea necesario. preservar la dignidad del paciente*(5)*.

Cuidados paliativos para asegurar la ortotanasia

Con el objetivo de garantizar un final de vida digno a las personas con enfermedades terminales, el CFM creó la Resolución 1.805/06, que garantiza la dignidad del paciente terminal, y permite la suspensión de tratamientos inútiles siempre que exista garantía de atención para aliviar el dolor. Para el cumplimiento de esta resolución, el CFM creó la Resolución 1931/09, que garantiza la prestación de cuidados paliativos*(4)*.

Sin embargo, surgen cuestiones éticas en los cuidados paliativos como resultado de las preocupaciones sobre cuándo y qué tipo de atención se debe ofrecer al paciente. Para ello, se basa en los cuatro principios de la ética médica: la autonomía, que garantiza el derecho del paciente a tomar una decisión; la beneficencia, que exige que el médico se comporte de la mejor manera con el paciente; la no maleficencia, principio rector, nunca debe causar daño al paciente; justicia, requiere que todos sean tratados bien y con equidad, y que los recursos de salud se distribuyan para un uso equitativo*(14)*.

El proceso de preparación del paciente para la muerte es un tema muy delicado e importante, pues es en este momento que se realizan las reconciliaciones y despedidas, por lo que es fundamental el ejercicio de la autonomía del paciente, cuando tiene capacidad de decisión. En situaciones como la UCI, donde el paciente pierde su autonomía, los familiares o el propio equipo médico tienen que tomar la decisión por el paciente, esta decisión se basa en lo que el paciente deseaba antes de estar en esa situación, respetando su religión y principios y qué es mejor tener una muerte digna y no sufrir distanasia*(5,14)*.

Por lo tanto, como una forma de ejercer la autonomía, el Consejo Nacional de Justicia de Brasil aprobó la Declaración 37, de la 1ª Conferencia sobre Derecho de la Salud, en la que el paciente puede hacer una declaración anticipada de sus deseos sobre tratamientos médicos en una situación de incapacidad, la cual ha facilitado e incrementado el proceso de ortotanasia*(12)*.

Conclusión

Frente al análisis, se advierte que el aumento de la supervivencia en la sociedad está acompañado de dilemas éticos sobre el pasaje entre la vida y la muerte: eutanasia, distanasia y ortotanasia. Por lo tanto, es necesario que el profesional médico tenga bien entendidos los conceptos de estos tres aspectos de la terminalidad, con el fin de poder decidir con mayor prudencia qué proponer a los pacientes, especialmente cuando son terminales o crónicos. Vale la pena resaltar la importancia del debate sobre la terminalidad durante la formación académica, con el objetivo de tener un mayor conocimiento sobre el tema, que en la actualidad aún es limitado, traduciéndose en conductas indebidas.

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VULNERABILIDAD Y CUIDADO DESDE LA PERSPECTIVA DE ENFERMERÍA: UNA REVISIÓN INTEGRADA DE LA LITERATURA

Maggie Campillay-Campillay[1], Cristina Yáñez-Corrales[2], Pablo Dubó-Araya[3], Isabel Sanjinés-Rodríguez[4], Patricia Pizcoya-Angeles[5], Patricia Chávarry-Ysla[6]

Resumen: La vulnerabilidad es un concepto ampliamente utilizado en la literatura de las ciencias sociales, e incorporado al ámbito sanitario con el desarrollo de la bioética y el modelo de determinantes sociales de la salud. Ha sido descrito por expertos como un concepto complejo y de gran utilidad para abordar poblaciones susceptibles de enfermar. Esto obliga a enfermería a identificar estos grupos y responder a sus necesidades de cuidado. Objetivo. Revisar la literatura para analizar las intersecciones en la relación conceptual entre vulnerabilidad y cuidado, desde una perspectiva de enfermería. Metodología. Se realizó una revisión integradora de la literatura basada en la sistematización propuesta por Whittemore y Knafl. Se consideró la literatura de los últimos cinco años disponible en las bases de datos Wos®, Scopus® y PubMed®. En la estrategia de búsqueda se utilizaron las palabras claves "vulnerability" and "care". Resultados. Se seleccionaron 18 artículos, coincidente con países que han desarrollado modelos sanitarios con enfoque social, como Canadá y Brasil. En el análisis se identificaron y describieron cinco temas en que se interceptan vulnerabilidad y cuidado; paradigma ontológico, epidemiológico, social y bioético, y la asociación entre vulnerabilidad y necesidades de cuidado. Conclusiones. La literatura da cuenta de la estrecha relación entre vulnerabilidad y cuidado, dado que la naturaleza de los cuidados profesionales de enfermería es la respuesta organizada socialmente a la vulnerabilidad humana.

Palabras claves: cuidados de enfermería, vulnerabilidad en salud, vulnerabilidad social, poblaciones vulnerables.

Vulnerability and care from the nursing perspective: a review integrated literature

Abstract: Vulnerability is a concept widely used in the social sciences literature, and incorporated into the health field with the development of bioethics, and the model of social determinants of health. It has been described by experts as a complex concept, and very useful for addressing populations susceptible to illness. This ethically obliges nursing to identify these groups and respond to their care needs. Goal. To review the literature to analyze the intersections in the conceptual relationship between vulnerability and care, from a nursing perspective. Methodology. An integrative review of the literature was carried out based on the systematization proposed by Whittemore and Knafl. Literature from the last five years available in the Wos®, Scopus® and PubMed® databases was considered. The keywords "vulnerability" and "care" were used in the search strategy. Results. 18 articles were selected, coinciding with countries with health models with a social focus, such as Canada and Brazil. In the analysis, five themes were identified and described in which vulnerability and care intersect; ontological, epidemiological, social and bioethical paradigm, and the association between vulnerability and care needs. conclusions. The literature reports the close relationship between vulnerability and care, given that the nature of professional nursing care is the socially organized response to human vulnerability.

Keywords: Nursing care, health vulnerability, social vulnerability, vulnerable populations.

Vulnerabilidade e cuidado a partir da perspectiva da enfermagem: uma revisão integrada da literatura

Resumo: A vulnerabilidade é um conceito amplamente utilizado na literatura das ciências sociais, incorporado ao âmbito sanitário com o desenvolvimento da bioética e o modelo de determinantes sociais da saúde. Foi descrito por especialistas como um conceito complexo e de grande utilidade para abordar populações suscetíveis a adoecer. Isto obriga eticamente a enfermagem a identificar estes grupos e responder a suas necessidades de cuidado. Objetivo. Revisar a literatura para analizar as intersecções na relação conceitual entre vulnerabilidade e cuidado, a partir de uma perspectiva da enfermagem. Metodologia. Realizou-se uma revisão integradora da literatura baseada na sistematização proposta por Whittemore e Knafl. Considerou-se a literatura dos últimos cinco anos disponíveis nas bases de dados Wos®, Scopus® e PubMed®. Na estratégia de busca utilizou-se as palavras chaves "vulnerability" and "care". Resultados. Foram selecionados 18 artigos, coincidentes com países que desenvolveram modelos sanitários com enfoque social, como o Canadá e o Brasil. Na análise identificaram-se e descreveram-se cinco temas em que se interceptam vulnerabilidade e cuidado: paradigma ontológico, epidemiológico, social e bioético, e a associação entre vulnerabilidade e necessidades de cuidado. Conclusões. A literatura dá conta da estreita relação entre vulnerabilidade e cuidado, dado que a natureza dos cuidados profissionais de enfermagem é a resposta organizada socialmente à vulnerabilidade humana.

Palavras chave: cuidados de enfermagem, vulnerabilidade em saúde, vulnerabilidade social, populações vulneráveis

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Introducción

La vulnerabilidad es un concepto de interés en el ámbito de la salud a partir del año 2000, coincidiendo con el auge de la argumentación bioética en el contexto de la investigación en los seres humanos, y con el desarrollo de las teorías de justicia social a nivel global*(1)*. Al respecto, Amartya Sen*(2)* expuso su preocupación por la equidad en el ámbito sanitario como medio para alcanzar el desarrollo de las personas, comunidades y países, teniendo como principal propósito "la mejora de nuestras vidas y de las libertades que disfrutamos" (p.17). En este sentido, la libertad a la que se refiere Sen, se asocia con la posibilidad de que todas las personas puedan gozar de un buen estado de salud y no estar expuestas a enfermedades o causas de mortalidad evitable, dada la relación condicionada entre prosperidad económica y salud.

A partir de esta perspectiva, el concepto de "vulnerabilidad" ha sido considerado de gran utilidad para priorizar las políticas de salud pública, al reconocer que existen personas que por sus características individuales o contextuales tienen mayor probabilidad de tener efectos adversos en salud. Sin embargo, la identificación de estos grupos en la población considerados "de riesgo" ha sido ampliamente criticada en la literatura, por su dificultad para abordar estas condiciones de una manera multidimensional y calificar a ciertos grupos como "vulnerables". Este aspecto contribuiría a su auto estigmatización y/o estigmatización social, además de asociarse a dimensiones absolutas (vulnerables, o no vulnerables) que invisibilizan la variabilidad de otros riesgos en la población general*(3-5)*.

Para Diciotti*(4)*, la vulnerabilidad, en un sentido más amplio, debe contribuir a abrirnos al mundo de los demás y despojarnos de nuestros propios prejuicios para observar con mayor atención las formas de vulnerabilidad, empleando nuestra energía en buscar soluciones que eliminen o mitiguen el daño o riesgos al que están expuestos estos grupos de personas. Basado en esto, la vulnerabilidad se refiere a las "desigualdades de diversa índole", cuya heterogeneidad amerita considerar distintas formas de solución. La vulnerabilidad, bajo esta perspectiva, es un concepto en construcción, extenso e indeterminado, que tiene importantes connotaciones morales, ya que no da lo mismo la valoración que hacemos de personas vulnerables o no vulnerables, y las acciones que se deciden colectivamente en razón de esta valoración.

Reducir las desigualdades en los países ha sido abordado por las Naciones Unidas a partir de 2015 en el objetivo de desarrollo sostenible (ODS) N.º10. Este objetivo considera empoderar y promover la inclusión social, económica y política de todas las personas, sin exclusiones o discriminaciones de ningún tipo. Considerando que el desarrollo de las personas contribuye a su salud y a gozar de la libertad de elección*(2,6)*.

Para la profesión de enfermería, la vulnerabilidad se asocia directamente con la acción de cuidar, dado que no es posible permanecer pasivo frente a situaciones en que las personas sean consideradas vulnerables*(7)*. Al respecto, la revisión de alcance realizada por Egry et al.*(8)* describió estudios sobre buenas prácticas de enfermería en grupos vulnerables, dando cuenta de que parte importante de la investigación disciplinar se ha focalizado en estos colectivos, personas mayores, infantes, adolescentes, mujeres, víctimas de violencia y personas con discapacidad; además del levantamiento de indicadores de seguimiento para estos grupos, en específico desde la estrategia de promoción de la salud. Esto conlleva acciones concretas con planes de atención, en correspondencia con los riesgos y necesidades identificadas que determinan los cuidados para cada uno de estos grupos de la población. En este sentido, las acciones de cuidado de las enfermeras son la forma tradicional de abordar la vulnerabilidad humana.

Desde el enfoque de derechos humanos, los profesionales de enfermería han considerado la vulnerabilidad el resultado de injusticias y desigualdades sociales*(9)*, revindicando que toda persona tiene derecho a la salud y a recibir cuidados cuando los necesite, independiente de su estatus social, capacidad de copago, raza, género o edad*(10)*. Aunque la capacidad de las enfermeras para influir en el macrosistema que determina la vulnerabilidad de las personas ha sido limitada*(11)*, la importancia de los cuidados en el microsistema familiar y comunitario, siguiendo el modelo ecológico, ha sido fundamental para los sistemas de salud*(12)*.

El propósito principal de esta revisión es relacionar los conceptos de "vulnerabilidad" y "cuidado", además de profundizar en estas dos áreas sustantivas para iniciar una discusión de interés disciplinar e interdisciplinar, y contribuir al desarrollo de los aspectos teóricos, prácticos y éticos de la profesión.

Metodología

Para cumplir con los propósitos del estudio se realizará una revisión integradora de la literatura que permite resumir la teórica y/o empírica previa, para una mayor comprensión del fenómeno de interés*(13,14)*. Con ese fin se aplicaron las fases de revisión propuestas por Whittemore y Knafl*(13)*:

Identificación del problema y construcción de la pregunta orientadora.

Una revisión rápida e inicial de la literatura sobre vulnerabilidad y su relación con el cuidado, advirtió la poca cantidad de artículos que abordan esta temática. Por ello se planteó la siguiente pregunta: ¿cuál es la relación conceptual entre los conceptos "cuidado" y "vulnerabilidad" presentes en la literatura científica y social, desde una perspectiva de enfermería?

Búsqueda bibliográfica y criterios de selección de artículos.

La búsqueda se realizó entre 2017 y 2022, correspondientes a los cinco últimos años, utilizando las bases de datos Web of sciencie (Wos), Scopus y Pubmed.

La estrategia de búsqueda incluyó solo en idioma inglés y consideró las palabras claves "vulnerability" and "care". Se utilizaron los filtros para que las palabras claves solo estuviesen contenidas en el título y, además, se seleccionó como tema "nursing".

Lo criterios de inclusión consideraron artículos primarios y secundarios, mientras como criterios de exclusión se retiraron los artículos en duplicado (diagrama 1).

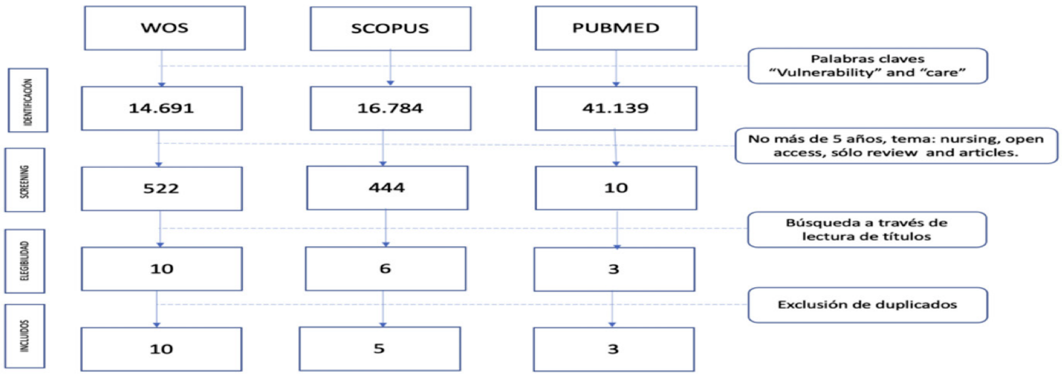
Evaluación de datos aplicando criterios de rigor a los artículos seleccionados.

En este punto, se consideró que utilizar las bases de datos Wos, Scopus y Pubmed da garantía de rigor, al ser artículos que fueron sometidos a exigentes criterios de confiabilidad y revisión de pares investigadores.

Análisis de datos que incluye reducción, visualización, comparación y conclusiones.

Los artículos incluidos fueron organizados (matrices 1 y 2), leídos en su totalidad y se utilizó como guía la pregunta orientadora establecida inicialmente. La última fase sintetiza los hallazgos relacionados con intersecciones entre los conceptos de "vulnerabilidad" y "cuidado", además de limitaciones del estudio que se exponen en el acápite de discusión.

Diagrama 1: Prisma.



Resultados

Matriz 1: Descripción de los artículos seleccionados según título, autores, año de publicación, país y tipo de diseño.

N.º	Título del artículo	Autor(es)	Año	País	Tipo de diseño
1	Vulnerabilidad social y necesidades de salud de población inmigrante en el norte de Chile	Ramírez et al.	2019	Chile	Cualitativo, análisis de contenido
2	The essence of care in health vulnerability: a Heideggerian construction	Feitosa et al.	2017	Brasil	Reflexión
3	Vulnerabilidad y cuidado	Mena P.	2021	Chile	Reflexión
4	Emotions, Feelings, and Experiences of Social Workers While Attending to Vulnerable Groups: A Qualitative Approach	Ruiz et al.	2021	Suiza	Cualitativo, fenomenológico
5	Vulnerability and Primary Health Care: An Integrative Literature Review	Barros et al.	2021	Brasil, Canadá	Revisión integrativa de la literatura
6	Well-being in long-term care: an ode to vulnerability	Gerritsen D.	2021	Holanda	Reflexión
7	Long-Term Care Admissions Following Hospitalization: The Role of Social Vulnerability	Godin et al.	2019	Canadá	Cuantitivo, analítico
8	Exploring the concept of vulnerability in health care	Clarck B y Preto N.	2018	Canadá	Reflexión
9	Risking vulnerability: Enacting moral agency in the is/ought gap in mental health care	Musto, Schreiber y Rodney.	2021	Canadá	Cualitativo, Grounded Theory
10	Nursing violent patients: Vulnerability and the limits of the duty to provide care	Dunsford J.	2021	Canadá	Reflexión
11	Care Ethics, Dependency, and Vulnerability	Engster D.	2019	Reino Unido	Reflexión
12	Vulnerability, Health Care and Need	Panitch V y Horne C.	2016	Canadá	Reflexión
13	Vulnerability and quality of life of older persons in the community in different situations of family care	Perseguino MG, Okuno MFP y Horta ALM.	2021	Brasil	Cuantitativo, analítico
14	Vulnerability, Care and the Constitutional State	Re L.	2019	Italia	Reflexión
15	Quality of basic health care and social vulnerability: a spatial analysis	Souza et al.	2021	Brasil	Cuantitativo, ecológico
16	The symbiotic relationship of vulnerability and resilience in nursing	East L, Heaslip V y Jackson D.	2019	Australia	Reflexión
17	Vulnerability	Liedo B.	2021	España	Reflexión
18	Vulnerabilidad social, genealogía del concepto	Valdés M.	2021	España	Reflexión

Matriz 2 Relaciones conceptuales entre vulnerabilidad y cuidado identificadas en la literatura revisada

Relaciones conceptuales entre vulnerabilidad y cuidado		Artículos que contienen la evidencia
Visiones paradigmáticas de la Vulnerabilidad y Cuidado	Perspectiva ontológica	2,3,4,5
	Perspectiva epidemiológica	4,5,7,8,13,16,17
	Perspectiva social	1,5,7,14,15,18
	Perspectiva bioética	2,8,9,10,11,12
Vulnerabilidad y necesidad de cuidados		1,3,6,11,12

Discusión

La vulnerabilidad social constituye un "rasgo dominante" en los países latinoamericanos, lo que se expresa en dificultades para enfrentar la complejidad del mundo actual*(15:9)*, fenómeno que no solo es atribuible al efecto de políticas socioeconómicas neoliberales, sino a la pérdida de un proyecto social común que ha ido debilitando la construcción de la identidad social de los individuos*(15,16)*. Por otra parte, las sociedades se han hecho más complejas, plurales, globalizadas y ofrecen un "amplio abanico" de posibilidades culturales*(16)*. Basado en esto, la vulnerabilidad es un concepto clave y central para la profesión. Sin embargo, a pesar de la amplia literatura al respecto, ha sido abordado principalmente desde una perspectiva institucionalizada e individualista, y mucho menos como una dimensión colectiva del cuidado. Probablemente, centrarse en la vulnerabilidad como una dimensión colectiva permitiría a las enfermeras identificarse e involucrarse en problemas de alcance global y ejercer su rol sociopolítico con mayor propiedad*(17)*. Contribuiría además a mejorar la asertividad social, evitando comportamientos performativos hacia estos grupos de la población*(18)*.

La literatura revisada permite proponer cinco relaciones conceptuales entre vulnerabilidad y cuidado:

Paradigmas de la vulnerabilidad y el cuidado

Se identificó cuatro usos diferentes para el concepto de "vulnerabilidad" asociados al cuidado, y que responden a las perspectivas: a) ontológica, b) epidemiológica, c) bioética y d) social.

Perspectiva ontológica

Desde la perspectiva ontológica, la vulnerabilidad es inherente al ser humano, con su finitud desplegada en sus dimensiones física, psicológica, espiritual y social. Es una forma de ser en el mundo, atribuible a la fragilidad intrínseca de la existencia humana*(19-22)*.

Los autores revisados coinciden en que el cuidado y vulnerabilidad están fuertemente asociados, dado que el "ser vulnerable" es el "ser de cuidado". Según Feitosa et al.*(19)*, el cuidado se asocia a la vulnerabilidad como una forma de vida, y es además una postura ética frente al mundo, que dispone a las personas que cuidan a comportamientos que favorecen las potencialidades de los otros como "sujetos de cuidado". Al respecto, Mena*(22)* expone que el acto de cuidar compromete al cuidador integralmente, independientemente del tipo de respuesta o apoyo que este pueda ofrecer; "específica, limitada e incluso protocolizada"*(22:278)*.

Continuando con Mena*(22)*, la dificultad asociada al acto de cuidar en la vulnerabilidad existencial es la imposibilidad de reconocer la amenaza específica, dado que la fragilidad es una condición humana en la que la existencia vulnerable siempre está en riesgo de ser dañada. La vulnerabilidad es la amenaza permanente de la existencia misma, una forma de existencia en la que el riesgo llega de forma inesperada e irrumpe sin que podamos hacer nada. Por tanto, el cuidado es la respuesta humana consciente e intencionada a la vulnerabilidad, para estar con el otro, estar alerta y atenderlo en un esfuerzo permanente por acogerlo. La enfermera, entonces, formada para cuidar, requiere de una atención permanente y focalizada en las necesidades del otro, y aun así estas necesidades de cuidado podrían exceder sus posibilidades, ya que la experiencia de cuidar es compleja y puede sobrepasar todos los modos de cuidado conocidos.

Por lo tanto, estamos llamados a cuidar y cuidarnos, dada nuestra naturaleza humana y vulnerable. Como seres humanos organizados socialmente, somos convocados a protegernos recíprocamente y atenuar cualquier potencial daño.

Perspectiva epidemiológica

La epidemiología social se ocupa de las desigualdades en salud, saber por qué enferman algunas personas y otras no, de forma complementaria a la epidemiología tradicional que se enfoca más bien en el riesgo biológico y psicológico de la población*(23)*. El interés de la epidemiología social es "comprender como la organización social da forma a la distribución de la salud y la enfermedad"*(24:80)*. De acuerdo con Cabieses (25), la vulnerabilidad de origen social "es una característica de sociedades que tienden a experimentar grandes diferencias entre grupos humanos en sus condiciones de vida y resultados de salud"*(25:25)*. Estos grupos sociales suelen ser diversos y estar en mayor desprotección para acceder al trabajo, vivienda, servicios sociales, educación y salud, o estar expuestos a condiciones adversas psicológicas o físicas que la población general*(18,21)*.

Al respecto, la literatura revisada enfatiza en la relación entre las determinantes sociales y la vulnerabilidad epidemiológica de ciertos grupos, al aumentar su posibilidad de enfermar o morir. Los autores destacan la relación entre vulnerabilidad y cuidados, relevando el hecho de intervenir de forma temprana y oportuna, ya que hacerlo tardíamente no evita el daño causado por las determinantes sociales estudiadas. Bajo esta perspectiva, el cuidado es interdisciplinario y colaborativo, hace énfasis en el cuidador profesional que, a pesar de estar mejor preparado para realizar acciones de cuidado, debe contar con espacios de autocuidado y de autosanación por el esfuerzo permanente para abordar las exigencias de su trabajo*(20,21,26,27)*.

Una de las principales críticas a esta perspectiva, es que el modelo de determinantes sociales es contextual y estructural, y por lo tanto la condición de vulnerabilidad no puede ser modificada en el corto plazo, y poco pueden hacer los grupos clasificados como vulnerables para mejorar su situación. En este sentido, las vulnerabilidades están relacionadas con las políticas públicas y la capacidad del Estado para crear oportunidades de desarrollo para todos, junto con estrategias que atenúen las grandes desigualdades*(28)*. A partir de esto, los autores consideran necesario utilizar la categoría "situaciones de vulnerabilidad", en lugar de "personas o grupos vulnerables", porque responde de mejor forma a esta perspectiva y, además, contribuye a evitar la estigmatización*(29)*.

Perspectiva social

La perspectiva social de vulnerabilidad es transversalmente recogida por la literatura revisada. Antes de la década de 1980 el concepto de "vulnerabilidad" se asoció inicialmente con grupos "jurídicamente frágiles y que requieren protección de sus derechos"*(21:10)*. Desde esta visión, los vulnerables serían personas con discapacidad mental o física, niños y adolescentes, adultos mayores y personas institucionalizadas*(21)*. Posteriormente, de acuerdo con Valdés*(30)*, el concepto abarca el campo de la salud y las ciencias sociales, al estar relacionado directamente con las "estructuras y procesos socioeconómicos de desigualdades causantes de la vulnerabilidad"*(30:4)*. La relación directa entre vulnerabilidad y desarrollo socioeconómico ha sido de interés de diversas organizaciones internacionales, que convirtieron el concepto en una herramienta esencial para "diseñar y orientar las políticas públicas en materia de desarrollo, así como las intervenciones de acción humanitaria"*(30:4)*.

A nivel sanitario, el enfoque de vulnerabilidad social es parte fundamental del marco conceptual del modelo de determinantes sociales de salud (DSS), especialmente importante para expandir políticas públicas que disminuyan brechas de desigualdad social, creen oportunidades y mejoren el estado de salud de la población. Sin embargo, estudios han demostrado la gran dificultad de los países para transitar de la identificación de brechas estructurales a soluciones concretas*(26,31,32)*.

Para Ré*(33)*, las desigualdades dañan la cohesión social, amenazan el interés público y erosionan el sentido cívico y la solidaridad social. Cuando un grupo reclama desigualdad y expone que sus derechos no son garantizados, reclama su condición de vulnerabilidad. Mientras, el *Estado receptivo* debe responder a sus demandas, ya que, bajo esta perspectiva, el cuidado es un deber del Estado, sin que ello implique caer en paternalismos.

Perspectiva bioética

La perspectiva bioética promueve el debate y la reflexión ética sobre cuestiones de afectan la salud y la vida; liberada de presupuestos dogmáticos, es plural, multidisciplinar y laica. Basada en el respeto irrestricto por los derechos humanos y el reconocimiento de que en las sociedades existen diversas formas de ser y vivir, fomenta el debate informado y promueve las buenas prácticas profesionales y sociales*(34)*.

Los artículos revisados que abordan la vulnerabilidad social apelan en su mayoría al principio de justicia distributiva para procurar subsanar los problemas de desigualdad social que afectan de manera global a las sociedades contemporáneas*(19,28,35-37)*, adhiriendo de forma transversal al modelo de DSS promovido por organizaciones internacionales. Para Rawls (38), la justicia social considera un conjunto de principios que contribuyen a que la sociedad pueda consensuar el cómo distribuir de mejor forma los beneficios que genera. Sobre esta base, mejorar brechas en desigualdad va más allá de la declaración de principios: es una cuestión cívico-política, dado que el acceso a oportunidades de desarrollo no depende solo de las posibilidades individuales de sus miembros, sino también de acuerdos colectivos.

Bajo esta perspectiva, la persona considerada vulnerable debe recibir cuidados de la sociedad, relevando las oportunidades, evaluando sus necesidades y evitando el paternalismo. Profesiones como enfermería tienen la responsabilidad de cuidar, priorizando la prevención del daño y esforzándose por mantener la autonomía de las personas y comunidades el mayor tiempo posible*(28,39)*.

A nivel sanitario, han sido consideradas especialmente vulnerables las personas o grupos que por su condición o funcionalidad cuentan con menos o pierden su autonomía al ser evaluadas como dependientes. Ejemplo de esto, son las personas mayores frágiles, personas en situación de discapacidad o infantes en edad preescolar. En este punto, la ética del cuidado proporciona un marco fundamental para establecer responsabilidades de cuidado para estos grupos*(35)*.

Vulnerabilidad y necesidad cuidados

Los autores revisados sostienen que la vulnerabilidad puede afectar distintos ámbitos de la vida y la salud, y hacerse presente en todas las edades. Sin embargo, en términos individuales ha sido el diagnóstico de *dependencia* el que se relaciona directamente con mayor vulnerabilidad y necesidad de cuidados. Por ejemplo, lo que acontece en los extremos de la vida: infancia y vejez. En esta última, la mayor edad actúa como un predictor de mayor fragilidad y dependencia, lo que condiciona mayor vulnerabilidad y necesidad de cuidados*(37,40)*.

Cuando las personas dependientes no pueden satisfacer adecuadamente sus necesidades básicas y de cuidado sufren el daño consecuente. Por ejemplo, un niño que no recibe cuidados nutricionales adecuados o afecto, alterará irremediablemente su desarrollo físico y psicológico. Además, la dificultad para satisfacer necesidades de cuidado puede provocar frustración en las personas, dado que muchas veces esto impide el ejercicio adecuado de los roles sociales, como ser madre o padre, estudiante, profesional, trabajador, etc. Por tanto, sufrir vulnerabilidades resta posibilidades de desarrollo personal y social a las personas, mientras los cuidados oportunos contribuyen a su dignidad*(37)*. Estas necesidades no satisfechas no son producto de la naturaleza, sino de una injusta distribución de oportunidades en la sociedad. Atender estas vulnerabilidades no consiste solo en empatizar afectivamente, sino en fomentar instituciones justas y solidarias*(37)*. Exige además de los cuidadores un enfoque especial, y estar alertas para movilizar todos los recursos disponibles*(22)*.

Desde la perspectiva de la ética del cuidado, la dependencia genera responsabilidades, por lo que los seres humanos tienen la responsabilidad de cuidar a otros, considerando los distintos momentos de la vida. Esto sobrepasa al ámbito sanitario, ya que en las distintas etapas vitales se puede alcanzar una alta vulnerabilidad, perder la autonomía y requerir apoyo social*(35)*. Por ejemplo, las persona mayores dependientes requieren necesariamente de otras personas y/o cuidadores para satisfacer sus necesidades básicas y seguir adelante con sus vidas*(35,41)*.

Otros grupos considerados vulnerables socialmente, como la población migrante, presentan múltiples dificultades para acceder a servicios de cuidado por su desconocimiento de cómo funciona el sistema de salud en el país que los recibe. En este sentido, profundizar en estas brechas puede contribuir a desarrollar mejores políticas de cuidado para estos grupos*(32)*.

Conclusión

"Vulnerabilidad" y "cuidado" son conceptos estrechamente relacionados. Las visiones paradigmáticas identificadas en la literatura revisada —ontológica, epidemiológica, social y bioética— aportan a una mayor comprensión teórica y práctica de los conceptos. Estas se interceptan y complementan para dar cuerpo a los modelos sociales de la salud. Por lo que contribuyen a una mayor comprensión del proceso de vulnerabilidad y cuidado.

Al respecto, los grupos considerados vulnerables requieren de visibilización, levantamiento de necesidades y acciones concretas en su favor. Si bien las grandes dimensiones que causan injusticias, desigualdades y vulnerabilidad se relacionan con políticas de Estado modificables en el largo plazo, la influencia de las acciones socio-comunitarias y colectivas de enfermería y su experiencia en el cuidado son un aporte concreto en el corto plazo, ya que se ejecutan con pocos recursos e impactan en un nivel micro ecológico.

La principal limitación de este estudio se relaciona con la escasa literatura relacionada con vulnerabilidad y cuidado originada por la disciplina de enfermería. Por lo que el trabajo realizado se apoyó en literatura proveniente de la filosofía, la sociología, la antropología y la salud pública.

Conflicto de interés

Las(os) autores declaran no tener conflicto de interés.

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THE RELATIONSHIP BETWEEN COVID-19 BURNOUT AND THE MORAL SENSITIVITY OF HEALTHCARE PROFESSIONALS

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Abstract: This study aimed to examine the relationship between the burnout of physicians and nurses and their moral sensitivity during the pandemic. This was a descriptive and correlational study. This study was carried out with physicians and nurses who were continuing to work actively during the pandemic. Snowboard sampling method was utilized. The total mean score of the participants on the MSQ was 90.78±19.10. The total mean score of the COVID-19 Burnout Scale was 34.52±9.65. A statistically weak and significant correlation was found between the COVID-19 Burnout Scale and the MSQ total score, as well as the "benefit" and "conflict" sub-dimensions. It was determined that as MSQ total scores, "benefit" and "conflict" scores decreased in healthcare workers, COVID-19 burnout scores increased. In our study, the moral sensitivity of the participants was found to be moderate, and their burnout levels were found to be high. Although there was a weak relationship, it was observed that burnout levels increased as moral sensitivity levels increased. It is crucial that we learn from pandemic experiences and transfer this knowledge to future generations. In particular, we must assimilate these important lessons into training in order to develop and protect the moral sensitivity of healthcare professionals.

Keywords: COVID-19 Burnout; Ethics, Healthcare Professional; Moral Sensitivity

La relación entre el burnout por COVID-19 y la sensibilidad moral de los profesionales sanitarios

Resumen: Este estudio pretendía examinar la relación entre el burnout de médicos y enfermeras y su sensibilidad moral durante la pandemia. Se trató de un estudio descriptivo y correlacional, y se llevó a cabo con médicos y enfermeras que seguían trabajando activamente durante la pandemia. Se utilizó el método de muestreo de Snowboard. La puntuación media total de los participantes en el MSQ fue de 90,78±19,10. La puntuación media total de la Escala de Burnout COVID-19 fue de 34,52±9,65. Se encontró una correlación estadísticamente débil y significativa entre la Escala de Burnout COVID-19 y la puntuación total del MSQ, así como las subdimensiones "beneficio" y "conflicto". Se determinó que, a medida que disminuían las puntuaciones totales del MSQ y las puntuaciones de "beneficio" y "conflicto" en los trabajadores sanitarios, aumentaban las puntuaciones de burnout de la COVID-19. En nuestro estudio, se observó que la sensibilidad moral de los participantes era moderada y que sus niveles de burnout eran elevados. Aunque existía una relación débil, se observó que los niveles de burnout aumentaban a medida que lo hacían los de sensibilidad moral. Es crucial que aprendamos de las experiencias pandémicas y transmitamos estos conocimientos a las generaciones futuras. En particular, debemos asimilar estas importantes lecciones en la formación para desarrollar y proteger la sensibilidad moral de los profesionales sanitarios.

Palabras clave: burnout COVID-19, ética, profesional sanitario, sensibilidad moral

A relação entre o burnout pela COVID-19 e a sensibilidade moral de profissionais de cuidados à saúde

Resumo: Esse estudo objetivou examinar a relação entre o burnout de médicos e enfermeiras e sua sensibilidade moral durante a pandemia. Esse era um estudo descritivo e correlacional. Esse estudo foi realizado com **médicos e** enfermeiras que continuaram trabalhando ativamente durante a pandemia. O método da amostragem em snowboard foi utilizado. A média total dos participantes no MSQ foi 90,78±19,10. A média total na Escala de Burnout pela COVID-19 foi 34,52±9,65. Uma correlação fraca e significante foi encontrada entre os escores totais na Escalas de Burnout pela COVID-19 e MSQ, assim como nas subdimensões "benefício" e "conflito". Determinou-se que como os escores totais na MSQ e os escores "benefício" e "conflito" diminuiram em trabalhadores de cuidados à saúde, os escores de burnout pela COVID-19 aumentaram. Em nosso estudo, a sensibilidade moral dos participantes foi considerada ser moderada e seus níveis de burnout considerados serem altos. Embora tenha havido uma correlação fraca, foi observado que os níveis de burnout aumentaram quando os níveis de sensibilidade moral aumentaram. É essencial que aprendamos das experiências com a pandemia e passemos esse conhecimento para as futuras gerações. Em particular, nós devemos assimilar essas importantes lições em treinamentos, de forma a desenvolver e proteger a sensibilidade moral de profissionais de cuidados à saúde.

Palavras chave: Burnout pela COVID-19, Ética, Profissional de Cuidados à Saúde, Sensibilidade Moral

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Introduction

Burnout is a physical and psychological threat to employees in professions that require intense relationships with people, such as medicine/nursing. It was first identified by Freudenberger as "the state of exhaustion that occurs in the internal resources of the individual as a result of failure, weariness, decreased energy and power, or unsatisfied desires"*(1)*. According to Brenninkmeijer (2003), burnout is a mental state caused by chronic stress in business life. This potentially severe syndrome can be a consequence of factors such as a heavy workload, an excessive level of control, insufficient rewards, negative relationships with colleagues, lack of justice, value conflicts, long working hours*(1,2)*.

The COVID-19 pandemic has resulted in most of the factors that can cause healthcare professionals to experience burnout. In particular, healthcare professionals have been working in a stressful environment for about two and a half years due to their low numbers, the excessive workload, the necessity of working with protective clothing, the risk of infection, and the deaths loss of their colleagues. Since burnout, which has physiological and psychological repercussions for employees, can also negatively affect service quality, it is important to determine the current state of exhaustion caused by this stressful environment.

Healthcare professionals provide services to those in need of medical treatment and care. Practices to ensure the well-being of patients are generally value-laden initiatives with a moral dimension*(3)*. Therefore, such work can result in ethical problems and conflicts. In order to solve the ethical problems that might arise during medical practices, it is necessary to first identify and acknowledge them*(3)*. Healthcare professionals are expected to display a high level of moral sensitivity in their medical decisions. However, the current pandemic has been very difficult and stressful for these professionals. It is important, therefore, in terms of employee health, service quality, and education planning, to determine how this difficult situation affects the burnout and moral sensitivity of healthcare professionals. We aimed to examine the relationship between the burnout of physicians and nurses and their moral sensitivity during the pandemic.

Methods

Design

This was a descriptive and correlational study.

Sample and Settings

This study was carried out with physicians and nurses who were continuing to work actively during the pandemic in "Y". All private or public health institutions and family health centers were included in the study. The sample size was determined by power analysis, which calculates the statistical power of the sample size*(4)*. According to the calculation conducted using the G*Power 3.1 program, the sample size was determined to be 260 (130 nurses and 130 doctors) with an effect size of 0.45, a margin of error of 0.05, a confidence level of 0.95, and a population representation of 0.95*(4)*. According to Cohen (1988), a sample size for which power values ranging from 0.90–0.99 are calculated should be reached*(5)*. Snowboard sampling method was utilized. The study was completed with a total of 448 participants (302 nurses and 146 physicians).

Data Collection

The study data were collected through a Sociodemographic Information Form, the COVID-19 Burnout Scale, and the Moral Sensitivity Questionnaire to ascertain their moral sensitivity. Media platforms and invitations sent through personal e-mail addresses were employed for data collection. In addition, a preliminary study was carried out with a total of 40 participants (20 physicians and 20 nurses). Then, the questionnaire form was revised according to their feedback and suggestions.

Data Collection Tools

Sociodemographic Information Form: This form asks about the socio-demographic characteristics of the participants (gender, age, profession,etc.).

Moral Sensitivity Questionnaire (MSQ): This questionnaire was developed by Lützén in 1994 to determine the moral sensitivity shown in the ethical decision-making process*(3)*. The adaptation of the scale to Turkish and the assessment of its validity and reliability were conducted by Tosun (2018). This 7-point Likert-type scale consists of 30 items and six sub-dimensions, including autonomy, benevolence, holistic approach, conflict, practice, and orientation. This scale high scores on the scale indicate low moral sensitivity. In this study and for the Turkish version of the questionnaire, the Cronbach's alpha was 0.84*(6)*.

COVID-19 Burnout Scale: This 5-point Likert-type scale consisting of 10 items was adapted from the Burnout Criterion-Short Version*(7)*. The scale's total score is obtained by adding 10 items and ranges from 10–50 points. A higher score indicates higher levels of burnout related to COVID-19. The Cronbach's alpha coefficient of the scale is 0.92*(8)*. In our study, the Cronbach's alpha coefficient for the whole scale was found to be 0.93.

Data Analysis

The data analysis was performed using Statistical Package for the Social Sciences (SPSS) 21. For the independent pairs, comparisons between groups were made using the significance test (t-test) of the difference between the two means in the data with normality assumption. Additionally, for the independent multiple groups, comparisons between groups in the data with normality assumptions were made with the ANOVA test. The Tukey test was employed to determine from which group the difference originated.

Correlation analysis was performed to examine the relationship between the measurement values. The Pearson correlation coefficient was used because the data displayed normal distribution. The level of significance in statistical analysis was $p < 0.05$.

Ethics Approval

The study was performed according to the ethical standards of the Helsinki Declaration and Good Clinical Practice guidelines. It received ethical approval from the "X" University Faculty of Medicine Ethics Committee for Non-Invasive Clinical Research and the Ministry of Health of the Republic of "Y". Moreover, permission was obtained from the owners of the scales used in the study. Data were collected after receiving informed consent from each study participant. Participation was entirely voluntary.

Results

Of the participants, 67.4% were nurses, 32.6% were physicians, 80.1% were female, and 66.5% were married. Their mean age was 38.09±8.40 years, and the mean number of working years was 14.71±9.48. In addition, 61.8% of the participants also worked with COVID-19 patients. The demographic characteristics of the participants are presented in Table 1.

The total mean score of the participants on the MSQ was 90.78±19.10. There was no statistical difference between the ethical sensitivity of the participants and their occupation, gender, age, marital status, and years of work. However, a statistically significant difference was found for the total scores of the MSQ based on the institution of the participants ($p<0.05$). The difference was especially significant for employees working at a private health institution (Table 2).

The average "autonomy" of the participants was 19.68±6.19, the average "benefit" was 12.53±4.13, the average "holistic approach" was 12.75±4.34, the average "conflict" was 13.44±3.32, the average "application" was 12.43±3.93, and the average "orientation" was 8.18±3.51. In the "benefit" sub-dimension, the mean score for men was higher than the mean score for women. It was remarkable that the mean scores of physicians for "benefit" "holistic approach" and "orientation" were lower than those of nurses for these dimensions.

A statistically significant difference was found in the scores for "autonomy" depending on the institution, marital status, and age; for "benefit" depending on the institution, gender, and marital status; for "holistic approach" depending on the institution, age, marital status, and years of work; for "conflict" depending on age, marital status, and years of work; and for “orientation” depending on age, occupation, and years of work (p≤0.05). There were no statistically significant relationships between other variables (Table 2).

The total mean score of the COVID-19 Burnout Scale was 34.52±9.65. In our study, the total scores on this scale were significantly higher for nurses than physicians, women compared to men, and those who worked with COVID-19 patients compared to those who did not work with them. In addition, a statistically significant difference was found in the total scores of the COVID-19 Burnout Scale depending on the institution where the participants worked (i.e., a state hospital) (p<0.05). There were no statistically significant relationships between other variables (Table 3). However, a statistically significant difference was found in the total scores of the COVID-19 Burnout Scale depending on institution, gender, profession, and work in a pandemic clinic (p<0.05). No other statistically significant relationships between other variables were found (Table 3).

The relationship between the COVID-19 Burnout Scale and the MSQ is presented in Table 4. A statistically significant very low, negative correlation was found between the COVID-19 Burnout Scale and the MSQ total score, as well as the “benefit” and “conflict” sub-dimensions. It was determined that as MSQ total scores, “benefit” and “conflict” scores decreased in healthcare workers, COVID-19 burnout scores increased. In other words, although there is a weak relationship, the level of burnout increased as the level of moral sensitivity increased.

Discussion

Most of the scientific studies on the COVID-19 pandemic are related to the diagnosis, treatment, and course of the disease. However, another issue that is as important as the clinical aspects of the disease is the status of healthcare professionals. They encountered more traumatic and complex situations in their work environment than previously, a situation compounded by the fact that they had already been experiencing burnout before the pandemic. As a result of COVID-19, they had to work under extraordinary conditions and away from support. At the same time, health professionals had to deal with many ethical problems and decisions that often led to burnout in this population.

In this study, the relationship between the moral sensitivity of healthcare professionals and their COVID-19 burnout was investigated. As there is only one study in the literature investigating a similar association*(9)*, the researcher used other articles that measured the level of burnout and moral sensitivity of healthcare professionals in an attempt to present a comprehensive discussion of the study results.

This study showed a moderate overall level of moral sensitivity in nurses and physicians. In the study by Alyousefi et al. (2021) with physicians*(10)*, Kirilmaz et al. (2015)’s study with physicians and nurses*(11)*, and Palazoğlu and Koç (2019)’s study with emergency nurses*(9)*, the moral sensitivity of the participants was found to be moderate. In addition, contrary to the findings of this study, in Khodaveisi et al. (2021)’s study with nurses who take care of COVID-19 patients, Amiri et al. (2019)’s studies with healthcare professionals, and Ohnishi et al. (2019)’s studies with psychiatric nurses*(12-14)* moral sensitivity levels were found to be high. This difference could be due to different cultural and organizational contexts, personal characteristics (such as attitudes towards care, religious beliefs, and values), and work areas.

Moral sensitivity levels of healthcare professionals differ according to studies. Ethical background, gender, moral values, culture, religion, upbringing, education, age, clinical experience, and clinical practice can affect the level of moral sensitivity*(9,11,15-17)*. In our study, a significant difference was found in terms of the institution, similar to the results of Seo and Kim (2022), which likely results from its ethical climate*(18)*. No relationship was found for other sociodemographic variables.

Further, in the study of Seo and Kim, working in the COVID-19 direct response department was seen to have an impact on moral sensitivity*(18)*. In our study, however, no significant difference was found between the moral sensitivity levels of those who worked in COVID-19 units and those who did not work.

Studies have shown that the pandemic causes burnout*(8,19-22).* It has been reported that factors such as heavy and increased workload, too much overtime, fear of being infected and infecting others, the necessity of working with protective clothing, the long duration and uncertainty of the pandemic, significant changes in daily life routines, and long-term preventive measures cause the burnout of health workers*(8,19,23-25)*.

Moroń and Biolik-Moroń stated that COVID-19 burnout may be a persistent risk factor for mental health problems*(26).* Yildirim et al. also found that the pandemic caused extreme psychosocial effects, especially for healthcare workers*(27)*. Finally, Alkhamees et al. discovered a high rate of burnout and depressive symptoms in psychiatry residents (roughly 27.3%) and a significant positive correlation between them during the COVID-19 pandemic in Saudi Arabia*(28)*.

Health professionals experienced more burnout in the relatively early stages of the pandemic and became exhausted over time during the pandemic process*(23)*. This study used a scale specifically for COVID-19 and was conducted two years after the onset of the pandemic. Given these factors, it can be said that the data have a high likelihood of accurately revealing the effect of COVID-19 on the burnout of healthcare professionals.

In our study, the COVID-19 burnout of physicians and nurses was found to be high. Similarly, in Derya's study with emergency service personnel, the levels of COVID-19 burnout were seen to be high*(29)*. Other studies have also shown that healthcare professionals have experienced high levels of burnout during the pandemic*(8,24,28,30-32)*.

In our study, a statistically significant difference was found between the total scores of the COVID-19 Burnout Scale depending on the institution (i.e., working in a state hospital). It was thought that this situation was caused by the health policies of the country, the excessive workload of healthcare workers, especially in government institutions, and taking on additional roles during the pandemic.

In our study, nurses' burnout scores were found to be significantly higher than those of physicians. Similarly, Pappa et al. 2021 and Denning et al. 2020 found that nurses experience higher levels of burnout compared to other healthcare professionals*(33,34)*. This may be due to factors such as increased workload, exposure risk, and length of care, as well as the fact that nurses encounter suffering, death, and ethical dilemmas more frequently because they are in closer contact with patients.

In our study, the burnout scores of women were found to be significantly higher than those of men. Similarly, in the study of Yıldırım and Geçer (2021) women were more likely to experience exhaustion*(35)*. This situation was probably due to the increase in workloads at home for women due to the restrictions experienced during the pandemic.

The burnout scores in our study for those who worked in pandemic clinics were found to be significantly higher than for those who did not. Healthcare professionals working in these wards experienced heavy workloads, irregular work hours and conditions, and the pressures of caring for terminally ill patients. At the same time, emerging infectious diseases, such as COVID-19, involve complex ethical issues. So, during the pandemic, they had to make critical decisions and experienced intense stress. Making ethical decisions and experiencing ethical problems may affect the well-being and cause the burnout of healthcare professionals*(10,33,36-39)*. In our study, while there was no difference in moral sensitivity between those working and not working with COVID-19 patients, there was a difference for burnout. This data can also be considered as an indicator of the increase in the burnout of healthcare professionals while making decisions and maintaining their moral sensitivity.

While having to deal with ethical problems can cause burnout*(18)*, burnout can also cause ethical insensitivity*(40)*. In an ethical conflict, a high level of moral sensitivity is very important to correctly recognize the problem and make the right decision*(9,18)*. Thanks to moral sensitivity, healthcare professionals perceive ethical problems and patient needs*(41)*. In this study, a weak negative correlation was found between MSQ scores and COVID-19 burnout scores. It was determined that as MSQ scores decreased in healthcare workers, COVID-19 burnout scores increased. In other words, although there is a weak relationship, the level of burnout increased as the level of moral sensitivity increased. Similarly, in the study by Palazoğlu and Koç (2019), a very weak correlation was found between MSQ scores and burnout*(9)*. Therefore, it is important to examine ethical problems experienced while evaluating the burnout of healthcare professionals.

Conclusion

In our study, the moral sensitivity of the participants was found to be moderate, and their burnout levels were found to be high. Although there was a weak relationship, it was observed that burnout levels increased as moral sensitivity levels increased.

It is important to determine the moral sensitivity of healthcare professionals and their burnout resulting from the pandemic, which has deeply affected all segments of society. In order to protect the moral sensitivity of healthcare professionals, there is a need for activities that support them, as well as reduce and prevent burnout.

It is crucial that we learn from pandemic experiences and transfer this knowledge to future generations.

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DENTAL STUDENTS' EMPATHY LEVELS AND OPINIONS ABOUT ATTRIBUTES FOR "GOOD DENTIST": A COHORT STUDY

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Abstract: Empathy is fundamental to the physician-patient relationship and influences the clinical outcomes. The aim of this study was to determine the dental students' empathy levels and to compare their opinions on attributes of a "good dentist". This cohort research was included 79 dental students volunteering to participate in the study at a public university. The data were collected by the Dökmen's Empathic Tendency Scale (ETS) and Empathic Skill Scale (ESS). In this study, from the orientation day to the end of the third-year, the dental students' ETS mean scores (respectively 69.59 and 68.34) and ESS mean scores (respectively 142.53 and 140.00) showed a decline. At the end of the third-year, starting clinical rotations and taking patient responsibility may lead to decrease the empathy levels of students. The findings of our study show that female students have higher empathy tendency and skill scores compared to male students ($p<0.001$). In the ranking of the attributes required to be a good dentist, empathy was ranked 4th by the first-year students, while final-years students placed empathy in second rank ($p<0.05$). According to these results, it is possible to claim that the dentist candidates realized that being empathetic is necessary to be a good dentist.

Key words: dental ethics, dental students, empathy, good dentist, physician-patient relations

Niveles de empatía de los estudiantes de odontología y opiniones sobre los atributos del "buen dentista": un estudio de cohorte

Resumen: La empatía es fundamental para la relación médico-paciente e influye en los resultados clínicos. El objetivo de este estudio de cohorte —que incluyó a 79 estudiantes de odontología de una universidad pública que se ofrecieron como voluntarios— fue determinar los niveles de empatía de los estudiantes de odontología y comparar sus opiniones sobre los atributos de un "buen dentista". Los datos se recogieron mediante las Escalas de Tendencia Empática (ETE) y Habilidad Empática (EHE) de Dökmen. Desde el día de orientación hasta el final del tercer año, los puntajes medios ETE de los estudiantes de odontología (69.59 y 68.34, respectivamente) y los puntajes medios de EHE (142.53 y 140.00, respectivamente) mostraron una disminución. Según la literatura, al final del tercer grado, iniciar rotaciones clínicas y asumir la responsabilidad del paciente puede llevar a disminuir los niveles de empatía de los estudiantes. Los hallazgos de nuestro estudio muestran que las estudiantes tienen una mayor tendencia a la empatía y puntajes de habilidad en comparación con los estudiantes ($p<0.001$). En el ranking de los atributos requeridos para ser un buen dentista, la empatía ocupó el cuarto puesto en estudiantes de primer año, mientras que los de último año colocaron la empatía en segundo lugar ($p<0.05$). De acuerdo con estos resultados, es posible afirmar que los candidatos a dentistas se dieron cuenta de que ser empáticos es necesario para ser un buen dentista.

Palabras clave: ética dental, estudiantes de odontología, empatía, buen dentista, relaciones médico-paciente

Nível de empatia de estudantes de odontologia e opiniões sobre os atributos de "bom dentista": um estudo de coorte

Resumo: A empatia é fundamental na relação médico-paciente e influencia os resultados clínicos. O objetivo deste estudo foi determinar os níveis de empatia de estudantes de odontologia e comparar suas opiniões sobre os atributos de um "bom dentista". Esta pesquisa de coorte contou com 79 estudantes de odontologia voluntários para participar do estudo em uma universidade pública. Os dados foram coletados pela Escala de Tendência Empática (ETE) de Dökmen e Escala de Habilidades Empáticas (EHE). Neste estudo, desde o dia da orientação até o final do terceiro ano, os escores médios do ETE dos alunos de odontologia (respectivamente 69,59 e 68,34) e os escores médios do EHE (respectivamente 142,53 e 140,00) apresentaram declínio. No final da terceira série, iniciar os rodízios clínicos e assumir a responsabilidade do paciente pode levar à diminuição dos níveis de empatia dos alunos. Os achados do nosso estudo mostram que os alunos do sexo feminino apresentam maior tendência à empatia e pontuações de habilidades em comparação aos alunos do sexo masculino ($p<0,001$). No ranking dos atributos necessários para ser um bom dentista, a empatia foi classificada em 4º lugar pelos alunos do primeiro ano, enquanto os alunos do último año colocaram a empatia em segundo lugar ($p<0,05$). De acordo com esses resultados, é possível afirmar que os candidatos a dentista perceberam que ser empático é necessário para ser um bom dentista.

Palavras-chave: ética odontológica, estudantes odontológicos, empatia, bom dentista, relações médico-paciente

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Introduction

As described in literature, the empathy refers to "the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another of either the past or present without having the feelings, thoughts, and experience fully communicated in an objectively explicit manner"*(1).* Most clinical and counseling psychologists, however, agree that true empathy requires three distinct skills: the ability to share the other person's feelings, the cognitive ability to intuit what another person is feeling, and a "socially beneficial" intention to respond compassionately to that person's distress*(1,2).* In the context of healthcare, empathy can be defined as cognitive and behavioral features that involves the ability to understand how a patient's experiences, concerns, perspective, and feelings are influenced by their symptoms and illness, and the capability to communicate this understanding to the patient. This definition emphasizes the establishment of empathetic communication with the patient for better clinical outcomes*(3-5).*

In medical and dental education, various skills that contribute to the quality of health care could be strengthened by empathy, and medical and dental schools are increasingly aware of their role of in the development empathy of their students. However, there are concerns that the student's empathic disposition may deteriorate during undergraduate medical and dental education, and this will adversely affect the patient-physician relationship*(4,6).* Medical and dental students are anticipated to be empathetic towards their patients as they become clinicians*(7).* However, considering the evidence relating empathy to desired therapeutic and patient outcomes, it is a potential concern that empathy may be declining in medical and dental students. Empirical studies*(8-13)* that directly address the question of changing physician empathy suggest that empathy declines among medical students during training. These studies also found a decrease in medical students' empathetic tendency over the years. Chen and colleagues reported in their cross-sectional study, a noticeable decline in empathy scores in third-year medical students as compared with their second-year counterparts*(10).* Similarly, in a cohort study which was published by Hojat and his colleagues*(6)* significant changes in medical students' empathy during medical school was determined. The decline in empathy scores was observed at the end of the third year which persisted until graduation. In another cross-sectional study with dental school students, Sherman and Cramer*(4)* noticed a significant decline in empathy in second-year students. Unlike medical and dental students, it has been determined that empathic skill level has increased in nursing students over the years*(14,15).*

Since the profession of dentistry has a special trust position in the society, some privileges are given to the profession. In return, the profession makes a commitment to society that its members will adhere to high standards of ethical behavior. Trying to be a good dentist is part of these ethical standards. The characteristics of a good dentist involve certain attributes such as "skillful management of time", "ability to handle people", "recognition of one's own limitations", "having good technical ability", "respect for others' values and feelings", "able to communicate well" "trustworthiness" and "empathy"*(16-18).* As empathy is an important quality for dentists to possess if they are to be moral (i.e., "good") practitioners, then it follows that measuring a candidate's ability to empathize with others could be an important admission criterion to be a good dentist*(5).*

Objective

Although empathy is an integral component to the patient-physician relationship, there has been relatively little research on this important subject topic. Furthermore, the literature contains limited information about the dental students' empathic abilities or attitudes toward empathetic relationships in Türkiye. The previous cohort studies on empathy conducted in our country mostly included medical and nursing students. However, there is also a need to evaluate the changing emphatic levels of dental students using a cohort design. Considering that there is not enough research on this subject yet, we aimed to gather the data from dental students and planned a cohort research study to measure the changes in empathic tendency and skill levels during the undergraduate years of dental education. This study also investigated the attributes of "good dentist" with respect to the opinions of dental students.

The objectives of the present study were:

1.to examine the changes empathy levels of dental students from the orientation day to the end of the fifth year.

2.to compare the first and the fifth years dental students' opinions regarding the main factors contributing to be a "good dentist".

Methods

This study approved by the Çukurova University Research Ethics Committee was planned as cohort longitudinal design. The participants consisted of 79 dental students (35 males and 44 females) who were followed up throughout their five-year training at Cukurova University School of Dentistry[2] between the years 2016-2021. In September 2016, 102 students were registered in the Cukurova University School of Dentistry. During the orientation program at the beginning of their first year, all students were invited to participate this cohort longitudinal research. Participation was voluntary and only 79 students agreed to participate in the study. These students were informed about the research goals, steps, and the length of the study.

Assessment Tools

For measuring the empathy, the data were collected by the Dökmen's Empathic Tendency and Empathic Skill Scales. Of the many tools for measuring empathic skills, in our study, we preferred to use the Turkish Empathic Tendency Scale (ETS) and Empathic Skill Scale (ESS) developed by Dökmen*(19),* since these scales are the instruments proven validity and reliability for Turkish society. The empathy scales were completed by the participants during the orientation period. Subsequently, the ETS and ESS were readministered to this cohort study five more times in dental school near the end of their first, second, third, fourth, and fifth years in 2016 through 2021.

Empathic Tendency Scale (ETS): ETS was developed by Dökmen in 1988*(19)* with the aim of measuring the potential of an individual to establish empathic relationships in daily life. ETS is a 20-item, 5-point Likert scale. The lowest points obtained from the scale are 20 with highest points of 100. Total points represent the empathic tendency of participants. High points show high empathic tendency, while low points show low empathic tendency.

Empathetic Skill Scale (ESS): ESS was developed to evaluate the empathetic skill of an individual by Dökmen*(19)*, consists of two forms as scale "A" and "B". There are 6 different problems about daily life and 12 one-sentence empathetic reactions below each problem that can be said to the person with the problem. People are asked to choose 4 of the empathetic reactions below the problems. The point corresponding to each chosen reaction is given based on ESS-A form to the individuals who choose 24 reactions in total, four reactions for each 6 problems. The minimum point is 62 and the maximum point is 219 to be taken from ESS and when the point is high it means the empathy level is high and when the point is low it means the empathy level is low. ESS is grouped as very low (62-92), low (93-124), medium (125-156), high (157-188) and very high (189-219)(19).

In this study, the reliability of the scales was examined by the test-retest method. ETS and ESS reliabilities were respectively found to be as r=0.881 ($p<0.001$) and r=0.984 ($p<0,001$). Both scales can be described as highly reliable.

For collecting the data relating to the attributions of "good dentist", a questionnaire was developed by reviewing the literature *(20-23)* and participants were asked to rate the attributions on a 10-point scale (from "0 = no importance" to "10 = very important").

Statistical Analyses

Statistical analyses were performed with SPSS v22 package program. The normal distribution of data was tested by the Shapiro Wilks test and the comparison was made by t-test in independent groups and paired t test in dependent groups,

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[2] The dental curriculum in Turkey is five years. Cukurova University School of Dentistry's curriculum runs a 5-year program, comprised of 3 years of preclinical work followed by 2 years of clinical work (clerkships).

and descriptive statistics were given as mean± standard deviation. The comparison of the data that did not show normal distribution was made by Mann Whitney U test in independent groups and Wilcoxon test in dependent groups and descriptive values were given as median (min-max) values. According to whether the relationships between the variables show normal or not, the relationships with the Pearson correlation coefficient or the Spearman sequence correlation coefficient were examined. The before and after variation of categorical variables was done with the McNemar Bowker test. Categorical data are given in frequency and percentage. The reliability analysis of the scales was analyzed by test-retest method. The significance level was accepted as $p < 0.05$ in all tests.

Results

This longitudinal research was conducted on 79 dental students (35 male, 44 female) out of 102 first-year students who agreed to participate in the study. The median age of the students at the orientation day was 19 (min-max: 18-23).

The first table shows the comparison of Empathy Tendency Scale and Empathy Skill Scale mean scores of the same students from their beginning semester in 2016 to the end of last semester just before their graduation in 2021 (Table 1). Analysis of differences in ETS and ESS scores from the orientation day of dental school to the end of the third year showed a decline in empathy, which is consistent with previous reports. The second and the third tables show the compared mean scores (Table 2 and 3).

As shown in the tables 4 and 5, the female students consistently have high scores than male students in every year of dental school. Gender differences in all the test administrations were statistically significant ($p<0.001$ and $p<0.05$) (Table 4 and 5).

This study also investigated the opinions of dental students concerning the attributes of a good dentist, and whether their views changed according to the year. The five main factors contributing to be a good dentist were chosen by dental students. The attributes are listed in order of descending importance according to the respondents (Table 6).

Discussion

While the medical students' empathy level has been extensively studied in the literature, the cohort studies investigating empathy of dental students are limited. Considering the lack of empirical research, the present study was planned to evaluate the empathic tendency and skill levels of the dental students and their empathy scores were followed over years. In our cohort study, empathy tendency and skill scores appear to increase during the first-year of dental school but falls after the third-year (before first clinical year) ($p<0.001$), and the scores gradually rise through the final year of dental school ($p<0.05$). There are statistically significant differences between the scores.

On the orientation day, the students' empathy tendency mean score was 69.59, while empathy skill mean score was 142.53. At the end of the final-year, the students' empathy tendency mean score was 70.15, while empathy skill mean score was 144.49. Although the empathy scores of students increase from year to year, both empathy tendency and skill average scores remain in medium level.

According to the medical literature, the levels of empathy begin to decrease in the third year, when most medical students begin clinical rotations and thus interact directly with patients*(6,8,10,24,25)*. Studies have similarly found that first-year dental students have significantly higher empathy scores than students in any of the subsequent three years of dental school and the empathy scores also decreased after patient care responsibilities began*(4,7)*. Our results are consistent with previous studies*(3,4,6,8-13)*, suggesting that empathy decreases during clinical training in medical and dental school. In this study, from the orientation day of dental school to the end of the third year the ETS mean scores (respectively 69.59 and 68.34) and ESS mean scores (respectively 142.53 and 140.00) showed a decline in empathy.

For empathy, females are generally found to have higher scores than males. Previous studies have

Table 1: The Year Differences for the Empathy Tendency and Empathy Skill Scores

	ETS		ESS	
	Students number=79		Students number=79	
Year	Mean	SD	Mean	SD
Orientation day-(2016)	69.59	6.98	142.53	14.61
End of year 1	70.11	6.87	142.87	13.15
End of year 2	69.65	6.90	142.76	15.01
End of year 3	68.34	6.70	140.00	12.58
End of year 4	69.08	6.84	142.67	11.27
End of year 5-(2021)	70.15	6.65	144.49	10.09

Table 2: Empathy Tendency Score comparisons with orientation day

Years	ETS (n=79)	Comparisons with orientation day	P
0	69.59±6.98	-	-
1	70.11±6.87	0-1	<0.05
2	69.65±6.90	0-2	0.409
3	68.34±6.70	0-3	<0.001
4	69.08±6.84	0-4	<0.05
5	70.15±6.65	0-5	<0.05

Table 3: Empathy Skill Score comparisons with orientation day

Years	ESS (n=79)	Comparisons with orientation day	p
0	142.53±14.61	-	-
1	142.87±13.15	0-1	0.561
2	142.76±15.01	0-2	0.680
3	140.00±12.58	0-3	<0.001
4	142.67±11.27	0-4	0.782
5	144.49±10.09	0-5	<0.001

Table 4: Empathy Tendency mean scores for males and females

	Male (n=35)	Female (n=44)	P
ETS 0	66.86±6.19	72.14±6.74	0.001
ETS 1	68.34±6.49	71.52±6.92	0.040
ETS 2	66.74±6.11	71.98±6.68	0.001
ETS 3	66.23±5.87	70.93±6.65	0.002
ETS 4	69.69±6.76	73.43±6.50	0.015
ETS 5	69.83±6.65	73.95±5.98	0.005

Table 5: Empathy Skill mean scores for males and females

	Male (n=35)	Female (n=44)	p
ESS 0	136.0(95.0-169.0)	153.0(112.0-175.0)	0.011
ESS 1	136.0(95.0-170.0)	153.5(109.0-177.0)	0.014
ESS 2	136.0(94.0-170.0)	153.5(109.0-177.0)	0.008
ESS 3	132.0(95.0-170.0)	153.5(109.0-177.0)	0.004
ESS 4	137.0(95.0-170.0)	153.5(125.0-177.0)	0.009
ESS 5	137.0(95.0-170.0)	154.5(126.0-177.0)	0.005

Table 6. The attributes mostly stated by the first-year and the final-year dental students

	Importance rating (mean scores)	
	Initial measurement (Orientation day)	Final measurement (End of year 5)
Professional competence	8.89	7.03
	P=0.049	
Being trustworthy	7.63	7.30
	P=0.613	
Communicating effectively with patients	7.16	8.69
	P=0.035	
Empathy	6.87	8.05
	P=0.030	
Respecting patients' dignity and choices	6.57	7.23
	P=0.912	

reported similar relationships between gender and empathy scores*(10,12,26,27).* Our study also showed that the empathic tendency and empathy skill scores of female students were significantly higher than those of male students ($p<0.05$). On the orientation day, the female students' empathy tendency and skill mean scores were respectively 72.14 and 153.0, while male students' empathy tendency and skill mean scores were respectively 66.86 and 136.0. At the end of the final-year, the female students' empathy tendency and skill mean scores were respectively 73.95 and 154.5, while male students' empathy tendency and skill mean scores were respectively 69.83 and 137.0.

The empirical studies*(4,6,8-13)* that directly address the question of empathy suggest that empathy declines among students during training. Health-care students' empathy levels can be affected by different causes such individual socio-cultural factors, socio-cultural environment of the school and education curricula. Distress and elitist thinking (being a doctor is a member of a privileged group) may be other factors could explain the decrease in empathy amongst medical students*(28).* Several stressful aspects of dental education and training, such as long workhours as well as dependence on technology for dental practice and limited chairside interactions, time pressure may contribute to decreases in empathy*(29).*

One of the aims of this study was to investigate the characteristics of a "good dentist" according to the opinions of dental students. While the first-year students stated the "professional competence" as the most important feature to be a good dentist, at their fifth-year the same students stated that the most important feature to be a good dentist was the "communicating effectively with patients". There are statistically significant differences between the students (P=0.049 and P=0.035). Additionally, the attribute of empathy was in the fourth rank for the first-year students while this attribute was in the second rank for the final-year students (P=0.030). There are statistically significant differences between the students. According to these results, it is possible to claim that the dentist candidates realized that being empathetic is necessary to be a good dentist.

The "good dentist" is the one who diagnoses properly, plans treatment within the professional care, implements a therapy that ensures clinical quality and makes an effective communication. However, the commitment to always act in the patient's best interest lies at the basis of being a "good dentist", even when it is against the dentist's own best interest*(5,17).*

According to the Nash*(5),* some may not be good dentists because of their deficits in knowledge, problem solving or skill. It is also possible that their failure in professional goodness could be related to a deficiency of empathy. Because of this deficiency, these dentists can't take on their patients' perspective, they can't really respond to their patients' need in a truly caring manner.

Limitations

The present study was limited by being restricted to dental students at a single Türkiye university. Our research results cannot be applied to all the dental school students in the country. More wide-ranging research would be necessary before generalizations are made.

Conclusion

The most important factor in ensuring patient satisfaction is the empathetic communication between the health personnel and the patient. Based on existing literature demonstrating that empathy declines in medical and dental students throughout the training experience, the expectation of this study was that some decline in empathy would be observed. The findings of this study may present a new perspective for curriculum designers, educators, and researchers. The implementation of a curriculum that includes empathy courses into the undergraduate dentistry education will contribute to the development of an effective physician-patient communication during clinical internships. Considering the evidence relating empathy to desired patient outcomes, it is a potential concern that empathy may be declining in medical and dental students. Professional ethics requires that dentists "treat their patients as they would want to be treated" and thus understanding empathy's role in human behavior is important to all health professionals.

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UTILIZACIÓN DE IMÁGENES DE PACIENTES PARA MARKETING MÉDICO

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Resumen: El uso de estrategias de imagen en las redes sociales médicas está cada vez más extendido, cumpliendo el límite ético establecido por el CEM. Sabiendo esto, el presente estudio buscó comprender el problema de la exposición de los pacientes en las redes sociales médicas. Para ello, se realizó una revisión bibliográfica a partir de las bases Scientific Electronic Library Online (Scielo), PubMED, UpToDate, LILACS, incluyendo artículos en inglés, español y portugués publicados a partir de 2018. Así, se percibió en algunas ciudades la tendencia a crear leyes para regular esta exposición, dado que el uso de imágenes se ha vuelto rutinario en la publicidad médica, como una forma de demostrar resultados. Sin embargo, esta práctica está muy acompañada de faltas éticas como recomienda el CFM.

Palabras clave: marketing, redes sociales, médico.

Use of patient image for medical marketing

Abstract: The use of imagem strategies in medical socieal networks is increasingly widespread, meeting the ethical limit established by the CEM. Knowing this, the present study sought to understand the problem of patient exposure in medical social networks. For this, a literature review was carried out from the Scientific Electronic Library Online (Scielo), Pubmed, UpToDate, LILACS databases, articles in English, Spanish and Portuguese published from 2018 onwards were included. Thus, a tendency was noticed in some cities to create laws to regulate this exposure, given that the use of images has become routine in medical advertising, as a way to demonstrate results. However, this practice is greatly accompanied by ethical failures as recommended by the CFM.

Keywords: marketing, social media, doctor

Uso de imagem de pacientes para marketing médico

Resumo: A utilização das estratégias de imagem nas redes sociais médicas está cada vez mais disseminada, encontrando-se no limite ético estabelecido pelo CEM. Sabendo disso, o presente estudo buscou entender a problemática da exposição do paciente nas redes sociais médicas. Para isso, foi feita uma revisão da literatura a partir das bases Scientific Eletronic Library Online (Scielo), PubMED, UpToDate, LILACS, foram incluídos artigos em inglês, espanhol e português publicados a partir de 2018. Assim, percebeu-se em algumas cidades a tendência de criar leis para regular essa exposição, haja vista que a utilização de imagens tornou-se rotineira na propaganda médica, como forma demonstrar resultados. Todavia, tal prática vem acompanhada grandemente de falhas éticas segundo o preconizado pelo CFM.

Palavras-chave: marketing, redes sociais, médico

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Introducción

El uso estratégico de imágenes de pacientes por parte del médico, como una forma de persuadir a la comunidad, se ha convertido en una práctica más actual, con el fin de demostrar la efectividad de los tratamientos y la calidad de la atención mediante la difusión de resultados a través de los medios de comunicación*(1)*. Igualmente, las nuevas formas de reproducción fotográfica, con avances cada vez mayores en la calidad visual, van en la línea de la aparición de herramientas que corrigen defectos y optimizan el producto final, lo que contribuye a una medicina cada vez más visual. Esto, que busca captar una mayor audiencia para el profesional, por medio del marketing, principalmente en las redes sociales. Sin embargo, el sensacionalismo y la autopromoción son empleados constantemente por el anunciante, lo que no cumple con los principios éticos de orientación exclusivamente educativa de las ilustraciones en la medicina*(2)*.

Con el mismo propósito, la Resolución del CFM N°2.126/2015, en sus tres primeros párrafos, menciona que las redes sociales tales como blogs, sitios web, *Facebook, Instagram, WhatsApp*, *Twitter* y similares, no tienen permiso y no pueden publicar fotografías y audios que corrobora por competencia desleal, restringiendo tanto al médico como a los establecimientos compartir resultados y demostraciones pre y posprocedimientos, con el objetivo de autopromocionar y sensacionalizar la atención médica*(3,4)*. Después de todo, la intención del promotor está dirigida a mostrar los mejores resultados, el mal resultados trae insatisfacción a los pacientes, debido a la ilusión que pueden traer los materiales publicitarios, por ese motivo, que se recomienda por los Consejos Regionales de CFM, la normalización y orientación a los médicos de la no publicación de materiales de este tipo y propósito, a fin de evitar cuestionamientos en disputas legales por parte de los pacientes*(3)*.

Además, el aumento desenfrenado de nuevas instituciones de formación médica hace más encarnizada la lucha por el espacio y la búsqueda de empleo dentro del ámbito médico, lo que amplifica la competencia y aumenta la preocupación de los recién graduados en el área, por lo tanto, aumenta el incentivo de los profesionales en la investigación de nuevos medios y métodos para destacarse y alcanzar nuevos hitos en su carrera, en busca de lo promoción social y una mejor calidad de vida*(2,5)*.

Metodología

La elaboración del estudio se realizó a partir de revisiones bibliográficas referenciadas en las bases de datos Scientific Electronic Library Online (SciELO), PubMED, UpTo Date, LILACS y en el Consejo Federal de Medicina (CFM). Para desarrollar el trabajo se formularon pasos a seguir, tales como: la definición del tema rector, sus criterios de exclusión e inclusión, la búsqueda de información asertiva para la base temática con criterios específicos, además del análisis e interpretación de los resultados obtenidos para la elaboración de la revisión. Cabe señalar que la temática escogida se limitó al uso de imágenes de pacientes para marketing médico. En este sentido, se utilizan artículos publicados en los siguientes idiomas, portugués, español e inglés, en vista de su excesiva importancia a nivel mundial, sustentados en los criterios de inclusión en artículos publicados a partir de 2018 correlacionados con el tema mencionado, y bajo criterios de exclusión incompletos trabajo, publicaciones menores a 2018, no relacionadas directamente con el tema. Ante ello, se realizó un análisis de 9 artículos publicados entre 2018 y 2022, teniendo en cuenta las resoluciones del CFM, entre 2011 y 2015.

Discusión

A priori, el uso de imágenes de pacientes para publicidad médica se ha convertido en un lugar común, en este contexto, urge distinguir publicidad marketing y propaganda*(1)*. El Código de Autorregulación Publicitaria de Brasil nombra las primeras como actividades destinadas a promover el consumo de bienes y servicios pero la presentación de contenido que instiga a los pacientes a procedimientos médicos induce una posible demanda de consumo de un determinado servicio*(6)*.

Además, la publicidad, que tiene como principal objetivo cautivar a los usuarios la utilización de los bienes presentados, no tiene fines económicos, solo el ideal de difundir ideas a diferencia del marketing, en el que involucra todas las etapas de la producción, siendo el conjunto de actividades realizadas para crear y llevar las mercancías a su destino final6. En ese contexto, estos términos aplicados en la relación médico-paciente, a pesar de la libertad otorgada al anunciante, existen límites que la permean, regulados por el Código de Ética Médica (CEM), en el que determina las acciones que se pueden tomar o no, con el objetivo de asegurar el prisma de la veracidad, la transparencia y garantizar que se cumplan las expectativas del paciente, frenando el engaño y el abuso*(7)*.

Es imperativo que la influencia de las redes sociales en medio de este tema acentúe el problema, debido a la vasta y casi ilimitada cantidad expresiva de mensajes publicitarios, que no pocas veces llegan a una audiencia incalculable, este descontrolado y creciente vehículo de información permite su uso. de manera irresponsable y desenfrenada, facilitando el encubrimiento de deslealtades por parte de quienes lo utilizan*(4)*. Tal como lo establece el numeral 3, artículo 23, del Consejo Nacional de Autorregulación Publicitaria (CONAR), el cual dice que los anuncios no pueden abusar de la confianza del cliente, ni explotar su falta de conocimiento o experiencia, para beneficiarse de su credulidad*(8)*.

En algunas regiones del país se han creado leyes para intentar el control, en Río de Janeiro se publicó en el Diario Oficial del Ejecutivo en diciembre de 2019, que la difusión de imágenes llevó a los hospitales a prohibir el uso de teléfonos inteligentes por parte de los empleados, debido a la exposición de pacientes hospitalizados o durante procedimientos*(9)*. Los informes de fugas de contenido se han vuelto comunes, exponiendo la vulnerabilidad y la privacidad de la persona asistida, siendo eso contrario con las disposiciones de la Constitución Federal de 1988, el derecho a los derechos de autor de la imagen y la no exhibición de la misma, también en Goiânia, fue instituida la Ley Municipal N° 9.830 que impide a los médicos, técnicos quirúrgicos, enfermeros, técnicos de enfermería y otros profesionales de la salud portar dispositivos propios que cuenten con grabación de audio o video desde 2016*(10)*.

En consecuencia, vale la pena recordar que la existencia de normas no garantiza su plena observancia, existen numerosos casos de médicos que publican por voluntad propia, con el objetivo de apalancar sus carreras, de tal forma que se ignora el presupuesto de las leyes y conductas preconizadas por la bioética, la atención médica, mismo con las repercusiones administrativas y judiciales*(6)*. A partir de esto, es notorio que la inclusión de registros visuales tiene un impacto significativo, en el contenido que se puede extraer de forma adecuada y legal, en el acceso a la presentación de enfermedades, también ha facilitado el avance de innovaciones técnicas y que ha hecho que la producción de conocimiento sea acelerada y fluida*(11)*.

Sin embargo, las nuevas tecnologías traen consigo una inadecuada manipulación por parte de malintencionados, práctica que dificulta la propagación de la esencia para la que fueron creadas, debido la creación de leyes que prohíben el uso de dispositivos tecnológicos que deberían tener como finalidad promover una mayor accesibilidad*(11)*. Tal mal va en contra del escenario científico, provocado por el temor por parte del sistema judicial a permitir el libre uso de dispositivos privados, lo que hace que la relación médico-paciente se vea envuelta en una desconfianza, en la que el ciudadano se siente vulnerable a la exhibición de su intimidad*(7,11)*.

Conclusión

Debido a la evolución tecnológica, la apropiación de imágenes se ha convertido en una rutina para la creación de anuncios para profesionales médicos. Esto está relacionado con la necesidad de mostrar buenos resultados para el público objetivo con la finalidad de sumar una mayor cantidad. Luego, se destaca la importancia de la formalización por escrito que debe obtenerse a través del diálogo y la escritura entre médico-paciente.

También podemos observar una cierta positividad en relación con los avances tecnológicos y la facilidad de los pacientes que son reticentes a la información, buscando activamente ciertos procedimientos y especialidades médicas que son poco publicitados. Por otro lado, existe una errónea manipulación y difusión de la información, provocando malestar y daños irreversibles a la sociedad. Con esto, entendemos que el uso de vehículos de comunicación facilita grandes hazañas, pero también puede causar daños irreversibles.

Por lo tanto, el médico que sigue debidamente la constitución brasileña y el código de ética médica es respaldado por su conducta. Sin embargo, entre los estudios buscados, se observó una gran falla del profesional en relación con el uso de imágenes y contenidos privados de los clientes como forma de propagar sus logros en la profesión. De esta forma, la búsqueda activa de control y el acto de denigrar la imagen es cada vez más restringido y severo, de modo a instituir nuevas leyes regionales con base en la CONAR y el CFM.

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CHALLENGES AND PRINCIPLED RESPONSES TO PRIVACY PROTECTION FROM BIOMETRIC TECHNOLOGY IN CHINA

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Abstract: Biometric technology has transformed human biological characteristics into a new form of privacy, and the misuse of this technology poses challenges to protecting this new privacy. This article initially defines biometric technology and biometric characteristics, further demonstrating why biometric characteristics belong to personal privacy and how biometric technology poses challenges to its protection. Through analysis, this article argues that the essence of these challenges is the conflicts between the ethical principle of privacy protection and the ethical principle of maximizing social benefits. In order to address these challenges, it is necessary first to weigh the fundamental ethical principles. The two basic principles of privacy protection and maximizing social benefits are not mutual antagonism but hierarchy, and this hierarchy should be based on the principle of practical feasibility. That is, applying biometric technology should first meet the principle of practical feasibility and, on this premise, realize the principle of maximizing social benefits based on not infringing on the principle of privacy protection.

Keywords: biometrics, biometric technology, biometric characteristics, privacy protection, the hierarchy of ethical principles

Retos y respuestas de principio a la protección de la intimidad por la tecnología biométrica en China

Resumen: La tecnología biométrica ha transformado las características biológicas humanas en una nueva forma de privacidad, y el uso indebido de esta tecnología plantea desafíos a su protección. En este artículo se define inicialmente la tecnología biométrica y las características biométricas; se demuestra además por qué las características biométricas pertenecen a la privacidad personal y cómo la tecnología biométrica plantea retos para su protección. Este artículo argumenta que la esencia de estos retos es el conflicto entre el principio ético de protección de la privacidad y el de maximización de los beneficios sociales. Para abordar estos retos es necesario sopesar primero los principios éticos fundamentales. Los dos principios básicos de protección de la privacidad y maximización de los beneficios sociales no son antagónicos, sino jerárquicos, y esta jerarquía debe basarse en el principio de viabilidad práctica. Es decir, la aplicación de la tecnología biométrica debe cumplir primero el principio de viabilidad práctica y, a partir de esta premisa, realizar el principio de maximización de los beneficios sociales sobre la base de no infringir el principio de protección de la intimidad.

Palabras clave: biometría, tecnología biométrica, características biométricas, protección de la intimidad, jerarquía de principios éticos

Desafios e respostas baseadas em princípios à proteção da privacidade da tecnologia biométrica na China

Resumo: A tecnologia biométrica transformou as características biológicas humanas em uma nova forma de privacidade, e o mal uso dessa tecnologia apresenta desafios para proteger essa nova privacidade. Esse artigo inicialmente define tecnologia biométrica e características biométricas, demonstrando posteriormente por que características biométricas pertencem à privacidade pessoal e como tecnologia biométrica coloca desafios à sua proteção. Através de análise, esse artigo discute que a essência desses desafios é o conflito entre o princípio ético da proteção da privacidade e o princípio ético de maximizar benefícios sociais. De forma a visar esses desafios é necessário primeiro ponderar os princípios éticos fundamentais. Os dois princípios básicos de proteção da privacidade e de maximizar benefícios sociais não são mutuamente antagônicos mas hierárquicos, e essa hierarquia deve ser baseada no princípio da viabilidade prática. Isso é, aplicar tecnologia biométrica deve primeiro atender ao princípio da viabilidade prática e, nessa premissa, compreender o princípio de maximizar benefícios sociais com base em não infringir o princípio de proteção da privacidade.

Palavras chave: biometria, tecnologia biométrica, características biométricas, proteção da privacidade, a hierarquia dos princípios éticos

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1. Introduction

In recent years, with the rapid development of underlying technologies such as big data and artificial intelligence, biometric technology in China has become increasingly widespread. From its initial use in specific public safety and criminal investigation fields, it has expanded to various public spaces such as high-speed railways, airports, customs, banks, companies, communities, and various large and small shops. At the same time, the leakage, theft and abuse of personal biometric data have become increasingly severe. In 2019, a face-swapping application called ZAO became popular in China. However, privacy infringement and individual portrait rights were gradually exposed. Because of that, the Ministry of Industry and Information Technology of the People's Republic of China (MIITPRC) inquired about the software operator*(1)*.In October 2019, Hangzhou Wildlife Park adopted facial recognition for admission without justifiable reason. Guo Bing, an associate professor at Zhejiang Sci-Tech University, sued the park after unsuccessful coordination due to concerns about privacy and personal and property rights infringement and eventually won - known as "the first case of Chinese facial recognition"*(2)*. In 2021, China's state media exposed that many well-known stores, including Kohler, BMW and Max Mara, installed facial recognition cameras to secretly collect many personal biometric data from customers*(3)*. Even more outrageous is that some cities have also installed facial recognition systems at public toilets for distributing toilet paper*(4)*. The ubiquitous cameras have caused great panic among people, especially when personal biometric data is obtained, used and traded without their knowledge. At the same time, biometric technology's security and reliability are also highly problematic. According to Tsinghua University's RealAI team report, 19 unfamiliar smartphones can be unlocked in 15 minutes using face recognition vulnerabilities*(5)*.

Biometric technologies such as facial recognition are growing wildly in China, causing many social and ethical problems. For a time, whether biometric technology should be developed and how it should be developed became the most urgent question to be answered. Among all the "justification" arguments for developing biometric technology, privacy protection is an essential ethical argument that cannot be bypassed. The challenges of biometric technology to privacy protection are also the most concerning issue among the ethical problems raised by this technology.

2. The definition of biometric technology and biometric characteristics

Biometric technology is a type of technology that automatically identifies or authenticates an individual's identity based on their unique physiological or behavioral characteristics*(6)*, which are biometric characteristics*(7)*. Among them, the recognition based on an individual's unique physiological characteristics is called classical biometric recognition, which mainly includes fingerprint, facial, iris, vein, DNA, etc.*(8)*.

Currently, the main function of biometric technology is the authentication of individual identity, which is generally accomplished by both authentication and identification. Authentication is a one-to-one comparison by comparing the characteristics provided by a person with the characteristics of the identity he declares*(9)*. This type of authentication allows local storage of biometric characteristics under personal control*(10)*, so users' privacy is relatively secure. Identification is a one-to-many comparison by collecting a person's biometric characteristics and comparing them with the identity characteristics in the database to determine the identity of the person to be identified*(9)*. The database is organized and controlled by one or more controllers with the help of one or more processors. Ultimately, biometric characteristics are no longer under the physical control of users, and they can no longer control how to use them on their own*(10)*. Biometric characteristics as a means of authentication or identification are very reliable because they allow a person to establish a strong relationship between an individual and their identity by verifying unique physical or biological characteristics for independent individuals*(11)*.

The reliability of biometric technology can also be reflected by comparing it with traditional identity recognition. Traditional identity recognition can be roughly divided into two categories: one is through "something you have"*(12)*, that is, physical objects to identify identity, such as ID cards, passports, keys, smart cards, etc.*(13)*; the other is through "something you know"*(12)*, that is, memorized password or PIN (personal identification number) to identify identities, such as passwords and codes*(13)*. These traditional identity recognitions have security and reliability issues, such as being easily lost, forgotten, copied, and cracked. Nevertheless, biometric technology is based on "something you are"*(12)*, that is, biometric characteristics. It has advantages such as uniqueness, lifelong immutability, portability, difficulty in losing and avoiding misusing, and anti-counterfeiting*(9)* to make up for the shortcomings of traditional identity recognition and make identity recognition more secure and reduce the risk of fraud. Therefore, it has begun to be widely used today. Currently, biometric technology is widely used in public and private sectors, including national security, criminal investigation and detection, account security authentication, financial transactions, and other aspects. Its application purpose is mainly based on social security and convenience.

At the same time, however, many ethical issues are associated with using biometric technology, such as privacy protection, autonomy issues, and social exclusion*(12,14)*. Among these issues, privacy protection is the central and most important concern, which is the focus of this paper.

3. The challenges of biometric technology for privacy protection

3.1. Biometric technology turns human biometric characteristics into a new privacy

Privacy, a fundamental human right, is often directly linked to freedom and autonomy and is a concrete manifestation of respect for human dignity. In biometric technology, privacy can roughly recognize in three different forms: physical privacy, decisional privacy, and information privacy*(15)*. Physical privacy refers to an individual's freedom to refuse contact with others or disturbing by others*(16)*; decisional privacy is the freedom of an individual to make choices that affect personal affairs independently*(17)*; informational privacy is the freedom of an individual to control or have some influence over specific information about oneself*(18)*.

Biometric technology uses an individual's biometric characteristics, which originally existed only as personal biological characteristics. However, due to the emergence and application of biometric technology, these characteristics, which originally existed only as individual characteristics, have become obtainable and have been transformed into personal information. Personal information refers to any information related to a natural person whose identity has been or can be identified, including personal name, address, date of birth, ID number, medical records, personnel records, photographs, and other information that can identify a specific individual when used alone or in conjunction with other information*(19)*. Among all personal information, that which an individual does not wish to disclose to society or be known by others is considered private information. The information derived from an individual's unique physiological or behavioral characteristics and recognized by biometric technology is precisely the part of identifiable personal information that the subject does not want others to obtain. Therefore, we can say that personal biological or biometric characteristics have become the personal privacy of citizens in the current society due to biometric technology.

3.2. Biometric technology poses various challenges to privacy protection

For one thing, by analyzing the technical principles of biometric technology, the use poses a significant potential risk to privacy. This risk is not only due to the possibility that information leakage may be caused by the current imperfection of biometric technology, which can result in loss and harm to the information subject. It is also due to the special properties of biometric characteristics that make such damage and harm, if it occurs, more severe than a general privacy breach. Compared with privacy in the traditional sense, personal biometric characteristics are more universal, unique and permanent because they belong to a specific person*(20)*. Universality is reflected in the fact that humans universally share biometric characteristics, making it possible for biometric technology to be applied to every individual. Uniqueness reflects the distinctiveness and particularity of everyone's biometric characteristics, making precise identification possible. Permanence is based on the stability of an individual's biometric characteristics, making biometric characteristics matching possible via biometric technology. However, these properties of biometric characteristics also put themselves in a dangerous circumstance while enabling the application of biometric technology. Based on these properties, biometric characteristics are often considered the most reliable identification way and are directly associated with sensitive financial information, personal medical data, communication accounts and data, social identity, and other personal information as the most critical information. Once an individual's biometric characteristics are leaked, the associated privacy information may also be leaked, leaving the individual in a state of "zero privacy". Their universality expands the scope of privacy violations to a broader range of subjects; Their uniqueness makes attacks and frauds using leaked biometric characteristics more precise; Their permanence makes the consequences irreversible once leaked. At the same time, due to the potential for analysis and mining of biometric characteristics themselves and the development of biometric characteristics collection technology and other contemporary high-tech applications, this potential has become easier to realize. The possibility of theft of fingerprints, irises, facial features, and other biometric characteristics has increased. As can be seen, biometric technology puts new privacy represented by personal biometric characteristics at high risk.

For another, from the perspective of the connotation of the concept of privacy, biometric technology has resulted in the loss of privacy of the subject. According to the concept of privacy, privacy includes the ability to control one's information, the autonomy of individuals over information closely related to themselves, and self-determination rights, including freedom*(10)*. Biometric technology, on the other hand, separates the subject's biological characteristics from the subject, making biometric characteristics as privacy, which is no longer under the control of the subject. At the same time, the loss of anonymity of biometric characteristics also causes the subject to lose autonomy*(21)*. With the subject's permission, the one-time use of biometric characteristics can still be justified, but the storage and secondary use of biometric characteristics require further analysis. The purpose of storing individual biometric characteristics is often for secondary use (except for local storage for verification purposes), but whether secondary use is informed and consented to by the subject is key to whether it can be justified. In practice, few operators inform or obtain consent in advance when using subject information again.

Moreover, the purpose of secondary use may not necessarily be what was informed at the time of collection, and some even exchange or sell information. In addition, there are cases where biometric characteristics are obtained without the individual knowing. For example, privately installed surveillance cameras on streets are constantly capturing facial features, gait and even emotions of subjects every moment. Similar examples include real-time traffic images. Additionally, more and more applications use biometric technology, and biometric sensors are constantly increasing in resolution, accuracy, and capture precision*(12)*, making the situation even worse. For example, the widespread use of fingerprint and facial unlock functions on mobile phones and the development of healthy monitoring applications such as sleep monitoring, heart rate monitoring and pedometers have made access to sensitive medical and health data more easily. All these cases indicate that people's ownership and autonomy over their biological characteristics are greatly challenged. In this process, people are treated merely as means and lose their due dignity.

Where is the boundary of privacy protection in the application of biometric technology? Under what circumstances is the application of biometric technology justifiable? How to deal with the challenges it poses to privacy protection? In order to answer these questions, principled responses must be given.

4. Principled responses to privacy protection from biometric technology

The challenges of biometric technology to privacy protection fundamentally lie in the conflicts between ethical principles. The formulation of solutions must be based on resolving these conflicts. Although the misuse of biometric technology may not necessarily be a good thing for protecting individual privacy, it has been widely used in some fields and brought great convenience in the current social development. At its root, the justification for using this technology comes from the utility derived from its use. Practical solutions can be developed only by addressing the relationship between privacy and utility.

4.1. The basic principles of the use of biometric technology

People take different positions on whether biometric technology should be used and whether privacy should be protected in its application. On the one hand, some advocate that a proactive relinquishment of privacy will determine the flourishing of personal and social virtue because people can freely share and use any information they desire in their own lives, which is the view of the "post-privacy movement"*(22)*. Others advocate the threat theory of biometric technology. They believe that biometric technology promotes and enhances the development of surveillance technology, which is inhumane, untrustworthy, and destructive to freedom*(23)*. The two opposing views are, in fact, extreme support for two ethical principles. The first upholds the principle of maximizing social benefit, intending to show that individual rights, represented by personal privacy, can be sacrificed to maximize social benefit.

In contrast, the second position upholds the principle of privacy protection and resists using biometric technology. Both positions are rather extreme, pitting the two principles diametrically against each other in an either/or manner, whereas in practice, our moral intuition tells us that both are needed. Suppose we relinquish the utility brought by biometric technology, such as convenience (avoiding queues, quickly answering questions, and timely access to information), efficiency (reducing costs and improving management efficiency), and spatial mobility (providing citizens with more convenient services, i.e., voting anywhere, services and movement of capital across borders through electronic services)*(23)*, it is difficult for society to develop and for human well-being to increase. If privacy is abandoned, human dignity and security are lost, and people are alienated into non-humanity. Human beings have pursued these ethical values throughout history and can co-exist under certain conditions.

In addition to the two principles mentioned above, we believe that an additional principle should be added — practical feasibility. Practical feasibility is such an important criterion because of the principle of "Ought Implies Can". In the *Critique of Practical Reason*, Kant says: "Pure geometry has postulates that are practical propositions, which, however, contain nothing more than the presupposition that one can do something if perhaps it were demanded that one should do it…"*(24)*. Human rationality and ability are limited, and moral law cannot require people to do what is impossible. This premise is one of the criteria used in formulating normative guidelines in many practical fields. Some scholars have further interpreted this: "When people use 'ought' to indicate action, the normative judgment only guides people in their actual activities to do a specific action when facing various available actions. The action indicated by the normative judgment must be something that people 'can' do; otherwise, it would force people to do something difficult and impossible to achieve its guiding purpose. For example, there is no obligation to require someone who cannot swim to jump into the water to save someone in danger"*(25)*. Similarly, when formulating ethical principles for applying biometric technology, the principle of practical feasibility should also be added; otherwise, even if criteria are established, they cannot be implemented in real life.

4.2. The hierarchy of different ethical principles

What is the relationship between different ethical principles? How should conflicts between basic ethical principles be resolved? These questions must be faced in responding to the challenges brought by biometric technology. Different perceptions of these questions have led to different positions, and we also present our position on this basis.

4.2.1. The position without conflict

On this question some people may challenge the validity of the question itself. Their stance is that there is no conflict between these ethical principles or that they are unaware of any such conflict.

One argument favoring biometric technology is that it can enhance privacy protection and is a "friend of privacy". The argument is based on the above-mentioned advantages compared to traditional identity recognition. Biometric technology provides stronger control over privacy protection, including defending personal identity, limiting access to information, and improving confidentiality*(26)*. Its application compensates for the weakness of traditional methods vulnerable to theft and falsification. Indeed, compared to traditional identity recognition, biometric technology is more reliable in recognition. However, it also entails more significant risks. As analyzed earlier, its universality, uniqueness, and permanence make the potential harm more severe than ever, even irreversible. Therefore, it is not reasonable to judge that there is no conflict between biometric technology and privacy protection based solely on the characteristics of biometric technology itself.

Another argument starts from the perspective that the characteristics recognized by biometric technology are non-personal and not owned by individuals. The question of who owns biometric characteristics after collection has been debated for a long time, especially for stored biometric characteristics. If we assume that once biometric characteristics are collected (even through legal procedures or informed consent), it is no longer owned by the collector but just digital information and has already been separated from the collector in its application. There is no issue of privacy infringement. However, is the premise that "stored biometric characteristics are not personal information" valid? Careful analysis of this premise reveals that the theoretical basis for supporting it is*(14,27)*: (a) stored biometric characteristics are meaningless digital numbers and not personally identifiable information; (b) biometric images cannot be reconstructed from biometric templates. For the first point, these stored "meaningless digital numbers" are extracted and transformed from individuals and are unique and can identify individuals*(14,28)*. For the second point, there are reports that biometric images can be reconstructed from templates*(14,29,30)*. Therefore, the view that "stored biometric characteristics are not personal information" is invalid. Thus, the position of no conflict based on this premise cannot stand.

4.2.2. The position of existing conflicts

In contrast to the position of without conflict, the position of existing conflicts is the view held by most people, acknowledging that there are conflicts between privacy protection and maximizing social benefits. The conflicts between the two can be intuitively aware of in real life. For example, when biometric technology is applied to public surveillance, it aims to maintain social order and combat crime. However, this means that citizens are constantly exposed to the surveillance of others. Fingerprint and face recognition payments also improve efficiency, save social and economic costs, and bring more significant social benefits while personal privacy has been transferred elsewhere. Within companies, attendance is checked through fingerprints and face recognition, ensuring the company's efficiency while controlling employees' privacy. These conflicts are inevitable, but in the face of conflicts, we cannot abandon either side. We cannot have social safety without personal privacy or disregard social interests only to defend individual rights.

4.2.2.1. Previous Solutions

Many acknowledge the existence of conflicts but do not provide a solution based on ethical principles. They only vaguely propose strengthening privacy protection in the technical field, reducing the probability of biometric characteristics being stolen, or preventing the abuse of biometric technology. However, this only increases the practical feasibility of privacy protection and does not explain how to choose when facing conflicts between privacy protection and maximizing social benefits. The problem cannot be fundamentally solved.

Similarly, providing answers based on specific situations cannot fundamentally solve the problem. The judgment of specific situations is also based on a complete set of rules or guidelines, which must be based on rigid criteria. Moreover, on the one hand, judging every action specifically is not realistic. On the other hand, it is impossible to ensure that all factors and the consequences' pros and cons can be fully considered in a specific situation.

There is little discussion and weighing of basic ethical principles (first-order) in existing discussions. Instead, there is more discussion about formulating specific ethical governance principles (second-order) and operational guidelines (third-order). We believe that to solve the problem truly, and we must first respond from the basic ethical principles and weigh them against each other. Moreover, this kind of weighing must first carry out the ranking, weigh out priorities, and then further formulate specific ethical governance principles and operational guidelines based on the weighing of ethical principles.

4.2.2.2. The solution based on the hierarchy of ethical principles

Based on the above discussions, we believe that solving this problem requires fundamentally formulating the hierarchy of principles, that is, at the level of fundamental principles, should adhere to (i) the principle of practical feasibility; (ii) the principle of privacy protection (individual rights); (iii) the principle of maximizing social benefits. First, the principle of practical feasibility should be met, and on this basis, the principles of privacy protection and maximizing social benefits should be weighed. In weighing the two, the author believes that to achieve the principle of maximizing social benefits, satisfying the principle of individual privacy protection must be a prerequisite.

First and foremost, why do we need a hierarchy of principles? Primarily, from an etymological perspective, the Greek root of ethics is "ethos"*(31)*. Hegel pointed out that this word — ethos, especially in the Greek historian Herodotus, means "exquisite dwelling (vorzüglim Wohnung)"*(32)*. It means that it is in an "exquisite dwelling" that human beings develop natural and humane "habits" that enable them to lead a "good life"*(33)*. Therefore, ethics does not just focus on metaphysics but rather studies which choices are better in human practice. Only by comparing them can better choices be made. Secondly, from an individual perspective, developing any science and technology must benefit humans. Thirdly, from the perspective of the characteristics of science and technology, they all eventually move from the primitive and simple form to the form of integration and adaptation with ethics. Therefore, if biometric technology is to develop, it must adapt to ethics during its development process and balance the relationship between different ethical principles.

Next, how should we prioritize? As previously mentioned, formulating a guideline or a rule for a certain behavior implies that it can be achieved because "Ought Implies Can". If it is "impossible", then the formulation of such a guideline or rule is meaningless and merely empty talk. Whether it is the introduction of guidelines for applying biometric technology, the standardization of means for obtaining 'informed consent', or the stipulation of measures to strengthen privacy protection, they must first meet the principle of practical feasibility under current technological conditions.

After satisfying the principle of practical feasibility, the principle of privacy protection and the principle of maximizing social benefits are weighed. This paper argues that the principle of privacy protection takes precedence over the principle of maximizing social benefits. This view can be well defended from both deontological and utilitarian perspectives. From a deontological perspective, individual fundamental rights represented by privacy rights are basic human rights that represent the human free will and personal dignity. Their legitimacy derives from themselves and cannot be used as a means to an outer end. Individual fundamental rights can be arbitrarily violated if maximizing social benefits is prioritized. From a utilitarian perspective, privacy protection hinders information use and increases social costs (for example, making epidemiological research more difficult because, without informed consent from subjects, statistical data cannot be collected) *(23)*. However, the crisis of confidence caused by privacy violations also significantly increases social costs. Achieving so-called "maximum social benefits" by violating privacy rights cannot achieve maximum utility. We cannot equate maximizing social benefits with maximizing economic benefits or with maximizing immediate benefits. Therefore, actions that promote maximum social benefits at the expense of privacy cannot be reasonably defended. From a rule utilitarian perspective, whether a specific action maximizes benefits cannot be used as a criterion for judging the justification of an action but should be indirectly linked to the principle of maximum utility through a set of rules*(34)*. An action is justifiable or defensible if and only if required by one or a set of principles that, if followed, will bring more significant benefits to society than any other principles*(34)*. As mentioned above, privacy protection may not directly promote maximum social benefits. Nevertheless, if everyone follows this rule, social trust will be guaranteed in the long run, and society can develop more stably. Biometric technology can make great development in its application due to gaining more trust in accessing information. Therefore, only by taking privacy protection as a prerequisite can true maximum social benefits be achieved.

The hierarchy of ethical principles is the most priority criterion. On this basis, specific ethical governance principles of the second-order are formulated, such as the principle of purpose explanation and permission during the data collection and the principle of informed consent and transparency during application. Furthermore, on top of that, make specific operational guidelines for the third-order, such as during the data collection: anyone asked to voluntarily submit a biometric identifier should (i) be fully aware of the potential risks; (ii) have the ability to understand the consequences of their actions; and (iii) consent to such actions in the absence of harm or threat*(35)*. The biggest challenge to this framework may come from social security. The traditional view may hold that law enforcement is an example of individual privacy rights giving way to public interests. In response to this point, we must first clarify that privacy protection does not mean that privacy cannot be used. Law enforcement's use of surveillance or biometric database does not necessarily result in privacy violations. It can be obtained through legal procedures. Compliance with legal procedures is a guarantee for protecting privacy. It is an example of maximizing social benefits based on privacy protection.

5. Conclusion

Through an in-depth analysis of the challenges of biometric technology to privacy protection, this paper concludes that the essence behind it is the conflicts between the two most fundamental ethical principles, namely maximizing social benefits and privacy protection. It provides a solution based on the hierarchy of ethical principles: biometric technology should be developed, but the premise of development is that ethical principles represented by the principle of privacy protection take precedence, and of course, these are based on the principle of practical feasibility. *The Personal Information Protection Law of the People's Republic of China* has come into effect, which echoes the ethical requirement of prioritizing privacy protection. Also, it provides a legal system guarantee for practical operations that can realize privacy protection. The solution based on the hierarchy of ethical principles proposed in this paper is to maximize social benefits further to ensure individual privacy rights, the premise of which is based on the principle of practical feasibility. It provides a solution to the ethical governance of biometric technology from the most basic principles and can be regarded as a first-order principle. It is the source for setting specific ethical governance principles and operational guidelines in the second and third orders and is also the basis for ensuring that biometric technology develops ethically. Based on this foundation, specific ethical governance principles in the second-order and operational guidelines in the third-order can be determined through Reflective equilibrium methods. At the same time, when formulating specific guidelines, attention must be paid to external regulations such as ethical review and legal regulation of biometric technology to achieve "good governance" in its use.

Conflict of interest

We claim no conflict of interest is associated with the "Challenges and Principled Responses to Privacy Protection from Biometric Technology in China" paper.

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FACE, FACIAL RECOGNITION TECHNOLOGY AND PERSONAL PRIVACY

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Abstract: The privacy problem of facial recognition technology is that commercial companies obtain people's facial information without the consent of individuals and use facial information to infringe on the privacy of individuals. The importance of human privacy in facial recognition technology is reflected through facial ethics, which requires others to perform corresponding obligations to individuals, such as oral care. Through the analysis of the privacy issues of facial recognition technology, it is found that the two elements of "without personal informed" and "without personal consent" together form the basis for commercial companies to violate personal privacy. The principle of informed consent includes the principle of informed and the principle of consent, which is derived from the principle of informed consent in medical ethics. This paper improves the principles of informed consent in medicine and ethics to better address facial recognition privacy issues.

Keywords: facial recognition technology; privacy issues; facial ethics; informed consent

Rostro, tecnología de reconocimiento facial y privacidad personal

Resumen: El problema de la privacidad en la tecnología de reconocimiento facial es que las empresas comerciales obtienen información facial de las personas sin el consentimiento de éstas y utilizan la información facial para vulnerar la privacidad de las personas. La importancia de la privacidad de las personas en la tecnología de reconocimiento facial se refleja a través de la ética facial, que exige que otros cumplan las obligaciones correspondientes con los individuos, como el cuidado bucal. A través del análisis de los problemas de privacidad de la tecnología de reconocimiento facial se descubre que los dos elementos de "sin información personal" y "sin consentimiento personal" juntos forman la base para que las empresas comerciales violen la privacidad personal. El principio de consentimiento informado incluye el de información y el de consentimiento, que se deriva del principio de consentimiento informado de la ética médica. Este artículo mejora los principios del consentimiento informado en medicina y ética para abordar mejor los problemas de privacidad del reconocimiento facial.

Palabras clave: tecnología de reconocimiento facial; cuestiones de privacidad; ética facial; consentimiento informado

Face, tecnologia de reconhecimento facial e privacidade pessoal

Resumo: A questão da privacidade na tecnologia de reconhecimento facial é que as companhias comerciais obtém informações faciais das pessoas sem seu consentimento e usam informação facial para infringir sua privacidade. A importância da privacidade humana na tecnologia de reconhecimento facial é refletida através da ética facial, que exige que se cumpram obrigações correspondentes para com os indivíduos, da mesma forma como com cuidados orais. Através da análise de aspectos de privacidade na tecnologia de reconhecimento facial, encontrou-se que os dois elementos "sem informação pessoal" e "sem consentimento pessoal" juntos, formam a base para companhias comerciais violarem a privacidade pessoal. O princípio do consentimento informado inclui o princípio de informação e o princípio de consentimento, os quais derivam do princípio do consentimento informado em ética médica. Esse artigo melhora os princípios do consentimento informado em medicina e ética para melhor incluir aspectos de privacidade no reconhecimento facial.

Palavras chave: tecnologia de reconhecimento facial; aspectos de privacidade; ética facial; consentimento informado

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1. Introduction

There is a huge market demand for facial recognition technology due to its convenience and security. In the future, with the improvement of accuracy and speed of facial recognition technology, it will be widely accepted around the world. The gradual popularization and application of facial recognition technology in society have made people feel the safety and convenience of facial recognition. But do people think about the technology and the various rights violations it causes when using facial recognition technology? It is undeniable that the emergence of facial recognition technology can indeed bring people convenience and safety, but is convenience and safety really what users want? When users' rights, especially privacy rights, are violated, What should users do?

Commercial companies in the real world use facial recognition technology to develop products to meet people's needs on the one hand and use facial recognition technology to obtain facial information of users or individuals for other purposes, such as better price discrimination. In the process of people using facial recognition technology, people's privacy rights are constantly being taken away. Faced with the privacy problems of facial recognition technology, this paper believes that the principle of informed consent in medical ethics can effectively solve the above problems.

This paper finds that the key to the violation of user privacy by commercial companies using facial technology lies in the fact that commercial companies collect users' facial data and other extended personal data without the user's consent and the user's knowledge, and use other personal data derived from users' faces for other purposes. Of course, all the purposes are based on the violation of users' privacy. It can be seen that the two elements of "without the user's informed" and "without the user's consent" are the key to the violation of user privacy by commercial companies. The principle of informed consent includes two small principles, one is the principle of informed, other is the principle of consent, and the principle of informed consent is the basis of the principle of informed consent in medical ethics. The principle of informed consent not only makes users pay due attention to the information, purpose, and use of facial recognition technology, but also pays attention to the "voluntary" and "non-mandatory" use of facial recognition technology by users.

2. Privacy invasion predicament of face recognition technology

The rapid development of artificial intelligence will undoubtedly make people's lives more convenient. At the same time, as the application of artificial intelligence in biometrics, facial recognition technology has brought about tremendous changes in people's lives along with smart mobile devices. An obvious example of this is that almost all smartphone manufacturers have added facial recognition modules to their mobile phones. The facial recognition technology in the facial recognition module can help users realize functions such as facial recognition unlocking and facial recognition electronic payment.

Facial recognition technology has been widely used in the following fields, such as video games, virtual reality, human-computer interaction, personal smart device and computer login, digital application login, mobile payment, Internet recording, video surveillance, electronic surveillance, suspects tracking, and finding lost children, etc. Facial recognition technology (machine recognition technology of face) can be generally expressed as: for the static image or video image of a given scene, the use of stored face database to identify or verify one or more people in the scene*(1)*. Of course, the above expression of facial recognition cannot fully summarize the characteristics of this technology. With the advancement of facial recognition technology, it has been possible to realize facial recognition for individuals in moving scenes to confirm their identity.

The ultimate purpose of facial recognition is to identify or verify the individual in the scene. Its main realization logic is to capture the stationary person or the moving person through the camera in the device with the help of intelligent devices, such as personal computers or mobile smart devices. Subsequently, the computer compares and verifies the personal facial features extracted from the scene with the personal facial information in the background database. Finally, the system realizes the operation of facial identity recognition such as passing or rejecting. The current facial recognition technology relies on the related algorithms and technologies derived from machine learning and artificial intelligence, and with the rapid progress of technology, it realizes the iteration of functions and has developed to a very terrifying level. Specifically, most advanced facial recognition programs employ a type of neural network called a convolutional neural network (CNN). The system uses algorithms such as convolution to perform continuous complex analysis of images and even uses advanced analysis to identify people, animals, objects, or scenes*(2)*.

Are human faces completely incapable of replicating one-to-one? The answer may be no. Deepfake technology, born in 2017, may be able to challenge facial recognition technology. Deepfake technology was first used by hackers to create pornographic videos - replacing the female avatars in the videos with the avatars of their favorite celebrities. Deepfakes use a generative adversarial network called Gan, where an algorithm called a generator is fed random noise and turned into an image, which is then added to a stream of real images of celebrities. From this, it can be seen that Deepfake can create a face that is almost the same as a real person through AI algorithms and use it to deceive other people (maybe in the future will also deceive the facial recognition system). For example, hackers and other criminals use Deepfake technology to copy the target's face and pass the facial recognition system, then they can operate illegally as the "ghost" behind the real customer.

At the same time, facial recognition can be rendered useless by creating a "real" face, or by "sabotaging" the system. There's currently a tool called Bose that blocks certain facial recognition software from doing facial recognition. The tool can break facial recognition systems by adding other elements to the internet before uploading photos that look indistinguishable to the naked eye, but the hidden features hinder the detection system*(3)*. If facial-faking technologies like Deepfake and facial-recognition attack tools like Bose continue to develop, they could cause widespread social problems.

The field of application of facial recognition technology can be divided into commercial applications and non-commercial applications. Usually, commercial applications necessarily have facial recognition technology built into various applications, and the facial recognition function is applied when the user uses the application. It's hard to imagine people abandoning facial recognition technology when faced with options that serve the same purpose. People often opt for facial recognition because it is fast and secure, allowing people to pay by pointing the camera on their phone screen at them. Non-commercial facial recognition applications are also emerging. Some of the best examples are technology companies, such as Baidu, Tencent, and Microsoft, which are developing apps to help find lost children. This kind of app is based on cloud technology and scans facial images to determine whether the child in front of the camera is the same as the missing child. At present, these companies have found some missing children through facial recognition technology. Baidu, for example, has successfully found the six-year-old abducted Fu Gui's loved ones 27 years after he was lost*(4)*.

Facial recognition technology is widely used, making people feel as if their facial information and images can be used by software or commercial companies at any time. When people use some software or smart devices with facial recognition technology, this software or device will confirm through various reminders that the user agrees to let this software obtain their facial information and make reasonable use. However, some software, devices, or products from commercial companies do not tell users that they have taken facial information and used it for other purposes. For example, Facebook's facial recognition is enabled by default; Facebook's system works only if users choose to keep it as default. So in 2015, users in Illinois accused Facebook of violating the state's Biometric Information Privacy Act when collecting biometric data*(5)*. Of course, Facebook users have discovered their facial information and filed a lawsuit to expose this unethical behavior to the public. However, some software or smart devices will turn on the device's camera without the user's agreement to obtain the user's facial information. Privacy consultant Dylan Curran claims Apps can take photos and videos without telling users, run real-time facial recognition to detect facial features or expressions, and even stream cameras to the internet in real time*(6)*.

Some commercial companies have been able to identify the user's facial information through facial recognition technology and obtain additional personal information through the user's facial information. An Internet company called Clearview AI has developed a facial recognition software called Clearview, which can not only accurately recognize human faces like other facial recognition software, but also can use the recognized face or face picture to link to the location of the web page where the images appear, as well as a link to almost all of the person's publicly available images. The backbone of the system is a database of 3 billion images that Clearview claims to have scraped from Facebook, YouTube, Venmo, and millions of other sites, and it's far beyond anything the U.S. government or Silicon Valley giants have built. While proponents cite the use of the technology to prevent or deter crimes, including child sexual abuse*(7)*, the emergence of this software will also greatly increase other risks. For example, people can get relevant information about strangers by taking photos of them, and then entering the personal homepage of social networking sites to carry out harassment or abuse; criminals obtain photos of the school where the victim is studying through the software, to know the school of the victim, which is more conducive to criminals to carry out the kidnapping.

3. Personal privacy and facial ethics

Ethics has had a complex and protracted discussion of privacy. As to why privacy is important, one view holds that the value of privacy is intrinsic and ultimate, a condition and right inseparable from human dignity*(8)*; Another view holds that the right to privacy is not a fundamental right, because every violation of one's privacy is already a violation of some other rights*(9)*. The first view shows that privacy is essential for autonomy and protection of human dignity, this view is linked to human dignity; the second view, which shows that privacy is the basis of many other human rights, links privacy to other rights. Philosophers have worked hard to define privacy, and the definition of privacy is often associated with the word "proximity." Michael J. Quinn thinks that the privacy people have is the right to allow areas that are inaccessible to others*(10)*. This definition can be expressed as: privacy enables us to create barriers and management areas to protect ourselves from unnecessary distractions in life, which enables us to understand who we are and how we interact with the world around us. When others violate our privacy, it violates the individual's right to freedom, especially the negative freedom of individuals. Isaiah Berlin argues that the subject (a person or group of persons) is allowed or must be allowed to do what he is capable of doing without interference from others*(11)*. If you simply summarize negative freedom, it is "freedom from...". Berlin believes that what the concept of negative freedom emphasizes is "not being interfered with by others", and the core of "not being interfered by others" lies in non-coercion, that is, the field where I can act in other ways, and there is no intentional interference by others. In other words, individuals are not artificially prevented from achieving a certain purpose.

As seen from the above examples of commercial companies invading individuals through facial recognition technology, these companies usually obtain personal facial information without the user's knowledge. Personal facial information is necessarily part of an individual's physical privacy. If an individual knows and agrees that a commercial company obtains his/her facial information and data through facial recognition technology, then this behavior can be regarded as a transfer of power, that is, an individual transfers his privacy rights to a commercial company. However, when the commercial company obtains the user's facial data and information without the user's knowledge, that is the commercial company violates the individual's right to maintain dignity, especially when the commercial company uses facial recognition technology without the user's knowledge. Other behaviors infringe other rights of users, including but not limited to negative freedom rights and portrait rights. Whether it is price discrimination and identity discrimination against users through facial recognition technology, or criminal activities caused by the disclosure of personal information through facial recognition technology, it shows the violation of negative freedom caused by the abuse of facial recognition technology. To a certain extent, the right to portrait is also a kind of right to privacy, because both portrait and facial privacy use the face as the main carrier.

The rules to protect privacy enables us to assert our rights in the face of serious power imbalance, especially since the current commercial companies use various technical means to obtain our facial privacy without our permission. No privacy means we don't have the right to protect our facial information from being disclosed. When commercial companies use facial recognition technology to violate people's negative rights by invading privacy, there is no doubt that they are violating the iron law of "freedom from...". People all hope that they will not be treated unfairly, that they will not be prejudiced, and that they will not be harmed by the disclosure of their privacy.

However, it would be too simplistic to reveal the importance of privacy in facial recognition technology alone. After all, other science and technology also bring privacy problems, such as big data technology. In cyberspace, especially in the era of big data, loss of privacy can easily occur. The world's technology giants have all used big data technology to assist their business operations, such as Amazon, Alibaba, JD, etc. As e-commerce giants, Amazon and Alibaba usually use big data technology to "portrait" users to better recommend other similar products to users. When these e-commerce platforms implement price discrimination against users, big data technology must be used. Big data technology must obtain a large amount of data from users, including browsing history of products, purchase records, time spent on products, prices of browsed products, personal account number, ID number, contact information, etc. In the context of e-commerce, many consumers' personal information is collected without their knowledge, and consumers do not know what purpose the collected personal information will be used for.

It can be seen that when discussing the privacy issues of other technologies, including the aforementioned commercial companies' use of big data technology to violate users' privacy, although the means and methods of obtaining users' privacy are different from those of facial recognition (big data technology collects users' historical browsing records and personal information, facial recognition technology "scans" a person's face), the result is to recommend products and so on. Therefore, if we talk about privacy issues and the importance of facial recognition in this way, it must be no different from discussing other technologies. So what if the true privacy importance of facial recognition technology could be differentiated from other technologies? This paper believes that the biggest difference between facial recognition technology and other technologies, such as big data technology, is the human face, that is, the importance of facial recognition privacy must have its important ethical significance. In ethical terms, it has facial ethics.

A human face is a part of a person's appearance. The same hands, feet, height, skin color, and figure are all important signs to distinguish it from others. However, the biggest difference between a human face and other "human features" is that the face is individually identifiable, which means that if a person loses his torso, leaving only his head, others will still be able to identify "who you are". From this, it can be seen that the human face is one of the important elements of human self-existence, but the above analysis is only an analysis at the physical level and does not show people that the face is the philosophical foundation of self-existence.

Emmanuel Lévinas, a famous Lithuanian philosopher, has conducted an in-depth discussion on the relationship between ethics and the face. Therefore, this article will start with Levinas' theory to analyze the human face. The ethical significance of the face, especially the significance of the face to the existence of the self and its basis for the communication between the self and others. Levinas believes that the human face has a very upright state, and its sense of confrontation with exposure is defenseless. The skin on the face is the most exposed skin, which means that people's inner world can be fully presented through the face. Emmanuel Levinas said:

It calls to me above and beyond the given that speech already puts in common among us. What one gives, what one takes reduces itself to the phenomenon, discovered and open to the grasp, carrying on an existence which is suspended in possession-whereas the presentation of the face puts me into relation with being. The existence of this being, irreducible to phenomenality understood as a reality without reality, is effectuated in the non-postponable urgency with which he requires a response*(12)*.

"It" here refers to a person's face. This passage shows that the face (face) is not only the embodiment of self-existence at the physical level but also the self-existence of the inner spiritual world. The face is the existence of the self at the physical level that can be understood by people without too much explanation. As mentioned above, when a person loses the body and only the face exists, others can also identify it, just like the identity card on the national identity card. Only the facial image is required as the only picture of the human body. Although the ID card also includes the ID number, the personal facial photo on the ID card is still the main basis for identifying a person. It is not difficult to understand that the face is the existence of the self at the physical level and the self-existence of the inner spiritual world.

What would you do if you were faced with a sad individual with a crying face? One might say, I'll ignore it, but most people will have the moral feeling of caring for that grieving person and will most likely talk to him because of primitive human sympathy. That is, as Niklas Toivakainen analyzes Levinas' Ethics of the Face, All our reactions to others are always about the other's "face." This suggests that morality is not about constructing a theory or extending morality (although this can be related to the general moral claims of the other party), but always about a dynamic of opening up to the other party, allowing the other party to touch us without limit, rather than running away from it, repressing /suppressing how the other person touches us, and how we respond to each other*(13)*. That is, in Levinas' view, the face is the origin of human discourse, the ethical relationship between the self and the other, leading to obligations from the self to the other. In this way, each is connected to others by being simultaneously self and as part of society as a whole. This also shows that the ethical significance of the face is that the face can reflect the existence or actual situation of the individual's inner spirit, that is, the face is the embodiment of self-existence, whether it is spiritual or material, and at the same time, the outside world (such as other people) can pass Facial features (such as crying) to show certain obligations to people, such as oral care. Therefore, it can be said that the face represents the dignity of the person, but also the moral obligation of others to the self. Therefore, facial recognition technology must ensure that the realization of personal existence and the external does not cause moral harm to the individual, such as an invasion of privacy. Especially in the digital age, with the widespread use of facial recognition technology, commercial companies or individuals (such as hackers) can obtain people's facial information through different means, and people will also upload their facial pictures to various digital media, such as Weibo, WeChat Moments, etc. People share and interact with others through their faces, as sending a laughing emoji on Weibo indicates that their psychological state is happy, then others will comment on it, or have a good conversation and communication; someone posts a crying face, others will show moral concern for him, or comfort him.

The above example is of course the external moral obligation to the individual, but Levinas' face ethics is not so simple. It shows that the face is a channel for external communication with the self, and the external should pay attention to the corresponding moral obligations of others, that is, the external do moral things to individuals. This paper believes that when facial recognition technology obtains personal facial information, individuals must not want others to conduct unethical behaviors on themselves, especially outsiders should not conduct evil operations on personal facial information and personal privacy information obtained through the face. That is, the problem is only how to understand the obligations of the self to others whose existence is complicated by their digital masking and creative appearance.

4. Discussion and conclusion

Informed consent is a principle of medical ethics applied to the medical field. Informed consent, that is, patients, have the right to know their conditions and can decide on the prevention and treatment measures taken by medical staff, which has been widely accepted by the Eastern and Western medical circles and recognized by patients. The starting point is also patients' rights. The violation of user privacy by facial recognition technology can also be regarded as a violation of the user's rights. Of course, privacy rights are the most critical, but the right to obtain negative freedom cannot be ignored. This section provides a detailed analysis of why the principle of informed consent is important in facial recognition and how the principle of informed consent in medical ethics can be applied to the privacy issues of facial recognition technology.

Through the above case of how facial recognition technology violates user privacy, it can be deeply analyzed to discover how commercial companies violate the essence of user privacy. When people use some software or smart devices with facial recognition technology, this software or device will use various reminders to make users agree to let this software obtain their facial information and use it reasonably. But this is not all, some software, devices, or commercial company products do not inform users that they have access to facial information for other uses. At the same time, in addition to obtaining facial information without the user's permission, obtaining other information through facial information is also a reflection of the invasion of privacy caused by facial recognition technology. Some commercial companies have been able to identify users' facial information through facial recognition technology and use facial recognition technology to obtain additional personal information through facial recognition for other purposes, such as customer priority discrimination or price discrimination. It can be seen that the main manifestations of the privacy problems of facial recognition technology are divided into two types: first, commercial companies obtain the user's facial information without the user's consent or the user's knowledge; second, after obtaining the user's facial information through legitimate or improper means, the commercial companies can obtain other private information of the user through the facial information, such as identity, occupation, mobile phone, hobbies, etc. And without the user's knowledge or consent, the commercial companies engage in other commercial, non-commercial, legal, or illegal conduct. It must be pointed out that the latter must be based on the former, which cannot be achieved without facial recognition technology.

When people discuss whether science and technology are good or evil, they usually think that science and technology itself are neutral, and it is no good and evil. Therefore, people's evaluation of the good and evil of certain science and technology usually does not start from the technology itself, but from the subject who uses the science and technology. People interpret the problem as the fact that technology products have only extrinsic value*(14)*. This also means that when we analyze the problems caused by facial recognition technology When it comes to privacy issues, it is also possible to start from the main body of a commercial company, rather than simply from the facial recognition technology itself. Of course, it is not impossible to discuss the good and evil of facial recognition technology itself, what needs to be done is to analyze the good and evil of the intrinsic value of facial recognition technology. Philosophers distinguish two kinds of values: instrumental values and intrinsic values*(15)*. The former is the value that can bring other benefits, while the intrinsic value is good value in itself. For example, the tool value of facial recognition is that it can accurately identify the lost child and find the lost child through facial recognition technology. This is the value of external goodness.

Whether it is the first manifestation or the second manifestation of the facial recognition problem, what these two manifestations have in common is that the commercial company collects the user's facial data without the user's consent and without the user's informed and uses the user's facial information and other personal information for other purposes. It can be seen that the two elements of "without user consent" and "user unawareness" constitute the key for commercial companies to violate user privacy, and these two elements are also the basis for medical ethics to formulate the principle of informed consent. There are two main situations in which the patient's right to informed consent is violated during the implementation of medical behaviors: the first is the inability to understand the information provided by the physician because of the inability to obtain true and comprehensive information or the limited level of cognition, and ultimately leads to the abandonment of this right; the second is that when the physician performs the duty of disclosure, the realization of the patient's right to informed consent is hindered due to the existence of bad motives. It can be seen that the violation of patients' rights in medical behavior has a potential commonality with the privacy problem of facial recognition. Therefore, we can improve the characteristics of the principle of informed consent in medical ethics (divided into the principle of informed and the principle of consent) concerning the privacy issues of facial recognition technology and take it as the main ethical principle to solve the privacy issues in facial recognition technology.

4.1 Informed Principle Application of Facial Recognition Technology

The informed principle means that users can know what they need, have full knowledge of the advantages and disadvantages of facial recognition technology, and can make rational judgments about their gains and losses. The informed principle does not require users to be completely rational, and it is unrealistic to be completely rational. The principle of knowledge is intended to explain that when users use facial recognition technology, commercial companies or other units must enable users to know the specific circumstances of facial recognition through various forms, including but not limited to setting up user terms for users to read. User terms or other forms that allow users to know must inform users of relevant information in their use of facial recognition, such as the user's facial information will be collected and included in the database; the user's facial information will be used for other operations, for example, it helps users to better purchase products (facial recognition technology can analyze users' preferences and allow commercial companies to recommend products to users through facial recognition technology). However, this is still not enough, especially for the emerging technology of facial recognition, users should also know the relevant information about facial recognition algorithms. Although, some commercial companies will claim that the facial recognition algorithm is a company secret, especially when the company's facial recognition technology is at the forefront of the industry. But there is a difference between technical trade secrets and the rationale and general design of an algorithm, which should be accessible to the public so that the public can fully trust the system*(16)*. That is, although the algorithms may be trade secrets to commercial companies or other individuals and are protected by laws such as intellectual property laws, the overall design ideas and philosophy of the algorithm must be disclosed to users, and users must be told some details of the algorithm (eg, whether the algorithm can automatically turn on the camera). This information is released to let most non-professional users know some of the details of the facial recognition process. All in all, users must be able to obtain sufficient information about facial recognition technology, and the facial recognition technology provided by commercial companies or other individuals has sufficient information and authenticity.

4.2 Consent Principle Application of Facial Recognition Technology

The key to the principle of consent is voluntary versus non-coercive. When individuals use various applications based on emerging technologies, or commercial companies use emerging technologies to achieve other purposes, users will not be required to sign a consent confirmation. With the emergence of smart devices, especially the popularization of smartphones, more and more people are concerned about whether people agree with commercial companies to obtain personal privacy information. Some companies may give some terms for users to read before users use related mobile phone smart software (some of this software rely on facial recognition technology), such as collecting personal mobile phone numbers, SMS records, mobile phone gallery, fingerprints, and other information. Users can use this software after confirming their understanding and agreement. However, it is worth noting that although some companies will give users access to these terms, this does not mean that users have the right to choose voluntarily, and sometimes it is mandatory. Because, some software is already set, not agreeing to the terms will not allow the user to start using the software. Therefore, it can be seen that such terms have hidden “mandatory” because the user’s “disagreement” with the terms will lead to the “unusable” of the software. Consent is closely related to informed consent. Logically speaking, consent must be established based on informed consent. Because the user is unaware of various circumstances, such as the purpose and means of facial recognition technology, the user must not consent. However, there is still a certain distance between reality and theory. Some commercial companies will not fully inform consumers of the specific purpose of facial recognition, the means of obtaining the face, and details (such as whether the camera is used privately, the general framework of the algorithm of facial recognition technology, and whether the privacy of users is violated) in the user terms. information about whether the user’s privacy is infringed) is completely told to consumers; what’s more, no information about facial recognition technology is given to users at all, as if facial recognition technology has become “invisible” between users and commercial companies, this results in users having no idea that they are a potential target for facial recognition technology. Therefore, the principle of consent must be able to effectively solve the above problems. This article attempts to summarize the principle of consent as, firstly, when commercial companies use facial recognition technology, they must let users know that they are using facial recognition through various means (such as user terms); secondly, users cannot be forced to agree to the terms of use (if they do not agree to the terms, they cannot use the software of facial recognition technology); finally, commercial companies cannot make individuals have the principle of consent to use (such as personal use of facial recognition technology must be prohibited in the absence of user terms for users to read and agree to).

It must be pointed out here that the principle of informed consent must be given to users or individuals by commercial companies. The principle of informed consent includes the principle of informed and the principle of consent, both of which must be satisfied. Moreover, commercial companies must first satisfy the principle of informed consent of users and then satisfy the principle of consent of users. The former is the basis of the latter. If these two principles cannot be satisfied, or only one of them can be satisfied, the function of the informed consent principle will be lost, and the privacy of users or individuals will still be violated.

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CONSIDERACIONES ÉTICAS Y CIENTÍFICAS DEL INICIO DE LA VIDA SOBRE EL ABORTO EUGENÉSICO EN ENFERMEDADES GENÉTICAS INCAPACITANTES EN PERÚ

Hugo Hernán Abarca Barriga[1]

Resumen: El artículo expone conceptos actuales biológicos, así como algunos planteamientos filosóficos acerca del inicio de la vida, que se examinarán en relación con la necesidad del aborto eugenésico. Se presenta el concepto de "exdurantismo", en el que la combinación del nuevo genoma nuclear y mitocondrial hacen único al individuo; además, se concibe al complejo genómico como "integrador somático" que dirige el desarrollo embrionario, y se muestra la problemática en el caso de las violaciones que provocan embarazos, el aborto eugenésico en enfermedades genéticas incapacitantes o la utilización de embriones posterior a la fertilización *in-vitro*.

Se plantea que la dignidad de la persona comienza desde la concepción. Frente a la detección de una enfermedad genética, grave o letal, se debe ofrecer soporte económico y social, de diagnóstico y tratamiento; además, desde la salud pública, una mayor inversión para plantear estrategias de tamizaje, diagnóstico, manejo e investigación.

Palabras clave: aborto eugenésico, comienzo de la vida humana, fertilización *in-vitro*, embrión de mamíferos, enfermedades genéticas congénitas

Ethical and scientific considerations of the beginning of life on eugenic abortion in disabling genetic diseases in Peru

Abstract: The article presents current biological concepts, as well as some philosophical approaches to the beginning of life, which will be examined in relation to the need for eugenic abortion. The concept of "exdurantism" is presented, in which the combination of the new nuclear and mitochondrial genome makes the individual unique; furthermore, the genomic complex is conceived as a "somatic integrator" that directs embryonic development, and the problematic is shown in the case of rape that causes pregnancies, eugenic abortion in incapacitating genetic diseases or the use of embryos after in-vitro fertilization.

The dignity of the person begins at conception. When a serious or lethal genetic disease is detected, economic and social support, diagnosis and treatment should be offered; in addition, public health should invest more in screening, diagnosis, management and research strategies.

Keywords: eugenic abortion; beginning of human life; fertilization *in vitro*; embryo, mammalian; inborn genetic disease.

Considerações éticas e científicas do início da vida sobre o aborto eugênico em enfermidades genéticas incapacitantes no Peru

Resumo: O artigo apresenta conceitos biológicos atuais, bem como algumas abordagens filosóficas sobre o início da vida, que serão examinados em relação à necessidade do aborto eugênico. É apresentado o conceito de "exdurantismo", no qual a combinação do novo genoma nuclear e mitocondrial torna o indivíduo único; além disso, o complexo genômico é concebido como um "integrador somático" que dirige o desenvolvimento embrionário, e é mostrada a problemática no caso de estupro que resulta em gravidez, aborto eugênico em doenças geneticamente incapacitantes ou o uso de embriões após a fertilização in vitro.

Argumenta-se que a dignidade da pessoa começa na concepção. Diante da detecção de uma doença genética, grave ou letal, devem ser oferecidos apoio econômico e social, diagnóstico e tratamento, bem como maior investimento em saúde pública em estratégias de triagem, diagnóstico, gestão e pesquisa.

Palavras chave: aborto eugênico, começo da vida humana, fertilização *in-vitro*, embrião de mamíferos, enfermidades genéticas congênitas

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Introducción

Existen en nuestro país muchos vacíos legales en lo que respecta a la protección integral de la salud de las personas con enfermedades genéticas*(1)*, así como el resguardo de la vida desde la fertilización*(2)*.

Entonces, uno de los problemas que se observa cuando se trata de plantear soluciones basadas en pruebas científicas y en la moral de nuestra población es la deshumanización, que no se da solo desde la parte médica, sino también en la sociedad en sí misma, provocada a su vez porque un individuo observa al prójimo de manera diferente, ya sea por su apariencia o naturaleza (disimilitud)*(3)*, y que incluso se podría acrecentar esta disimilitud cuando se tiene al frente a un paciente con una enfermedad genética o se "escucha" sobre los embriones o los fetos.

En ese sentido, mostraremos algunos conceptos básicos de biología del desarrollo, así como de pensamientos filosóficos actuales que sustentarían cuándo se inicia la vida y, basados en estos, plantear posibles soluciones sobre el aborto libre eugenésico, así como el descarte de embriones producto de la fertilización *in-vitro* en parejas infértiles o siendo parte del diagnóstico genético preimplantacional.

Organización biológica y formación del cigoto

Los seres humanos estamos conformados por alrededor de 37,2 billones de células*(4)*; sin embargo, cada individuo tiene un genoma nuclear, es decir, "una sola información nuclear" que se repite en todas nuestras células, la cual contiene entre 19 y 21 mil genes que codifican principalmente proteínas*(5)*. Mientras que el genoma mitocondrial, heredado matrilinealmente, solo tiene 37 genes y que el número de copias de ADN mitocondrial que posee una célula es de 100 a 10 000*(6)*. Además, es importante resaltar que algunas veces esta información no es la misma en las diferentes mitocondrias, a lo que se denomina como "heteroplasmia"*(7)*.

Con relación a la formación del cigoto, proviene de dos células completamente diferenciadas y adquiere su totipotencialidad posterior a la fertilización. Para alcanzarla el oocito debe completar la meiosis II y una activación específica del genoma, el cual ocurre a los dos días aproximadamente*(8,9)*.

Posterior a estos dos fenómenos comienza la división celular del cigoto, para observarse al cuarto día el blastocisto (figura 1), gobernado por un sistema propio, provocando un primer cambio morfológico hasta el estadio de ocho células, donde, además, cada una de las células son iguales en su forma, y entre 1-3 horas de alcanzar las 8 células. Los blastómeros comienzan a mostrar signos de polaridad el cual establece el dominio apical y el basolateral y recién las células son diferentes en el estadio de 16 células cuando toman posición interna o externa*(8)*. Sin embargo, existe evidencia de que la polaridad estaría presente en el oocito *per se* y previa a la fecundación, donde la distribución de las organelas y moléculas es asimétrica; indicando, por lo tanto, estructuras preestablecidas*(10)*.

Por otro lado, existe una tendencia a dividir la etapa embrionaria en dos estadios, la preembrionaria y la embrionaria propiamente dicha. La primera se establece desde la fecundación hasta la implantación, es así que en esta etapa se reconoce que las células tienen una totipotencialidad y eventualmente una posibilidad de formar gemelos*(11)*.

Este genoma individual debe ser activado para ejercer su influencia determinante en varios de los rasgos, desde físicos (ej. altura)*(12)*, pero que también es modificado ambientalmente. Es así que Yunta (2016) argumenta que desde la fecundación existe un individuo por la novedad biológica, el genoma actúa como un centro organizador, observándose así una continuidad biológica (fecundación, desarrollo y muerte), siendo específica para la formación de *Homo sapiens* y este a su vez tiene una capacidad de relacionarse y unirse*(11)*.

Aspectos filosóficos del inicio de la vida

Muchas veces se plantea que el ser humano comienza su vida a partir del momento que aparece la personalidad. Esa realidad y riqueza multidimensional se va manifestando de manera progresiva desde el inicio como ente vivo y único*(14)*. Sin embargo, Pardo (2007) nos menciona que si bien

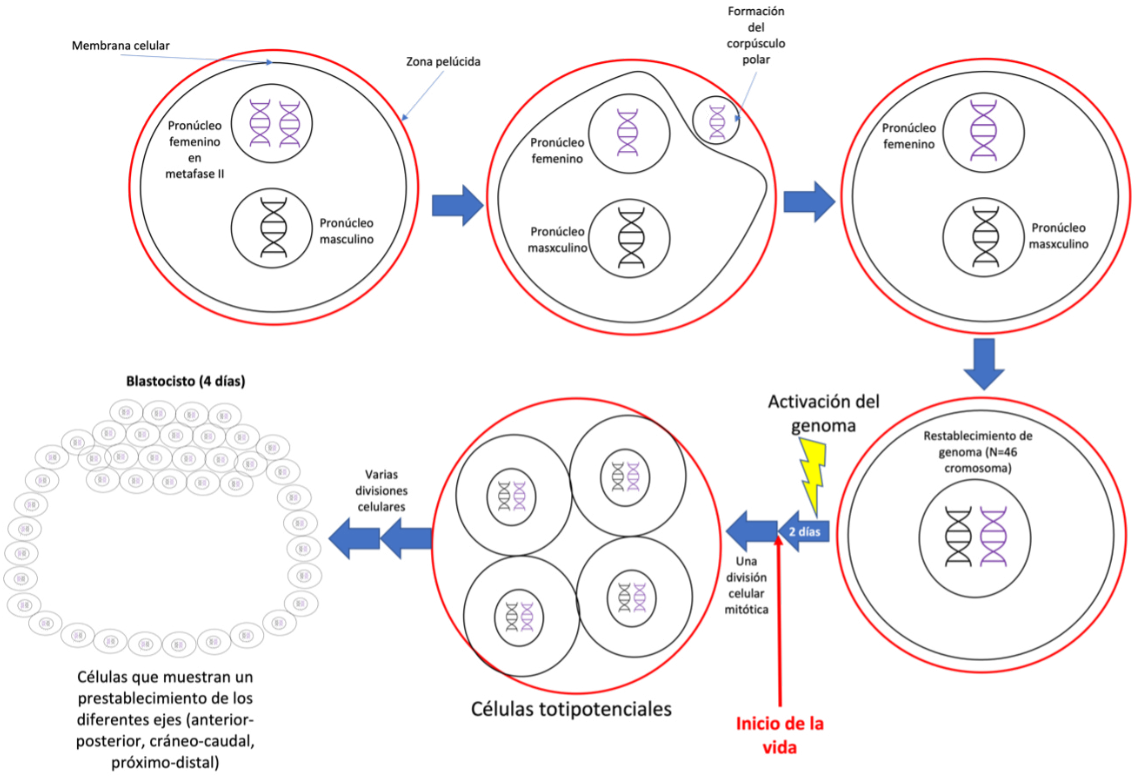

Figura 1. Inicio de la vida. Posterior a la concepción y a la culminación de meiosis II del oocito, recién aparece la activación del genoma, el cual estaría indicando el inicio de la vida.

la evidencia científica está basada principalmente en el método hipotético-deductivo, demostrado con experimentos y en conclusión se tiene una ley científica e hipótesis no falseadas, entonces es muy complejo realizar afirmaciones como el de “la vida comienza en…” o “esto no es un ser humano”*(14)*, ya que el estudio experimental con embriones tiene sus correspondientes dilemas éticos. Por lo que se debería utilizar la filosofía para saber qué es y cómo identificar la vida, y qué es un hombre, es decir, realizar una perfilación de la materialidad del ser humano*(14)*.

Entonces, podemos afirmar que un ser vivo tiene automovimiento, donde se incluye conceptos como nutrición, metabolismo, crecimiento, respiración, entre otros; es una unidad, posee una corporalidad orgánica, un modo de ser y tiene objetivos naturales*(14)*. Yendo en esta misma línea, Pardo (2007) menciona que el hombre, es una especie (*Homo sapiens*), tiene un carácter personal y es una sustancia (que, según Descartes, es aquello que existe por sí mismo, sin necesidad de otra cosa)*(14)*. Entonces, con todas estas apreciaciones, Pardo plantea si deberíamos caer al reduccionismo genético, teniendo una respuesta negativa, porque únicamente no somos la herencia del ADN nuclear parental, sino que existe una dependencia del genoma mitocondrial materno y del epigenoma que puede ser cambiante a lo largo de la existencia, así como los propios cambios en nuestro proteoma (información proteica) y lógicamente sus relaciones con el medio ambiente. Es así, para comentar de una manera gráfica el epigenoma, son esos cambios que no modifican la se-

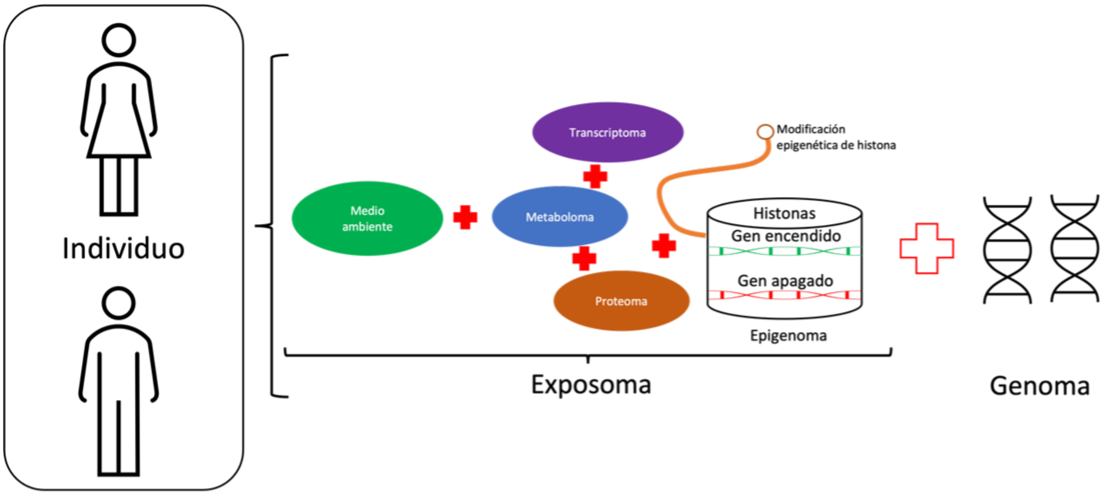

Figura 2. Relación entre el genoma y el exposoma determinante de las características de un individuo.

cuencia o la información genómica, sino que son las modificaciones químicas que se observan, por ejemplo, en las histonas que pueden activar o silenciar ciertos segmentos de nuestro genoma. Por lo que nuestra individualidad no solo está determinada por el genoma (nuclear y mitocondrial), sino por su relación con el exposoma, que incluye al epigenoma, proteoma entre otros y su acoplamiento global con el medio ambiente (figura 2).

Otros autores plantean que el inicio de la vida comienza desde la concepción, sin embargo, muchos detractores indican que el cigoto tiene la posibilidad de formar gemelos, por su condición de totipotencialidad*(15)*. En este sentido, Efird & Holland (2019), estando a favor del concepcionismo, hacen uso del concepto filosófico de "exdurantismo", que sostiene que los objetos materiales están totalmente presentes en un tiempo determinado y persisten en virtud de tener contrapartes momentáneas en diferentes instantes*(15)*, y que conceptos como endurantismo —que consiste en que el individuo está totalmente presente en todo momento de su existencia, o el de perdurantismo que es cuando un objeto está conformado por una serie de fases, estadios o partes temporales— definen de manera incompleta el inicio de la vida*(15)*. Es importante resaltar que estos dos planteamientos están basados en cómo un objeto se observa a lo largo del tiempo, pudiendo entenderse que el cigoto, al ser totipotencial, podría formar dos individuos distintos en otro momento; sin embargo, al utilizar el concepto de exdurantismo, el objeto sigue siendo el mismo, a pesar de cambiar su forma e incluso su funcionalidad*(15)*.

Contrario a esta mirada, Brown (2019) habla de "integración somática", mostrándonos que, para que la vida sea conceptualizada como tal, es relevante la integración del funcionamiento de sistemas y órganos mayores; entonces, en contraparte, la muerte, según esta conceptualización, es cuando el sistema fisiológico del cuerpo cesa para desintegrar la totalidad, en la que el cerebro o encéfalo es el regulador máster*(16)*. Entonces, los agregados orgánicos simples que forman parte de estos sistemas y órganos están compuestos por componentes biológicos y no biológicos que no resisten activamente a la descomposición entrópica*(16)*. Brown (2019) señala que el estado moral del ser humano deberá ser asumido por ser una condición suficiente: posee el derecho a no morir injustamente y el derecho de no ser dañado injustamente mediante experimentos médicos*(16)*. Entonces, define un organismo como aquello que posee compuestos orgánicos, rodeados de una membrana que permite que el estado interno complejo resista a la entropía y al intercambio bidireccional. Es así que el concepto de integración somática no solo está referido a la homeostasis de una persona, sino que se observa a diferentes niveles*(16)*. Brown menciona que esa misma conceptualización de la integración somática se extrapola al embrión, marcando una división del periodo embrionario en precoz y tardío. El primer estadio es el precoz (preembrión), que es hasta los cinco días posterior a la concepción, siendo un agregado orgánico con posibilidad de división gemelar*(16)*. El segundo estadio (embrión tardío) también es un agregado orgánico, pero tiene además una insuficiencia para mantener la homeostasis, ya que es dependiente de la madre y se inicia posterior a la implantación; por otro lado, el desarrollo de los sistemas y órganos es en paralelo y sin un comando central globalizado*(16)*. En este punto, muestra el ejemplo del sistema circulatorio, el cual termina su desarrollo y comienza el control del embrión recién en el estadio Carnegie 23 (8 semanas)*(16)*. Concluye que ningún estadio de desarrollo embrionario tiene un estado moral, y si se le atribuyera sería por otras razones, como las simbólicas, religiosas o de carácter público*(16)*.

Aborto

Es la interrupción de la gestación antes de las 22 semanas, clasificado en cinco tipos: espontáneo, libre, eugenésico, terapéutico y mixto*(17)*. Es importante reconocer que es un fenómeno mundial y que el aborto provocado (puede ser libre o eugenésico) alcanza al 36% de todas las gestaciones en países desarrollados, lo que según Yunta (2016) ocurre por permisivismo moral, emancipación de la mujer, crecimiento demográfico e intereses político-económicos*(11)*. En Perú está permitido el aborto terapéutico desde 2014 (RM Nº468-2014-MINSA), definido como la interrupción voluntaria de un embarazo antes de la viabilidad fetal por razones de salud materna*(17)*. Pacora (2014) muestra aquí su preocupación, por considerar que esta guía es una puerta de entrada para introducir el aborto legalmente (eugenésico o libre), debido a que la madre podría estar perturbada psicológicamente o haber sido víctima de abuso sexual*(17)*.

Por otro lado, Blackshaw & Rodger (2019), que están a favor del aborto libre, ponen como punto de partida el *problema del aborto espontáneo*, el cual se observa en el 70% de las gestaciones y, por lo tanto, desde la mirada concepcionista, que concibe al embrión como estado moral, debería ser un problema de salud pública, por las "vidas" que se pierden, y que no se plantean soluciones para evitar esas muertes y que absurdamente se tiene una mirada reduccionista al estado moral *per se(18)*. En esta misma línea, Watson (2019) plantea que el *aborto es un bien moral*, porque a la madre se le debería otorgar una salud integral, incluida la felicidad; y que, por otro lado, el feto es una "sustancia" gobernada por el ADN, al cual, en otros tiempos, lo llamaban el "alma"*(19)*. Watson (2019) utiliza la integridad, libertad y dignidad materna, que serían parte del principio de autonomía de la madre; así como el principio de beneficencia, porque previenen los daños de un embarazo forzoso y de una satisfacción familiar, y por último ayuda a la justicia, porque la mujer lo realiza por tener una mejor economía para un acceso sociocultural superior*(19)*.

Es importante resaltar que el aborto libre y voluntario —conocido también como interrupción voluntaria del embarazo— es la terminación deliberada del desarrollo del feto, que puede ser clandestino o legal, según el marco constitucional de cada país*(20)*. Orjuela-Ramírez (2012) sostiene que este procedimiento es usado como práctica anticonceptiva para espaciar, limitar o posponer las gestaciones, y que la aceptación social depende del significado de la maternidad en el caso de uniones no formalizadas. Todo esto podría ser agudizado en algunas zonas o grupos étnicos específicos*(20)*. Por ello, los motivos para decidir el aborto voluntario serían la ausencia o pocos recursos afectivos, económicos, soporte familiar-social que permita aceptar la maternidad*(20)*.

Poniendo en la balanza la decisión de proceder o no a la culminación del embarazo, Theofanidis et al. (2013) muestran dos corrientes filosóficas relacionadas con la decisión del *aborto eugenésico*, definido como la terminación del embarazo cuando el embrión o feto presenta alguna anomalía, y nos ofrece el ejemplo en el caso si el embrión/feto padece de anencefalia*(21)*. La primera corriente se basa en la *deontología*, que plantea que nadie tiene el derecho a matar, incluso si esta acción salva la vida de otra persona, por lo que no se califica a las consecuencias de una decisión correcta o incorrecta*(21)*. Mientras que para el utilitarismo es importante alcanzar el mayor equilibrio entre el beneficio y el perjuicio, con un cálculo cuidadoso de las consecuencias de una decisión moral; en ese sentido, el aborto puede ser planteado moralmente como una medida correcta, ya que se debe considerar que existiría un mayor número de personas beneficiadas*(21*.

Problemáticas relacionadas con el inicio de la vida y el aborto eugenésico

Existen procedimientos médicos que en algunas situaciones tienen un fuerte componente de selección eugenésica de embriones y en otros se relacionan exclusivamente con el inicio de la vida, siendo estos la fertilización *in-vitro*, la anticoncepción de emergencia, y el diagnóstico preimplantacional y prenatal.

Fertilización in-vitro (FIV)

Otra consideración relacionada con los aspectos éticos y el inicio de la vida, es el exceso de embriones fertilizados *in-vitro*, de los cuales algunos se puede utilizar para investigación, donación a otras parejas infértiles o permitir que el embrión perezca*(22)*. Con relación al uso de células embrionarias donadas para investigación, se comenzó a utilizar desde 1988*(23)*. Es así sus usos tienen la finalidad de conocer los mecanismos de la diferenciación celular, exploración sobre los trasplantes terapéuticos y probar nuevos fármacos o la respuesta a toxinas*(11)*. Murphy (2013) argumenta que los embriones “extras” pueden perecer o ser utilizados para investigación, aplicando el criterio del doble efecto, porque la finalidad de la FIV es la reproducción y, por otro lado, durante la concepción natural muchos de los embriones fertilizados mueren espontáneamente*(24)*. Por otro lado, Delander (2013) afirma que el control en el número de embriones “extras” puede y debe estar regulado, tal como lo hacen algunos países*(22)*. En este sentido, existen países que permiten, bajo supervisión, la creación de embriones para investigación, como el Reino Unido o algunos estados de EE.UU., mientras que en Alemania no se permite estudios en embriones humanos*(25)*. Sin embargo, el uso de las células madre pluripotentes inducidas o iPSC (*induced pluripotent stem cell*) puede ser un camino para continuar con las investigaciones*(26)*.

Anticoncepción de emergencia

No se ha podido demostrar con certeza el mecanismo de acción del levonorgestrel, empleado como anticoncepción de emergencia, existiendo referencias que indican que impide, retrasa o altera la ovulación, altera la función lútea, afecta el flujo de espermatozoides y estabiliza el endometrio. Este último mecanismo es el que evitaría la implantación del cigoto*(27,28)*.

Diagnóstico preimplantacional y prenatal

Finalmente, comentaremos el uso del diagnóstico preimplantacional y prenatal con fines eugenésicos. En el primero, se seleccionan los embriones sin ninguna anomalía en el genoma y estos son implantados. Mientras que el diagnóstico prenatal se realiza en pleno curso de la gestación, que puede o no ser invasiva. En ambos casos, los objetivos de estos diagnósticos, según Dukhovny & Norton (2018), son mejorar los resultados o desenlaces en las mujeres, neonatos y sus familias, tener una mayor disponibilidad de tratamientos prenatales y natales, así como la terminación del embarazo. No obstante, para alcanzar esos objetivos deberá existir autonomía y una justicia distributiva*(29)*. Es así, que a *sotto voce*, el objetivo del diagnóstico eugenésico es tener una mayor población sana, menos gasto público en personas con malformaciones o discapacidades, siendo, por lo tanto, más económico detectar fetos con anomalías y evitar su nacimiento(*11,30)*.

Conclusión

En el Perú no existe un marco constitucional para algunos de los procedimientos descritos previamente. Nuestra intención es que estos vacíos legales deben ser reemplazados con normas y leyes basadas sobre todo con criterios médico-científicos, sociales y culturales. En términos estrictos, la constitución del genoma nuclear y el inicio de la vida del nuevo ser comenzaría cuando el oocito completa la meiosis II y se forma el segundo corpúsculo polar, que podría durar, posterior a la penetración del espermatozoide, entre dos a 4,5 horas*(31)*. Además, si nos basamos en el concepto filosóficos de “exdurantismo”, el individuo es el mismo a pesar de sus diferentes potencialidades, incluida la posibilidad de formar gemelos. Por otro lado, tomando en consideración el concepto de "integridad somática", el genoma establece desde la etapa de blastocisto y utiliza una serie de mecanismos moleculares para controlar el desarrollo embrionario y la espacialidad del embrión (polaridad). Incluso en algunas especies se ha demostrado que los ejes están ya preestablecidos por las diferentes concentraciones de moléculas y organelas en el mismo oocito*(32)*.

Con relación a la terminación de la gestación libre en nuestra sociedad, se debería continuar fortaleciendo las leyes y normativas actuales, basadas sobre todo en los datos científicos relacionados con el inicio de la vida, la humanización y similitud; siendo importante informar a nuestra población estos conceptos, lo cual afianzaría su moral y el pensamiento de la mayoría de las personas. En este sentido, las familias y en especial las gestantes de embriones o fetos con anomalías congénitas y enfermedades incapacitantes, deberían ser atendidas por un Estado con un marco legal sólido que asuma los costes de atención, incluyendo el diagnóstico y tratamiento, lo cual estaría en concordancia con las corrientes que están en contra del aborto libre eugenésico e incluso el posterior a una violación. Como es de conocimiento, muchas de las anomalías congénitas y enfermedades incapacitantes tienen como etiología cambios en el ADN*(33)* y, por lo tanto, todos estos pacientes deberían tener el soporte holístico de toda la cadena de atención compleja que merecen.

Vemos con mucho asombro, que los seguros de salud en nuestro país desconocen sin empatía la atención integral de las enfermedades genéticas, olvidando y excluyendo las necesidades complejas del diagnóstico molecular, el cual es determinante para reconocer el pronóstico, riesgo de recurrencia y en muchas entidades ofrecer un tratamiento personalizado*(34)*. Entonces, observamos que muchos de los decisores de salud están en contra de implementar estas nuevas tecnologías de diagnóstico y tratamiento, mostrándonos su pensamiento utilitario, haciéndonos pensar que están a favor a que cada familia pueda elegir voluntariamente la continuación o no de la gestación.

Otro aspecto directamente relacionado con el inicio de la vida y sus implicancias de terminación de la gestación, es el uso de levonorgestrel como anticoncepción de emergencia en los casos de violación, por lo que, para establecer su uso o no, deberíamos primero tener mayor evidencia sobre sus mecanismos de acción o generar esa información para definir si tiene efecto sobre el cigoto, provocando así el aborto. En todo caso, a través de una sentencia judicial, su uso actualmente está garantizado en las Instituciones públicas del Perú*(35)*, lo cual estaría en concordancia con que la decisión es personal, siempre y cuando se estableciera previamente la atención adecuada del trauma físico, el uso de anticoncepción de emergencia, el cuidado de la salud mental y la prevención de enfermedades de transmisión sexual*(36)*.

No menos importante es la normatividad pendiente de ser aprobada acerca de la fertilización *invitro*, a lo cual definitivamente se debería agregar el control del número de embriones obtenidos, ya que en muchas oportunidades los embriones "extras" pudieran ser susceptibles de descarte, siendo que nuestro fin como sociedad es preservar la vida. Y en este mismo punto estaría el diagnóstico preimplantacional con fines eugenésicos, para lo cual como puntos a favor estarían, desde la practicidad, el de disminuir el número de nacimientos con enfermedades genéticas incapacitantes, empujando a una disminución de gastos al sistema y de manera directa a la misma familia, una probable disminución en las desuniones conyugales y una mejora en el desempeño profesional, sobre todo de la mujer. Sin embargo, todos estos argumentos se desarman si se considera que con ello se estaría afectando la vida de los embriones descartados. Por lo que es importante reconocer que esta situación podría ser evitable parcialmente, al evitar uniones en las que los padres son portadores de enfermedades recesivas autosómicas o ligadas al cromosoma X, mediante el diagnóstico prematrimonial*(37)*.

Entonces, en el Perú se deberá emprender discusiones juiciosas, basadas sobre todo en los conocimientos científicos y filosóficos, y llegar a un consenso que nos permita descartar como práctica clínica no utilizar la terminación del embarazo eugenésicamente o la eliminación de embriones con anomalías severas. Sin embargo, la sociedad debería ser congruente con esa decisión y no observar corrientes filosóficas utilitarias, de tal manera que se pueda ofrecer a la ciudadanía el soporte necesario desde el diagnóstico y tratamiento de las enfermedades genéticas, así como el apoyo de las universidades y centros hospitalarios para conocer y reconocer con mayor precisión las otras variables que influyen en el pronóstico. También, plantear terapéuticas novedosas que podrían paliar el estado de salud de las personas e incluso cambiar el rumbo del curso de las enfermedades genéticas, mediante, por ejemplo, las novedosas terapias génicas, inmunomoduladores o trasplante de células hematopoyéticas, haciendo que sea una sociedad justa no solo desde un punto de vista moral y legal, sino que sobre todo sea contrastable con actos médicos empáticos, sin disimilitud, y humanos desde el inicio hasta el término de la vida.

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HACIA UNA ÉTICA GLOBAL TRANSHISTÓRICA A PROPÓSITO DEL *LIBELLUS DE MEDICINALIBUS INDORUM HERBIS. CÓDICE DE LA CRUZ-BADIANO, 1552*

Fernando Lolas[1]

Introducción

La reciente publicación de una completa y admirable edición facsimilar de este documento, con extensos comentarios de reputados especialistas mexicanos, permite algunas observaciones sobre un concepto de bioética global *transhistórica*, con lazos sustantivos con la hermenéutica. Este comentario inicia la elaboración de este concepto.

En 1990 el papa Juan Pablo II restituyó a México un texto que quizá constituye el primero compuesto sobre *materia médica* en la Nueva España*(1)*. Se trata del llamado códice de la Cruz-Badiano.

Según acreditados estudiosos, este códice fue compuesto por inspiración de don Francisco de Mendoza, hijo del entonces virrey Antonio de Mendoza. Fray Jacobo de Grado, de la orden de San Francisco, encargó su redacción al “indio principal” Martín de la Cruz, quien lo compuso en lengua náhuatl y castellano. Fue Juan Badiano, nativo de Xochimilco, quien lo puso en latín, concluyéndolo en Tlatelolco en el Colegio de Santa Cruz, en la fiesta de Santa María Magdalena del año 1552. No es posible saber si el texto latino es traducción de uno preexistente o transcripción de exposición efectuada en náhuatl.

Se trata de un códice, texto no impreso pero encuadernado, de 70 folios (140 páginas), realizado sobre papel italiano, encuadernado a la usanza europea, de 15,2 x 20,6 x 2 cm. El texto está escrito con caligrafía cancilleresca propia del siglo XVI. Contiene 244 nombres de plantas y solamente 185 ilustraciones, de factura indígena, reproducidas con sus glifos y características del medio en que viven y de su indicación terapéutica. Se encuentra distribuido en 13 capítulos que se inician con recetas para males de la cabeza y concluyen con las señales de la muerte. Aunque pareciera seguirse una tradicional distribución de “*a capite ad calcem*”, hay interpretaciones que vinculan el número de capítulos y su disposición a aspectos de la cosmología mexica, y que destacan el papel de la representación gráfica en las culturas mesoamericanas, culturalmente distinto del imperante en el orbe europeo.

Historia

Descubierto en la Biblioteca Vaticana por Charles Upson Clark en 1929, existe una copia incompleta en la Biblioteca de Windsor, encontrada alrededor de la misma época.

Se desconoce cómo llegó este precioso texto a España, aunque es muy probable que Juana de Austria, hermana del rey Felipe II, quien terminó profesando en el Imperial Monasterio de las Descalzas Reales, lo haya integrado al repositorio de esta institución hasta que su sobrina, la infanta Margarita de Austria, quien también profesó como sor Margarita de la Cruz, lo obsequiara a su boticario personal, Diego de Cortavila y Sanabria, respetado miembro de la intelectualidad cortesana y asiduo cultor de la “espagiria”, disciplina entre la alquimia y la ciencia, al tiempo que miembro de cenáculos madrileños entusiastas de los nuevos aires renacentistas, con grave peligro de delación ante las autoridades inquisitoriales.

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Es razonable suponer que cuando Francesco Barberini, sobrino del papa Urbano VIII y miembro de la *Academia dei Lincei*, visitara Madrid a comienzos del siglo XVII, lo hiciera acompañado de su amigo y condiscípulo Cassiano dal Pozo, quien había recibido del príncipe Federico Cesi, fundador de la Academia dei Lincei, el encargo de acopiar materiales sobre temas de botánica y herbolaria medicinal. Dal Pozo llevó a Italia el *Tesoro Messicano*, texto abreviado por Nardo Antonio Recci de la monumental obra del protomédico Francisco Hernández de Toledo sobre hierbas medicinales del Nuevo Mundo y la copia del Libellus que quizá fue vendida por Cortavila al bibliófilo.

El códice se integró a la Biblioteca Barberini hasta que en 1902 ésta fue incorporada a la Biblioteca Vaticana, en la cual fue descubierto en 1929. Es plausible suponer que Cassiano dal Pozo mandó preparar la copia adquirida por el rey inglés Jorge III, descubierta en Windsor por Giussepe Gabrieli. Hay noticia de otra copia hecha por el matemático Franscesco Stelluti, también de la Academia dei Lincei, la cual no ha sido encontrada.

Ediciones previas

José Sanfilippo Borrás*(2)* describe las ediciones que ha tenido el códice desde su descubrimiento, Destacan la de Gates, de 1939, publicada en Baltimore por *The Maya Society* y la Universidad *Johns Hopkins*, una edición mexicana inédita del mismo año de Demetrio S. García y la más conocida de Emily Walcott Emmart de 1940, facsimilar con traducción que se titula *The Badianus Manuscript (Codex Barberini, Latin 241) Vatican Library. An Aztec Herbal of 1552.* Se mencionan también las ediciones mexicanas de 1952, de Francisco Guerra, y la de 1964, patrocinada por el Instituto Mexicano del Seguro Social, con traducción de Angel María Garibay y extensos estudios. Luego están las ediciones del Fondo de Cultura Económica de 1991, de la Secretaría de Salud de 1992, una electrónica de 2008 en CD, con un opúsculo explicativo de Carlos Viesca, una inglesa de 2009, la de la revista *Arqueología Mexicana* de 2013, la de la Asociación Farmacéutica Mexicana de 2017, la de la Secretaría de relaciones Exteriores de 2021 y la última y definitiva de la Facultad de Medicina de la UNAM y del Palacio de la Escuela de Medicina de 2022, en la que se basa este comentario.

Sorprende que el códice, llamado en esta última edición "De la Cruz-Badiano", haya sido preparado en un único ejemplar, existiendo ya en la Nueva España imprenta desde la década de 1530. Esto permite dudar de que se tratara solo de un texto de "materia médica", al estilo de los herbolarios europeos. Es probable que su riquísima ornamentación estuviera destinada, más que a la difusión de un saber propiamente médico, a ser un obsequio para el emperador Carlos V, con el objeto de resaltar el trabajo del Colegio Santa Cruz de Tlatelolco y sus académicos indígenas y obtener financiamiento y privilegios, como efectivamente ocurrió durante el reinado de Felipe II. Avalan esta presunción, además, dos hechos significativos. Las plantas están designadas por sus nombres náhuatl y, aunque no todas proceden del Valle de México sino también de regiones alejadas, es improbable que pudieran encontrarse en Europa, especialmente si sus designaciones han sido un problema para su correcta identificación botánica. Por otra parte, no es una simple lista de especies de valor medicinal, sino un "recetario" que contiene indicaciones para tratamientos de condiciones que no siempre se identifican con la nosología humoral renacentista europea, a veces combinando yerbas con otros tratamientos como minerales y bezóares.

Está acreditada la existencia de sus promotores y autores, al igual que la labor del colegio franciscano de Tlatelolco, fundado por el virrey a instancias de Fray Juan de Zumárraga, que podría considerarse una suerte de universidad para indios principales en cuyas aulas se enseñó también una medicina sincrética hasta varios años después de redactado el códice*(5)*. Es significativo que Bernardino de Sahagún, quien recopiló informaciones médicas de informantes diversos a partir de 1558, no mencione ni a Matías de la Cruz ni a Juan Badiano, lo que indica que este códice no se integró al acervo médico convencional.

Cuestiones pendientes

La principal cuestión que plantea este valioso documento se refiere a la integración de saberes. Más allá de su relevancia terapéutica y considerando que sus intenciones podrían relacionarse con el deseo de fama de la familia Mendoza (Francisco de Mendoza, sobrino del virrey Antonio, quien luego también lo sería del Perú, murió el mismo año de su composición), sin ignorar la posibilidad de un negocio de importación de hierbas medicinales, las interpretaciones no deben soslayar que se trata de una obra que conjuga el saber tradicional del *ticitl* (curandero mexica) con el andamiaje conceptual de la medicina europea. Las claves de una lectura integradora son un desafío permanente. Para las culturas mesoamericanas, la idea europea de "libro" no era desconocida, como demuestra la palabra *amoxtli,* que significaba literalmente "hojas de papel pegadas", según el erudito Miguel León-Portilla*(3)*. Sin embargo, debe observarse que la imagen y su interpretación podrían tener significaciones culturales que deben indagarse, ya que la iconografía no solamente parecía tener valor mimético o estético sino además simbólico en la Mesoamérica prehispánica*(4)*. Es por esta razón que la "lectura" del códice exige una inmersión en la singladura cultural y en la cosmovisión de una cultura que estaba en proceso de absorción por la hegemonía europea y sus modos de decir y conceptualizar.

La búsqueda de puentes conceptuales no se puede circunscribir solamente a la interpretación en términos del acervo médico. Las nociones de lo frío y lo caliente, que aún perviven en las concepciones populares de salud y enfermedad, la necesidad de contar con testimonios perdurables (como la grafía y la escritura), la fusión de lenguas y sus connotaciones aparentes en los intentos translaticios de traducción, son factores esenciales para el proceso de interpretar y comprender que exige la pluralidad de universos intelectuales a que se enfrenta la historia de los saberes. Reducir el códice "De la Cruz-Badiano" solamente a su eventual valor como "*liber medicus*" parece estrechar el alcance de sus implicaciones y limitar la expansión de horizontes culturales que ofrece.

Bioética global transhistórica

La mayoría de las presentaciones sobre el concepto de bioética destacan su aparente modernidad, su introducción al léxico académico en el siglo XX y sus vertientes médica y ambiental, históricamente explicables.

El códice De la Cruz-Badiano permite examinar la "mentalidad bioética" desde una perspectiva transhistórica. Si lo esencial de esta mentalidad, al menos en las versiones de Jahr y Potter, es la íntima ligazón entre seres humanos y entorno, con énfasis en lo *médico* (ampliamente entendido, como relación entre seres que busca atenuar lo deficiente o lo anómalo) el examen de antiguos documentos permite proponer una perspectiva hasta ahora ignorada en el discurso sobre "bioética global".

Esta expresión se ha entendido en dos formas principales. Primero, como extensión planetaria, de implicaciones geopolíticas, que indaga por las implicaciones morales de prácticas y conceptos en diversas culturas y grupos, y también como la aspiración de que los avances civilizatorios alcancen a todos los seres vivientes, preservando el ambiente, evitando su depredación y exaltando el afán de equidad que debe presidir los esfuerzos científicos en relación con la salud humana*(6,7)*.

En ocasiones, este discurso adquiere una perspectiva moralizante simple, con admoniciones y llamados a la solidaridad biosférica y humana, ya sea bajo la forma de una "ciencia de la supervivencia" utilitarista, como predicaba Potter, o como manifestación compasiva de la estrecha solidaridad entre la Naturaleza y la humanidad, como se deduce de Jahr.

El examen de documentos históricos permite extender la noción de "mentalidad bioética" a otros períodos históricos. Plantea como desafío la *comprensión* e *interpretación* de cosmovisiones que explícita o implícitamente plantean la pregunta sobre las relaciones entre seres humanos y mundo circundante, que incluye personas, animales, plantas y ambiente. Es una *hermenéutica de la salud* entendida ampliamente, si por salud se concibe no solo el bienestar humano individual sino la plenitud y el florecimiento de lo viviente*(8)*. Es posible plantear tal intento de comprensión y de sugerencias para la acción desde una perspectiva religiosa teocéntrica o bien desde lo "laico" o "agnóstico" de las ciencias*(9)*. En ambos casos se trata de substratos de creencias, aunados o no con racionalidad instrumental y reflexión basada en la investigación empírica. La clásica distinción entre *belief* y *data* (creencia y datos) debe ser reexaminada a la luz de los comportamientos individuales y sociales y tiene eficacia en conseguir aquel estado que todas las culturas consideran ideal, codificado bajo términos como *eudaimonía*, salud, bienestar, bien-ser. El énfasis reciente en *One Health* (una salud) no hace sino reconocer que lo global no solo es aspiración o deseo en consonancia con una moral universal, sino precondición de existencia fértil y productiva en los planos individual, social, económico y político*(10)*. Cuando Rudolph Virchow concluía que *la medicina es una ciencia social* intuía que el modelo individualista de bienestar no puede extrapolarse sin más a las comunidades humanas, que se rigen por nociones incorporadas a los conceptos de salud pública, salud internacional y salud global.

Se abre un desafiante campo de estudio. La bioética también —en tanto *mentalidad dialógica*— es investigable en el registro histórico y los documentos antiguos. Sin duda códices y registros antiguos pueden leerse bajo la óptica de la racionalidad científica europea y estadounidense. Incluso como imitaciones de prácticas "occidentales", notables anticipaciones o curiosidades dignas de la atención del antropólogo, el etnógrafo o el sociólogo. No de otro modo nacieron la ciencia antropológica al estilo de Edward Tylor*(11)* o las crónicas de los conquistadores europeos que vieron costumbres y productos de otras civilizaciones como variantes algo anómalas o desviadas de la humanidad auténtica, concebida en la Europa ilustrada como el "uso correcto" de la razón y la sujeción a la "religión verdadera".

Hay pueblos que *crean* textos y pueblos que son *creados* por los textos de otros pueblos. La lectura de los códices —y aquí el ejemplo del texto De la Cruz-Badiano es ejemplar— puede hacerse desde puntos de vista ajenos a sus creadores o intentar desentrañar su realidad propia. Quizá esto requiera no solo de "relativismo cultural", sino también de inmersión en cosmovisiones que obligan a pensar "como" sus creadores. Así como Martin Heidegger intentó hacer filosofía retrotrayéndose al pensamiento más fundamental y reconstruir el entramado creencial y racional desde una perspectiva renovada y renovadora, los comentaristas del códice que nos ocupa proponen, explícita o implícitamente, una re-construcción "cosmovisiva" de un mundo humano extinguido o en proceso de fusión con otros universos conceptuales. Este proceso de "aculturación", "hibridización" o "fusión de horizontes" puede formularse en clave bioética. Solamente hay que abandonar la idea de que bioética es una moderna invención de toma de decisiones procedimental; sus categorías y principios responden a un contexto cultural específico y solventan necesidades de un mundo tecnificado e individualista. Intentar superponer el "mantra de Georgetown" (autonomía, beneficencia, no maleficencia, justicia) u otras nociones y principios a contextos que son distintos por cultura, lenguaje y cosmovisión empobrece la radical experiencia de la Otredad, el gran problema de la civilización en todo plano, desde el individual interpersonal hasta el societario. Bioética, biopolítica, eco-bioética, neurobioética, en tanto concepciones abarcadoras y dialógicas, son radicales invariantes de lo humano que se expresan en la riqueza de sus diversidades. No solo en el espacio. También en el tiempo.

Que muchas especies listadas en el códice De la Cruz-Badiano desafíen la taxonomía botánica occidental (o, mejor, no indígena) sugiere que sus descripciones y representaciones no perseguían la finalidad mimética o descriptiva de los herbolarios europeos de su época. Como recetario, no es asimilable a las prescripciones de la "biomedicina" actual; su nosografía y terapéutica pertenecen a otra cosmovisión. Esto obviamente se aplica a otras formas "tradicionales" de pensamiento "médico", como la ayurvédica o la china, con sus categorías y denominaciones intraducibles a los "catálogos" diagnósticos de las clasificaciones actuales europeas o estadounidenses.

La *bioética transhistórica* es, en un sentido muy cabal, bioética *global*. No solamente enriquece diversidades geográficas o geopolíticas o justificaciones morales universales. Lo "global", que en el discurso convencional parece ser solo absolutización de un punto de vista local y temporal (transitorio), merece ser ampliado al tiempo vital de la especie humana, el histórico y el prehistórico.

Esta publicación encomiable de los estudiosos mexicanos es un buen punto de partida.

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JAMES F. DRANE, UNA VIDA DE COMPROMISO

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> *Idealmente, la mejor metodología* [en bioética] *sería clínicamente práctica y filosóficamente sofisticada. Si la cooperación entre especialistas en ética de América del Norte, Europa y América Latina avanza, ambos objetivos podrían estar más cerca de realizarse.*
>
> James F. Drane, 1990*(1)*.

James Drane, uno de los fundadores de la bioética, falleció con 93 años el 17 de abril de 2023 en Edinboro, Pennsylvania. Jim Drane, como le llamaban sus amigos, fue una persona comprometida con el tiempo que le tocó vivir. El tiempo en el que apareció y se desarrolló la bioética, J. Drane se comprometió con muchas causas, algunas de ellas fueron: la libertad de conciencia, promoviendo un catolicismo liberal; la vulnerabilidad, defendiendo a las personas con discapacidad, con su novedosa propuesta de valoración de la competencia a través de una escala móvil; los profesionales sanitarios, con su invitación a que desarrollasen una ética de las virtudes, especialmente en la relación clínica; con Iberoamérica, donde ayudó a trasladar la cultura bioética*(2,3)*.

Un teólogo prometedor

J. Drane nació en Chester, Pensilvania, en 1930. Era el mayor de diez hermanos de una familia católica humilde que provenía de Irlanda. Tras estudiar en St. James High School, entró en el Seminario católico de St. John, en Little Rock, Arkansas. Se graduó en teología en la prestigiosa Universidad Gregoriana de Roma, donde coincidió con el teólogo Hans Küng y con Joseph Ratzinger, futuro Benedicto XVI. La estancia en Roma le abrió el interés por la medicina: "Mi profesor de teología moral era el padre Francis Hurth, S.J. que tenía un gran currículum y además era médico. Utilizaba casos médicos para aplicar principios éticos a situaciones concretas. Otro profesor de teología moral era el Padre Edwin Healy, que había escrito varios libros sobre medicina y ética, y usaba también casos éticos de medicina"*(4)*. En 1955 se ordenó sacerdote, siendo su primer destino un hospital ("Allí me vi, cara a cara, con muchos de los problemas éticos creados por las nuevas tecnologías y por las nuevas intervenciones médicas"). Después de la estancia en el hospital, le asignaron como docente en el Seminario de St. John.

Debido a sus dotes intelectuales y académicas, el obispo le envió a Madrid para doctorarse en la Universidad Complutense. El filósofo José Luis López Aranguren, conocido por su oposición al franquismo y por defender las libertades civiles, dirigió su tesis doctoral sobre "Las bases de la tolerancia" (1963). Es curioso que desarrollara una tesis sobre tolerancia religiosa en la España del nacionalcatolicismo, donde la tolerancia, precisamente, brillaba por su ausencia. Pero había sido enviado a España por este motivo: en pleno Concilio del Vaticano Segundo querían que influyera en la tradicionalista jerarquía eclasiástica española, para intentar cambiar sus convicciones sobre la libertad religiosa. En su tesis, J. Drane justificaba la libertad y la tolerancia religiosa. Pretendía humanizar y flexibilizar la ortodoxia católica. Pensaba que la iglesia debía abrirse a los nuevos tiempos, lo que no significaba que tuviera que rechazar sus fundamentos: el Evangelio. Esta tesis fue una constante en toda su obra.

El encuentro con Aranguren fue esencial para J. Drane. Se convirtió en un referente intelectual y vital para él. Siempre se consideró en deuda con su maestro. Además, Aranguren le puso en contacto con intelectuales españoles como Pedro Laín Entralgo, decisivo en su obra futura.

Compromiso con la libertad: por un catolicismo liberal

Tras doctorarse, J. Drane regresó a Estados Unidos. Estuvo muy implicado en asuntos de integración racial y en las relaciones ecuménicas con protestantes y judíos. Sensible con los dudas y con el sufrimiento de las

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parejas católicas que deseaban mantener relaciones sexuales sin querer tener más hijos, en 1967 publicó unos artículos en *Arkansas Gazette* donde cuestionaba la doctrina oficial de la Iglesia respecto al control de la natalidad*(5)*. J. Drane defendía que las parejas que no querían tener más hijos pudieran usar métodos anticonceptivos. La popular revista *Life Magazine* divulgó sus ideas en el reportaje "Voice and torment of a rebel priest. Birth control (Religious aspects)", en el que J. Drane señalaba cómo le habían telefoneado mujeres llorando: "Sé que mucha gente sufre a causa del problema del control de la natalidad"*(6)*.

J. Drane recibió una carta de su obispo Albert L. Fletcher, en la que se le suspendía del ejercicio del sacerdocio y se le expulsaba del seminario. Argumentó que sus ideas no contravenían ningún principio ético ni eran contrarias a la moral. Su caso fue trasladado a Roma, donde se ratificó la decisión del obispado. Le ofrecieron ser destinado a una lejana parroquia y guardar silencio, o retractarse públicamente. Rechazó ambas cosas y solicitó el estado laico.

Con 37 años, J. Drane se encontró fuera de la iglesia católica, pero sus ideas le abrieron otros caminos. El protestante James Gustafson, profesor de ética en la Universidad de Yale, le invitó a ese sitio. Allí publicó un libro imprescindible para comprender los inicios de la bioética, *Authoroty and Institution: A Study in Church Crisis* (1969), en el que denunciaba la postura de la iglesia católica respecto al control de la natalidad. En Yale coincidió con Daniel Callahan, con el que estuvo unido el resto de sus días. Gracias a una beca de la Fundación Ford, J. Drane y D. Callahan viajaron por todo el mundo para estudiar el aborto en diferentes culturas. Tras este viaje D. Callahan publicó *Abortion: Law, Choice and Morality* (1970), otro libro esencial en los preludios de la bioética, y fundó *The Hastings Center*. Paralelamente Andre Hellegers estableció el *Kennedy Institute* en la Universidad de Georgetown. J. Drane, por su parte, aceptó una oferta de la Universidad de Pennsylvania en Edinboro para desarrollar allí una nueva disciplina: la bioética. J. Drane no dejó de ser católico ni de defender un catolicismo abierto y liberal. Una de sus mejores obras es *More Humane Medicine: A Liberal Catholic Bioethics* (2003)*(7)*.

Compromiso con los discapacitados: *the sliding scale*

En los años 1970, para ampliar su formación en la nueva disciplina que iba desarrollar en Edinboro, asistió a la Facultad de Medicina de la Universidad de Georgetown. Su interés por las personas vulnerables le llevó a solicitar una estancia como interno en la *Menninger School of Psychiatry*. La *Menninger Clinic* estaba dirigida por el prestigioso psiquiatra Karl A. Menninger. Allí J. Drane detectó la dificultad que tenían los psiquiatras para tomar decisiones con sus pacientes, debido a que no es sencillo saber si son competentes para decidir. Por este motivo, a principios de los años 1980 desarrolló la primera escala para medir la competencia de los pacientes para tomar decisiones, la denominada "escala móvil" (*sliding scale*), popularizada como la "escala Drane".

La escala de J. Drane, a diferencia de lo que se hacía antes, vinculaba la competencia con la situación clínica concreta del paciente. Esta evaluación cambiaba la valoración clásica que se realizaba en psiquiatría, que sencillamente evaluaba la competencia de forma estática a través de diversos test, sin tener en cuenta el tipo de decisión en juego. La escala clasifica a los pacientes en tres grupos. En función de la evaluación mental del paciente y del tipo de decisión que se tiene que tomar, se le considera competente o no competente para tomar la decisión. La escala se publicó en JAMA en 1984*(8)* y un año después en Hastings Center Report*(9)*. La escala móvil de J. Drane fue una gran contribución para avanzar en la valoración de la competencia de los pacientes. Ha sido una gran ayuda para los clínicos pero, sobre todo, ha servido para que los enfermos sean mejor considerados y tomados en cuenta al decidir sobre su salud.

Compromiso con los profesionales: cómo ser un buen médico

J. Drane no había olvidado España, y en 1987 regresó a la Universidad Complutense para trabajar con Pedro Laín Entralgo en la ética de la relación clínica. En Madrid desarrolló una propuesta sobre la profesión médica y sobre la relación clínica. En 1988 publicó su libro más conocido: *Becoming A Good Doctor: The Place of Virtue and Character in medical Ethics(10)*, en el que exponía la importancia de recuperar el carácter ético del médico como fuente y base de una buena práctica médica, ideas que impregnan otras obras posteriores como *Clinical Bioethics: Theory and Practice in Medical Ethical Decision-making* (1994)*(11)* o *Caring to the end* (1997)*(12)*.

J. Drane advierte que la ética médica norteamericana se reduce al análisis de casos y al establecimiento de normas y reglas para la resolverlos, olvidando las cualidades del carácter de los profesionales en su relación con los enfermos. En *Becoming a Good Doctor* señalaba cómo muchos médicos han perdido la capacidad de "ver al otro", virtud básica y esencial de la práctica médica. Sufren una especie de agnosia que les impide reconocer lo esencial del ser sufriente. Esta pérdida se produce, entre otros motivos, porque no se enseñan las virtudes propias de la medicina. La adquisición de virtudes es un proceso complejo que se articula en varios pasos. En primer lugar, debe existir un ideal de vida hacia el cual dirigirse, que para el médico es el específico de su profesión: atender a la persona enferma en toda su dimensión. Este ideal debe crear un compromiso incondicional y absoluto. A partir de ahí surgen las virtudes: actitudes y disposiciones concretas. El buen médico debe creerse primero una cierta forma de vida y, después, entregarse decididamente a realizarla. Solo así se podrá convertir en una persona virtuosa.

Las virtudes de la medicina serían la confianza, la compasión, la amabilidad, la simpatía, la escucha, la paciencia, la honestidad, la amistad, la veracidad, la actitud de servicio, la bondad, el ser atento, la actitud de respeto o la beneficencia. De ellas hay cuatro prioritarias: la benevolencia, relacionada con el establecimiento de un diagnóstico, pronostico y tratamiento: la veracidad, puesta en práctica en la comunicación con el paciente: el respeto hacia el otro, esencial en la toma de decisiones, y finalmente está la virtud de la amistad, básica para canalizar los sentimientos y que debe articular la relación médico-paciente, en especial la confianza. Como puede verse, el modelo de relación médico-paciente de J. Drane está muy influido por Pedro Laín Entralgo. Además de las virtudes de la medicina, también se debe desarrollar las virtudes cardinales, eje del resto de virtudes: fortaleza, prudencia, templanza y justicia. Solo cuando la virtud específica del médico entra en armonía con las virtudes generales se puede hablar de un buen médico.

La virtud no consiste en adquirir cualidades por separado, sino de buscar que surjan de un carácter obtenido a partir de un ideal de vida que da unidad y coherencia al proyecto vital. Diferentes virtudes producen diferentes formas de conducta, pero desarrolladas y practicadas en conjunto dan como resultado personas buenas y médicos buenos. Las personas buenas, los médicos virtuosos, responderán con comportamientos correctos y apropiados como forma de respuesta natural y habitual antes que calculable. Poseer un carácter ético adecuado es un punto de partida imprescindible, que tiene que combinarse en la toma de decisiones con el manejo de reglas, normas, principios, circunstancias y con el análisis de las consecuencias.

Compromiso con la bioética: trabajo y amistad con Iberoamérica

Durante la estancia en Madrid, en 1987, J. Drane coincidió con algunos de los bioeticistas españoles de la primera generación, como Javier Gafo y Diego Gracia. La influencia de J. Drane sobre la primera generación de bioeticistas españoles fue fundamental: les mostró el nuevo enfoque bioético que se estaba desarrollando en Estados Unidos y Diego Gracia viajó hasta allí con él para conocer de primera mano la nueva disciplina. El norteamericano facilitó el giro de Diego Gracia desde la antropología médica de Pedro Laín Entralgo a la bioética.

A finales de los años 1980 la Oficina Panamericana de Salud (OPS), sección americana de la Organización Mundial de la Salud, escogió a J. Drane para trabajar en su departamento legal, con el fin de introducir la bioética en Latinoamérica, especialmente en la investigación con seres humanos. J. Drane no pretendía exportar la bioética norteamericana, sino ayudar a desarrollar una bioética que expresara la perspectiva latinoamericana*(13,14)*. Viajó por Latinoamérica para identificar a las personas que debían impulsar esta disciplina, desconocida entonces en América Latina, a través de programas formativos. Estos fueron, entre otros, Fernando Lolas (Chile), José Alberto Mainetti (Argentina), Roberto Llanos (Perú), Alfonso Llano (Colombia) y Manuel Velasco-Suárez (México). J. Drane también realizó gestiones para establecer en 1996 el primer Master de bioética en América Latina, apoyado por la OPS en Chile y dirigido por Diego Gracia. Tras jubilarse en 1992, la Universidad de Pennsylvania creó el *James F. Drane Bioethics Institute*, desde donde J. Drane continuó desarrollando programas formativos y de investigación para estudiantes y profesores latinoamericanos y europeos. El objetivo de sus programas era que los estudiantes y profesores trabajasen por la bioética latinoamericana.

Agradecimiento

En nombre del *Instituto de Ética Clínica Francisco Vallés*, queremos agradecer a James Drane su apoyo a las “Lecciones Magistrales de Bioética James Drane”, que él mismo inauguró en 2016 de la mano de su querido Miguel Sánchez*(15)*. Las “Lecciones” sirven de homenaje a Jim y reconocen la aportación de un bioeticista al desarrollo de la bioética en Iberoamérica. Tras Jim han participado Mark Siegler, Mario Bunge, Javier Sádaba, Diego Gracia o Joseph Fins.

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HANS-MARTIN SASS (1935-2023): IN MEMORIAM

Amir Muzur[1]

On February 6, 2023, Hans-Martin Friedrich Ludwig Sass died. A memorial was held for him in Pilgrim Lutheran Church in Bethesda, MD, and in the Washington Plaza Baptist Church in Reston, VA, where Hans-Martin resided after he had retired. He died with 87, in sleep, preserving full brightness of his mind up to his last days. One might say: a blessed departure of one German-American. But what a full and dynamic life is to be uncovered behind those modest lines: a life of a curious, warm, lively being who, with a smile and energy, permanently and positively changed so many people and careers. Born on December 4, 1935, in Hagen, Germany, to a family of the Pastor Hans and Else Sass, Hans-Martin was raised together with his brother Klaus and sister Annemarie. After the high school in Gelsenkirchen, he studied literature, geography, and philosophy in Erlangen, receiving PhD in Münster in 1963 and habilitating in Bochum in 1972. From the Ruhr University, thanks to a Volkswagen-Foundation scholarship, in 1980, he visited Kennedy Institute of Ethics in Georgetown, Washington D.C.: it is here that Hans-Martin, up to then expert for Hegel and Marx, turned into a medical ethicist. Like in many similar occasions, moreover, he became a fervent scholar and populariser of the discipline, recalling the times of his first experiences as a teacher, when he used to transform complex issues into stories to be more easily accepted by the pupils (that is probably why he will like so much the 2-3 pages long articles by Fritz Jahr). Working hard on connecting German and American scholars, and on introducing modern medical-ethical concepts to Europe, Hans-Martin kept his particular "dual" position (Philosophy Professor in Bochum and Senior Research Scholar at Kennedy Institute) up to the end of his career, sponsored also by the German Federal State of North Rhine-Westphalia. He organised courses, developed clinical-ethical methods (Bochum Protocol), edited advance directives (on decision making in healthcare), etc. In Germany, Hans-Martin founded the Bochum Centre of Medical Ethics, the Göttingen Academy of Ethics in Medicine, edited periodicals (*Ethics in Practice*; *Medical-Ethical Materials*), and directed General German Society for Philosophy (1975-1981). In 1985 and 2001, respectively, he became a professor at People's University of China and Peking Union Medical College. For his work, including a dozen of books and more than 250 papers, Hans-Martin Sass was honoured by the title of the Knight of Justice of the Order of Saint John and Germany's Cross of Merit.

Those believing (and studying) a broader version of bioethics than the mainstream one (that is, bioethics reduced to the issues of medicine and research), can never overestimate the influence Hans-Martin had on them: his pioneering work on Fritz Jahr from 2007, soon translated into Croatian and English and published in the *Kennedy Institute of Ethics Journal*, changed the entire future of bioethics. For Hans-Martin, this also was a geginning of a new era: coming to Rijeka for the world congress in 2008 and the first conference on Jahr in 2011, he persuaded me to jointly edit two collections dedicated to Jahr and publish them at Lit (Münster/Zürich), just as he persuaded Christian Byk to do the same in Paris, and instigated Natacha Lima to translate Jahr's articles into Spanish and Leo Pessini into Portuguese. He somehow enjoyed the "race" in which he, Florian Steger and I engaged in searching for further articles by Jahr. Hans-Martin "analyses" of Jahr were not necessarily profound, and yet they were somehow witty and ingenious, such as emphasizing Jahr's short sermon form and his bromide-induced vertigo.

An interesting question is how Hans-Martin came to know about Jahr and his article from 1927. In the preface to the translation of Sass's article from 2007 into Croatian, Ivan Šegota tells an anecdote about his conversation with Sass during one dinner in an Australian-Dalmatian fish restaurant in Sydney in 2004:

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> *On that occasion, I told him how I had heard some of our colleagues in America mentioning Potter had not been the first to "coin" the word "bioethics" because one German had done it forty years before Potter. But - I added - Potter told me in a letter that he had never heard of this German and the German word "Bioethik". Apparently, after that conversation, Sass started "digging" in German literature and unearthed Fritz Jahr and his term "Bio-Ethik".*

Once later, Šegota will recount that he heard about this mysterious "German" from Warren Reich in 2003, at a conference in Portugal: Reich allegedly justified the Americans who had resisted Potter's candidacy for the Nobel Prize. However, Warren Reich would later claim to me that he first learned about Jahr from Sass. It is also unlikely that Šegota corresponded with Potter about Jahr (that is, "the German"), since Potter died in 2001.

Hans-Martin himself, however, offered different versions of the story. In an interview given in the spring of 2011 on the way from Rijeka to Zagreb to the young Argentinian scientist Natacha Lima, Sass will claim that he discovered the copy of the Kosmos journal from 1927 with Jahr's article by accident, during a visit to an antiquarian. Other times he will say that "he worked seriously on Jahr, probably in 1995 or 1996, and that in November 1996, his assistants bought him a Kosmos from 1927, found in an antique shop, as a birthday present. The third time will allow the possibility that he talked about Jahr with Šegota in Taiwan (sic!), but that he discovered Jahr thanks to Eva-Maria Engels' article from 1999 (so from *Metzler's Lexicon*), and that only in 2004 or 2005. Since Hans-Martin's first paper on Jahr was published in 2007, the latest version seems the most likely.

No less interesting is the evolution of Sass's attitude towards Van Rensselaer Potter. In the book *Bioethik in den USA*, edited by Hans-Martin in 1988, there is no Potter among the authors on the reference list, nor does Hans-Matin mention him at all, but in his highly cited 2007 article (the first to report globally on the discovery of Fritz Jahr's work), Hans-Martin mentions Potter in the very first sentence.

After he lost his wife Renate in 2004, Hans-Martin could still be enjoying the love of his daughters Gabriele and Angelika and granddaughters Elisabeth and Anna. But number of colleagues and students he disseminated all over the world is not easy to count. We can only hope that, on those unimaginably beautiful fields of Elysium to which we all are drifting to, we shall get one more chance to have a beer and a chat with the friend we already miss so much.

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CENTRO DE BIOÉTICA UC, 1993-2023: UN PUENTE ENTRE PASADO Y FUTURO

Iván Pérez, Luca Valera, Paulina Ramos[1]

Los inicios

El Centro de Bioética de la Pontificia Universidad Católica de Chile fue creado el 19 de julio de 1993 por el entonces rector Dr. Juan de Dios Vial Correa, dando así continuidad al trabajo de su predecesora, la Unidad Docente Asociada de Bioética de la Facultad de Medicina. Fueron relevantes en su fundación los profesores Carlos Quintana, Alejandro Serani, Manuel Lavados y Andrés Valdivieso. Bajo el liderazgo de sus distintos directores[2], y hasta muy recientemente, tuvo además a su cargo la formación en bioética en la Facultad de Medicina, tanto de pregrado como de postítulo. Destaca en este periodo la creación, el año 2001, del Magíster en Bioética, programa pionero en el país, cuyo desarrollo académico fue mérito de sus primeros directores, destacando el aporte de la Dra. Paulina Taboada, quien lideró el programa por más de una década.

En estas tres décadas de trayectoria, el Centro de Bioética ha contado entre sus académicos titulares o visitantes con destacadas personalidades, tales como Juan de Dios Vial, Elio Sgreccia, Josef Seifert, Alfonso Gómez-Lobo, Alejandro Vigo, Crescente Donoso, Patricio Ventura-Juncá, Paula Bedregal, María Alejandra Carrasco, Fernando Chomalí y Mariano Crespo, entre otros[3].

Actualmente, el Centro de Bioética UC se configura como un espacio de investigación, extensión, comunicación y diálogo interdisciplinar sobre las cuestiones éticas relacionadas con el poder de las nuevas tecnologías sobre la vida y, más en concreto, con los avances de la biomedicina y las neurociencias.

Cambios recientes

El año 2015, la Facultad de Medicina, con el fin de potenciar las tareas de investigación y extensión del Centro de Bioética, crea la Unidad Docente de Ética de la Salud (UDES), que asume a partir de esa fecha la docencia. Desde sus inicios, el Centro ha realizado y apoyado diversas actividades de extensión, entre las cuales se destacan tres diplomados (2 virtuales y 1 semipresencial).

Otra año relevante para la historia del Centro fue en 2018, cuando se realizó un proceso de evaluación de los últimos años de trabajo y se sentaron las bases para su desarrollo en el mediano y largo plazo. Así, bajo la conducción del Dr. Luis Ibáñez, decano de la Facultad de Medicina, junto al Comité Asesor de decanos de las facultades integrantes del Centro de Bioética y con el apoyo de las máximas autoridades

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[1] Centro de Bioética UC, Chile.

[2] Directores del Centro de Bioética UC:
1993-1997: Dr. Carlos Quintana
1997-2000: Dr. Pedro Rosso
2000-2006: Dr. Patricio Ventura-Juncá
2006-2012: Dra. Paulina Taboada
2013-2014: Dr. Mauricio Besio
2014-2015: Dr. Felipe Heusser
2015-2018: Dr. Alejandro Serani
2018-2021: Prof. Luca Valera
2022 a la fecha: Dr. Iván Pérez

[3] El Dr. Juan de Dios Vial presidió la Pontificia Academia para la Vida (1994-2004) y fue sucedido en el cargo por Monseñor Elio Sgreccia (2004-2008).

de la universidad, se definió un proyecto de desarrollo que permitiera dar respuesta a los nuevos requerimientos de la Universidad, de la Iglesia y del país. Este proyecto fue encargado al entonces director Profesor Luca Valera.

Las líneas de investigación

Es destacable señalar que las actividades de investigación están presentes desde los inicios de este Centro, relacionadas con los fundamentos biológicos, antropológicos y éticos del inicio de la vida así como con los dilemas del fin de la vida. Los cambios del entorno mundial, el desarrollo de las tecnologías en la vida humana, los complejos problemas que dicen relación con la sustentabilidad de la vida humana han comprometido a un plan de desarrollo del Centro de Bioética que considera: a) una mayor vinculación del quehacer del Centro con la actividad cotidiana de nuestros médicos, hospitales y clínicas; b) el desarrollo de investigaciones interdisciplinarias; c) la apertura nacional e internacional, y d) una presencia activa de los académicos del Centro en el debate público en defensa de la vida humana, orientando y dialogando a partir de una identidad sólida y clara.

A los temas que ya se abordaban con gran provecho en el Centro (ética clínica; ética, medicina y vida humana; ética de la investigación científica), gracias a los aportes de los nuevos investigadores provenientes de distintas facultades se agregaron líneas de investigación en ética de la salud pública, genética, tecnoética y ética ambiental.

Los frutos y las proyecciones

Para concluir, cabe destacar algunos frutos generados en el Centro de Bioética en los últimos años, que pueden orientar sus líneas de trabajo futuro. En primer lugar, el gran compromiso interdisciplinario del Centro, tanto en su composición (en su planta académica participan profesores de las facultades de Medicina, Filosofía, Biología, Teología y Derecho) como en sus investigaciones. Segundo, la participación del Centro en el debate público: su presencia en los medios de comunicación y sus aportes a las políticas públicas han sido plenamente reconocibles y evidentes. También en su labor de extensión, en la que fue un hito destacado el lanzamiento el año 2020 de BioeticaLabUC, multiplataforma digital que busca entregar información, argumentos y propuestas en relación con las implicancias éticas, jurídicas y sociales de los avances científicos y tecnológicos sobre la vida. En tercer lugar, el crecimiento en el ámbito de las investigaciones científicas. En los últimos cinco años sus académicos han publicados artículos con la afiliación al Centro de Bioética en revistas como *The Lancet*, *The Journal of Medical Ethics*, *Environmental Ethics*, *Theoretical Medicine and Bioethics*, *Science and Engineering Ethics*, *Zygon*, lo que destaca la calidad de las publicaciones del Centro. Un gran desafío para el futuro es seguramente obtener el mismo impacto en cuanto a fondos concursables y *grants* internacionales. Un proyecto que verá la luz en este 2023, y que recoge el trabajo de los últimos cinco años del Centro, es el libro colectivo *Cuerpos vulnerables*, que pretende ofrecer una interpretación a los problemas bioéticos actuales a partir de los conceptos de “corporeidad” y “vulnerabilidad”.

En los próximos años se espera que el Centro de Bioética UC fortalezca sus líneas de trabajo con un marcado acento interdisciplinar, y así siga siendo un referente de la disciplina a nivel nacional e internacional.

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MEDICINA, RELIGIÓN, BIOÉTICA

DRANE, JAMES

Medicine, Ethics, Religion.

Acta Bioethica Supplementa. Estudios transdisiciplinarios. LIT Verlag Zürich 2018 (ISBN 978-3-643-91015-8).

Fernando Lolas Stepke[1]

En éste, el último libro de James Drane (1930-2023), es importante destacar el subtítulo: *A Christian Bioethics and A Philosophy of Life*. Constituye en realidad una suma del saber y sentir de una persona que, a través de su biografía y trabajos, contribuyó a reflexionar sobre la bioética y la medicina, lo cual exige una suerte de exégesis e invita a conocer sus aportes. En 2005[2] publiqué en *Acta Bioethica* una relación de su vida y trabajos que destacó tres aspectos: su insobornable convicción cristiana católica, sus contribuciones al establecimiento del discurso bioético en Iberoamérica y su visión sobre la medicina que, aunque no ejerció, conoció de modo profundo a través de la reflexión.

En este volumen se reiteran, enriquecidas con experiencias personales, ideas expresadas en otros libros. *Becoming a good doctor. The place of virtue and character in medical ethics* (Sheed & Ward, Kansas, 1988, 1995) destaca la importancia de la virtud como dimensión del carácter de profesionales cuyo prestigio y aprecio se basan en la relación entre personas que necesitan y personas que brindan ayuda en las inevitables vicisitudes de la vida. En *More Humane Medicin*e (Edinboro University Press, 2003) argumenta desde un punto de vista que califica como "católico liberal", sobre cómo enfrentar la tecnificación de la medicina y la medicalización de la vida. Otro libro importante es *A Liberal Catholic Bioethics* (Lit Verlag, Berlin, 2010), porque reitera sus convicciones fundamentales respecto del núcleo ético de la profesión médica. Además, en un significativo *Postscript* titulado *The story of one liberal catholic bioethicist* aporta noticias biográficas de gran valor.

En este breve recuento biográfico, Drane detalla cómo, tras el Concilio Vaticano Segundo, estimulado por la comisión a la que Juan XXIII ordenó estudiar el tema de la anticoncepción, él pensó que el papa siguiente, Paulo VI, emitiría una encíclica de "*aggiornamento*" que aceptara sus conclusiones. Ocurrió que, por el contrario, este pontífice emitió la "infamous" (sic) "*Humanae Vitae*" en que vuelve a la postura más conservadora. Lo que molestó a la jerarquía fueron no solamente sus artículos sobre la anticoncepción, sino algunas afirmaciones objetando la "infalibilidad papal", una construcción dogmática del siglo XIX, debida a Pio IX y el concilio Vaticano I. Este pontífice gobernó la iglesia católica 32 años, entre 1846 y 1878, y cimentó ese dogma de la infalibilidad. Por razones bien explicadas, esto se confundió con inmutabilidad de las convicciones y con la verdad absoluta propiciada por el Papado, condenando así

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[2] Lolas, F. Rehistoriar la bioética en América Latina. La contribución de James Drane. *Acta Bioethica* 2005; 11: 161-167.

a muchos fieles a una suerte de incertidumbre sobre qué hacer cuando una familia numerosa no puede seguir creciendo por estrechez económica o cuando se trata de prevenir embarazos indeseados. Además, Drane sugiere que los papas no deben permanecer muchos años en el oficio, que la duración de sus mandatos debe limitarse y que el conservadurismo afincado en la infalibilidad dogmática y doctrinal es algo que atañe más a la política institucional que a las enseñanzas evangélicas.

La peripecia biográfica de James Drane, quien tras larga y dura litigación salió al estado laico (sin aceptar una reclusión en algún lugar apartado de la diócesis que lo conminaba a retractarse) explica muchas de sus convicciones. En su último libro no deja de reconocer que nunca abandonaría su condición de católico y que la religión, rectamente entendida, es un fuerte acicate para la virtud que debe impregnar el *ethos* médico. Concibe la medicina como intrínsecamente apostolado moral y lamenta la mercantilización inducida por la ideología capitalista y los fuertes intereses de las industrias farmacéutica, electrónica y administrativa (los hospitales son empresas, las compañías de seguros velan por obtener márgenes para sus accionistas, los fármacos son impuestos por el mercado). En este plano, es interesante que cite a Ortega y Gasset reiteradamente. "Yo soy yo y mi circunstancia" es un recuerdo de que el contexto influencia las decisiones y las acciones. Y el contexto de las sociedades laicas, capitalistas y "exitistas" supone que el interés de "beneficiar" y "no hacer daño" puede ser reemplazado por el de "tener éxito" y "ganar dinero".

Cuando conocí a James Drane, a fines de los años 80 del siglo XX, sus enseñanzas y ejemplo contribuyeron poderosamente a afincar el discurso bioético en el continente americano. Había sido llamado a la OPS (Organización Panamericana de la Salud) para aconsejar sobre problemas asociados a la investigación con sujetos humanos. Su asesoría generó muchas iniciativas, la no menor de las cuales fue crear lo que al comienzo se llamó "Programa Regional de Bioética para las Américas y el Caribe", instalado en conjunto con la Universidad de Chile y el gobierno de Chile a partir de 1994, que me correspondió dirigir entre 1998 y 2010, al terminar mi periodo como vicerrector de la Universidad de Chile. Su permanente estímulo y sus lecciones académicas y vitales fueron decisivas para instalar programas de maestría en bioética en muchas universidades de Iberoamérica (Chile, Perú, República Dominicana, Argentina) y el apoyo a iniciativas en otros países, la creación de Comisiones Nacionales de Bioética (paradójicamente nunca creada en Chile, aunque contemplada en la ley 20.120) y las vinculaciones con pioneros latinoamericanos como Alfonso Llano en Colombia, José Alberto Mainetti en Argentina y Manuel Velasco-Suárez en México, además de la contribución de Diego Gracia Guillén desde España para crear una "masa crítica" de usuarios de la mentalidad y el discurso bioéticos[3].

De esta historia el libro final, testimonial, da poca cuenta, pero merece recordación. El tema central insiste en las virtudes personales para el recto ejercicio de la medicina, concebida como vertebrada éticamente desde su mismo comienzo como oficio en la Grecia hipocrática. Es probable que alguien objete que la argumentación se basa solamente en la experiencia estadounidense, pero lo que afirma sobre el capitalismo, la mercantilización y la medicalización es también válido en otros países. Por lo demás, no deja de insistir el autor en la determinación cultural de las prácticas sociales y los caracteres individuales.

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[3] Lolas F. Bioética en Iberoamérica: Un recuento personal. En Álvarez JA. (editor) *Ensayos sobre ética de la salud. Aspectos clínicos y bioéticos*. Vol. 2. Aspectos clínicos. Xochimilco: Casata al Tiempo, Universidad Autónoma Metropolitana; 2014: 195-199.

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SOBRE LA VIDA HUMANA SEGÚN ORTEGA Y GASSET

ACEVEDO, JORGE

Ortega y Gasset ¿Qué significa vivir humanamente?

Editorial Universitaria, Santiago de Chile, 2015 (ISBN 978-956-11-2493-6) 189 págs.

Fernando Lolas Stepke[1]

El título de este libro desconcierta. Si bien las reflexiones que incluye, reproducción modificada de textos ya publicados, están siempre ligadas al pensamiento de Ortega, su contenido es mucho más amplio y más profundo que una simple alusión a la obra del filósofo español. Hay notables intuiciones, agudas observaciones, originales planteamientos, todos expresados con esa brillante economía expresiva que caracteriza a la obra del profesor Acevedo. Es de destacar su meticulosidad al momento de citar fuentes, su profundo conocimiento de las distintas ediciones de la obra de Ortega y Gasset y las opiniones de sus comentaristas y exégetas.

Este libro podría haberse titulado: *Contribuciones al estudio de la vida humana*, agregando —si fuera adecuado— "considerando la perspectiva de Ortega y Gasset" como un subtítulo. De otro modo, el lector no avisado podría creer que se trata de un comentario —otro más— de la obra de aquel "*primum inter pares*" de los filósofos de habla hispana. Es de destacar que sus tres secciones — "Ser y vida humana", "Filosofía" y "Historiología y Estimativa"— son todas dignas de atenta lectura, pero es la tercera la que mayor atención concitará entre quienes emplean el discurso bioético o desean adentrarse en sus complejidades.

Vida humana como radical esencial y razón vital como "existenciario" relevante son claves del pensamiento orteguiano que se repiten una y otra vez. Originan esas sutiles y a veces paradójicas afirmaciones sobre la circunstancia, el sujeto, el objeto, lo inefable y lo"inefado", la estimativa o valorativa y —¿por qué no agregarlo?— la necesaria "estética" que puede derivarse de la razón vital. La sensación de lo correcto y lo bello que se identifica con el prefijo "orto": ortovitalidad, ortotanasia, por decir algo. Esa plenitud de sentido de las intuiciones orteguianas se usa para discurrir sobre asuntos muy diversos, desde la historicidad hasta la axiología. Sin descuidar la valiosa distinción entre *historiología* o metahistoria e *historiografía* o narración de hechos. Sin olvidar, en este plano, la sutil distinción de von Ranke entre *Historie* (*was in derTat geschehen ist*, lo que realmente ocurrió) y *Geschichte* (*was erzählt wird*, lo que se narra). Son múltiples las incitaciones que emanan de esta fructífera distinción, que supera con creces las llamadas "filosofías de la historia", que suelen ser imposición doctrinaria de devenires inevitables o convicciones particulares que no iluminan sino entenebrecen el "sentido de la historia" (si es que cabe algo como eso). No puede dejar de recordarse *Ursprung und Ziel der Geschichte* de Jaspers, o las reflexiones de Jacques Maritain. Leyendo a Acevedo se entiende el gran valor de las categorías de Reinhard Kosseleck rotuladas como *Erfahrungsraum* (ámbito de experiencia) y *Erwartungshorizont* (horizonte de expectativas) que tanto ayudan para comprender acontecimientos, "largas duraciones" (al estilo a la francesa de los *Annales*), personas "importantes" ("héroes" de Carlyle) o formas de ascenso y colapso de formas de gobierno.

Dentro de los muchos aspectos que cabría comentar y expandir de este libro, la clásica distinción

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orteguiana entre ideas y creencias merece mención. En un antiguo texto mío que mereció el Premio Municipal de la ciudad de Santiago en 1974[2], sugería estudiar la "americanidad" no desde lenguaje, política o historia sino, justamente, a partir de las creencias. Éstas, como sabemos, pueden ser explícitas y manifiestas o implícitas y encubiertas. A veces ni siquiera se sabe que "se está" en ellas, porque forman un substrato tan basal e inefable del ser persona que se requiere un gran esfuerzo de intro y extrospección para ponerlas e manifiesto. Y aun así, a veces no se las quiere aceptar porque no corresponden al estereotipo que de sí mismas fraguan las personas. La americanidad enjuiciada a través de las creencias es una forma más honesta de describirla y valorarla. Una disciplina de lo creencial está insinuada en estas páginas.

También merecen especial atención, al menos para este comentarista, las observaciones sobre la obra del filósofo Ibn Jaldún. Ya en el siglo XIV este sabio islámico anticipaba las oscilaciones de la vida comunitaria en su dimensión de gobierno o Estado, y anticipaba lo que ha constituido, desde entonces, una tensión entre el sedentarismo y el nomadismo. Tema éste que constituye la clave de ese libro agudo de Mackintosh-Smith, *Los árabes*, escrito por un oxoniense que vive en Yemen más de treinta años y que, precisamente, rastrea esta "arabidad" hasta sus confusos orígenes preislámicos. Se entiende allí —en un ejemplo que es paradigma— no solamente el desconcertante ir y venir de dinastías, la entrega del poder a quienes se acercan a él y terminan por dominarlo, y la inestabilidad inherente a las distintas corrientes del Islam. Reflexionar sobre la idea imperial tomando como base estas observaciones es un tema apasionante.

Una de las contribuciones más sugerentes es la del capítulo 10 de la Tercera Parte, en la que Acevedo analiza la axiología o estimativa orteguiana aportando un conocimiento profundo sobre un tema que tantos matices adoptó en la obra del filósofo.

Sin duda alguna, una aportación maciza digna de lectura y estudio.

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[2] Lolas, F. "Sobre americanidad". En NOTAS AL MARGEN. Ensayos. Colección Travesía, Editorial Cuatro Vientos, Santiago, 1985. (el original, incluido en "Temas y digresiones", data de 1974, año en que recibió el Primer Premio en los Juegos Gabriela Mistral de la I. Municipalidad de Santiago)

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VALERA, LUCA
Espejos. Filosofía y nuevas tecnologías
Herder, Barcelona, 2022.

Cristián Borgoño[1]

El libro de Luca Valera destaca por dos cualidades fundamentales, en primer lugar, un profundo conocimiento de la reflexión filosófica contemporánea sobre la tecnología, con todos sus matices y diferencias. El autor hace gala de un dominio poco usual en esta área de conocimiento, particularmente en lengua española. En efecto, Valera se pasea por la bibliografía más reciente en inglés como por el jardín de su casa. Este hecho hace del libro una valiosa introducción a los debates más recientes que se actualizan prácticamente en tiempo real. En segundo lugar, el libro proporciona una propuesta de análisis filosófico sistemático del fenómeno de la técnica moderna a partir de una metáfora sugerente, como es la del espejo, que le permite al autor organizar un poliédrico análisis de la tecnología ejemplificándolas con la técnica contemporánea y organizándolas según las funciones de un espejo: duplicar, transparentar, modificar, acercar y reflejar. Esta segunda cualidad da al libro una unidad poco frecuente en los textos de la disciplina y será el hilo conductor de la sintética presentación del contenido del libro que haremos a continuación. Más que ahorrar a los lectores la invaluable experiencia de leer este texto, lo que pretendo hacer es un recorrido que permita destacar tanto la unidad del texto como sus contenidos más relevantes y dignos de profundización.

Para ilustrarnos la función de reflejar del espejo, Valera dirige su mirada a la clonación y el avatar, mostrando como el espejo no genera (puesto que la generación implica, de suyo, novedad) sino que produce; es más, como el espejo (re)produce, es decir, no puede sino partir de la mimesis de algo existente. En el fondo, la clonación es la negación misma de la apertura de la generación a la novedad, en parte porque es incapaz de hacer otra cosa, en parte porque lo que se desea es lo dado. Como decimos popularmente: más vale viejo conocido. La clonación es la negación de la innovación intrínsecamente asociada a la reproducción sexuada y, por ello, una profunda negación de la lógica de la generación humana, que es suplantada por un producto tecnológico. Por su parte, en la reflexión sobre el avatar Valera vuelve a la carga sobre las necesarias distinciones entre el original y la copia, entre la imagen del espejo y el sujeto que la genera, anulando toda pretensión de identidad por más que subsista un deseo de desaparecer en la imagen (Cf. La película *The Lawnmower Man*, en español, El Hombre del Jardín). En el fondo, como señala el autor con particular acierto: "la persona no se puede copiar, el individuo, sí" (p. 89). Al mismo tiempo, el autor muestra como esta distinción pone en evidencia que la persona es a la vez sustancia y relación, siendo lo primero aquello que es incomunicable, mientras la relacionalidad será siempre un accidente en estas instancias de generación tecnológica, precisamente en cuanto están a disposición de la misma técnica.

A la función de transparentar del espejo corresponde para Valera la capacidad de la tecnología de reflejar la actividad humana, proporcionando infinidad de datos sobre ella; datos que saturan nuestra capacidad sensorial y nos hacen vivir siempre en la superficie de los fenómenos. Vuelve aquí el tema de la supraliminalidad de la técnica moderna, destacado por Günther Anders. No sólo, esta saturación nos hace vivir en una superficie que está hecha a nuestra imagen y semejanza: los filtros que contienen los gestores de las redes sociales y los motores de búsqueda, hacen que nos introduzcamos en auténticas cámaras de eco, donde lo que se nos muestra se construye a medida de nuestra identidad. En otras palabras, no somos capaces de ver más allá del espejo o bien estamos inmersos en una casa de espejos. En otras palabras, la transparencia e hiperabundancia de la información hacen imposible la comunicación auténtica. Otra

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dimensión de la transparencia es la imposibilidad de salir del espejo, estamos siempre siendo objeto de una mirada tras el espejo que tiene potencialmente conocimiento total de lo que hacemos, es lo que se ha llamado sociedad de la vigilancia o capitalismo de la vigilancia, para hacer alusión al texto de Shoshana Zuboff.

La capacidad de deformación de los espejos es ampliamente conocida, todos conocemos espejos cóncavos y convexos que entregan imágenes distorsionadas, demostrando precisamente la capacidad de torcer la luz a nuestro antojo (a veces nos juegan una mala pasada, como los espejos retrovisores de los automóviles). Cuando esta deformación es voluntaria, lo que buscamos normalmente es mejorar respecto a lo que somos realmente. El mejorar forma parte de nuestro dinamismo interno, de las motivaciones profundas de nuestro obrar. Pero lo que se puede lograr por la *praxis* es ahora alcanzable para la *poiesis:* esta es la esencia del doping deportivo, por ejemplo. La transformación, como la del espejo, es meramente exterior; es una transmutación de la corporeidad, pero no de la persona, salvo por su relación con el cuerpo. Precisamente al tocar el cuerpo, la deformación de estas tecnologías es permanente y no temporal como la del espejo. Pero más problemático aún es la naturaleza heterónoma de esa perfección, que de autonomía sólo tiene la posibilidad de moverse hacia ella, pero no la capacidad de diseñarla. Se nos ofrecen más bien productos que trayectorias de perfección, es decir, procesos que nos perfeccionan en el hacerse y no sólo en el resultado, como toda actividad práctica. El cuerpo se transforma en un proyecto a producir con la tecnología, no con la agencia libre. En ese sentido, Valera muestra con claridad que el ideal tecnológico de perfección es extrínseco y por ello, inevitablemente contradictorio en cuanto ateleológico, esto es, no correspondiente a un dinamismo interno de quien se transforma. Peor todavía, son modelos de perfección globalizados, es decir, uniformes y elitistas, poco respetuosos de la diversidad, más allá de los ideales que definen las élites. Y, al mismo tiempo, variables, en cuanto sometidas a las veleidades de las élites de turno. No dejan salir a flote la exigencia de autenticidad de cada ser humano y la sustituyen por la de conformidad. ¿En ese contexto, tiene sentido seguir buscando la perfección? Parece ser que la única perfección que vale la pena alcanzar es aquella propia del *telos* de cada persona, mas no aquella impuesta desde fuera por la sociedad, por mucho que pueda ser un objeto de deseo.

Pasando a la función de acercar, Valera nos recuerda que los espejos pueden también acercarnos, ayudarnos a vernos mejor. El problema es cuando nos acercan tanto que ponen en evidencia nuestros límites. Los robots producen este efecto, nos gusta que se parezcan a nosotros, pero si se parecen demasiado nos resultan repulsivos. Su similitud, unida a la intrínseca capacidad de mejora del artefacto, nos hace temer la obsolescencia. Permanecen como cosas distantes. La tecnología nos acerca ideales de perfección previamente inalcanzables. En otras palabras, nos dan la ilusión de fundirnos con la tecnología, cuando en realidad nos separa de ella un abismo insuperable.

Reflejar y reflexionar es la última acción que Valera analiza para concluir su metáfora del espejo y también para dar un cierre especulativo al texto. La metáfora se construye a partir de nuestra inmersión en esta casa de los espejos que es el mundo tecnológico: la tecnosfera. La idea de que el lugar determina nuestro ser (la topología determina la ontología) sirve a Valera para desarrollar la idea de la interconexión entre el ser humano y los artefactos, a la manera de la conexión entre el ser humano y el ambiente. De esa manera, dando un paso más, el conocimiento de la máquina es el conocimiento del ser humano y viceversa. Sin embargo, en esta confrontación, el ser humano queda mal parado porque resulta obsoleto, mientras los artefactos mejoran continuamente, el ser humano está atado a la invariabilidad o a lenta variabilidad de su corporeidad. Es más, a la desechabilidad de los artefactos, fruto de la obsolescencia programada, sigue necesariamente la desechabilidad de los seres humanos, incapaces de esa perfección que desean alcanzar, pero que termina por ser su tumba debido a que es un blanco siempre en movimiento. La persistencia de lo desechado, que, como dice Winner, siempre termina en algún lado, es quizás nuestro mejor recordatorio de que otro camino es posible al de reemplazar lo natural por lo artificial, que comienza por nuestros cuerpos, pero termina inevitablemente queriendo abarcarlo todo.

Para concluir, quisiera describir dos ámbitos para los que el libro de Luca Valera constituye un valioso aporte. En primer lugar, para la bioética, disciplina de la que el autor es un eximio cultor. A la bioética le ha faltado una reflexión más profunda sobre la técnica moderna. Cuando Potter, autor bien conocido por Valera, vio el peligro del divorcio entre la ciencia y las humanidades no profundizó en el rol de la técnica moderna en la destrucción del ambiente. Tampoco el filón más tradicional de la bioética ha profundizado en la naturaleza de la técnica moderna como marco general donde se insertan las biotecnologías que la bioética contemporánea tan minuciosamente analiza. La excepción que confirma la regla es quizás Gilbert Hottois, que desarrolla las intuiciones heideggerianas y las aplica a la bioética (Cf. *El paradigma bioético*). En ese sentido, el texto de Valera proporciona el telón de fondo necesario para la reflexión bioética, un aporte que espero sea recibido y profundizado por los colegas de la disciplina.

En segundo lugar, y por las mismas razones, este texto es un aporte para el desarrollo de una teología de la tecnología, tarea pendiente aún ya bien entrado el siglo XXI. En efecto, esta teología no puede sino desarrollarse en diálogo con la reflexión filosófica de la que el texto de Valera es un muy buen exponente. De otro modo se corre el riesgo de abrazar acríticamente visiones tecnofílicas o tecnofóbicas como lo demuestra el oscilante debate teológico sobre algunas aplicaciones de la técnica moderna y sobre el mismo fenómeno técnico en general. Para poder desarrollar una teología de la técnica (o de la tecnología), profunda y equilibrada se requiere del valioso aporte de la reflexión filosófica, por lo que no podemos sino estar agradecidos de este esfuerzo que Luca Valera pone a nuestra disposición.

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CARRASCO, MARÍA ALEJANDRA y VALERA, LUCA (editores)
50 Años de Bioética. El Futuro es Hoy

Tirant Lo Blanch, Valencia, 2021, pp. 202. ISBN: 9788418970375.

Ricardo Rozzi[1]

Este libro conmemora los 50 años de la escuela bioética inaugurada por Van Rensselaer Potter en los Estados Unidos de Norteamérica en la década de 1970. En su artículo "Bioethics: The science of survival" (1970), Potter introdujo la palabra "bioética" en EE.UU. con una visión científica y humanista que expandió en sus libros *Bioethics: Bridge to the future* (1971) y *Global bioethics: Building on the Leopold legacy* (1988). Potter fue un bioquímico estadounidense y profesor de oncología en la Universidad de Wisconsin-Madison, desde donde proyectó una visión ecosistémica en el ámbito de la salud y forjó el concepto de una "bioética global", acercando íntimamente las perspectivas de la bioética y la ética ambiental. Respecto de esta última, para Potter fue especialmente influyente la ética de la tierra de Aldo Leopold.

Los editores de *50 Años de Bioética. El Futuro es Hoy* recalcan esta visión potteriana de la bioética que no queda confinada a temas ético-clínicos, sino que aborda problemáticas ambientales y globales. Luca Valera (p. 162) propone que "la idea de Potter era buscar una sabiduría (*wisdom*) útil para una "ciencia de la supervivencia" (…) Apuntaba a un paradigma, no a una 'receta'". Para comprender claramente las ideas de Potter es necesario entonces aclarar el concepto de "supervivencia". Valera (p. 163) destaca cuán cercanos son los conceptos de "supervivencia aceptable" de Potter y la "ética de la tierra" de Aldo Leopold.

Considerar este libro en *Acta Bioethica* es pertinente por al menos tres motivos. Primero, porque en medio de las pandemias que nos afectaron, como parte del cambio socio-ambiental global actual, el enfoque potteriano es apropiado para tratar las causas biológicas, ecológicas y culturales de estas afecciones, cuya gestación, epidemiología y tratamiento trasciende con mucho a los confines de las relaciones médico-paciente dentro de hospitales. En segundo lugar, el libro *50 Años de Bioética* compila seis textos esenciales de Potter, cinco de los cuales nunca han sido traducidos al español. Por consiguiente, contribuirá significativamente a difundir las ideas potterianas en Iberoamérica y otras regiones hispanoparlantes. En tercer lugar, los textos de Potter son críticamente examinados por los editores María Alejandra Carrasco y Luca Valera (ambos del Centro de Bioética UC) y cuatro comentadores que introducen perspectivas fraguadas bajo distintas disciplinas en distintas regiones del mundo.

Anor Sganzerla (Programa de Posgrado en Bioética, Pontificia Universidad Católica de Paraná, Curitiba, Brasil) y Diego Carlos Zanella (Programa de Posgrado en Enseñanza de Humanidades y Lenguajes, Universidad Franciscana, Santa María, Brasil) resaltan la necesidad de integrar las ciencias y las humanidades, en particular las ciencias biológicas y la comprensión de valores éticos, para abordar los complejos problemas socioambientales actuales, incluidos los problemas de salud. Luis Miguel Pastor (Facultad de Medicina, Universidad de Murcia, España) reitera la falta de atención a la bioética de Potter en el mundo hispanoparlante y revisa las contribuciones que han hecho a la bioética hispánica los pensadores de cuatro ámbitos académicos: (1) médicos y científicos, (2) filósofos, (3) teólogos y (4) estudiosos del derecho (civil, penal y de la filosofía del Derecho). Pastor (p. 151) subraya que "en el mundo iberoamericano los problemas socioeconómicos tienen una fuerte repercusión en la vida humana y su salud. La presencia de bolsas de pobreza y la falta de justicia social se mezcla con la invasión de la tecnología y la exportación de modelos de vida que afectan a una población muy rica en

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tradiciones, tanto autóctonas como derivadas de la fusión con las españolas o de poblaciones europeas inmigradas en estos últimos siglos (…) [En] un contexto como el iberoamericano (…) [las] iniquidades deben ser juzgadas éticamente, no solo porque afectan a la vida humana sino porque también modifican drásticamente ecosistemas muy importantes del planeta". Finalmente, Henk Ten Have (Center for Healthcare Ethics, Duquesne University, Pittsburgh, EE.UU.) advierte que a fines de la década de 1960 las imágenes de la Tierra como un globo solitario en el espacio exterior contribuyeron a que las personas tomaran conciencia que habitan en un mismo planeta. Metáforas como la "nave espacial de la Tierra", la "red de la vida", y recientemente el "hogar común", incluido en el subtítulo de la encíclica del Papa Francisco "Laudato si: sobre el cuidado de nuestra casa común", han reforzado la conciencia acerca de la necesidad de cuidado de la Tierra.

Los ensayos de Potter y los conceptos introducidos por los comentadores tienen implicaciones para la interpretación de la ética global en la que no hay separación entre la Tierra de sus cohabitantes. Por ello la coeditora, María Alejandra Carrasco, hace un llamado a la necesidad de un drástico cambio de hábitos de vida para lograr una supervivencia aceptable de la especie humana y el conjunto de cohabitantes no humanos. Por eso, los valores de responsabilidad y cuidado son fundamentales. Carrasco termina este libro afirmando que su propósito es comunicar el enfoque de la bioética de Potter que nos interpela para establecer una nueva ciencia y una ética que continúan en construcción. Concluye que, para esta tarea, se requiere una nueva: "[i] integración de ciencias y humanidades, que se opone al paradigma o al modelo de ciencia moderno; [ii] una ciencia práctica, pues estudia la acción humana y en ese sentido está abierta a las contingencias; y [iii] normativa, en cuanto indica un 'deber ser' de nuestra conducta en relación con la totalidad del ecosistema al que pertenecemos" (Carrasco, p. 199).

Este libro plantea estímulos valiosos para la discusión de la bioética en el mundo hispanoparlante. Su lectura podría enriquecer el enfoque potteriano, al incorporar por un lado problemáticas socioambientales que adquieren dimensiones extremas en Latinoamérica y, por otro, considerar la diversidad de conocimientos ecológicos y prácticas ambientales albergadas por diversas culturas que habitan esta región.

TABLA DE CONTENIDOS
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Documentos

Recensiones