

# Medical Ethics Code: an Analysis from Ethical-Disciplinary Cases Against Medical Professionals within the Specialty of Psychiatry

ORIGINAL

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## Abstract

**Objective:** To identify the nature of infractions committed by doctors working within the field of psychiatry, between 2010 and 2016, from the scope of appeals within ethical-disciplinary cases judged at the Plenary Tribunal of the Federal Medical Council, based on the medical ethics code, and to list some elements that make it possible to outline the professional profile of those involved.

**Method:** This was a document-based investigation in the form of a retrospective and descriptive study. Data were gathered using the Federal Medical Council (CFM) database and from consultation of judgments issued by the Plenary Body of the Medical Ethics Tribunal (TSEM), of the CFM. The investigation used a sample consisting of 206 appeals and 19 referrals, totaling 224 appeals by doctors who underwent trials. We took into account cases judged between April 13, 2010 and August 3, 2016. Three databases were used in the investigation: cases (224); doctors facing charges (191) and cases/penalties (146). Based on the records of the 191 doctors charged, the ethical-disciplinary cases of seven doctors working in psychiatry were analyzed specifically for the present study, whether or not they had a specialist title. Characterization of infractions committed encompassed references to the articles of the medical ethics code most frequently infringed in the field of psychiatry, along with a survey of the motives for these infractions and some characteristics relating to these professionals' profile.

**Results:** Among the findings from this investigation, infractions of the articles of the medical ethics code can be highlighted, such as ar-

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ticle 30 “[...] *Use of the profession to corrupt customs and to commit or favor crime [...]*” and article 40 “[...] *Taking advantage of situations arising from the doctor-patient relationship to obtain physical, emotional, financial or any other advantage [...]*”. The professional profile of those involved in these cases was also shown: the average age was 49.8 years, and all of these professionals were male. The mean length of time since graduation among the psychiatrists with appeals to the plenary body of the TSEM was 31.2 years at the time of judgment. The punishment handed down most frequently was to strike these professionals off the register, reaching the percentage of 42.9%. Among the five professionals with specialist titles, four complemented their studies with specializations, after the episode that originated the ethics charges.

**Conclusion:** The data gathered showed that the professionals were punished for irregularities in the sphere of ethics, including issues going beyond technical and/or scientific competence. This makes it possible to highlight that punishments proportional to the seriousness of the infraction act were applied, along with the importance of bioethics in medical training and the need for specialization, from the results of the judgments on ethical-professional cases before the plenary body of the TSEM.

#### Keywords

Bioethics; Medical Ethics Code; Professional Conduct; Medical Ethics; Psychiatry Specialty.

## Introduction

In Brazil, the Federal Constitution states that “the exercise of any work, trade or profession is free”, but with the reservation that this is so, provided that “the professional qualifications that the law establishes are complied with” [1]. For doctors to be legally qualified to practice the profession, they must have diplomas issued by official medical schools or that are recognized in this country, along with registration in the respective Regional Medical Councils [2].

The Federal Medical Council (CFM), together with the Regional Medical Councils (CRMs), are autarchic entities regulated by means of decree [3]. Their primary function is to monitor, inspect and evalua-

te the professional practice of doctors who work in different branches of medicine in Brazil, and to judge any infractions, based on the medical ethics code [4].

Therefore, the Medical Councils are important bodies for defending society with regard to the population’s health, with the purposes of inspection and standardization of medical practice, defense of ethical professional practice and good technical and humanistic training, and quality assurance regarding provision of medical services [5].

The medical profession needs to be connected to ethically committed behavior, and to be practiced with humanity and sensitivity, case by case, respecting patients and society. According to Sarlet

[6], to construct a true medical subject, (...) morality, ethics, rectitude of character, sincere empathy, welcoming otherness, social conscience (...) are indispensable requirements.

The councils are composed of a collegiate body of doctors who are elected by their regularly registered peers through direct secret election, by an absolute majority of votes, in accordance with the councils' internal regulations [7]. They are structured into chambers and plenary bodies for the purpose of adjudicating complaints against doctors who violate medical ethics, within a system of norms that assures counter-argument and full defense, with the means and appeals inherent to this, in compliance with the fundamental rights and guarantees provided for in the Brazilian Constitution [1].

The norms for protecting ethics judgments are drawn up by the peers themselves [7], including with public consultation to the population. These discipline ethical medical action and establish the configuration of doctor-patient relationships, as well as the duties and rights of these professionals, thus regulating the entire process of the cases in sphere of ethics. Ethical practice is called the medical ethics code (CEM) [4] and the procedural process, i.e. the rite of the judgments, is called the Code of Ethical-Professional Process (CPEP) [8].

Regarding the task of judging appeals relating to matters of ethical nature that are placed before the CFM, the composition and organization of the CFM comprises plenary bodies and chambers. For example, the Higher Medical Ethics Tribunal (TSEM) deals with appeals for acquittal or in relation to disciplinary penalties imposed on doctors by the regional councils. These penalties may range from a confidential warning to striking these professionals off the register. The competence of TSEM is set forth in CFM resolutions and in the law that created medical councils [2].

Appeals to the plenary body are placed as a consequence of decisions handed down in ethical-professional cases that were determined by means

of a majority vote in the chambers of the CFM; or decisions to annul professional practice that were issued by regional councils (CRMs); or decisions submitted to the chambers regarding decisions reached unanimously in the ethical-professional cases by the chambers of the CRMs; or decisions handed down by a majority or unanimously in ethical-professional cases heard by the plenary body of the CRMs [8]. The procedures of ethical-professional cases take place under conditions of confidentiality.

### The specialty of psychiatry

As provided by law 3.268/1957, which is in force in Brazil [2], a doctor with a diploma registered in a Regional Medical Council (CRM) may work in any field, even without a specialist title. Consequently, CFM has been unable to create a norm to make it compulsory that acts within the field of psychiatry can only be performed by doctors with this title. However, this reality may change through the regulations of the normative competencies of CFM, as prescribed by law 12.842/2013, also known as the Law of Medical Acts [9].

In Brazil, there is still no legal requirement for a specialist title in Psychiatry, although the main goal of this specialty encompasses relief of suffering and mental wellbeing of patients. The legislation in force [2] only determines that, in order to announce actuation in any branch or medical specialty, professionals need to be registered in the CRM. Regarding the specialty, the CFM norms recommend that, to perform procedures, doctors need to have specific training. This indispensably includes training of three years and a title obtained through a medical residency program in psychiatry (CNRM) or through a competition arranged jointly by the Brazilian Medical Association (AMB) and the Brazilian Association of Psychiatry (ABP) [10], among other recommendations and determinations defined in related resolutions.

However, it needs to be stressed, as mentioned before, that law 12.842/2013 discipline the super-

visory attributes of CRMs and the CFM, encompassing inspection and control of procedures of an experimental nature when these do not meet the requirements determined by that law [9]. In this context, the CFM is expressly authorized to lay down norms regarding medical procedures, and may also consent to them through requiring that doctors practicing them have a certain degree of technical knowledge. The CFM may also prohibit doctors who do not have a specialist title from performing certain procedures. One example of this power/duty is the recent CFM resolution 2.113/2014 [11], which was issued because of the need to control both patients and doctors involved with compassionate therapy using cannabidiol. This resolution established that only medical specialists in neurology and its areas of practice, or in neurosurgery or psychiatry, may prescribe cannabidiol for treatment of childhood and adolescent epilepsy, when this is refractory to other treatments.

It is also worth mentioning the recent decree 8.516/2015, which was issued to regulate training in relation to the National Registry of Specialists, with the objective of providing support for the Ministries of Health and Education, as a source of information for setting parameters for actions within Public Health and healthcare training [12]. This register will have official information regarding the medical specialty of each medical professional, coming from the databases of the National Commission of Medical Residency (CNRM), the CFM, the Brazilian Medical Association (AMB) and specialties related to these bodies. The same decree also establishes a Joint Commission of Specialties, within the scope of the CFM, and gives it the competence to define the country's medical specialties, by consensus. In this, the CNRM has the responsibility to determine the competence matrix for the training of specialists within medical residency [12].

In 2013, given the importance of this topic, the CFM consolidated several resolutions in the field of psychiatry, reiterating the universal principles of

protection for human beings, defense of private medical acts performed by psychiatrists and the minimum safety criteria for hospitals or psychiatric care of any kind, while also defining a model for anamnesis and expert script within psychiatry [13].

Psychiatry fulfills a well-defined social function, which makes it distinct from other areas of medicine. It seeks to affirm the dominant values in social and human relations. Costa, quoting Reinaldo (2004), [14] stated that: "[...] psychiatry directly affects the bodies of people; it is a reality that plays a role in transformation of the subject, thus taking on the burden of his life and guiding his existence [...]".

For the most part, this specialty treats vulnerable patients, while always facing the dilemma of exercising its authority and, at the same time, respecting the decisions of its patients, who often present reduced autonomy due to their disease.

Koerich [15] accurately observed that, in the case of the mentally ill, daily practice is confronted with the complication that some mental illnesses affect the thought process. Thus, "[...] information and consent may be greatly altered by the way the patient interprets the doctor's words and integrates them into his pathological system." Likewise, Wijnendaele [16] pointed out that "certain serious mental illnesses are accompanied by a decrease in consciousness, i.e. in the ability of patients to perceive the pathological nature of their condition."

In turn, the actions of bodies such as the ABP has great relevance in regulating medical practice within the specialty of psychiatry. However, ultimately, it is up to the plenary body of the TSEM to judge ethics cases against doctors with or without specialist titles, and to make judgments. It may apply penalties ranging from confidential warnings in the form of a notice of reservation (the most lenient penalty) to cassation of the professional practice (the most severe penalty). Although psychiatry is not among the medical specialties that present

the highest numbers of ethics lawsuits [17], it is not free from violations of ethical precepts.

In this light, the present paper aimed to identify the nature of the infractions committed by doctors practicing within the field of psychiatry, between 2010 and 2016, from the scope of the appeals against ethical-disciplinary cases judged at the plenary tribunal of the CFM, based on the medical ethics code. This paper also aimed to list some elements that would make it possible to outline the professional profile of those involved.

## Method

### Sample

The sample was composed of seven ethics cases judged by the plenary body of the TSEM, in which the professional was either a psychiatry specialist or acted within this specialty in the episode that caused the case to be brought. The mean age of the doctors thus charged was 49.8 years (SD = 10.2) when the episode occurred. All of these professionals were male.

### Procedure

This study comprised a survey, in which ethical-professional cases in the field of psychiatry were extracted from the CFM database. Its scope consisted of ethical-disciplinary cases that were judged at appeal level, i.e. appeals and referrals in ethical-professional cases, (in office or out of office), by the plenary body of the CFM. Cases judged between 2010 and 2016 were considered, and specifically from April 13, 2010, to August 3, 2016. Cases that were opened at the primary level at CRMs before 2010 received their final judgments from the federal plenary body during this period.

### Data analysis

Data were analyzed using the Excel and SPSS (version 21) statistical software. Descriptive statistics

were used, such as mean, standard deviation and frequency.

## Results

Among the psychiatrists with appeals to the plenary body of the TSEM, the mean length of time since graduation was 24.6 years (SD = 9.97) when the episode occurred, 29.7 (SD = 9.8) when the case was opened and 31.2 (SD = 9.8) at the time of the judgment, such that the mean time that elapsed between the occurrence of the episode and the beginning of the case was 5.1 years (SD = 2.3), as shown in **Table 1**. The mean time taken for the judgment to be reached was 1.7 years (SD = 0.8), from the date when the case began, for the plenary body of the TSEM to issue a ruling on the case.

The mean age of the doctors at the time of the judgment was 56.6 (SD = 10.5). It was 49.8 (SD = 9.8) at the time when the episode occurred, and 55 (SD = 10.2) at the time when the case was opened, as shown in **Table 2**.

Among the seven cases analyzed, only in three of them did the doctors have a specialization title in psychiatry. The other four doctors concluded their specializations after the infraction occurred and one of these specialized in another field.

**Table 1.** Relationship between the length of time since the doctor graduated and the cases and penalties (n = 7).

Individuals' length of time since graduation	years	Mean length of time since graduation
When the episode occurred	03 - 25(2) - 28(2) - 29 - 34	24.6
When the case was opened	08 - 30 - 31 - 33 - 35(2) - 36	29.7
At the time of the judgment	10 - 30 - 32 - 36(2) - 37 - 38	31.2

Source: Federal Medical Council, 2010-2016.

**Table 2.** Relationship between the doctors' mean age and the cases and penalties (n = 7).

Individuals' ages	years	Mean age
When the episode occurred	29 - 48 (2) - 53 - 54 - 56 - 61	49.8
When the case was opened	34 - 54 - 56 (2) - 60 - 62 - 63	55
At the time of the judgment	36 - 55 - 56 - 59 - 61 - 64 - 65	56.6

Source: Federal Medical Council, 2010-2016.

Furthermore, the articles of the CEM that were infringed were noted, including the possibility that more than one infraction per case could exist. These results are shown in **Table 3**.

As shown in **Table 3**, the articles most often infringed were numbers 30 and 40, which state, respectively

**Table 3.** Quantification of articles of the medical ethics code that were infringed, between 2010 and 2016.

Article number	Total	
	N	%
30	3	21.4
40	3	21.4
14	2	14.2
102	1	7.1
35	1	7.1
58	1	7.1
80	1	7.1
81	1	7.1
77	1	7.1

Source: Federal Medical Council, 2010-2016.

*Use of the profession to corrupt customs and to commit or favor crime" and "Taking advantage of situations arising from the doctor-patient relationship to obtain physical, emotional, financial or any other advantage*

Following this, the frequencies of the punishments given by the plenary body of the TSEM in relation to the cases judged were ascertained. These results are shown in **Table 4**.

**Table 4.** List of punishments in the seven cases.

Penalty	Percentage	
	N	%
Cassation	3	42.9
Total and definitive suspension	1	14.2
Confidential censure	1	14.2
Suspension for up to 30 days	1	14.2
Unknown	1	14.2

Source: Federal Medical Council, 2010-2016.

Thus, as shown in **Table 4**, 42.9% of these professionals were struck off the register. The second most frequent result was precautionary interdiction (14.2%). This should not be confused with a penalty: rather, it is a measure that suspends medical practice until the final judgment of the case has been handed down, given the plausibility of the right invoked. This has the aim of ensuring the effectiveness of the main proceedings and, at the same time, avoiding injuries that patients fear and the risk of dissipation of the result from the case (CPEP).

It needs to be emphasized that no previous research specifically dealing with violations of ethical precepts by specialists in psychiatry or doctors who were acting in this specialty could be found. What can be found in the literature are surveys relating to specific CRMs, which take into account all specialties. Furthermore, taking the reference point of the state of São Paulo, which has the largest population of doctors in Brazil [18], the number of doctors involved in ethics cases has grown over recent years. Over the ten-year period from 2001 to 2011, this number grew from 1.022 to 3.089, thus representing an increase of 302%. The rise in ethics complaints has a variety of causes, such as greater awareness of the population about their rights, pre-

carious working conditions, especially in the public sector, influence of the media, deterioration in the quality of the doctor-patient relationship [17, 19] and the poor training of doctors during undergraduate and postgraduate studies [17]. However, the Regional Medical Council of São Paulo has pointed out that, in addition to the deterioration of medical education, the evolution of the quantity of complaints is linked to the increase in the numbers of doctors [20].

It seems obvious that violations of bioethical principles have consequences for the population served [21]. Within psychiatry, the doctor-patient relationship is peculiar, because even if it obeys a general principle of caring for the health and dignity of patients, its ultimate goal is to collaborate such that the patient returns to the path of growth and emotional maturity. In carrying out this task, doctors need to make significant efforts towards helping their patients to better understand the origin and meaning of their symptoms [22].

## Discussion

The results found in the present investigation showed that the profile of the doctors involved in cases judged by the plenary body of the TSEM was very similar to what was found in other studies that sought to investigate doctors involved in ethical-disciplinary cases, regardless of their specialty [23]. Moreover, it was also noticed that this profile was also similar to what was seen in other surveys that considered the entire medical population, whether or not there were any ethical-disciplinary charges [17, 23]. These professionals were all male and graduated more than 20 years previously.

The prominent position (from a socioeconomic point of view) that many professionals have already reached at this point in their careers reinforces the "magical thinking" of omnipotence. Another possibility may relate to the level of financial reward that doctors start to have after entering the job market,

in which they feel the need, over time, to increase their number of sources of income (shifts, jobs and underpaid activities) [24].

It is also worth mentioning the role of the training that the doctors involved in these cases had had. Among the cases analyzed, just over half of the professionals did not have a specialist title in psychiatry at any time during the procedures of the case, even though the case against them was framed within this specialty. In relation to those who did have a specialist title, only one of them was already a specialist before the episode that caused the case, while the other two doctors obtained their specialist title after the beginning of the case against them. Coherently with these results, it was seen that the search for technical improvement can serve as a protective factor against errors that cause damage to patients and, consequently, ethics lawsuits, since this increases the degree of trust in the services rendered, thereby making the doctor-patient relationship closer [23].

This aspect of training was also reflected in the articles infringed in these cases. Even though these do not relate specifically to traditional medical errors, in which harm is done to a patient through an improper technical procedure, this may reflect a failure in the professional's training. Bioethical principles should be used in examining and understanding situations of conflict that are present in the daily care provided for patients. Violation of this care by doctors may cause serious damage to patients.

The plenary body of the TSEM has stated that medical professionals are not allowed to disrespect human rights, corrupt customs or commit or favor crime. Likewise, it has emphasized the importance of doctors' relationships with patients and relatives, and has punished those who, in this relationship, obtain physical, emotional or financial advantages, or advantages of any other nature [4]. Such acts, above all, weaken two bioethical principles, namely: beneficence, "because the professional undertakes

to evaluate the potential risks and benefits (individual and collective) and to seek maximum benefits, thereby reducing harm and risks to the minimum" [15]; and non-maleficence, which is what "determines the obligation not to inflict damage intentionally" [26].

Punishment for doctors, which is provided for by law and through the CEM, has a preventive deterrent purpose. The medical profession is thus aware that if an ethics offense is committed, the individuals concerned may be reprimanded by their peers, in any of the following manners: confidential warning in a notice of reservation; confidential censure in a notice of reservation; public censure in an official publication; suspension of professional practice for up to 30 days; and as far as being struck off the register, after referral to the Federal Council, from which there is no rehabilitation [27].

Thus, violation of ethical precepts gives rise to liability to a variety of punishments. These punishments may even influence civil and criminal trials, even though such proceedings are independent, since the principle of independence of different courts is not absolute, and influence from other spheres is accepted. In this context, doctors have a duty to know about and respect ethical precepts, or else they may face the penalty of severe punishment from the medical councils. These bodies have autonomy to exercise administrative policing power over the conduct of professionals whose cases they assess [24].

Given the findings of the present investigation, it can be concluded that the objectives were met. However, like any scientific endeavor, it was also not free from limitations. These limitations relate to the low number of cases analyzed. Although this reflects the fact that psychiatry is not one of the areas of activity with the highest numbers of ethics cases, as also observed by other authors [17, 23], there is a need to make observations over a longer period of time. This would also make it possible for these data to serve as criteria of comparison between

the period in which the new CEM 2009 has been in force [4] and the period of the old CEM 1988 [28]. Nonetheless, this limitation does not reduce the relevance of the present investigation, which may serve to direct medical bodies such as the ABP and CFM towards interventions that seek to reduce the numbers of acts that violate the ethical precepts of the CEM.

### **Some points about bioethics and its relationship with the medical ethics code**

Today, the need to establish debates on issues that present plurality and that require interpretation in the light of different perspectives cannot be denied. Hence, bioethics is important as a body of knowledge that has the aim of enabling understanding of life in its various dimensions. It requires a multi, inter and/or transdisciplinary stance within its structural basis, to allow questioning in relation to conflicts of value raised by techno-scientific, social and cultural development, among other issues, especially those relating to living beings, and particularly to humans. Development of awareness based on specific references relating to life in society that lead to a condition of "more than living" and a situation in which different social groups live together respectfully, without impositions, but through understanding paradigms that fit diverse realities, is sought.

From a historical point of view, the terminology of bioethics was coined by the American doctor Van Rensselaer Potter, at the beginning of the 1970s. This expression was configured in the book "Bioethics: the bridge to the future". In Potter's bioethics, "ethics" and "biological knowledge" were taken to be interrelated, and this represented an attempt to delimit a space (even though without stable foundations) and an opening for humans to assure their survival and that of the planet. This initial connotation focused on issues of global ethics and, more precisely, on the ethics of preserving the planet in the future. In this regard, it incorporated

expanded concepts relating to the "quality of human life" (including respect for the environment and ecosystem), as well as specific biomedical issues [29].

However, the bioethical concerns relating to the environment and the planet that Potter proposed were, in a way, pushed into a secondary position through limitation to the scope of biomedical, under strong influence from the founder of the Kennedy Institute of Ethics, Andre Hellegers, in 1971. This researcher led a study group formed by doctors and theologians who viewed medical and technological progress with concern, along with the implications and challenges regarding the "ethical systems" of the Western world. They therefore reaffirmed that bioethics was a bridge between medicine, philosophy and ethics [29]. Thus, the "biomedical approach" came to prevail as the basis for construction of bioethical thinking. Consequently, bioethics arose strongly in this form in the United States in the 1970s, spread through Europe in the 1980s and reached the rest of the world in the 1990s.

To reach rapid understanding of the American principlist bioethical paradigm, two early studies that portrayed bioethics need to be mentioned. The first was the Belmont report, dated 1978, which aimed to address issues relating to controlling research that was conducted on human subjects. This report referred to three principles that should be considered: respect for people (autonomy), beneficence and justice [30]. However, it can be noted that the term "autonomous person" can be understood to mean an individual who is "capable of deliberating on his personal goals and acting under the guidance of that deliberation", among other things [17, 23].

While the Belmont report only considered ethical matters relating to research conducted on human subjects, the researchers Beauchamp and Childress returned to the principlist view in 1979 [25], but encompassing the field of clinical practice and care. Thus, through their Principles of Biomedical Ethics, these authors consolidated bioethics under the ae-

gis of four principles: autonomy, beneficence, non-maleficence and justice.

In view of this trajectory, "principlist" bioethics can be highlighted as resulting from American culture, influenced by Anglo-Saxon philosophical pragmatism and solidified both in the sphere of procedures and in the decision-making process.

What should be emphasized is that the "Anglo-American" vision concentrates on individualistic perspectives and categorizes the principles, especially when it comes to the autonomy of the person. Thus, the principle of autonomy was gradually ranked in relation to other principles, and this contributed towards adoption of an individual view of conflicts, which was taken to be the priority in analysis and decision-making processes. Thus, bioethics became disseminated beyond the United States with this point of view, as pointed out by Garrafa [31].

*it is Anglo-Saxon bioethics, with strong individualistic connotations, for which the basis of support rested on the autonomy of social subjects. In turn, one of the operational or practical consequences of this was the requirement or necessity to apply so-called informed consent statements [31].*

The evolutionary process of bioethics (going from its birth to the present day) as a body of knowledge has also contributed to the evolution of life in society at the same time. This has occurred through reaching greater epistemological and methodological depth, with a view to incorporating the latest debates, in addition to those already in existence. European scholars have contributed incisively to the field of bioethics and have questioned the principlist view through the notion that if this is taken alone, it becomes insufficient to analyze the changes and the ethical "macroproblems" that emerged in the twentieth century and the beginning of the twenty-first century [32]. In addition, fissures in the social fabric have become disproportionate among the

countries of both the northern and the southern hemispheres, notably due to the impact of globalization and situations resulting from this.

Thus, themes such as vulnerability, discrimination, humanization, social exclusion and transgenderism, among many other questions of the present day, are now incorporated under this broad and diversified field named bioethics and need to be debated more strongly, considering both global and local boundaries. This is particularly because understanding of what will become bioethics in this early part of the twenty-first century may vary from one context to another and from one nation to another [32].

In this globalized sphere, bioethics has a preponderant role in consolidation of paradigms for coping with social, cultural and other problems. It follows that bioethics presupposes its own dynamics and incorporation of an increasingly expanded and committed view. Scenarios pointing towards diversity and plurality of positions, visions and values, sometimes in a conflicting and extremely radical way, require revision of the founding issues of bioethics, and certainly from its principles, to the point of perhaps incorporating reference points and criteria of other orders that take into account the multiplicity of points of view of different social groups.

Thus, ethics codes represent consolidation of ethical principles that are taken on by society, according to Segre and Cohen [33]. On the basis that principles are changeable, it is evident that codes consequently always need to be altered bearing in mind the dynamics of "ethical thinking". These updates need to be accomplished through critical analysis and periodic review of conflicting and even resistant issues.

Thus, through focusing on aspects of human life in its broadest sense, bioethics deals with the incessant questions relating to the relationships between theoretical reflections based on great principles and how these apply to individuals or groups. Bioethics therefore tests the principles of respect for patients'

autonomy and solidarity, and demands that other people should be regarded with respect and dignity [29].

Among the strands of medical ethics, doctors' obligations towards society and towards human beings as holders of rights and the issue of human rights in the doctor-patient relationship, among other things, have been established through coding.

In relation to CEM 2009, it needs to be borne in mind that this was drawn up under the influence of the principlist vision, although conceptual evolutions were incorporated. Insertion of new elements into existing bioethical reference points allows medical professionals to develop their practice, which is increasingly responsible, human and historically contextualized. Thus, according to Nunes [34], universal values can and should anchor human relations and professional practice.

Therefore, in considering bioethical foundations within medical practice, it was decided in the present investigation to reflect, albeit briefly, on the principles of beneficence and autonomy. The principle of beneficence refers to the ethical obligation to maximize benefit and minimize injury [27]. Hence, professionals need to be convinced and technically informed regarding practices that assure beneficial conditions of treatment and reception for patients. From the basis that the principle of beneficence presupposes that no deliberate damage is inflicted, the principle of non-maleficence consequently arises. It is therefore established that medical action should always imply reduction of harm or injury to the patient's health. Through not harming the patient, the aim is to reduce the possible adverse effects of diagnostic and therapeutic actions.

In turn, the principle of autonomy emphasizes that people are empowered to deliberate regarding their personal choices. People therefore should be treated with respect regarding their decision-making and freedom of choice. As stated in the CEM, it should be noted that the relationships of medical professional with their patients must necessarily pre-

suppose the principle of autonomy. This implies that it is forbidden to carry out any procedure without firstly explaining it to the patient or guardian and receiving consent to proceed, except in situations of imminent danger of loss of life [4].

Autonomy implies self-determination by an individual with regard to making decisions relating to his or her life, health, physical-psychological integrity and social relationships. It presupposes the existence of options and freedom of choice and requires that the individual should be able to act in accordance with the deliberations made. Respect for self-determination is based on the principle of the dignity of human nature, in accordance with the Kantian categorical imperative, which states that the human being is an end in itself [35]. Certain variables contribute towards making an individual autonomous, such as biological, mental and social conditions. In some transient or permanent situations, a person may have present diminished autonomy, and third parties then have the role of making decisions.

It is therefore evident that the principles of beneficence and autonomy considered here cannot be seen separately from the other principles and reference points, given that a multidisciplinary approach is adopted for the purpose of analysis.

### Study limitations

This study presented important limitations regarding the absence of any other research samples with the same objective. Such samples would arise through analysis on judgments from the plenary bodies of CRMs that would point out the infractions that carried the heaviest penalties, along with other data in the field of psychiatry, from professionals either with or without specialist titles.

Another important limitation relates to the sample size. Because of the small number of cases involving acts within psychiatry, only the results found in relation to these cases could be considered.

### Contributions towards the field of activity of psychiatry professionals

Among the contributions of the present investigation towards the field of activity of psychiatry professionals, it needs to be highlighted that it aimed to deepen the knowledge of the adjudicating actions of the medical councils. In particular, it aimed to focus on ethical-professional cases against doctors in Brazilian states and their reviews by the plenary body of the Federal Council. Furthermore, the types of infractions and ethics penalties to which professionals acting within the field of psychiatry were subject were ascertained, thus demonstrating that in judging situations of infraction, the medical body and peers of the accused handed down punishments of greater severity.

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### Conflict of interest

The authors report that there was no conflict of interest.

## Note

The sample for this investigation comprised 206 appeals and 19 referrals, thus totaling 224 appeals by doctors who were facing charges. Cases judged between April 13, 2010, and August 3, 2016, were taken into consideration. Three databases were used in this investigation: cases (224); doctors facing charges (191) and cases/penalties (146). This text relates to the PhD thesis in Bioethics of the first author of this article, which is to be defended at the University of Porto, Portugal, in 2018, and which has been accepted for publication in the Brazilian Journal of Medical and Biological Research: (Gracindo, Giselle. Threats to Bioethical Principles in Medical Practice in Brazil: Period of the New Medical Ethics Code. Accepted for publication in the Brazilian Journal of Medical and Biological Research (6988.R1), on November 23, 2017. [bjournal@terra.com.br](mailto:bjournal@terra.com.br).

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