ETHICS AND DEONTOLOGY OF MEDICAL EDUCATION AND NURSES IN PORTUGAL

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Abstract

This article discusses deontological issues of health care professions in relation to their ethical foundation. We present four models of teaching ethics and deontology in doctors' training and the results of a PhD research on the teaching of these subjects in nurses' training in Portugal. Given the importance of bioethics in deontological training of health care professions, we present a comparative analysis of. bioethical principles enunciated by Beauchamp and Childress (1979), related to 'ethics of justice', and Kemp's(2000) proposal, associated to an 'ethics of care'. Given the ambiguity of these bioethical expressions, we focus on the analysis of its contents and the need to discuss the fundamentals of ethical training of doctors and nurses in relation to the ethical theories they are derived from. Utilitarian ethics, duty ethics, virtue ethics, when the analysis of bioethics' fundaments is not trained, the duty of caring of suffering can be put at risk.

Keywords: Training; Ethics; Deontology; Health care professionals

1 INTRODUCTION

The studies that, in the twentieth century, had as their object the professions, have defined themselves as to what distinguishes them from other occupations, by the following set of characteristics:

- A group of expertises;

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- The autonomy in the professional practice;
- The issuance of prior credentials that are indispensable to the professional practice and the ability to self-regulation (exercised by professional associations, in an independently way or in collaboration with the State);
- A code of ethics;
- Social recognition

This set of features enabled, for centuries, to recognize the profession of Physician. As for the nursing profession (and even more in other fields of health activity), such recognition has just happened (or it is still taking place).

In the society of information that we live in, it can not parallel conceal, the growing importance of the competence notion as "a set of cognitive abilities and motor skills, as well as attitudes, values and theoretical-practical knowledge required to perform a specialized function of a way that is socially recognized and acceptable" (TOBÓN, PIMENTA, GARCIA, 2010, p.131). This concept, although, the visible equivocality in the use made by international[3] documents, fully justifies the need for an evaluation of the knowledge acquired though the formal education, prior to the profession practice, and, moreover, it shows how the individual is never fully prepared for the work, legitimizing the need for training and eventually the possibility of professional cards and identification forfeiture.

What is the role of ethics and deontology in the context of competence for healthcare professionals (physicians and nurses)? What is the contribution of teaching this subject throughout the formal education for the formation of a competent profession? How to make the assessment of their ethical responsibilities? Is the ethical and deontological dimension present throughout their courses

We will not focus on the analysis of all these issues. The only issue presented, in a propaedeutic way, is an analysis of the ethics and professional deontology teaching models for the courses of health professionals (physicians and nurses) in Portugal.

[3] It is possible to find the word 'competence' as a synonym, for example, of capacity, of qualification, of ability, efficiency. On the other hand, the different way of classifying the competences (WEINERT, 2004) that creates overlays that increase the ambiguity. Bonilla (2010) identifies two divergent directions: an instrumental perspective, whereby the definition of goals or standards of competence serves to evaluate their performance on tasks or functions deemed relevant to an external evaluator that is sometimes anonymous (teacher, employer, government, customer, etc.) a systemic approach that relates the acquisition of knowledge, skills and values to the individual context in which they apply, as well as the processes and outcomes. In the last perspective, the measure of competence is unable to solve concrete problems and it is reflected in educational activities, employment, social economic and political. This perspective is also consistent with a concept of lifelong learning and community.

2 MODELS OF TEACHING PROFESSIONAL ETHICS AND DEONTOLOGICAL IN THE TRAINING OF PHYSICIAN

The models of medical training, in relation to the Ethics and Deontology, is mainly focus on the Bioethics and on the deontology considerations of legal venue, where there is often some confusion between both dimensions (for example, as regards the secrecy (CDMP, art. 83; CDENF, art. 45). It happens in almost all around the world, and Portugal is not an exception.

The way that these subjects are organized in the medicine undergraduate courses, usually takes one of four models that we will describe (HAFFERTY, FRANKS, 1994; HAFFERTY, 1998; OLIVEIRA, 2009).

1. In the older universities, it is common to face the teaching of ethics and deontological ethics as an autonomy unit, often in the first years of the undergraduate course, occurring that at times the contents appear decontextualized in relation to the other training areas.

It is noted that in favor of this model, in which, as noted Pellegrino (PELLEGRINO, THOMASMA, 1988) and reiterated Hafferty and Franks: "ethics, as a distinct subject matter with its own body of literature and methodology, is as teachable as any other discipline" (Hafferty, Franks, 1994, p.864). However it can not be forgotten that "the knowledge of ethics cannot be expected to guarantee virtue. […] students arrive at medical school with their own values […] that are not changed much by a course in ethics, a viewpoint […] frequently endorsed by basic science faculty" (HAFFERTY, FRANKS, 1994, p.864).

In Portugal, in our opinion, this is the model found in the universities considered 'classsics', as of the Porto one.

2. In some universities that have been emerged more recently, the Ethics and the Deontology is no longer a curriculum subject or an independently training area, before integrating (Ethics, more often) in the formation of other curriculum subject, with a type of applied ethics, resorting to active methods such as the PBL (Problem Based Learning). So when, for example, studying Obstetrics and Gynecology, there is a module dedicated to solve problems in this area, involving ethical decisions. The Deontology appears with a higher relevance, either as independently mandatory or optional training course (Forensic Medicine, for example).

Thus it seeks to link the gap between the different expertise areas and the ethical reflection, with the expectation that students, even if only in professional training, standardize values and practice. In our Portuguese university, the one that most resembles to this model is probably the Algarve University.

A third model can also be found in newer universities, where it joins to classical training areas (even with innovative methodologies) a Humanities area (with autonomous character, or inserted in another area, such as Community Health), in which links the teaching of ethics, and Deontology (along with other subjects such as history of medicine, training and other aspects of humanistic kind, such as literature, music, etc.). The methods range from the more expository type and the applied ethics, or even deontological dilemmas in specific contexts of training in traditional areas.

The aim is to create conditions for the students, from their training courses, to question the values framework, previously created, and consequently become fair professionals and trustworthy people, performing the double integration: ethical scientific-formation training, professional-social-values. In other words, the academy wants in this model not only train expert doctors, but also good human beings. Such purposes are broadly identified in the institutional advertising of the integrated Masters in Medicine of the University of Minho, in Portugal.

3. In the last model, we detected all the training *curriculum* led to the formation of humanistic doctors, inserting in this teaching framework of traditional areas. There is an appreciation of clinical practice in relation to "basic science" and areas considered smaller, as the "public and/or community health". The teaching of Ethics and Deontology has a mixed character in terms of methodology, being especially modules that use the exposure (in particular with regard to the foundations of the Bioethics), as well as active methods such as PBL and the roleplaying. This model does not exist in Portugal.

3 MODELS OF TEACHING ETHICS AND PROFESSIONAL DEONTOLOGICAL IN THE TRAINING OF NURSES

The data that we present below results from the content analysis of the *curricula* and the programs of 22 Nursing[4] Schools in Portugal, based on the following categories: Ethics, Bioethics and Deontology. Such content analysis also considered the document: Relating Recommendations to the Teaching of Ethics and Deontology in the nursing courses[5], produced by Order of Nurses, which is based on international documents, including the WHO (World Health Organization).

In all institutions that responded to the survey, there is the teaching of ethics, and the courses adapted to the "Bologna Process", the course unit (CU) taught only appears in the 1st year of the undergraduate courses.

Similarly, Bioethics is taught in all institutions, while Deontology is present in only 21. There is, however, a large discrepancy in the type and hours allocated to CU establishments adapted or not the «Bologna Process».

There is also the presence of a great variety of names to define the CU (with respect to the Ethics, there are more than 15 denominations) and the contents placed therein; there is still a large discrepancy in the workload between the different courses units. In conjunction with these data, the difficulty arises from several institutions comply the recommendations of the above document mentioned, in terms of programmed contents.

Thus, only five of the 22 studied institutions follow all the recommendations of that document, as explained below.

- Concerning to the Ethics: to the development of ethical skills, the most relevant programmed contents are: principles and foundations of ethics, virtue and values, principles and foundations or nursing ethics, ethical theories, decision-making and ethical dilemmas.
- Concerning to the Deontology: important contributions are themes as the historical path of the Deontology, the regulation and professional self-regulation, rights, duties and incompatibilities, emphasizing the possibility of different approaches to the obligations reflected in the Deontological Code (for example, in safeguarding clients' rights, in relation to safety or to the excellence of care, etc.).

[4]This study was prepared as part of the doctoral dissertation: Reis, Ana (2009). The Teaching of Ethics and Deontology in the Nursing Undergraduations.. Braga. Faculdade de Filosofia. UCP. The thesis was oriented by one of the authors of this article.

[5]Cf CJOENF. In bibliographic references.

- Concerning to the Bioethics: it is suggested the query, the analysis and discussion of articles published by the Jurisdictional Council journal of the Order of Nurses (CJOENF, 2006), in the section of Ethics in Nursing, as well as the conclusions of the National Council of Ethics in Life Sciences: CNCV, 2011).

3.1 Bioethics principles and deontological codes

The reference to the deontological codes and to the bioethics that we have just mentioned in the ethical and deontological formation of nurses has a parallel in the training of physicians. However, considering how both groups consider the respective deontological code, it is necessary to make some distinctions, as it follows.

The association between bioethics and deontology is justified by the derivative character of the deontology, understood as a legal tool that draws its strength of the association that it adopts, but it seeks its foundation in the current scientific knowledge and the reflection on the fundamental ethical principles. The very wording of the Deontological Code of the Portuguese Physicians (DCPP, 2010) considers, in its preamble, the following text as legal nature and dynamic character, derived from the Medical Ethics.

However, as a result of this approach, it often becomes deontology the ambiguities of the bioethics concept (referring to the problems that it is posed to human action; or the phenomena of life considered as a whole, or the specifics of human life, particularly in relation to its beginning and to its end, or, even, the clinical implications of such phenomena). On the other hand, the frequent divorce between the scientific research and ethical knowledge and the reasons (anthropological, axiological and ontological) raise new ambiguities and difficulties of bioethical reflection and, on the professional deontology teaching.

The comparative analysis of physicians' and nurses' deontological codes reflected a divergence of perspective that it is in the teaching of ethics and, in turn, also reflects the dual perspective of the emerging "bioethical principles'. Beauchamp and Childress (1979) formulated in the early times of bioethics, the four principles still considered essential in this context: beneficence, non-maleficence, justice and autonomy. Pellegrino believes that these principles are based, from the standpoint of objectiveness, in bringing the cure. In our understandings, from the ethical reasons, there is some ambiguity, because while they stand in a consequentialist perspective (they are good the actions that lead to positive or favorable consequences) they provide a way of proceeding seems close to Kant (Kant, 1984), deducing

the concrete practice of application on those principles (which assume universally valid). The nature of the disease determines the procedures (it does not matter who the patient is, what is his/her situation or even who is the doctor). So the criteria for judging the goodness is also impersonal (like the "ideal observer" of consequentialism). Often, with the explanation of the principle of beneficence, it is encountered a distinction between charity and benevolence, emphasizing the superiority of the first, justified by the reason universality for the volatility of feelings.

The deontological code of the Portuguese physicians (DCPP, 2010) states in its preamble the principles of the Chicago School, although, it reflects other principles (vulnerability, dignity, integrity), it is recognized by some international documents (Kemp, 2000), so its fundamental focus. Deontology is in this framework, "the set of rules of ethics that, with character of permanence and the necessary historic adaptation in its formulation, the physician should observe […] in the exercise of their professional activity" (DCPP, art. 1). The procedure ethically adjusted consists in the fulfillment of obligations (duties) universally applicable and rationally deduced from these principles.

From the verification of this way of proceeding, it is resulted, concerning its interpretation, the parallels with the so-called "ethics of justice", or identified as the Kantian ethics, or even the theory of moral development Kohlberg (1981) known by the same name. However, this approach is illegitimate by following the philosophical principles of the Chicago School and leads to ambiguities, as it is further explained.

As for the deontological code of nurses[6], it is focused on service excellence, indicating that the paradigm in which is based is different: it is not the formulation of axioms for the logical deduction of universal duties, but the responsibility that informs all and each of cares taken. This perspective, usually designated as "ethical care", allows, firstly, to incorporate into the deontological consideration all situations where it is possible to cure (by which is more universalizable), calling on the other hand, to a range of personal skills, exceeding the rational or intellectual (compassion, trust, commitment, as manifested in acts of hospitality, listening, help…) in order to define the character traits that define the normal behavior of the professional and characterize as a person.

Although the principles are formulated (vulnerability, dignity, care, integrity, but not forgetting the previous beneficence, non-maleficence, justice and autonomy), these are not a

[6] See: Orders of Nurses. Status of the order of nurses**.** Decree-Law N. 104/98 of April, 21. Diário da República I Serie A, N. 93, of 21/4/98 (attached). Chapter VI – Of Profissional Deontology.

starting point for logical reasoning, before trying to set out the conditions for the care of the vulnerable person, one and only, away from the perspective of healing as the sole purpose, and viewing it as way of caring.

Thus, the bioethical principles, which underpin the deontology of nurses, approach the prospect of Peter Kemp, for whom autonomy, dignity integrity and vulnerability are expressions of the goals to be met the standards for a “good life” (Kemp, 2000). In this context, the fundamental principle is the vulnerability, ontologically prior to the others and the result of mutual recognition of the human need and finitude.

The starting point of the deontological professional moves away from “What principles apply to this case? Which one is more important? to What problems do this person blame me? Or which one(s) of them am I more responsible? In this context, beneficence can not do without benevolence.

3.2. “Ethics of justice” (KHOLBERG, 1976 and 1981) versus “ethics of care” (GILLIGAN, 1982)

The terms “ethics of justice” and “ethics of care”; although may be applied in the context of deontological professional, were created to describe the models of moral development (within the psychology and moral education) and they use, therefore, the word ethics improperly, because they do not seek its philosophical foundation of a way of acting, but its description, accompanied by evidence spontaneously justification empirically gathered.

The first comes from the Kohlberg research with children and adolescents, with the presentation for further discussion and resolution of moral dilemmas. From the answers, Kohlberg provides a moral development theory into six stages, in which each defines a way to make decisions and reflect on moral issues (what is good and what is evil). These stages are grouped in pairs and follow the following order: pre-“conventional”, “conventional” and post-conventional”.

The term “conventional” that characterizes the midpoint of the scale and by reference to which to define the other two, depicts the theoretical and practical acceptance of the rules, habits and expectations set by the society or the authority, precisely because as such they are imposed. At this level, the individual has internalized the rules and accepted them as the “social force”. At the pre-conventional stage, the individual becomes able to differentiate

themselves from the rules and accept them, no longer by its social power, but for their suitability for general moral principles (Kohlberg, 1976).

The correlate of this theory to the moral education implies that the “social force” can be considered fair, where the proposal of a school as “fair community”, which establishes the relations of reciprocity and allows for reflection on the rules (by free discussion of moral dilemmas), and the development of the human ability to access the understanding of the universal moral principles (fairness, reciprocity) and deduct their actual behavior.

It should be noted that the definition of what is “fair” can not be done within the framework of the theory of Kohlberg’s moral development, but it requires a reflection of a philosophical nature. Indeed, “the fair is the socially accepted” (typically conventional stage) to “the fair is socially acceptable” (typically of the fair community) is the step that is not referred “the socially accepted must be fair” which presupposes, to another level, the definition of fair and its foundation, along with the differentiation between casual and universal.

The final stage of Kohlberg’s moral development identifies itself with the realization of Kant’s categorical imperative (“proceeds that from the act it can be found a universal rule”: Kant, 1984), and – in the proposal of the “fair community” – it requires the students to have the conditions for accessing the proposal, because, in such a community, everyone would act in accordance with this standard. However, the level which moves Kohlberg is the practice, not the fundamentals (of justification) for this same practice. And when it is precisely undertaken the moral education of children and young people or the training deontological professional, it is not possible to deny asking the first person: why should I proceed in this way? What is the cause of action according to the socially established and not according to pleasure? How do I know if the set is actually socially fair or if it is not more than a custom that is continued by inertia?

It is noted that Kohlberg built his theory from the answers to the dilemmas of the male subjects in their entirely. Forward it is concluded that the moral perspective of women do not go beyond level 3, in which the moral decisions and the reasons are not based on the social system of rules and principles, but in the networks of relationship between two or more individuals.

This conclusion would ask Carol Gilligan (1982) the question about the universality of application of the theory of Kohlberg. The studies showed evidence the possible reversibility of moral development as the one that defined it, since it proves the possibility of individuals

in higher states, when reaching adulthood, resolve to a relativism characteristic of earlier ages and apparently exceeded. As an alternative to Kohlberg's explanation that not all social experiences are equally relevant for moral development, Gilligan proposed that there might be other forms of moral reflection that the model did not contemplate.

Building on previous work on early socialization and gender identification, Gilligan concludes that the difference between the shapes defined as male and female are not the result of evaluating morally, nor an inferiority of woman, not a biological characteristic. The difference is – Gilligan concludes, according to Chodorow – the fact that women are usually the primary caregivers of children, resulting in a girls identify with their mothers, the subject of same-sex embodying the affective and care, while the sexual identification of boys would lead to deny those dimensions.

Then Gilligan came to the study of a "moral specificity of women", providing evidence for what came to constitute itself as a "feminist ethics" whose key points are the care, recognition, acceptance and attention to each other as well as social construction and learning skills such as morally so important as fairness and reciprocity.

As a sequences, it has developed, the oppositions justice/care or its complementarity, emphasizing on the second perspective that care is not a character trait defined biologically, neither the value of affection and attention to the other as opposed the justice is a female inferiority, suggesting, in terms of moral education, that care is a universal human value.

It is precisely in this point that it is found an identical weakness that is considered in the end of the brief summary of Kohlberg's position: what is the foundation to consider care as a universal value? And if at any time, the care and the justice are pointing to the opposite directions, how to choose? And on what basis?

These questions (such as those formulated above) show that moral educations (which may fall into the deontological training) need a foundation of diverse nature.

3.3 From the practice to the substantiation: consequentialism, duty ethics, virtue ethics

We considered three broad guidelines as to the reasoning of ethics (consequentialism, duty ethics, virtue ethics), which are distinguished by the view that adopts the assessment of what constitutes morality of any act (ROSELLÓ, TORRALBA, 2002).

The “consequentialism"[7] is based on the assessment of the potential goodness of a particular action assessing the consequences, including for this purpose the following aspects: what kind of consequences can be considered good? Who is the first beneficiary of this action? Why are the consequences appreciated and who carry out this judgment?

In contrast, the duty ethics (exemplified by the Kantian perspective) deduces the possible goodness of an act in its intrinsic nature (an evil act is always bad, regardless of the benefits that there could have for any of those involved) and “virtue ethics” focus on the character of the moral subject.

The different types of consequentialism can be distinguished from those who are beneficiary of the actions in question or of which the subject’s motivation to act: It is not lingered in the assessment of each particular one, but it is noted that the principles of the Chicago School (the line of Beauchamp and Childness, 1979), taken together, apply to the field of consequentialism bioethics. The appreciation of the alternatives of action and the option for one of them is made from the foreseeable consequences: maximize the good (welfare) for the greatest number, with its reverse side to minimize the evil, even for the greatest number, combine with the balance between the consequences for the individual (autonomy) and groups of greater or lesser extent to which it belongs (justice). The assumption of an ideal observer, equipped with all possible knowledge, allows, according to the consequentialists, to remove risks of seeking the own interest and responsibility. It is also from the “ideal observer” who can establish the normativity (and justified the distinction before pointed between beneficence and benevolence). It comes now the “rule consequentialism”, which states that a morally correct behavior implies the obligation to follow certain basic rules, and thus appears near the deontologism. However, it should be noted that while for this last point, the obligation of the moral norm results from its absolute and universal character, so that its value is of practical order:

> […] the best argument for rule-consequentialism is not that it derives from an overarching commitment to maximise the good. The best argument for rule-consequentialism is that it does a better job than its rivals of matching and tying together our moral convictions, as well as offering us help with our moral disagreements and uncertainties (HOOKER, 2000, p.101).[8]

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[7] This term, meeting the critical appraisal of a group of authors and theories, was consecrated by Anscombe, G. E. M., 1958.

[8] The best argument for consequentialism is that it derives from a global commitment to maximize the good. The best argument for consequentialism is the one that does a better job than its rivals on to match and tie our moral convictions, offering us help with our moral disagreements and uncertainties (Free translation of the editors)

Similar reasoning could be done on the ethics of virtue: the behavior that produces the best consequences is the virtuous, so this is the most useful to the community and thus raises the pleasure of the subject, therefore, the virtuous is what should be achieved by the consequentialist view. However the authors that are included in the designated *virtue ethics* do not accept this plea, distinguishing between other objective (inherent to the act nature) and the result (the result actually achieved).

The “virtue ethics” is leaded to the Greek *arête*. It mainly connotes to the Aristotelian ethics (Aristotle, 2009), teleological type, in which the good was the purpose for which human actions were directed. He was closely linked to the conception of happiness of a whole community, and even of nature, given the community interdependence existing in the Greek society, and that linked the notion of what, from the modernity, it is considered how individual happiness and sense life. Note that the distinction between ethics and morality comes up with the Roman culture, which implies a distinction between good (as purpose – ethics) and the social good (as a consequence – morality). There was also the assumption in the Athenian culture, at least since Socrates, which corresponded that act ethically meant the good use of the *logos*.

In this context, *ethos* referred to the appropriate path to reach the good, and the *arête* mediated the purpose end and the concrete action. Truth and justice (within the limits of legitimacy of a slave society, to only mention, to the contemporary eyes, an awkward issue of Athenian culture) were the most valued virtues, the first was the intellectual order and second, the practical order. “The virtue is a disposition to the decision on the action and emotions, determined by the ration and how would determine the prudent man” (ARISTOTLE, 2009, 1106b 36-1107a 2). Note that the provision to which it is referred is of potential type, not being determined so innate, not so social. To act virtuously is equivalent to act with prudence (*phronesis*).

In the twentieth century, however, virtue ethics were taken up by authors such as Alasdair Maclntyre (1984), Pellegrino and Thomasma (1988), and others.

The last authors attempted to construct models of sustained ethical that unlink the bioethics from the power of consequentialism, the overvaluation of individual autonomy over other principles. Thanks to this recent move, it started to enumerate a set of bioethical principles, which the central is the vulnerability, as set out before. Intended to resume the importance of patient beneficence from the virtues developed by caregivers in the practice of

health care, this is obtained, thus the practice of the virtues of balancing, prudence, justice, for example. It is argued that ethical decisions in the context of health (and illness) must be taken not only concerning the will of the individual patient, but also the community context in which the patient lives, which holds an important role in the construction of meanings.

4 CARING SUFFERING AND ACAEMIC FORMATION

Constituting suffering an unpleasant experience of internal disintegration perceived by a person that usually attributes causally to something (perceived so) outside there are incremental intensities of this type of experience (CASSELL, 2004).

Although we face an universal phenomenon in ontogenetic history of every human being and the history of phylogenesis of our species, this gradual intensity could not, at least so far, to be the target of an universal measuring instrument, or even evaluation – obviously – the almost exclusively subjective character of this experience that makes us all onto metaphysically.

Caring for someone assumes that the other needs our help, so the most fundamental function of any health care provider, whether formal or informal, is to alleviate the suffering that makes one so fragile and vulnerable. "Heal when possible, always taking care" is the maximum that would make sense to train as a mantra in training doctors. Unfortunately, the second part of the maximum there is usually broken, becoming heritage, at least executive, mostly of the nurses and the social service professionals.

Caring for the people's suffering has implicated an ethical solitude, of solidarity and responsibility, further highlighted when it is taken care of those who are close to us, but there are also others that, verbally or otherwise, ask us for assistance.

Considering the curricular structure of most courses of Medicine and Nursing, the possible reflection *locus* and learning about the suffering would be courses on Ethics, Bioethics and Deontology. Unfortunately, many professors teach those courses, as it was described, without the ethical and axiological roots that led to them. However well intentioned, many decisions of health professionals are well trained to cause more suffering to patients, whether they are based only on the performance of duties, or only in assessing to possible consequences of their acts.

In both attitudes would have been even distinguish between patients' duties and responsibilities of professionals, as well as the consequences of acts of professional and undertaken by the patients.

In many instances, there are inconsistencies in the fulfillment of bioethical and deontological, which may be due to the fact that they are based on these ethical principles (and perhaps ontometaphysics systems) of totally different orientation, and even mixed together. Thus, for example, *the principle of non-maleficence* can be based on the Kantian ethics of duty, while of *the principle justice* is clearly consequentialist. When a health professional has to choose between these two principles, only the awareness on the ethical current that makes you believe in will guide you. It is therefore essential that, before being in a real context, it has reflected on the different ethical currents and it has incorporated it. The *curricular* of these professionals should provide the reflection on the grounded ethical and do not be limited to the presentation and discussion of bioethical principles of moral dilemmas. However it does not always happen, which makes the health cares suffer in deciding and, of course, for patients who depend on them in so many ways.

The training of doctors and nurses is often not devote to differentiate between pain and suffering, nor to reflect on the continuity between these two existential realities. In our view, in the context of ethics and deontology it will be possible to explore these issues.

If the practice of care can be considered a common denominator regarding doctors, nurses and, in general, to all health care professions, relating directly to the reduction of suffering of patients and their families, then it is possible to identify, in those professions, a morality of care. From the phenomenological analysis of this, way enroll up to be the modes and conditions that make an *ethos* of care, and it is based on ethical reflection.

In our opinion, the training of health professionals focusing on understanding and practicing the virtue ethics can guide them to an effective decrease of human suffering, because it involves developing the capacity of prudent judgment, so necessary in making ethical decisions. However, more than the affirmation of a model, it is argued that the ethical and professional conduct of health professionals to make the discussion of the reasoning of the last practice and bioethical principles.

Resumo

Abordaremos a deontologia de profissões de saúde (médicos e enfermeiros), relacionando-a com os seus fundamentos éticos. Apresentamos quatro modelos de ensino da ética e deontologia na formação dos médicos, e os resultados da pesquisa de doutorado sobre o ensino dessas disciplinas na formação de enfermeiros em Portugal. Dada a importância da bioética na formação desses profissionais, explicitam-se duas orientações fundamentais neste campo: os princípios bioéticos enunciados por Beauchamp e Childress(1979), relacionados com uma 'ética da justiça', e a proposta de Kemp(2000), próxima de uma 'ética do cuidado'. Dada a ambiguidade dos termos 'ética da justiça' e 'ética do cuidado', detemo-nos na análise de seu conteúdo e na necessidade de discutir os fundamentos da formação ética de médicos e enfermeiros, reportando-os às concepções éticas de que se derivam: ética utilitarista, ética do dever, ética da virtude. Indicaremos algumas repercussões da ausência de fundamentação ética na função cuidadora destes profissionais.

Palavras-chave: Formação; Ética; Deontologia; Profissionais de saúde

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REFERÊNCIAS

ANSCOMBE, G. E. M. Modern Moral Philosophy. **Philosophy,** 33(124), p.1-19, (1958). Disponível em: <http.//www.philosophy.uncc.edu/mleldrid/cmt/mmp.html>. Acesso em: 10 mar. 2010.

ARISTÓTELES. **Ética a Nicómaco**. São Paulo: Atlas Editora, 2009.

BEAUCHAMP, T.; CHILDRESS, J. **Principles of Biomedical Ethics**. Oxford: Oxford University Press, 1979

BONILLA, J. C. Reflexiones sobre la Educación Basada en Competencias. **Revista Complutense de Educación**, Madrid, n.1, p. 91-106, 2010. Disponível em: <http://revistas.ucm.es/index.php/RCED/article/view/RCED1010120091A/15205>. Acesso em: 03 fev. 2011.

CASSELL, E. **The Nature of Suffering and the Goals of Medicine**. Oxford: Oxford University Press, 2004.

CNECV.(Conselho Nacional de Ética das Ciências da Vida). **Pareceres vários**. Disponível em: <https.//www. Cnecv.pt>. Acesso em: 10 set. 2011.

GILLIGAN, C. **In a different voice. Psychological theory and women's development**. Cambridge MA: Harvard University Press, 1982.

HAFFERTY, F.; FRANKS, R. The Hidden Curriculum, Ethics Teaching, and the Structure of medical Education. **Academic Medicine**, 69(11), p. 861-871, 1994.

HAFFERTY, F. Curriculum Reform. Confronting Medicine's Hidden Curriculum. **Academic Medicine**, 73(4), p. 403-407, 1998.

HOOKER, B. **Ideal Code, Real World**. Oxford: Oxford University Press, 2000.

KANT, E. **Crítica da Razão Prática**. Lisboa: Edições 70, 1984.

KEMP. P. Four Ethical Principles in Biolaw. In J. D. Rendorff, & P. Kemp *et al*. (ed.) **Bioethics and Biolaw**, Partners Research (p.13–22), Barcelona: Institut Borja de Bioètica. Copenhagen. Centre for Ethics and Law, 2000.

KOHLBERG, L. **Essays on Moral Development.** The Philosophy of Moral Development. Vol. I. San Francisco: CA. Harper e Row, 1981.

______Moral stages and Moralization. In Lickona, (ed). **Development and Behavior.** Theory, Research and Social Issues. New York: Rinehart and Winston, 1976.

MACINTYRE, A. **After Virtue**. A Study in Moral Theory. Indiana: University of Notre Dame Press, 1984.

OLIVEIRA, C. C. Humanidades na Formação Médica: Realidade ou Farsa? **Reflexão e Ação**, Santa Cruz do Sul, n.2, p. 225-242, 2009.

ORDEM DOS ENFERMEIROS. **Código deontológico [CDENF].** Disponível em: <www.ordemenfermeiros.pt/legislacao/Documents/.../CodigoDeontologico.pt>. Acesso em: 20 set. 2011.

ORDEM DOS ENFERMEIROS. Conselho jurisdicional [CJOENF]. **Recomendações relativas ao ensino da Ética e Deontologia no curso de Enfermagem,** 2006. Dísponível em:<http://www.ordemenfermeiros.pt/comunicacao/Revistas/ROE_23_Novembro_2006.pdf>. Acesso em: 20 Set. 2011. Ordem dos enfermeiros. **Estatuto da ordem dos enfermeiros.** Decreto-Lei nº 104/98 de 21 de Abril. Diário da República I Série A, nº 93, de 21/4/98 (anexo).

Ordem dos médicos. **CÓDIGO DEONTOLÓGICO DOS MÉDICOS PORTUGUESES** (CDMP). Disponívelem:<http.//www.ordemdosmedicos.pt>. Acesso em: 30 out. 2011.

PELLEGRINO, E.; THOMASMA, D. **For the Patient's Good.** The Restoration of Beneficence in Health Care. New York: Oxford University Press, 1988.

REIS, A. O Ensino da Ética e Deontologia nas Licenciaturas em Enfermagem. Tese (doutorado em Filosofia, Bioética)) - Universidade Católica Portuguesa, Braga, 2009.

ROSELLÓ, F., TORRALBA I. **Ética del Cuidar.** Fundamentos, contextos y problemas. Barcelona: Institut Borja de Bioètica / Fundacion MAPFRE de Medicina, 2002.

TOBÓN, S.; PIMIENTA, J.; FRAILE, J. **Secuencias didácticas.** Aprendizaje y evaluación de competencias. Mexico: Pearson, 2010.

WEINERT, F. Concepto de competencia: una aclaración conceptual. In D.S Rychen, & L.H Salgarik (Ed.). **Definir y seleccionar las competencias fundamentales para la vida.** (p. 94-127). Mexico: Fondo de Cultura Económica, 2004.

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