requirements for health, aiming to prevent adverse health outcomes. Principle two: Public health should achieve community health in a way that respects the rights of individuals in the community. Principle five: Public health should seek the information needed to implement effective policies and programs that protect and promote health. Principle seven: Public health institutions should act in a timely manner on the information they have within the resources and the mandate given to them by the public.

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Moral consensus theory: paradigm cases of abortion and orthothanasia in Brazil

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Abstract

Bioethics is a relatively new way of thinking about relationships in medical practice. It enables reflection on ethical conflicts, and opens up management options without dictating rules. Despite this historical context, medical ethics has been sidelined in the course of the development of bioethics.

Bioethical reflection does not automatically result in changes to conflict resolution in daily doctor-patient relationships. However, these reflections are important because they promote the search for a "moral consensus" that establishes new ethical rules for day-to-day medical practice. We suggest that there is no conflict between bioethics and medical ethics; rather, these areas interact to establish new standards of behaviour among physicians. The legalisation of orthothanasia in Brazil is one example of how this theory of moral consensus might operate. On the other hand, the legal battle on abortion illustrates how the law cannot change without such a moral consensus.

Introduction

Bioethics has received tremendous impetus as a fresh and non-traditional assessment of ethics in medicine since the 1970s. It is primarily viewed as the humanistic exercise of reflecting on the natural conflicts of a profession in which two parties, originally the doctor and the patient, attempt to relate in a complex manner.

Bioethics is a new discipline that aims to combine biology and human values, "but it has gradually shifted its attention away from the medical field and biological technology" (1). The moral codes of the medical profession were relegated to the sidelines. Many bioethicists believed that the professional codes were no more than rulebooks listing duties to be strictly fulfilled without the power to stimulate thinking in those who fulfil these duties.

Some view these moral codes as merely inelegant, but others view them as obsolete and even hypocritical (2). The latter perspective suggests that the codes of medical ethics, which originated from the Hippocratic Oath and the code of the British physician Thomas Percival (3), have no place in a globalised society with many conflict-provoking situations and moral issues. Therefore, while bioethics, which espouses a novel assessment of relationships and ethical conflicts, would open a range of management options without dictating rules of behaviour, bioethical reflection does not always modify the general practice of conflict resolution in daily doctor-patient relationships.

This dichotomy is erroneous. Ethics since Aristotle has been characterised by reflection on our own conflicts and values regarding appropriate human conduct. Such reflection is inevitably connected to the morals of a society. Conversely, morals and codes of conduct act as practical translations of this ethical reflection and represent the values of a particular social *corpus* (4).

Moral consensus

This "social practice" does not occur randomly. Social and professional groups inevitably disagree on the correctness of certain moral stands. These differences are dependent on subjective values, religious or political concepts and individual views. A discussion of these ideas, views and values is necessary to arrive at a minimum consensus (the term "consensus" is used here to reflect the majority view within a particular social and / or professional group) among the various parties involved, either within a social group or a group within different professions, and to establish standards and codes of conduct.

Therefore, in strict sociological terms, the establishment of moral rules and sets of duties that include all members of a particular social group is similar to a game in which the winners are the majority of supporters of a particular rule or principle.

For example, various codes of professional ethics ban sex with patients. This rule would have been preceded by ethical reflection of the conflicts that could arise when a doctor falls in love with or desires his or her patient. This standard would have been adopted, implemented and respected by all physicians only after the attainment of a minimum moral consensus that sexual involvement would be detrimental to the doctor–patient relationship.

The situation outlined above is intentionally simplistic, but this dynamic has the potential to occur in several areas of medical practice. Generally, "winning" groups within a community assert their values and arrive at a "moral consensus" on the part of the losers, who must accept and comply with the imposed rules.

The crisis of ethics

Moral and ethical codes are often imposed on individuals in the form of rules and duties, but these codes arise from a consensus that reflects the majority values within a particular social and / or professional group. One can argue that this social or professional group consensus can be achieved through the use of force. But we are talking about the "consensus" obtained through the democratic debate of ideas.

Both the philosophical reflection on ethical problems that plague certain social groups and the establishment of moral codes that emerge from these discussions through consensus appear at times of historical crisis. The crisis could be in the given society or within the medical profession itself. Hippocrates coined his oath when a growing distrust of doctors occurred in Greek society. His set of rules was aimed at reassuring the public that health professionals were committed to assisting their patients.

To illustrate this point, we borrow the concept of the "paradigm crisis" of Thomas Kuhn, a philosopher of science (5) According to Kuhn, theories and explanations that are used to explain natural phenomena are considered paradigmatic until the moment that they no longer satisfy the scientific community.

At this time, Kuhn states, criticisms of the prevailing theoretical model begin either because the pre- existing theory is insufficient to explain all of the variations of the same phenomenon, or because it does not explain some apparent anomalies of the previously studied phenomena.

This situation creates an environment for the development of a new theoretical model, a new paradigm that can better explain both the variants and anomalies of the phenomenon in question.

The notion of crisis can be implemented for ethical reflection in medicine. In general, these crises are represented by changes in technology and social values, which lead to the emergence of conflicts in the daily practice of physicians and their relationships with their patients. In these times of transformation, moral codes, and therefore ethics, may be temporarily unhelpful in ethical conflict resolution.

Therefore, reflections on these new conflicts must be conducted to ensure that the existing codes are adequate for the new social reality. The professional group can propose a different ethical approach that is better adapted to the new technological and / or social conditions. In a specific social context in times of crisis, society "shakes" ethicists into a deeper reflection on new values and behavioural changes. These situations are ripe for bioethics debates.

The ethics of daily life

Crises in human medicine are numerous and demand ethicists' increasing reflection on various topics. These demands can be effectively translated into questions, such as, "What should I do?" "What can I do?" and "What can't I do?" Such questions are heard when new inventions are introduced in the biomedical field, and often these questions are followed by a new statement: "This is not in the Code of Ethics!"

At first, these issues are brought to institutional ethics or bioethics committees, and individual cases are resolved without generalisation of conduct.

However, professionals desire generalisation, and wish for a guide to the "ethics of daily life" that will assist in the resolution of pressing yet basic questions. They look for guidelines that are more stable, more direct and more objective than the partial resolutions of ethics or bioethics committees.

The solution we expect adjusts the nature of professional conduct by the insertion of new standards into their professional codes. These standards can be carried in the professionals' "pocket memory" to ensure that their use is more commonplace.

Dynamic ethics and ethical paradigms

Snyder and Leffler of the Ethics and Human Rights Committee at the American College of Physicians state, "Medicine, law and social values are not static. Reexamining the ethical tenets of medical practice and its application in new circumstances is a necessary exercise." (6) Therefore, after a certain period of maturation, a dynamic philosophical analysis of ethical dilemmas in the most diverse corners of empirical observation generates (or does not generate) a new moral consensus within a social group. These periods of intense reflection create a moral consensus that the old code and ethics must be renewed to adapt to the new social reality.

A good example is the shift in what Thomas Kuhn describes as "the ethical paradigm" (5) of the paternalistic relationship between doctors and patients to a new standard of respect for the principle of autonomy.

This transition from paternalism to respect for patient autonomy occurred only after a period of crisis in which patients were better informed by greater access to scientific information, and questioned medical conduct.

Medical paternalism thwarted the efforts, by those interested in medical ethics, to reflect on the relationships of doctors and patients until a new moral consensus was reached, and respect for patient autonomy was integrated into the new codes of medical ethics. In other words, the principle of autonomy was "conquered" by patients and not "granted" by doctors.

However, ethical codes are unchanged when a moral consensus is not reached within a social group. The issue of abortion on demand is a classic example. Although the prohibition on pregnancy termination challenges the principle of autonomy for women, a consensus on the issue has not been attained in many societies, including Catholic countries like Brazil.

Building moral consensus around orthothanasia

The issue of orthothanasia is an example of moral consensus in Brazil. The practice was banned by law and the Code of Medical Ethics for many years. In 2007, the Federal Council of Medicine tried to issue a resolution, in the form of an addendum to the Code of Medical Ethics, permitting orthothanasia, or the withdrawal of care in a terminal illness to permit a "passive death". The federal prosecutor's office filed a representation before the Supreme Court to block the resolution. The judges initially ruled in favour of the prosecutors.

However, there was an extensive public debate, with several meetings between prosecutors and doctors, joint seminars on the subject, and demonstration (through media surveys) that public opinion was favourable to orthothanasia. Eventually a consensus was reached, and in 2009, the Code of Medical Ethics was amended to include a chapter on Fundamental Principles. Article XXII states: "In the irreversible and terminal medical conditions, your doctor will avoid the performance of unnecessary diagnostic and therapeutic procedures and allow the patients under their care all appropriate palliative care." (7). This modification established orthothanasia as appropriate in medical practice; it is now accepted by Brazilian society.

Building the moral consensus around abortion

In the case of abortion, however, pressure from religious groups prevented any such change. Most of the population of Brazil is Catholic, follows the religion's precepts and does not accept the practice of abortion. The law permits abortion only when the mother's life is threatened by the pregnancy, or when pregnancy results from rape.

However, starting in 2004, a battle on this subject involved all of Brazilian society, through the media as well as the professional associations and religious groups, and the issue of abortion of anencephalic foetuses entered the agenda of the Supreme Court where it was finally decided upon in 2012.

Opponents of abortion argued that legalising the abortion of an anencephalic foetus would open the door for the legalisation of abortion for other reasons. Further, in their view, the anencephalic foetus is a living human being. On the other hand, groups supporting the right to abortion argued against the notion that a woman should be required to bring, to the end of gestation, a foetus that would not survive outside the womb. They also argued that, in Brazil, the definition of death hinges on brain death, and an anencephalic foetus was not a living being since it has no brain.

On April 12, 2012, the Supreme Court ruled to permit abortion when there is foetal anencephaly (8). This was in a case filed by the National Trade Union of Health Workers supported by the Institute of Bioethics, Human Rights, and Gender. From this date, the conditions for performing legal abortions in Brazil are: a) when the pregnancy is life-threatening to the pregnant woman, and abortion is the only way to save the mother's life; b) when the pregnancy results from rape; and c) when the woman is pregnant with an anencephalic foetus, as it is specified in the Brazilian Penal Code.

However religious groups in Brazil continue to oppose abortion even when there is foetal anencephaly, and there is no moral consensus in the country on what is now a legal practice. Thus, despite this small advance, abortion remains illegal except in specific situations. In our opinion, there is a long way to go until it reaches a minimum moral consensus on this matter.

Building our own ethics

Ethics and bioethics do not exist separately; one feeds the other to encourage mutual advancement. Ethical reflection is empty without its counterpart in praxis. This sequence seems obvious, but this has not occurred in various parts of the world. According to the deontological approach based on Kant's moral philosophy, ethics is a matter of "doing the right thing". This is expressed in the form of codes for physicians in daily practice. This approach has been criticised on the ground that it "cannot be used to explicate all the moral requirements in biomedicine."(9) Another criticism is stated by Gillon: "Kant's moral philosophy is rejected by some philosophers as

offering far too austere, even arid, a version of morality in that it seems to have no central place for any moral obligation of beneficence, such as a positive duty to love others or at least to help them. A further criticism is of Kant's absolutism, for Kant was unequivocal that the supreme moral law applied categorically, without exception." (10).

However, this group of philosophers forgets that professionals who follow the rules may not possess the time, interest or willingness to reflect on these rules themselves. Many physicians do not want to be (bio)ethicists or moral philosophers. Many physicians are willing to behave in an honourable and honest manner, treat their patients with care and follow the moral principles of the society in which they live. A code of conduct provides them with a manual of rules that must be strictly followed.

In most cases, this is enough: the doctor provides the correct diagnosis and treatment, and the patient gets better. But what if things are not so simple? The cases of abortion for anencephaly and orthothanasia in Brazil are examples of such situations.

Such unforeseen ethical and moral dilemmas require a more sophisticated reflection that in turn requires the participation of the whole social body and not just a group of doctors. This is especially so in an extremely unequal society like Brazil. Only on achieving a moral consensus among all parties involved can we change codes of ethics and also cause them to be followed.

For some time now, Brazilian society has demanded the adoption of orthothanasia, and the right of a pregnant woman to abort an anencephalic foetus. However, only with the revised Code of Ethics was the first principle stated explicitly in the code in 2009. The legalisation of abortion of anencephalic foetuses still waits for a new revision of the code, although it is already provided for in the criminal justice system.

Codes of ethics can provide simple rules of good practice. On the other hand, these codes also call for doctors to evolve their own ethics based on "clean living" and a desire to treat their patients well. These are voluntary actions and a "public trust", in Percival's words (3). However, it is easier to do what the rule imposed by the code requires without having to think about each particular rule: How and why does this rule exist? What is its moral value? The physician often walks a long hard road to build his or her own ethics, which the French philosopher Michel Foucault calls a "subjective construction" of self-awareness, to improve his own being and reach his destination as "the one person he would be." (11). In other words, doctors have to obtain a full understanding of their person and their profession and seek to develop their human rationality and social ethics, and not act mechanically from rulebooks.

Pellegrino wrote: "Medicine is, therefore, a moral enterprise in two senses: first, in that its central and most characteristic function focuses on a right decision which is good for a patient; second, it explicitly codifies the values which should guide the good physician's decisions. But these considerations do not automatically make medicine an ethical enterprise, even though these codes are often called codes of ethics, and a physician who follows them is considered an ethical physician. To be ethical is not synonymous with following a code of moral principles. Ethics comes into existence, properly speaking, when morality itself becomes problematic, when the validity of beliefs about what is right and good comes into question or when a conflict between opposing moral systems or obligations must be resolved."(12). When morality itself becomes problematic, when conflicts opposing moral systems and values emerge, only a moral consensus between the parties involved, after deep bioethical reflection can solve the problem.

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