Gaps in medical school in the approach to ethics, bioethics, and palliative care: a challenge for professional training

Defasagem da faculdade de medicina na abordagem em ética, bioética e cuidados paliativos: um desafio para a formação profissional

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ABSTRACT
Medical education requires discipline, effort, and dedication for professional improvement, which complies with the requirement for vast, dynamic knowledge, including (bio)technologies in diagnostics and therapeutics. However, this process does not ensure the appropriate human training of health professionals to deal with an abrupt demographic transition of older people with several comorbidities as well as with an increase in life expectancy and in the risk of serious health-related suffering. There is a gap in bioethics education offered to undergraduate medical students, especially in bioethical principles (not only those related to biomedical and deontological ethics), which must be bridged before good communication, attitudes, behaviors, and, particularly, better decision-making can be demanded from medical actions. The advent of chronic and incurable diseases in recent decades has contributed to strengthening the hospice movement toward patient-centered care, highlighting an unmet demand for palliative care in the face of progressive, advanced, and critical conditions. Thus, personalism, a contemporary bioethical trend, in line with the principles of palliative care, calls for human training in bioethics by demonstrating the challenges of disease-focused care amidst the conflicts generated by biotechnoscience to provide comprehensive integrated patient-centered care.

Keywords: medical education, bioethics, chronic disease, palliative care.

RESUMO
A educação médica exige disciplina, esforço e dedicação para o aprimoramento profissional, o que obedece à exigência de um conhecimento vasto, dinâmico, que inclui as (bio)tecno logias em termos de diagnósticos e terapêuticas. Entretanto, tal processo não assegura a necessidade da formação humana do profissional de saúde ao lidar, diante de uma transição demográfica abrupta de idosos com diversas comorbididades, com um aumento da expectativa de vida e o risco elevado de sobrecarga de sofrimento relacionado à saúde. Há uma carência da educação bioética na graduação, em especial, dos princípios bioéticos (não apenas relacionados à ética biomédica, deontológica) ao exigir...
das ações médicas uma boa comunicação, atitudes, comportamentos e, preponderantemente, para a melhor tomada de decisão. O advento de doenças crônicas e incuráveis nas últimas décadas desde o século passado vem contribuindo para fortalecer o movimento hospice ao cuidado centrado na pessoa doente, alertando uma demanda não atendida por cuidados paliativos diante das condições progressivas, avançadas e os eventos críticas. Assim, o personalismo, tendência bioética contemporânea, em consonância com os princípios dos cuidados paliativos, convoca uma formação humana em bioética ao demonstrar os desafios do cuidado com foco em doença, em meio aos conflitos gerados pela biotecnociência para atender ao cuidado amplo e integrado com foco na pessoa.

**Palavras-chave:** educação médica, bioética, doença crônica, cuidados paliativos.

### 1 INTRODUCTION

Studies on ethics, bioethics, and palliative care are brought tightly together in terms of providing a comprehensive training for health professionals, especially physicians, requiring extensive deliberation and responsibility for actions. Therefore, including these topics in the standard medical curriculum aims to expand the scope of medical training and enhance physicians’ perceptions of their employability in order to better understand and respect the needs of vulnerable people in a state of illness. However, contrary to what is expected, what we observe are students who feel helpless or even uninterested in these topics that range from human sciences to health sciences, with insufficient or even no learning of them in academic medical centers as a possible cause. Thus, there is a compelling need for the field to change the curriculum in order to improve the training of health professionals both technically and ethically (RIBEIRO & POLES, 2019; ALMEIDA et al., 2008).

The path to becoming a doctor is not an easy one, it requires a lifelong commitment to behaviors that will set the basis for the journey: discipline and dedication. Logically, both behaviors take effort, persistence, and patience alongside, values that must be acknowledged and developed for the arduous task of *caring for people*. Because this primordial thought that drives an individual to become a doctor is unique, it demonstrates that the profession is a calling for
those who see the need of others as a mission, which unfolds into a greater commitment to restoring the comfort and well-being of those affected by an illness or condition.

Learning as much as possible about the human body, anatomically and physiologically, is the medical student’s first major movement, and considering all the movements of power that modern science has demonstrated over time, Cartesian dualism continues to impact medical training. Over the years in which students focus on expanding their knowledge of the healthy human body, followed by more years in which they begin the search for knowledge of the malfunction of this same human body, pathologically affected, the first lapses begin to appear in the face of that primordial, human thought of ‘caring for others,’ in which bioethical principles reverberate in the souls of the medical students, without them realizing it — dignity, otherness, integrity (GUIRRO, 2023). The hard years of medical education — flooded by the premise of technique and having the human body as a “field of investigation,” stimulated by the power of science, and used to master biotechnology — end up conquering that soul’s desire: the lapses widen and shift away from the purity in which once resided the vision of caring for ill people, of protecting them from suffering and restoring their functionality, thus beginning to be obscured by the biotechnoscientific paradigm (NIEMEYER-GUIMARÃES & SCHRAMM, 2017).

According to Castro (2019), medical “actions” should be built on the fidelity of the doctor-patient relationship, based on bioethical principles of respect for a person’s values and interests [autonomy], attention to otherness, and with the responsibility to offer the best possible care [beneficence and nonmaleficence] in a fair [justice] and sincere manner, without abandonment, alongside technical knowledge improved over years of training in the medical/scientific area. Discomfort occurs when modern doctors are seduced by or succumb to the most extreme charms of the Cartesian scientific method: the development of an essentially technical “pseudo-knowledge.”

Deficient teaching of humanities in health, particularly bioethics education, is in line with this move away from integrated person-centered care (from a
person’s interests and needs), where knowledge and mastery of bioethical principles should underlie the comprehensive training of health professionals, especially physicians, given the burden of care in managing the movements between health and disease, which will add more time to life expectancy with a chronic disease, incurable disease, and life limitations (NEVES JÚNIOR, 2016). In care practice, the advent of palliative care, with its principles consistent with personalist bioethical principles, aims to meet these demands, both the deficit in medical training and the lack of assistance in the area, not met by the fascination with the biotechnoscientific paradigm and the distance imposed by the preponderance of *technique* over comprehensive integrated care, aiming at human complexity in its physical, social, psychological, and spiritual dimensions (NIEMEYER-GUIMARÃES, 2018). A recent study to develop and validate an instrument to assess palliative care skills showed a trend toward insufficient performance in some basic skills in a sample of medical students in Brazil, which reinforces the need for better structuring of teaching interventions in the area (GUIRRO et al., 2021).

### 2 PERSPECTIVE

As Siqueira (2012) well described in his article on *bioethics education for health professionals*, value-based knowledge is essential, especially when dealing with people’s bodies and health:

“It has never been more important to reaffirm that education does not consist solely of instructing, but rather of **forming a person’s character**, providing them with **knowledge of values**. Our precarious moral pluralism has conceived education in the ‘anything goes’ scenario to obtain personal advantages at any cost, considering that the end always justifies the means [...]. By prioritizing this path to obtaining knowledge, **essential cultural values** are no longer cultivated, such as reading, reflection, memory of the past, and imagination. [...] Scientific rationalism and the atomization of knowledge offered by the modern university have made us lose the remembrance of what a supportive human society is” (siqueira, 2012, p. 66-67, emphasis added).

Based on this calling, it is essential to reflect on the liquid modernity in which we live intensely. Zygmunt bauman (2001) warns about the deviations of
humanity, which is fickle and has no references to values: the urgency of affinities with economic purposes and the strong attachment to consumption, an intentional reflection of the industrial revolution, are seen as more recognized than social and human — and even institutional — relations themselves. As an imperative to consumption, of greater importance than morality, people or even society began to be analyzed based on their goods and possessions, demonstrating a fragile or vulnerable aspect of personal relationships.

In a more forceful and direct way, Potter (2016) protests the fundamental role of universities and academic environments in resuming the direction of health professional training with great responsibility for the care of people, not allowing such intentional contagion from the biotechnoscientific paradigm and the strong seduction of biotechnology:

“Let us pin our faith not on science alone, or on production alone, but on a search for wisdom, a wisdom that will recognize man’s spiritual needs as well as his physical needs, a wisdom that will conquer by force of persuasion, a wisdom that will strengthen every individual member of society and make it possible for him to strengthen the society in which he lives. Let us use our tremendous capacity for production to produce the things that make us wiser, rather than the things that make us weaker. In this new challenge the universities have the basic ingredients of more and better [...] Only by combining knowledge from the sciences and the humanities in individual human minds can we hope to build a ‘bridge to the future’” (Potter, 2016, p. 74, emphasis added).

Siqueira (2012) also adds, mentioning Potter (2016), that universities should be attentive and interested in the ‘future of the humanity’ that they are training. To this end, academic centers would need to establish themselves as places of attraction and interaction with/among students, where the dynamic exchange of knowledge through the teaching-learning flow could establish a permanent reference to the truth, with guidance toward a better future, by transmitting to new generations not only the scientific knowledge they have sought, but especially value judgment:

“it becomes a reason for doubt whether the technological advances achieved in modernity society are being accompanied by a real improvement in people’s quality of life. The current academic community consists of a group of specialists, and the language of each
of the different centers of knowledge is so hermetic that not even the exercise of interdisciplinarity is possible. Van Rensselaer Potter’s historic work, ‘bioethics: bridge to the future,’ is considered the starting point of a new discipline that has gained privileged space in academic reflection” (Siqueira, 2012).

With reference to the need for training in bioethics, the contemporary trend of personalism brings together the fundamental elements for personal and professional improvement in the current context of public health: population aging (demographic transition since the middle of the 20th century); the increase in life expectancy; the advent of chronic diseases; the exponential increase in neoplasms and organ insufficiencies; increased suffering due to serious health-related problems (longer lifespan living with chronic disease-related symptoms); increased risk of frailty and disability due to chronic, progressive, and advanced diseases; and the high demand for palliative care (not met due to lack of education/training and availability of specialists) (Olshansky, 2018). Justifying the lack of preparation of health professionals to meet this demand and recognizing their responsibility for care, it becomes imperative to learn about personalist principles, which will correspond with the principles of palliative care: (1) defense of human life; (2) totality or therapeutic principle; (3) freedom and responsibility; and (4) sociability and subsidiarity. Secondary principles can be derived from these primary principles, and the most relevant for palliative care are (5) the principle of therapeutic proportionality and (6) the principle of double effect (Taboada, 2015, p. 105).

Such demand for palliative care becomes a requirement of society when palliative care is considered a basic human right and an essential component of comprehensive integrated care. As it is a multidimensional approach centered on patients and their families throughout the course of the disease, including the end of life, palliative care seeks to optimize quality of life, promoting human development and well-being while maximizing dignity. It should be practiced by all health care providers at all levels of care, as well as by palliative care specialists, and should be provided in any health care setting, including patients’ homes (Gómez-Batiste & Connor, 2017).
Therefore, the different definitions of palliative care have been reviewed, being presented as a medical specialty, training field, or a broad and integrated approach that should be initiated early and implemented as part of the *continuum* of care. That is, integrating palliative care at the beginning of an advanced, progressive, chronic disease can both improve symptom control and quality of life and support the provision of palliative care with sufficient evidence based on need rather than only on prognosis or disease stage. Palliative care is also currently considered an important component in responding to acute epidemics and humanitarian emergencies (RADBRUCH et al., 2020).

Therefore, palliative care training requires knowledge of bioethical principles (in line with the principles of palliative care described here), in which balance and experience will be necessary to deal with emotional stressors in the reality of health care practice. It is extremely necessary to cultivate *therapeutic empathy*, to be effective in communication skills, especially *empathic communication* about end-of-life care, which should be cultivated from the first years of medical school and during the medical residency training period (FRIST & PRESLEY, 2015).

**3 FINAL CONSIDERATIONS**

There is a need to promote and expand health professional training in the field of bioethics and in terms of assistance in order to promote adequate basic training in palliative care in line with the principles of care, responsibility, dignity, and protection of patients. Society deserves full access to this approach, based on changes in health policies, along with the awareness and responsibility of health care actors to promote and disseminate it as a means of cultural change in the face of the biotechnoscientific paradigm that we are experiencing.
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