

## **Moral conflicts and AIDS healthcare: conceptual contributions for a discourse ethics of care**

**Luzia Aparecida Oliveira<sup>I</sup>; José Ricardo de Carvalho Mesquita Ayres<sup>II</sup>; Elma Lourdes Campos Pavone Zoboli<sup>III</sup>**

<sup>I</sup>Secretaria Municipal de Saúde de São Paulo – Programa Municipal de DST/AIDS, Serviço Ambulatorial Especializado em DST/AIDS – Santana. Rua Dr. Luis Lustosa da Silva 339. Mandaqui 02406-040 - São Paulo, SP – Brasil. e-mail: [luzia.ao@usp.br](mailto:luzia.ao@usp.br)

<sup>II</sup>Universidade de São Paulo, Faculdade de Medicina da Universidade de São Paulo, Departamento de Medicina Preventiva

<sup>III</sup>Universidade de São Paulo, Departamento de Enfermagem em Saúde Coletiva.

### **ABSTRACT**

This paper presents a theoretical underpinning of discursive ethics-based care, as used in a study that examined the moral conflicts in assisting people living with HIV / AIDS. Based on Bioethics deliberative, it defines moral conflict as a conflict of duties. We used the ethics of discourse and the propositions of Care assuming that health work is highly relational and communicational. We conclude that the ethics of care recognizes the discursive basis of rationality in decisions that involve moral issues in everyday care. The search for conflict resolution, this perspective suggests a dialectical process in which the reasons for the arguments are considered. Evidence of different parameters, including those that are contradictory, but defensible, it enables the prudent decision making.

**Keywords:** Health work; AIDS; Bioethics; Care; Discourse Ethics

### **I – The Brazilian response to AIDS epidemic and moral conflict**

In the early 90's, the World Bank foresaw that about 1,2 million Brazilians would be infected by HIV in 2000. After a little more than two decades, AIDS mortality rates decreased by 50%; there was an increase in the period of survival of people living with HIV in at least five times, and the prevalence of infection in the population between 15 and 49 years old has remained stable (Grangeiro et al., 2009). Official estimates indicate there are 600 thousand people living with HIV in the country, which means a prevalence of 0,6% of adult population (Brasil, 2010). The success of the Brazilian program to control AIDS may result from, among other factors, the sanitary reform that culminated in the consolidation of the Brazilian Unified Health System (SUS). Undoubtedly, it is also a result of the great mobilization of people who, directly or indirectly, experienced the context of the new epidemic as well as its challenges.

Social movement activism in Brazil, as in many other countries, was a remarkable tendency in the search of positive responses to AIDS in health policies and actions. Not only did this movement claim for the control of AIDS epidemic but it also demanded attention to a diversity of demands of care, what has actively contributed to build the success of the current national policy.

If, on one hand, the advances achieved to control the epidemic in our context are huge, on the other hand, there are still innumerable challenges in health care. These challenges range from the lack of technological resources for appropriate treatment of cases in several regions of the country to issues involving relationships between professionals and patients.

The characteristics of transmission methods of this disease (sexual transmission, use of injectable drugs); stigmatization and prejudice that socially embed "judgments" of the affected people; increasing incidence of the disease among groups that live in situations characterized by several forms of structural violence – due to poverty, racism, gender hierarchies, gender oppression and social exclusion (Parker, 2002) – all of that makes the daily technical actions of professionals who take care of people living with HIV/AIDS bump into conflicts of different types, including, moral conflicts. Actions of professionals in case management need to incorporate to the therapeutic projects aspects of what may be called from the "private life" of the patients, in which their relationships and life contexts are identified. These relationships and conflicts relate to a system of socially validated rules, principles and values.

When professionals face situations that involve conflicting values and social rules, we can notice difficulties to produce responses based exclusively on protocols or to make use of any other *a priori* resource that may guide the action. This happens because, as Freitag (1997) points out, moral conflicts are present in situations in which, given the need to make an intervention that will deny a legitimate interest, the "best" decision cannot be found in any *a priori* procedure. A typical example regarding AIDS is the difficult question of telling the diagnosis to sexual partners of patients infected by HIV (Silva, Ayres, 2009). This matter involves issues related to respect for autonomy and dignity

of the patients, which are part of the normative plan that supports the duties and actions of health professionals.

The option for focusing the study on issues related to moral and its conflicts in the care for people living with HIV/AIDS is to show the evaluative and normative face that involves working in health, assuming that it does not refer to idiosyncratic<sup>1</sup> matters, but affects practical reasoning not grounded on apodictic logic (Gracia, 2005).

In fact, working in health demands from the subjects more than technical competences, we need *practical wisdom* to guide actions in a prudent way and combine technical excellence and ethical correction.

This paper, based on a theoretical-epistemological framework, results from a qualitative study on moral conflicts experienced by health professionals caring for people living with HIV/AIDS. The study was conducted between 2008 and 2009 in specialized health centers of the public health system in the city of São Paulo (Oliveira, 2009). The objective of this paper is to discuss the understanding and management of conflicts of values and duties experienced by professionals caring for people living with HIV/AIDS, grounded on Bioethics, as approached by Gracia; discursive ethics, in Habermas, and on the theory of Care, discussed in Ayres.

## **II – Moral conflict and deliberative bioethics: theoretical basis for managing conflicts in health care**

In a study that aimed to identify the principles that guided the decisions of health professionals when ethical problems emerged, Zoboli (2003) highlights the potential of recording facts related to moral conduct in relationships established in health care as a strategy to make it possible to relate ethical problems to a universe of meanings, motivations, aspirations, beliefs and values of these professionals. This approach, named “descriptive ethics” by Zoboli, is not directly related to questions such as: “what should be done?” or “what’s the adequate use of ethical terms?” On the other hand, it inquires “how people think they should behave in this particular situation, which is object of normative concern” or “which facts are relevant to normative ethics?” Or even more: “how do people really behave in this particular circumstance that causes ethical problems? From this perspective, the challenge is to understand the origins of different values that permeate health care situations and their implications to practices.

In these terms, and for the purpose of this article, we have turned to bioethics as a discipline that encapsulates the idea of applied ethics, as it proposes reflections on human values related to “performing” in health. This discipline considers technological aspects, their probability to interfere in people’s lives and in the planet, offering methodological and procedural

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<sup>1</sup> We refer to the etiologic meaning of the term idiosyncrasy: a set of elements whose combination constitutes individual temper and character; a psychological peculiarity prominent in an individual (Lalande: A e B; pg: 510, 1999).

resources that enable a multifaceted analysis to deal with conflicts involving human values, sciences and techniques applied to life. For this purpose, among other lines within this discipline, we rely on the propositions of Gracia (2009, 2005, 2001).

Bioethics, according to this author, can be understood as a deliberative bioethics, grounded on deliberation, hermeneutics, responsibility and prudence. It makes use of three interrelated analytical categories: facts, values and duties. For Gracia, moral experience is the starting point to explanation and it is established as a fact in phenomenological terms. The moral experience is the duty experience that delineates the fact, the moral fact from which all the explanations arise (the ethics theories). Moral experience is expressed in the fact that every human being makes this type of judgment; you feel that there are things you should do and other things you shouldn't and question yourself and the others about what you shall do and what you have done. Moral acting, in these terms, involves three faculties of human intelligence: cognitive (facts); emotional (values); volitional (duties). When facts are faced, the evaluative moment claims for the volitional one, i.e., the fact questions the subject about the recognition of values and demands his/her willingness to perform them in practical actions (Zoboli, 2010).

For this reason, the author defines the 'moral conflict' as a conflict of duties. Gracia (2009) states that *We should perform values, our only ethical duty is to perform values*; in this sense, the conflict takes place when there is a situation in which performing a specific value may imply in giving up another one, what wouldn't be desirable. In order to cope with this challenge, Gracia (2009) proposes a method to be applied in moral deliberation. This method intends to be a facilitator to find, in Gracia's words, *average or excellent terms* to make decisions about "what to do?", performing most of the values involved as possible or causing the least harm possible to them. Those are, by definition, prudent decisions.

Transferring this philosophical reflection to deliberations inside the space of a medical practice, Gracia (2001) assumes that practice and ethics share a common method of Aristotelian inspiration. He presupposes the search for prudent decisions both in ethics and in practice. In this sense, it is necessary to think over the consequences of specific decisions:

[...] El proceso de deliberación exige la escucha atenta (la angustia no deja por lo general escuchar al otro, precisamente porque se tiene miedo de lo que puede decir), el esfuerzo por comprender la situación objeto de estudio, el análisis de los valores implicados, la argumentación racional sobre los cursos de acción posibles y los cursos óptimos, la aclaración del marco legal, el consejo no directivo y la ayuda aun en el caso de que la opción elegida por quien tiene el derecho y el deber de tomarla no coincida con la que el profesional considera correcta, o la derivación a otro profesional en caso contrario (Gracia, 2001, p. 4).

Because it is an essential procedure in ethics, deliberation must take place every time individual or collective values are in conflict or have been threatened. One deliberates to make decisions. These decisions are always concrete; they cannot be made abstractly, and should take into consideration the circumstances of an act and their foreseeable consequences. It's impossible for the human mind to exhaust reality, then, the judgments of a deliberation will be reasonable, not completely rational. They will never have an apodictic character since reason is not the only element to have an important role, so do feelings, values, beliefs and affection. Prudence is not a target (an end, an objective to be achieved); but a space in which we can move to perform values, accomplishing our ethical duties. Ethical decisions are equivalent to concrete decisions made after careful deliberation (Zoboli, 2010).

Deliberation is a type of knowledge, since, during its course, the individuals involved in the situation of conflict are in a continuous, peaceful and non-coercive process of evaluation and change, many times, of their own points of view (Gracia, 2009).

For Gracia (2001), deliberation is a method, a procedure that allows us to deliberate about facts, values and duties; dimensions that compose the situations of moral conflict. It is possible to establish steps for this process, aiming at a critical analysis of the situations: presentation of the case; discussion of medical aspects (facts); identification of moral problems based on recognition of the values involved; choice of the moral problem to be discussed; identification of possible courses of action; deliberation of the best course of action; final decision; evaluation of the final decision taking pros and cons into consideration; analysis of the decision considering the possibility of having it defended publicly also taking pros and cons into consideration; evaluation of its legality, or even of its compliance or coherence with more general normative plans.

More than a method, the steps proposed by Gracia (2001) frame a pedagogy, since, in situations of conflict, commitment is reached when each part changes its interpretation of the common macro. Thus, deliberation is presented as an alternative to intolerant indoctrination and to tolerant neutrality regarding everything. There is a plurality of values and both homogeneity and admitting everything as morally valid or justifiable in this context of human life are impossible and undesirable.

The deliberative process may take place in the following contexts: personal, institutional and global. It is a way to define personal and collective duties in the conduction of our practical life, more precisely, of private and public morality, including work in Health (Zoboli, 2010).

All human beings make moral judgments; they feel that there are things they should do and there are others they shouldn't do, charging themselves and others with what they shall do or what they have done. Moral experience is universal, imperative and justifiable, and the moral subject is the one who experiences himself these three principles (Pose, Gracia, 2006).

In moral experience, there is a chain of facts, values and duties. Foundation reaches the level of facts, but argumentation is made in the level of values. They are the ones that bring moral obligation, not the facts, although the latter support the former. Ethical decision is not given; it must be built within these three dimensions through deliberation. Reason builds the concrete contents of moral life, i.e., it defines “good” and “evil”, which values to perform, and how, in the “reality of the world”. The contents of moral are an ongoing construction of “ what is perceived from reality”, hence its dynamic character of constant overcoming.

As moral subjects, health care professionals support their actions in socially validated ethical codes. They weave their opinions and reproduce evaluations on “life styles” by building in their practice actions that may be seen as a *dependent moral technique*, as named by Schraiber (2008,1997,1995) while investigating the work of medical doctors in contemporaneity. This is, in actions that articulate processes of work in which techniques apparently well defined by protocolled clinical criteria are used. Each professional makes judgments taking into account the particular situation, what shows certain autonomy of this work and its articulation to produce responses to social needs.

If, on one hand, the judgment of professionals, as an act, is also inspired by morality in the sense we have discussed; on the other hand, as social work, it should respond to specific needs of social or collective interest, such as the ones related to the epidemical control of AIDS, for example. In daily services, this duty (also as an expression of value), when managing a particular case, may imply in breaking with criteria, for example, of confidentiality, or even, denying the autonomy of a patient to make decisions in relation to how he intends to conduct his treatment and personal relationships. The dual mission of the professional - between clinical management of the case and potential risks of disease transmission - bumps into issues involving both individual values and interests of the patients and values and interests that may, generally, be in a public level.

As deliberation happens on a personal level, besides taking place on the institutional one - although Gracia’s methodological proposal (Gracia, 2001) was initially conceived as a method for ethics and bioethics committees in hospitals - it enables, in a more private context, the orientation of analysis and discussion of situations of moral conflict. This pushes the understanding of these situations beyond the two extreme possibilities of courses of action they refer to – for example, in the above-mentioned case of AIDS, the alternative between respecting the values of the individual or the collective values. The method, as it is to be operationalized, demands efforts to problematize different courses for the same situation. Avoiding extreme implicated courses, constructions that enhance the perspective for intermediary courses are searched; a spectrum in which a path to an excellent action may be found. Thus, it is expected that a range of possibilities for decision making that exist among the ones centered on the extremes should open.

The instrumentality of the method is in fact thought to support decisions in the clinic, which may seem a unilateral strategy that mainly reinforces the power of the doctor to impose his conduct. However, doctors, as other health professionals, can only put their decisions into practice for health care or any other action that involves the life of another person if this person agrees with them. Therefore, most of the time, for example, a discussion or a debate on cases by the health team is needed; an effort is made to understand disagreement or the impossibility for the patient to follow a specific indication or prescription. In this sense, the presence of the patient is represented, that is to say, in his “resistance” to considerations on his interests and objections to indications of the health service; point from which he is usually considered.

In the perspective of the deliberation method, the asymmetries in “doctor-patient” relationship need to be deconstructed - assuming that these subjects are interdependent - so that there are, in fact, decisions that result in concrete actions for the case.

In order to be successful, any health care project will depend on the capacity to establish agreements within the teams and between these teams and their patients, wagering on relations that tend to be symmetrical. We have talked about a “tendency to symmetry” because this is the regulatory idea; but perfect symmetry will never be reached in clinical work unless there are radical transformations in the way it is structured as a social process and as a professional task (Mendes Gonçalves, 1994). That is exactly what makes us defend that some type of deliberation within the clinic is possible and necessary: the clinic, due to its structural characteristics as a work process, claims for this symmetry as an ideal, while, at the same time, it tends to deny it in its concrete operation as technique, claiming, therefore, for constant watching and responses in a moral perspective (Gracia, 2009; Schraiber, 2008,1997).

Deliberation, as a bioethics proposal that assumes that human being has the ethical condition of being a “valid interlocutor”, leads us, in itself, to a theoretical field with which it has a rich interface, i.e., the discursive ethics.

Although in Gracia’s studies (2009,2005,2001) on deliberation we can find a path to identify moral conflicts and support for the process of prudent ethical decision making, it is still needed to deepen the understanding on how it is possible to reach rationally justified agreements. This process should be based on rational argumentation and take all the subjects involved in the decision making into consideration.

How can we match the purposes of the work in health, and its social rationalities and responsibilities, with life and health projects of the people under treatment? Which would be the basis to make agreements possible in situations of conflicts?

In search for references for this discussion, we have found in the propositions of the Theory of Communicative Action and rationality, based on the pragmatic linguistics of Jürgen Habermas (2003), some guidelines that

enable the coordination of action plans intersubjectively shared in interactions mediated by language.

### **III – Discourse Ethics: indications of expressive meanings of moral conflicts**

Assuming that we are ethical subjects, Habermas (1999) calls *moral* all the intuitions that tell us about the best way to behave considering the extreme *vulnerability of individuals* [...]. It is possible to understand moral as a protection device that makes up for this vulnerability structurally installed in socio-cultural life forms (Habermas, 1999, p.18).

In this perspective, moral codes of societies are molded to this human sensibility and move around the principles related to equality of treatment, solidarity and general well-being. In this case, moral codes have to fulfill a dual mission. The first one refers to the intangibility of individuals as they claim for equal respect for the dignity of each one they protect; the second one is equally related to intersubjective relationships, through which individuals remain members of a community. Both of these complimentary missions are in accordance with principles of justice and solidarity that are based on symmetry actions, expectations of reciprocity and communicative action (Habermas, 1999).

The discursive ethics in Habermas (1999, 1989), based on the Theory of Communicative Action, opens the possibility for a conception of moral in which this phenomenon is expressed in the communicative action that takes places within intersubjectively valid rules that support the actions of subjects. Valid rules presume pretensions of validity agreed and recognized by the agents they are submitted to. These rules can be discursively retrieved in case it is necessary. Communicative action is exactly the regulatory idea that enables the agreement among subjects who are communicatively competent, expressing an intersubjective recognition based on intentions of validity of rules and standards for conducts.

For Habermas, the validity of a discourse, depending on its purposes, has to follow three fundamental criteria of rationality: propositional truth (intentions related to judgments of the objective world); normative accuracy (related to judgments of the social world) and expressive authenticity (related to the subjective world).

For cultural traditions of the world of life to be interpreted, and result in rational orientation for an action, it will be necessary that they provide subjects involved in a dialog, with formal concepts of the objective world, social world and subjective world, what will permit pretensions of validity in these different plans. Only then, symbolic manifestations at a formal argumentative level that allows objective judgments of reasons to make choices or adopt a position will be generated. (Habermas, 2003).

When utterances begin to be problematized or questioned by the members of a community, its participants will have to abandon their pre-established



certainties and enter a process of argumentative construction of the validity in question.

In this case, the moral principle is in taking communication among the subjects as a praxis of mutual recognition, decentration and sharing of how what is good and what is fair are understood. Thus, the moral language game would interconnect utterances about judgments of how we should (or could or couldn't) behave, and reactions of agreement or rejection to specific standards or rules. Moral language also expresses reasons why the parts in conflict may justify acceptance or rejection (Habermas, 2004).

Returning to the "case" of AIDS epidemic; based on the exposed, one can assume that the peculiar way how agreements on what would be good and fair were built in this field has also produced a type of confrontation. Grounded on principles of equality in the plan of rights, intangibility of individuals and respect for their dignities, the organized movement of people directly or indirectly affected by the epidemic made use of the discourse of human rights and the right to health to claim for social responsibilities when facing a disease that affects all as members of the same society.

Then, demands posed in the construction of social responses to AIDS in contexts of health care highlight the human value in relations established among the subjects in these contexts (users and professionals). They also point out the need to emphasize communicative actions as able to provide recognition and consideration of the intrinsic values of the participants in the process of decision making about questions that affect the orientation of health practices.

Under this perspective, the moral principle is in taking communication among subjects as a praxis of mutual recognition, decentration and sharing of what is understood to be good and fair.

Teleologic<sup>2</sup> or strategic actions, as presented in the Theory of Communicative Action (Habermas, 2003), refer to actions in which actors realize goals or produce states of desirable things, electing, in a specific situation, the most congruent means and applying them appropriately. In this case, the decisions are directed towards achieving a purpose, guided by maxims and based on an interpretation of the situation.

We can consider the National Program Guidelines for STD and AIDS as an "interpretative discourse" that indicates the maxims on which the actions of professionals, from an institutional point of view, are primarily grounded.

The teleologic action becomes strategic action when, for this action to succeed, the actor interferes in the expectation of decisions of at least one other actor that also acts in order to reach his goals. As far as professional interventions are concerned, they are grounded on scientific knowledge and operating knowledge of techniques based on sciences (Schraiber et al., 1996; Mendes-Gonçalves, 1994, 1992). This way, the action will have well defined

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<sup>2</sup> In the scope of the discussion on rationality of an action based on sociological theories, Habermas presents four sociological concepts of action: teleologic action (used originally in political economy and by Neumann and Morgenstern in the theory of strategic games); normative action (from the sociology of Durkheim and Parson); dramaturgic action (in Goffmann) and communicative action (in Mead and Garfinkel).

specific purposes; what will impose the professional agents responsibilities to respond to social demands in their practice that are supposed to be organized to the defense of life and recovering of health. These principles are inspired by a certain (Hippocratic) tradition according to which the medical action always aims to benefit the patient, i.e., it is directed to his well-being.

However, if we adopt the harbemasian principle of sharing understandings of what is “good and fair” among the subjects involved in health care situations (professionals and users), especially in situations where there are no agreements, we will be forced to give up our certainties, placing them from now on, to be validated from the point of view of the users and their possible argumentations.

The possibilities of this mutual relationship in health care practices, aiming at the production of therapeutic projects coherent to projects of life and health of the people being cared, will allow us to reach the propositions of Care as discussed by Ayres (2009).

It is important to point out that this research, besides not ignoring other possibilities to approach the theme “care” in Bioethics, Philosophy, and, in general terms, in Medicine; is based on a specific framework of Collective Health, and shares the perspective of studies of Process of Work in Health within collective health (Ayres, 2002; Peduzzi, 1998; Schraiber et al., 1996; Mendes Gonçalves, 1994, 1992; Schraiber, 1993). This proposition assumes the work in health as a social work that expresses two dimensions in its actions: productive action, carrying certain rationality directed to socially defined aims, i.e., as a teleologic action; and communicative action, which is only carried out within interaction among the subjects.

If we consider an emancipatory perspective, it is meaningful to start from an eminently relational dimension of health practices, also taking into account its pragmatic character, with technological potential for practices, which, for Ayres, implies in:

[...] a side, an enlargement of meaning of what is understood by technology, highlighting not only its character of producer of goods, but also the inseparable dimension of production of worlds, construction of meanings that are able to be shared, which takes place in and through the construction of objects, products and instruments of work (Ayres, 2002, p. 153).

#### **IV –Care as praxis of mutual recognition**

A praxis of mutual recognition as a privileged strategy to act in health is expressed in the concept of Care proposed by Ayres (2009). Based on the hermeneutical phenomenological perspective, analyses of moral conflicts in health practices open to considerations of ontological structures of the *being*, as the *being-in-the-world*, the *being* that understands all the possibilities of human existence as well as its relations to others. It is worth noting that, in a harbemasian perspective, this *being-in-the-world* will always be considered from the perspective of how the subjects mutually build their identities and the

identities of their world through communicative actions, i.e., in the *world of life* (Habermas, 2003), a privileged place of values and standards, and where language is essentially directed to understand and share our daily life (Oliveira N, 1999).

In these terms, and looking at how relationships between professionals and users in health services are built, we find a possibility of mutual recognition and interaction of the subjects in the health care space that goes beyond the orientations based on a “complaint-conduct” logic. The dialogic of Care points to the recognition of the treated person as a *being-in-the-world* and his presence as so must be recognized in the way his matters regarding health are considered in relation to his projects of life and happiness (Ayres, 2009).

This way, the place of different “duties” and their conflicts are qualified. By considering the projects of life and happiness of the people treated in services of health, perceptions of necessities and claims are enriched, situated in their most unique meaning.

It is worth making use of one more analytical resource introduced in the reflection on Care in practices of health: notions of what was called by the author *technical efficiency (technical success)* and *practical success*, as practical dimensions in health. The idea of *technical efficiency (technical success)* is linked to elements that interfere in health and may be conceptualized and taken as objects passible of controlled interventions, a privileged field of nomological sciences and teleology of techniques. The idea of *practical success*, on the other hand, refers to the ethical and political character of practices in health taken as *praxis*, i.e., as an exercise of *choices*, in this case, shared choices of ways of life. This is what meanings attributed to *practical success* for health practices in Care are about.

In this article, we do not intend to bring results of the empirical study related to this theoretical construction, however, just to exemplify; we have dared to present an excerpt of a field research report that illustrates the idea explained here. The example highlights the dissatisfaction of a user who, besides being healthy, due to the success of her treatment (technical efficiency/technical success) that maintained her immunity preserved, demonstrated dissatisfaction due to changes that happened in her body, which were attributed to the continuous use of medications.

[...] Lipodystrophy. The first time I heard about lipodystrophy here, it was a patient of mine who cried a lot, [...]. She said she was ugly, and so on, and I said: "But what is important? You're alive, here, raising your son, you were so afraid of dying before raising your son ... You're healthy now, you are with a high CD 4, with undetectable viral load, you're really well, you're gonna live for many years, you will see your grown up son. What is more important, your appearance or your health? [...]" (Infectologist).

When, in this example, the user shows issues that are beyond the control of the disease as reasons for her dissatisfaction, she is demanding recognition of

her presence as a subject, valuing other aspects of life that should be considered. She retrieved, using her own way, other senses that she considered important for her “well-being”.

Let us return to the discussion on Care and add an important notion to it: that it is the *process of happiness* that expresses the essential sense of living that should guide health actions, making their technical and practical sides dialog productively, what characterizes a *contrafatic*<sup>3</sup> value. When we move toward taking care of someone we are making a move to value the experience lived; this experience is not limited to any “state of complete well-being or perfect morphofunctional normality”. The value we intend to perform here is not, and cannot be, pre-established.

As we saw in Gracia and Habermas, within the peculiarities of their frameworks and original objects of study, the value actions/reasons assume for an effective Care is only defined as such if based on facts – and duties in which they are transformed when the professional and the user meet.

“Ethics” for the professional performance based on Care, as presented here, highlights the sense of responsibility towards the *person* one takes care of. In this case, although technical compliance with the professional’s duties represents an ethically desirable point of view, it is certainly not enough. In fact, it is intended that the presence of the person at “whom” the intervention is targeted is not limited to “be-there-to-be-treated”. Beyond clinical and epidemiologic criteria, Care claims for the authentic presence of each subject (the care taker is not only a “technique performer” and the person being cared is not only an “object of technical intervention”). This point of view enables both of them to share choices about “what to do”, in a movement of mutual recognition of desirable ways of life. Therefore, it highlights the respect for *freedom, dignity and diversity*.

Assuming the perspective of Care, based on the recognition of the cared person’s projects of life and happiness, shows as objectives of health actions the search for *practical success*, always reached when we understand and manage the meanings of technical success, which is enabled by our techniques and sciences to whom health actions are directed. In Ayres words:

[...] Taking care of someone’s health is more than building an object and making an intervention on it. To take care, one needs to consider and build projects; to sustain, as time goes by, certain relationship between matter and spirit, body and mind, shaped in such a way that the subject opposes to the dissociation, inert and amorphous, of his presence in the world (Ayres, 2009, p. 37).

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<sup>3</sup> This neologism of conceptual character derivates from Habermas philosophy (Habermas, 1990), which makes use of this expression every time it intends to refer to “almost transcendental values”, i.e., ethical and morally guiding ideas of universal aspirations; although they are constructed with basis on the perception of value to human life of specific ideas or practices at the moment and to the extent these ideas face an obstacle and are denied by a concrete experience. In other words, they are perceived exactly because they have been denied and, in being so, are shown to be essential.

Thus, the horizon of Care in health practices claims for deliberation, considering its dependency on some premises: recognition that the other may be right, at least as right as I am, that his point of view may enrich mine, helping me to be more prudent; ability to listen and willingness to understand points of view different or opposite to mine; effort to give reason to my own options of value, as hard as it may be; ability to accept that I can fail, that I do not know everything, I make mistakes, I need the help of others, that in a debate I may not be right and that my arguments are never apodictic or able to exhaust the problem (Zoboli, 2010).

### **V- For a discursive ethics of healthcare**

In short, in order to understand and address the daily conflicts experienced by people living with HIV/AIDS (Oliveira, 2009), as well as other complex and delicate themes in health practice, it is argued as a theoretical perspective the assumption of the highly relational and communicational character of health work, interpreted here as an *ongoing and open dialog* between disagreements and conflicts experienced in work situation. When these disagreements take place in the moral sphere, deliberation, or deliberative bioethics, is presented as a system to dialogic confrontation of conflicting values.

The idea of “value” itself is conceived in an ethical horizon that only makes sense if we consider the act of living together, the interest of sharing objectives and ways of a life that can only be lived in common (Ayres, 2009).

If we analyze the problematic cases in the routine of health care of people living with HIV/AIDS, it will be possible to identify points of view of professionals and users related to ideologies and ways of life we consider appropriate for us and the other in a caring situation, or even the maintenance as central role the necessity of controlling the disease (Oliveira, 2009; Oliveira et al., 2009). Beyond discourses grounded on technical logics or disease control, there are aspects in decision making that we have to take as inherent to the world of life. These aspects tell us how social normality (our judgments of what is right to do in our relationship with the other) gets into the apparently neutral sphere of techniques. As we understand the professional/user encounter as a dialog in a shared world in which each one’s existential situation (their projects of happiness) is the first source of concrete sense of the technical action, we will also understand different problematic situations such as the confront of several assumptions of what one “must be” that direct the expectations and actions of these subjects. And, maybe, if we are successful, we will also be able to recognize the most prudent strategies to solve them.

The propositions of the Habermasian discursive ethics make it possible to recognize the positions assumed by the subjects in the moral plan as a rationality that seeks to validate itself intersubjectively within each concrete

situation that threatens a premise of the world lived. Changes in political and social discourses towards AIDS that ended up as a policy of confrontation were brought as analytical examples based on this framework. This theoretical construct shows an *ethics of practical reason* that may be recognized in the concrete propositions it is present, for example: in health interventions, the ideas of what is “good and fair” to be done, considering the individual as well as all the members of a community or society. Not only does this ethics involve self-knowledge and self-understanding but it also comprises some socially validated ideas and values (Habermas, 1989).

Concerned much more with aspects of *practical ethics* than the search of general principles of Bioethics, we could find in Gracia’s deliberative ethics (Gracia, 2009, 2005, 2001), and in its considerations on of issues related to moral conflicts – understood as conflicts of duties – a fruitful access to discursive ethics of care specifically to clinical decisions.

Based on these duties as an action directly related to performing human values, this author presents a systematic proposition that can support health professionals to make explicit which dialogs and on what duties they are effectively involved in situations of moral conflicts. This practical, deliberative ethics, together with discursive ethics and the concept of Care, recognizes that there is certain rationality in decisions that involve moral aspects in health care. It points out, however, that this rationality is not able to inform practice with basis on apodictic logics, i.e., that is derivated from abstract principles, as a logic and necessary result to direct correct acting.

In a tradition that goes back to the Aristotelian practical reason (Gadamer, 2003), it is assumed that in these situations professionals will have to submit the search for solutions of conflicts to a dialectical process in which the reasons raised are not exhausted by any final argument or the reasoning of a judgment. This opening allows several arguments, even controversial, to be defended and to bring wisdom to decisions. Deliberation, in these terms, consists of analyzing several intervenient factors perceived as being present in concrete situations by several participants in the situation of health care. Thus, the decision made, if not considered the best one beforehand, will at least be accepted by all the members involved in the situation as the most prudently acceptable and promising in its means and ends.

## **CONTRIBUTORS**

The author, Luzia Aparecida Oliveira, conceived and wrote this text. José Ricardo de Carvalho Mesquita Ayres guided the elaboration of the manuscript and was in charge of general supervision and final editing of this text. Elma Lourdes Campos Pavone Zoboli guided the discussion of issues related to Bioethics and was in charge of general supervision and final editing of this text.

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