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Ethics and commitment of the health professional after the productive restructuring: a metropolitan area in Southern Brazil

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This paper aimed to analyze the relationship between ethics and healthcare professionals' commitment subsequent to productive restructuration. This was a qualitative exploratory-descriptive study on thirty professionals (nurses, doctors and dentists) in a metropolitan region in southern Brazil. The relationship between ethics and commitment has been revealed to be a centerpiece for current healthcare and is also related to some aspects of contemporary social transformations, with the traditional beneficent-paternalistic commitment of the professions and the different logics in the public-private mix. When professionals are unable to subjectively and collectively deal with situations that compromise work ethics, space for moral distress is opened up. The search for humans who do not see themselves in isolation from the whole picture, but as subjects who think and can build an ethical differential in their "humanized" and committed work, seems significant in relation to building quality and excellence in healthcare.
Keywords: Ethics. Healthcare professional. Job market.

Introduction

Productive restructuring as a response to the crisis of the welfare state, which began at the end of the 1960s, has stimulated the emergence of a new conception of health: the new techniques and technologies that have been constructed and incorporated into the consumerist phase of 'being healthy to produce more' strengthen the liberal and market model in the field of health[1]. This intense technological incorporation has meant new jobs, workloads and work relations, as well as new processes of labor precarization, with a strong potential for capital accumulation[2]. However, in the midst of the debacle of the welfare state, the *Sistema Único de Saúde* (SUS – Brazil's National Health System) has been conquered by the Brazilian society as a citizenship right.

The resistance of the public health movement to the so-called medical-industrial complex produces advances and retreats in the construction of the SUS and stimulates changes in the care paradigms, consolidating distinct logics: one that is influenced by market mechanisms, and another one that is affected by the logic of social needs, which mobilizes professionals to rethink their role in care provision. This duality guides productivity and quality in the pace of work within the public-private mix and builds ethical traps to the health professional, as private interests overlap public ones, in the (direct or indirect) transfer of funds and management[3].

The parameters of health technologically expanded by the market are confronted by a broad idea of human being, civilizing profile and life, which triggers the debate about the need of an ethics applied to the new issues of technological advance and health actions. In Latin America this debate has become a new field of formulations guided by social vulnerabilities, human rights, power and justice[4].

This paper aims to analyze ethical problems concerning the way in which health actions and services have been produced in the public-private mix, focusing on the professionals' commitment to the essence of their work: the human being.

Methodology

This is a qualitative research of the exploratory-descriptive type, with individual, semi-structured interviews performed with 30 health professionals (10 nurses, 10 doctors and 10 dentists) from the metropolitan region of Florianópolis (Southern Brazil) who had work experience in the public-private mix. The study started with public service professionals linked to a Health Department of the region, and the subsequent subjects were gradually defined by snowball sampling: one interviewee recommends another, and the process is repeated until data saturation is achieved.

The project was previously approved by the Ethics Committee of Research with Human Beings of *Universidade Federal de Santa Catarina* – number 2461. In compliance with Resolution 196/96 of the National Health Council, the subjects voluntarily signed a consent document. The subjects are recognized by letter P followed by a number. Different work experiences were covered in the public sector: 8 interviewees from public hospitals, 11 from primary care units and 11 from dental specialty centers or emergency care units; and also in the private domain: 8 interviewees from private hospitals, 1 from a clinical analysis laboratory and 21 from clinics or private offices.

The results were analyzed by textual discourse analysis[5], which recommends: disassembling the texts into base units; establishing relationships among these units, forming categories; organizing a metatext with combination of meanings; and performing the analysis cycle of the metatext, generating results. The categorization was aided by the use of software for qualitative research, *ATLAS.ti - The Qualitative Data Analysis Software.*

Results and discussion

Ethics and commitment in current times

> "One thing that happens today is that this new generation Y, Z is not committed. If Hospital A offers more, they go to Hospital A: "I'm always searching for new institutions and better salaries"; it doesn't matter if it's private or public, if things don't work out here they don't care. They are well-informed, anything is moral harassment… they know what they're doing, but sometimes they forget about their duties. For example, "I was tired, there were a lot of patients and I had to work until 7 p.m, but at 6 p.m. I gave myself the right to leave", and the person gives herself the right and leaves. She's not committed, she's not ethical, it's complicated and even funny". (P29)

The debate about ethics regarding workers' commitment, which was revealed in the professional discourse, seems to be a key piece nowadays and is related to some aspects of contemporary transformations: precarious work relationships; struggle for professional growth at any cost, which generates a competitive inter-peer subjectivity; narcissistic selfishness above possibilities of relational commitment; weakening of the centrality of work in the guarantee of social rights and in the possibility of society transformation as a collective perspective; level of information about rights taken to the extreme in relation to duties; verbalized disposition of not going beyond what has been prescribed in the "use of oneself"; difficulty in perceiving oneself as part of a social or collective whole of work, in the construction of different alterities; and subordination of the public interest to the private one.

Responsibility towards the other is potent to head in the direction of the unknown other, especially when a third party enters the relationship: the social dimension understood as a moral community. In this sense, there is an increase in the need of codes, laws, jurisdictions and institutions that enable moral sense incarnated as social justice. A reality about the old contradiction of the moral relationship is the singularity of the *sub judice* relation of the collective dimension, an ethical challenge to which all human beings are exposed due to the very presence of the others. The question is: are the social interests relevant in the singularity of the professional/patient relationship?

> "The people who end up coming to work in the public service, I don't know if it's lack of training or lack of will, but they don't want to do the service we used to do when we started working. They have an aversion to it; they are incomplete professionals". (P1)

There is a perception according to which the professional commitment of the new generation that starts working in the service has changed. According to Bauman[6], in modern societies, the traditional normative regulation systems undergo a process of crisis and people seem to struggle to "free" themselves from human conducts that had been previously standardized by the social dimension, transferring these conducts to the sphere of individual life policies. The private dimension overlaps the public one in a movement of annexation: "the grand social view has been divided into a multitude of individual and personal valises which are very similar, but not complementary. Each one has been made according to the consumers' happiness" [6:34]. Following the principle of maximum pleasure means relegating a defensive role to social reality, a posture sustained by the promise of infinite consumption. This process makes each person become responsible for establishing their own limits, as if by a reflective instinct.

At the same time that the human being needs and desires to live in society to shelter from life's uncertainties, the traditional inter-human bonds are gradually losing their institutional protection and are being transformed into an obstacle to be overcome in the race for hedonistic freedom. This contradiction ends up reducing the importance of ethics at each given moment, under a hedonism that is taken to the extreme by market interests, which runs away from the social and historically constructed "must be". This individualization is not a "discovery" of the contemporary world, but it emerges as subjective-biographical aspects of civilization, especially in the capitalist industrialization.

> "Lack of goodwill is like this: I'm here to work 8 hours, I have 12 patients to assist and I won't do anything else. Some are like this: well, today I'm in a good mood, so I'll do everything. Well, today I woke up and my nail hurts, so I won't do anything, don't even look at me". (P25)

When the individual releases himself from traditional structures and bonds, he receives, in exchange, pressures from the job market, which means dependence on the market, on atomized mass consumption and on the standardizations and controls contained in both[7]. Science has been gradually targeted at technological advance subordinated to the imperativeness of profitability and has served the construction of needs that are even more abstract[8]. This promotes a normalization of lives that is guided by science and by the promise of eternal consumption; in addition, a scientific certainty that also produces risks and a self-reflectiveness that discloses this certainty. The very bioethical debate as a need generated by the threats of technical-scientific advance, fabricating a moral for science, assumes its own risks and limits[9].

At the same time that information has never been so present in people's daily life, connecting like never before worlds, civilizations, beliefs, cultures and economies, and enabling a collective and multicultural citizen who is connected in network, the exacerbation of consumption

desires that are never satisfied, permeated by naturalized particularistic interests, builds processes of emotional detachment and distance from possible human contents of truth. In a world that is commanded by money, the commitment relations that do not demand a bond that is purely financial are placed in the background, like the affective bond, the family bond, the socially hierarchic bond, the bond by maturity or wisdom – which ultimately mean social and human bonds. The space of the ethics of competitiveness is amplified, or rather, the space of anti-ethics naturalized as human essence, in a relativism that is stuck to the moment of here and now or to private interests.

The new production models require a more creative and reflective worker, and at the same time, capture subjectivity at work based on the precariousness of conditions and relationships. Feelings of fear and insecurity, configured in the loss of the protective power of work, contribute to shatter solidarity networks, but these networks are extremely necessary to the ethical reflection. There is a context of lack of social perspectives that transcend the established order, with intensification of individualism to the detriment of valuation of the subject and of class identity, putting the viability of collective health projects in check.

Lack of commitment emerges as a fact of the modern world, the effect and cause of a contradictory process: the restrained isolation of individuals, which hinders a reflective look over oneself as part of a social and historical whole, happens in a world that has been increasingly constructed in networks, in intercommunication spaces. The utopia of the rescue of "must be" in congruence with the "being" itself constitutes an essential movement in the daily routine of the health work, and it repositions the perspective of what is different, revolutionary and human beyond money, as a supportive individual in a committed relationship.

Commitment in the public-private mix

> "In the private sector, I asked the other day: "Do you know Mr. Smith?" "Yes, I do". "What's he like?" "He's a fantastic employee." What? How come? He's never worked one full week, he's always absent, even when the agenda is full, he doesn't tell anyone that he's going to be absent, I call him and the cell phone is off, then two days later he shows up as if nothing had happened. That is, the person has a behavior in the private sector that is totally different from his behavior in the public sector". (P25)

Some professionals and daily situations are cited as having a differentiated commitment in the public-private mix. In the dictionary, commitment is described as the state of being committed, that is: taking responsibility for, getting involved in, striving for[10]. In Hippocrates' oath, commitment means the promise to do certain things and avoid others; in principle, it would be a

deep bond that cannot be broken or that is broken with extreme difficulty. More than a civil or business contract, it would be a treaty that cannot be blurred like an alliance. According to Diego Gracia[1], the search for professional excellence associated with moral characteristics such as commitment has traditionally differentiated professions from other occupational roles. This would be a type of ethical commitment with moral justification of acts in beneficent paternalism, a classic paradigm in crisis, which follows different meanings:

1. professional excellence associated with the search for professional growth, related to competitiveness and technical knowledge. Occupations, like professions, seem to be imbued with the search for excellence in a corporate or liberal view of commitment, which means knowhow assumed as growth and status. This ideal of success is associated with class superiority as a social practice, identified with capital, not with work[11].

A conditioning of ethics transformed not only by respect to the other as an end in itself, but contradictorily, by the monetization of life, which incorporates exchange value into human relations, reifying them. In the Consumer Protection Code, occupation and profession are no longer differentiated as good service and beneficent professional service, especially when there is a promise of result. On the one hand, this protects; on the other hand, it trivializes: the procedures serve equally to consumption;

2. changes in the concept of beneficence: benefitting the others is imposed as a bioethical principle guided by a practice that has the meaning of protection and respect for autonomy. To Beauchamp and Childress[12,] the principle of beneficence is understood today as social calculation: it refers to the moral obligation of acting for the benefit of others, a utilitarian principle that has been criticized because it seems to allow that social interests prevail over individual interests and rights. In the Latin American bioethics, this beneficence incorporates the relation that exists between social vulnerabilities and sense of justice, following an understanding that starts from care and from the right to protection. The theme of solidarity, feelings and reflection incorporated into the collective ethical debate in the field of health encompasses the determinants and conditioners of social inequalities and constrains action possibilities that disrupt ethics[13].

According to Zizek[14], the construction of the self is only possible within a relation of belonging to a community, and within participation in the universal dimension of the public sphere as singular individuals extracted from substantial community identification, or in opposition to such identification. The construction of this consideration for others, perceived as community-based/social, must be saved from an "autonomist totalization" constructed to capture the workers' subjectivity in the new production models. An agenda for the valuation of the collective dimension and public interests revisits the construction of the individual, supportive and committed to different alterities, new class identities and precepts of social justice. Thus, commitment in the field of health is problematized:

In inter-peer professional valuation

> "I had 3 professionals who worked with me, then you arrive at the clinic and your partner is assisting a patient that was yours. This is horrible". (P3)

> "Many colleagues criticize the work of the other to earn money, to get the patient. This happens a lot". (P4)

> The result doesn't depend only on me, it depends on the entire team, on the continuity of the work; so, it's no use engaging in it as much as possible when my colleague doesn't do the same (P22).

The relation of commitment to the other professional means that what I do or think makes a difference not only to "me". A world under the auspices of the market and of insecurity at work, and marked by a strong risk relation between power and knowledge subsumed to the same market interests, provides a fertile soil for the configuration of an increasing inter-peer resentment. The ethics of "must be" loses space to relationships that are hardly filled by fraternal and collective bonds, and becomes an easy prey to hedonism. However, contradictorily, there is the construction of alternative knowledge/action spaces and the search for new public spaces and new collective identities. New relational and interdisciplinary spaces, as well as spaces of self-production at work, maintain ethics as the utopia of a new subject: a subject who reflects on himself and on his relationship with the other, and changes positively the course of the history of health work.

In the professional-patient singularity

> "Sometimes, the private sector worker goes from professional to professional until he finds someone who says what he wants to hear, which is not always the right thing to do; he invents something to get the client, performs the examination that the mother wants, that the father wants; do you have a health plan?, can you afford it?, then do the examination. Sometimes you give in so that you don't lose the patient". (P17)

A decision-making process is fair and acceptable, that is, ethical, depending on the principles it represents and if it produces a good decision or a good result as a consequence. The relationship between professional and patient is based on trust, and that is why it is different from commercial practices based on business contracts and relations. Thus, the understanding of

reciprocity seems to be right, not as a reward for personal commitment, but as an obligation of general beneficence towards patients and the society. The principle of beneficence incorporates the patient's autonomy, as the patient's interests are related to the professionals' duties towards him, but it supplants this autonomy when acting in the patient's best interest means leaving an irresponsible desire aside, even when the patient perceives it as a need.

According to Adela Cortina[15], in the dialogic relations of the search for a consensus, the misshapen reality must be replaced by ideal situations of dialog, so that the manipulation or alienation of the participants does not allow that private interests are accepted as universal. The question is: would this be viable in a context full of inequalities, private interests and coercion for consumption? How is it possible to maintain agreements where there is lack of commitment to the social other? How can we have a dialogic construction if commitment is a *sine qua non* condition in possible common agreements?

In institutional commitment

> "In the private sphere, I don't know if people are committed or it's because if you don't show up at work, if you present many medical certificates, you're fired. I don't know what's the difference, but here I see that people is less committed". (P27)

> "Ethics is complicated because ethics is basically the moral of the thing; so, you can say that there's no stimulus to make the professional produce a lot, and the fact that he doesn't produce much is neither unethical nor illegal". (P19)

Individualizing managerial strategies facilitate fragmented incorporations of new technologies, specializations, hermetic autonomies and entrenched hierarchies, which lead to the loss of the socializing character and of the altruistic dimension of work. The disruption of public/social spaces as a reference beyond work is transformed into a simple and objective demand for productivity, that is, there is an alienation of the very human meaning of work. Furthermore, the disruption of the collective-social apparatus with the establishment of a sociability restricted to the private interests of the private company is passed on to the public service as synonymous with administrative modernity.

The State public service's values of engagement, loyalty and dedication described by French workers as qualities of employees identified with their institution or missions[16] are systematically unsettled by this individualization based on profit-oriented professional excellence. The collective sphere loses the capacity for sharing values linked to a common experience – union-related, political or professional. There is a fragmentation that produces vulnerability, as well as a

subjective precariousness that reduces the importance of ethics and causes suffering in the workplace, as well as so many diseases of the soul.

The professional ends up assuming "possible practices" in order to remain minimally ethical in realities that coerce decision-making, avoiding moral suffering in situations such as management impositions or actions connected with political clientelism – which is still relatively common in the Brazilian reality.

> "Talking about ethics, what occurs is this political relation - they think that being in the coordination means having to do things independently of the obligation to the profession. But I use a very simple tactics: whenever someone asks me anything outside the standards, I ask them to do it in writing – I've been working here for a long time and I know how things work". (P12)

A public professional ethos has been historically suffering the conditioning aspects of patrimonial bureaucracy – the origin of clientelism, nepotism and corruption -; of authoritarian and centralizing administrative formats; and, more recently, of neoliberal private interests based on deliberate actions of discredit of the public/state sphere, constructing deleterious invisible codes when entrenched in the common moral. This meaning of social commitment suffers the setbacks of time and constructs, subliminally, distortions in the positive meaning of stability and corporatism, opening space for the constitution of a subjectivity characterized by "dragging one's feet", low productivity, passiveness and lack of commitment.

> "What I see that is unethical is the lack of will to provide assistance and, sometimes, restriction of assistance, not because of lack of material conditions, but because of lack of goodwill". (P2)

> "In the public service, there are professionals who don't want to do the work and then refer it to others. The professional says he can't do it, but he's just dragging his feet". (P4)

A work environment that is collectively fairer in the macro and micro spaces of health action, based on an inclusive view of professional and user, with conscious actions of respect to alterities and social needs from the standpoint of justice and protection, and, therefore, in the relation between the working subject and the collective/community-based/social dimension, is opposed to a deleterious resistance of the corporative or individual dimension against the ethical commitment that has a broad/social meaning. The evaluations of managements that consider

subjectivity and inclusiveness at work[17] are challenged to face this dimension of health action: the level of commitment that is dialogically and dialectically constructed among system, managers, patients/users and health professionals.

In the relation to a collective, invisible and mobilizing cause

> "It's always a concern when you're treating the patient without thinking about profit; I think we're always wondering if we could assist the public patient better, in case you had access, say, if you could fight for something else that you think would be possible. But generally speaking we do what we can with what we have, and we always try to give the best to the patient, but sometimes it isn't possible". (P13)

> "The professional isn't listening to the patient, he isn't paying attention to the patient. I think he feels he's underpaid, then he does things that are not right". (P6)

The strong ideological coercion that fragments the great human causes, the social transformations guided by dialectical conflicts regarding the emergence of new paradigms, the prevalence of truth constructed collectively and historically as a "must be", has made the market be viewed as part of human nature nowadays[18]. Ethical-political humanization projects already included in many aspects of professional education and action are hindered by an emptiness, so to speak, that is instituted in the public sector. There is an unsatisfactory construction of values guided by the reality of the other and not amalgamated with profit: commitment based on which stimulus: low salary, lack of equipment, political-clientelistic embezzlement? How can we think about a supportive individual/self, if it is not possible to conceive the socially committed individual?

The search for a human being who does not perceive himself as isolated from the whole, a human being that sees the collective dimension as a possibility-power for the singular individual, is related to being released from the socio-economic moorings of alienated[19] and atomized work. A movement that overcomes the barriers of the hedonistic individual demands a repositioning of the collective dimension, summoning health professionals to commit themselves to social needs, to a desire for alternatives and to a real possibility of construction of different paradigms – in a horizon drawn by several hands, rather than being lost in the emptiness of the isolated self. Committing to the other, being in the other's shoes, with solidarity and values that are not restricted to the capacity for payment, builds a path that is different from market ideology, which subordinates work, life, relationships and rationalities to currency as a universal value.

Commitment and moral suffering

> "As I know that I do a decent job in the public sector I feel more useful here. In the private sector they can search for another professional and in the public one, sometimes the assistance is assumed by aprofessional who doesn't even let the patient sit, who doesn't listen to the patient's complaint, who doesn't do what must be done either due to lack of time or because this particular professional assists patients differently when he's working at the private or at the public sector… so, I know I'm making a difference here". (P17)

The logic of the public service follows an ethical sense of social justice, beneficence and respect for autonomy, but also, an expressed feeling of love for the other, a sense of protection and intervention in persistent critical situations. Nowadays, in Brazil, given the intertwining between public and private permeated by the market ideology, the debate about ethics in an intersubjective construction as a relational subject with a strong collective/social basis seems to be central. Not as an ode to poverty or to voluntary services, but as an inversion of the liberal/private logic in public health. The collective and relational/human component incorporates commitment as a positive value, not subsumed to the imperativeness of profitability/productivity/secondary gain, but as a supportive co-participation that builds a different order: the public one.

Ethical commitment considers secondary vulnerabilities as significant, and protection as a free engagement that is committed to practice, "which can make it morally irrevocable"[20:80]. This process involves not only the planning and management of public policies, which raise a debate regarding the singular/universal relationship in the sense of rights and consequences of acts – with a certain degree of impersonality and impunity in the more general scope of accountability -, but also the health professional's role as a moral subject, with different degrees of commitment to the construction and protection of public good.

To Cecílio[21], the concept of moral worker needs to be beyond that of "functional man", of an actor who thinks and plays within the spaces that have been previously defined by leaders. On the contrary, a project that is able to overcome normalization from the outside to the inside, predicting what "good care provision" would be, should presuppose that the worker, and also the user, is not a blank sheet of paper; he uses his spaces of autonomy to perform his actions, as a subject with his own values and interests. Thus, a margin of autonomy in the workplace must be apprehended by the management as a real possibility of change.

It is observed that solidarity (not as charity), hope (of a story as a possibility) and the practices that are possible (for an ethical being who reflects on his own work and delivers more than what was prescribed) conform a scenario of resistance that possibly overcomes the material and relational problems imposed by reality, in the sense of a positive ethical commitment - which

faces an unequal social reality that makes the unknown other become vulnerable.

Belonging to the micro-space of the power relations that are located in the medical office or in the environment of a work unit/team must be overcome by belonging to the social norms. These values do not seem to be imposed or consented in the public sector, but requested, as they constitute a feeling of belonging to society and are considered fundamental in the construction of a subjectivity that feeds on the other, as the goal of every work, that is, a being of society.

Giving importance to the collective dimension at the workplace translates the professional's satisfaction in a space of education of himself as a subject, and this is directly related to user satisfaction and to the ethical mediation that is achieved. The relevance of valuing the professional is not related only to the secondary gain or to the salary gain that is attributed, but also to the construction of a relational response among user, management, professional and society. Thus, bioethical spaces of debate as an integral part of continuing education and of ethical relationships can construct a positive ethical commitment, for when situations that negatively affect ethics in the workplace are not dealt with subjectively and collectively, spaces are opened for moral suffering.

> "In the Family Health Strategy, sometimes we become helpless… it's very difficult, an assistance that a patient needs, or an emergency assistance, it's too much of a sacrifice. An ethical problem of… the word wouldn't be institution, but of how the health system is formed: it doesn't respect the patient as a human being". (P21)

> "We deal with the question of shortage all the time: shortage of medicines, of medical assistance, of vacancies for examinations... I find this issue of saying 'no' all the time very frustrating; at the end of the day, you end up feeling sick and disappointed". (P25)

The suffering is unveiled as a challenge: in the public sector, it is subsumed to a set of factors located where the professional/patient relationship is crossed by social determinants such as structural violence. When the professional relates user's rights to the possibilities of decision-making concerning what he thinks is best to the patient, he perceives some disrespect for citizen rights in situations that injure human dignity, like: scarce public resources to meet a large demand; problems to manage the public good; social determinants of the health-disease process; users' little autonomy and power of pressure; denied or delayed therapeutic procedures; and possibility of commercialization in the public/private intersection.

> "Sometimes you become frustrated in the public service because you see that the patient needs and examination, he may need better treatment

> and unfortunately he can't receive it, or sometimes, he can't receive it so fastly, and then we end up being used to the limitation". (P14)

A feeling of impotence is constructed, associated with impunity as an ethical problem translated as moral suffering. This suffering derives from incoherence between people's actions and their convictions, and it promotes psychological unbalance caused by painful feelings. These emerge when the professional is not able to foster morally adequate situations according to his conscience: "they recognize a personal action that is hindered by individual, institutional or social barriers"[22:682]. Feelings of anger and sadness are the main biopsychosocial effects of this moral suffering and they may lead to conformism, distancing from patients, increase in occupational diseases, depression, insomnia, anxiety and incapacity for concentration, feelings of guilt, professional loneliness, dissatisfaction, withdrawal from or abandonment of the profession[23].

Some types of compensation are collectively and individually constructed by "committed" professionals. However, sometimes, the suffering ends up being transformed into silent frustration, which undervalues the work and the action of the ethical subject. As a result, the professional may abandon his convictions about patients' rights, and he may commit mistakes or decide to escape, assuming services that demand less commitment or adhering to the logic of the private sector: higher salary and lower social involvement.

> "Many times we do things knowing that it is not the ideal solution, but it was what was possible to do in that situation. It's what happens here. Many times a patient needs to undergo a molar endodontic treatment, but he can't even afford the bus fare; afterwards, he'll have to be submitted to a dental crown procedure and he says that he won't be able to do it unless it's free. Well, then you know that this tooth will end up being extracted because the patient won't continue with the treatment". (P10)

Moral suffering emerges as constitutive violence: the molar, which is temporarily inadequate, imposes its restrictions on the possibilities of answers given by professional action, which strengthens the myth of the failure of public service. As a sub-product of these restrictions, a collective contribution is necessary to construct the moral integrity of the people involved, in education spaces, with ethical debates about varied themes - not only to punish a certain moral action, but to build inter- and cross-disciplinary values beyond deontological codes.

To Paulo Freire[24], a pedagogy of commitment requires qualification to intervene, to change the world, to transform it, to make it become more beautiful or uglier, in which case we become ethical beings. The fatalistic ideology of an unchangeable reality according to which there is nothing else to do must be replaced by a disposition to change the forms of struggle, instead of

giving the fight up. The subject/health professional as a popular educator starts from a position, a place with a different perspective: he should talk to people, research their level of knowledge, and investigate how people learn. The necessary dialog between popular and scientific knowledge enables to value the subjects.

Intercommunication based on knowledge exchange promotes the co-production of a differentiated relation, committed to the transformation of realities, to the subjects' reflection capacity and to the dignity of users, of the public health system and of the professional himself. Continuing education, in the sense of humanization, opposes commitment to fatalism and follows the path of the awareness-raising of the world, of interests that have been historically denied, of the presence of political and libertarian ideals, of autonomous subjects as makers of history.

Conclusion

A fragmented view of reality stimulated by the triad necessity/desire/consumption makes contemporary constructions of commitment become more complex. The singular relations between one another and between this particular and the whole, which has been denied, establishes "this is what we have for now" as an ideology, triggering some questions: what is really human without being impregnated with the competitiveness, the uneasiness, the existential crisis and the collective loneliness that characterize the modern world? How can we have commitment without dedication and trust? How can we have ethics without commitment?

The debate about ethics and about quality and excellence improvement in the logic of the public service starts from a working reality in which public and private interests are intertwined. This is more visible in regions with greater technological incorporation, high number of health plans and private health insurance, formation of service networks and dual employment relationship. This debate must consider: the importance of the professional as a subject of constructive health processes; social and individual vulnerabilities; strengthening of job satisfaction; construction of excellence in the public sector not subsumed to the imperativeness of profitability or to the liberal/private ideal; construction of a professional inter-subjectivity that allows one's perception of oneself as a singular part of a collective work and of a social whole; respect for differences; and engagement in collective needs.

The professional's commitment to the collective/social dimension established in the dialog between popular and scientific knowledge can rescue a human being who sees himself not as isolated from the whole, but as a subject who thinks and can construct an ethical differential in his work – at least while human beings continue to subordinate to the same capitalist scheme of society (even if it is contemporary), which does not allow the identification between pleasure and duty that happens when human beings cease to be viewed as commodities, in relations subsumed to class distinctions. The inter- and cross-disciplinary bioethical debate is pointed here as necessary for us to understand the changes that occur in health work and in the construction of a new

professional commitment: humanized and based on the social body.

Collaborators

Doris Gomes worked on the conception and writing of the article. Flávia Regina Souza Ramos took responsibility for the critical review of the manuscript.

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