Ethical judgement of doctors in Sergipe, Brazil

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Abstract

A documentary survey (2004-2013) was carried out of data from the Sergipe State Regional Medical Council, aimed at recognizing the profile of offending doctors, identifying the key complainants and their motivations, describing the results, punishments and length of legal proceedings and assessing the relationship between the provision of legal assistance and the success of the case. During the study period 318 disciplinary proceedings were initiated involving 337 doctors. The violations were mainly related to documents, death and doctor-patient relationship. Patients are the main complainants and 29 inquiries involved cases of Professional Ethics. The most common punishment was private notice of a confidential reprimand. There was a relationship between the provision of legal assistance and the success of the case. The profile of the offending doctor was: male, aged about 50 years, with more than 10 years' experience since graduating, and a specialist in gynecology and obstetrics. Knowledge of this profile of offending doctors allows the possibility of establishing direct preventive measures.

Keywords: Medical errors. Ethics. Legal process. Punishment.

Resumo

Julgamento ético do médico em Sergipe, Brasil

Pesquisa documental (2004-2013) nos dados do Conselho Regional de Medicina do estado de Sergipe, com o objetivo de conhecer o perfil do médico infrator, identificar os principais denunciantes e suas motivações, conhecer os resultados, punições, duração dos processos e avaliar a relação do auxílio advocatício com o sucesso da causa. No período, foram instaurados 318 processos disciplinares envolvendo 337 médicos. As infrações estão relacionadas principalmente a documentos, morte e relação médico-paciente. Os pacientes são os principais denunciantes, e 29 sindicâncias evoluíram para processo ético-profissional. A punição mais comum foi a censura confidencial em aviso reservado. O auxilio advocatício estava associado ao sucesso. Compõem o perfil do médico infrator as seguintes características: sexo masculino, cerca de 50 anos, mais de 10 anos de graduado, ginecologista e obstetra. Com esse panorama, temos um perfil do médico infrator e criam-se possibilidades de adotar medidas preventivas diretas.

Palavras-chave: Erros médicos. Ética. Processo legal. Punição.

Resumen

Juicio ético del médico en Sergipe, Brasil

Se trata de una investigación documental (2004-2013) a partir de los datos del Consejo Regional de Medicina del Estado de Sergipe con el objetivo de conocer el perfil del médico infractor, identificar a los denunciantes y motivaciones clave, conocer los resultados, las puniciones, la duración del procedimiento y evaluar la relación entre la asistencia jurídica con el éxito de la causa. En este período hubo 318 procesos disciplinarios que involucraron a 337 médicos. Las infracciones están relacionadas principalmente a los documentos, la muerte y la relación médico-paciente. Estos últimos son los principales denunciantes y 29 de estas causas evolucionaron hacia Procesos de Ética Profesional. La punición más común fue la censura confidencial con aviso reservado. La ayuda jurídica aparecía asociada al éxito. El perfil del médico infractor era: sexo masculino, cerca de 50 años, más de 10 años de graduado, especialista en ginecología y obstetricia. Con este panorama, tenemos un perfil del médico infractor y se generan las posibilidades para adoptar medidas preventivas directas.

Palabras-claves: Errores médicos. Ética. Proceso legal. Punición.

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Declaram não haver conflito de interesse.

Medical mal practice, nowadays, is cause for complaints to administrative and legal bodies as well as to the Conselho Regional de Medicina (Regional Medical Council CRM). We don't always know the profile of the professional involved and we also don't know the reasons for the complaints and which sanctions, if any, were applied.

Laws that regulate medical activities are not unique to our time. Since the Ancient Age, around 1700 BC, the Hammurabi Code – one of the first if not the first known code of conduct – already included, among its competences, doctor's performance [1-3].

The physicians have many functions and often patient's lives depend on their knowledge and skills. Faced with such power, the professional must take on numerous responsibilities, including the correct diagnosis and successful therapy. However, doctors are human beings and, therefore, prone to make mistakes [4].

According to Reason [5], some errors are more visible to the public eye. Medical error is one of the most dramatic examples and make for a tempting invitation to media exposure [6]. However, not everyone understands the conceptual difference between obligation of means and obligation of results. Obligation of means does not guarantee the result, as it happens in most of medical specialties, given the impossibility of ensuring the achievement of the purpose of what is intended. Therefore, breach of the obligation will only happen when the activity is not carried out with due diligence and due care. Obligation of result means that the promisor undertakes to achieve a particular result, ensuring its effective attainment [4,7].

Therefore, medical error does not mean lack of knowledge or technical skills, but may be due to other conditions. Thus, there is necessity for a trial [8,9]. The ethical and professional trial is the responsibility of the regulatory and supervisory body of the profession – the Regional Council of Medicine (CRM) – and is provided by the Code of Medical Ethics (CEM), which protects not only patients but also doctors, seen that 10 out of the 128 articles of the code cover professionals rights [10-13]. There are no official statistics in Brazil on the number of processes involving medical errors but, at the same time, the increase in lawsuits against those professionals is remarkable [4].

This article aims to know the profile of the accused doctor, identify key claimants and their motivations, check the results, sanctions and length of proceedings, besides evaluating the relationship of legal counsel with the success of the case.

Method

This is a documental research based on secondary data and done using lawsuits filed in the Conselho Regional de Medicina do Estado de Sergipe (CRM-SE – Regional Council of Medicine of the State of Sergipe). We considered all inquiries brought between 1 January 2004 and 31 December 2013 as criterion inclusion for processes in the research. The exclusion criterion was the no completion of the legal process by June 30, 2015, when the data for this research began to be systematically collected.

Three criteria were adopted to define the profile of accused doctors included in the survey: 1) the doctor mentioned in the complaint should be registered with the CRM-SE; 2) The doctor had been named at the time of the complaint; or 3) the doctor was named in investigative reports, in proceedings brought without other doctors being named. Doctors who had their name mentioned in inquiries but without (proven guilt were excluded from the research).

Statistical analysis was done using absolute and relative frequency, with the exception of the analysis that associated legal counsel to success in the legal process, and carried out by chi-square test ($p \leq 0.05$). The study was approved by the Comitê de Ética em Pesquisa com Seres Humanos (Ethics Committee on Research with Human Beings) of the Federal University of Sergipe and authorized by the CRM-SE, showing no conflict of interest.

Results

Profile of the doctors involved

The chosen variables to build the profile of those physicians were age, gender, years of experience since graduation and medical specialization. Age was divided into five age groups: 3.3% were younger than 30 years old; 24% were between 30 and 39 years old; 29.7% were between 40 and 49 years old; 33.5% were between 50 and 59 years old; and 9.5% were 60 years old or older. The predominant sex was male, making for 73% of the cases.

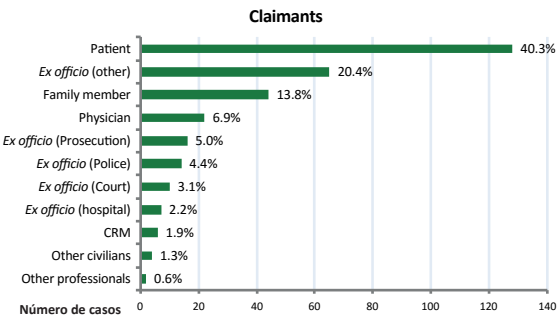
The number of years of experience since graduation was also divided by time intervals: 3.3% had less than five years of experience since graduation; 13.4% had between five and nine years; 14.5% between ten and fourteen years; 17.2%, between fifteen and nineteen years; 31.5% between twenty and twenty-nine years; and 20.2% had thirty years of experience since graduation or more.

Of the 337 reported doctors, 268 had medical specialization registered with the CRM-SE and, among these, the most common specialties were Gynecology and Obstetrics (20.1%), occupational medicine (17.9%), orthopedics and traumatology (9.3%) and general surgery (9.0%).

To identify claimants and their motivations for complaints

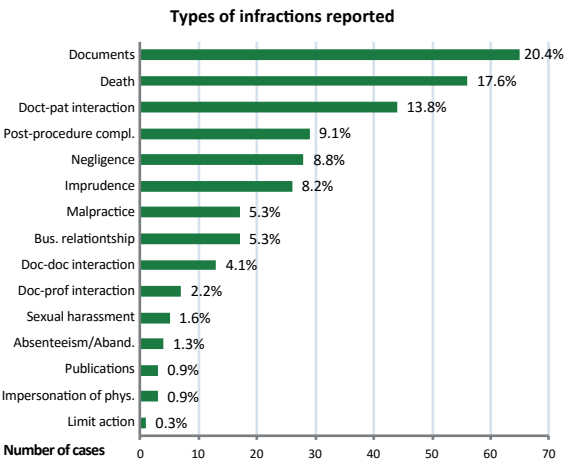
318 disciplinary cases involving 337 doctors were initiated in the period covered by the survey. There was a great variety of claimants in those cases (Chart 1), stressing that the largest number of complaints, 40.3%, came from the patients themselves. It was also noticeable an impressive increase in the number of complaints in the period considered (25 complaints in 2004 and 61 in 2013).

Chart 1. Distribution of claimants – CRM-SE (2004-2013)



Regarding the type of alleged infringement (Chart 2), the most cited were documentation's irregularities (20.4%), patient death (17.6%) and difficulty in the doctor-patient relationship (13.8%).

Chart 2. Distribution of kinds of reported infractions - CRM-SE (2004-2013)



Regarding the sector of the service provided, 64% occurred in the public sector and 36% in the private sector; 58% electively and 42% in a non-elective care (urgent or emergency); regarding the type of care provided, 66% were clinical and 34% surgical.

To know the evolution of the administrative process: punishment, length of investigations and PEP

Of the 318 inquiries, only 9.1% were taken to the "Ethical and Professional Process" (PEP- Processo Ético-Profissional). 3.8% of the inquiries already dealt by the CRM-SE, still before the PEP, had appeals to the Conselho Federal de Medicina (CFM – Federal Council of Medicine), of which 91% had their results held whilst only 9% of the results were modified by the CFM.

Of the open cases, 9.1% progressed to PEP, which corresponds, in absolute numbers, to 29 cases, of which 48% resulted in punishment. The other 52% were penalized. After these 29 PEP cases were closed in the CRM-SE, 21% of them had their results questioned and were directed to the CFM. 33% of them kept the initial result and 67% had their result altered.

At the conclusion of the 318 cases, only 4.4% ended in punishment: 58.3% of these corresponded to censorship through confidential warning; 16.7% advertence through confidential warning; 16.7%, official reprimand in an official publication; and only 8.3% were suspended from professional practice for up to thirty days. During the study period, no doctors lost their medical licenses.

The duration of investigations (in days), over the years, can be seen in chart 3. The average length of time of investigations during the study period was 503 days, which corresponds to approximately one year and four months. The PEP average time (Chart 4) was 1,301 days, with a maximum variation of 2,149 days and a minimum of 633 days.

Chart 3. Processing times of investigations of the CRM-SE (2004-2013)

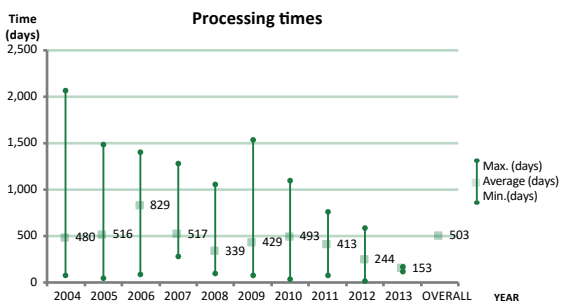


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Chart 4. Processing times of PEP in the CRM-SE and appeals sent to the CFM (2004-2013)

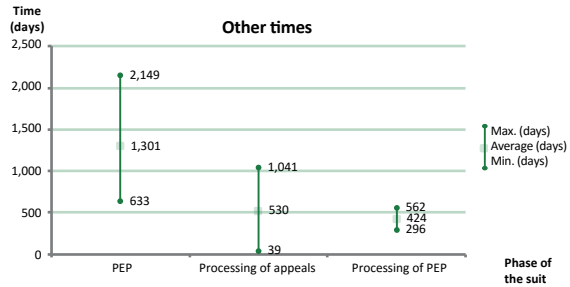
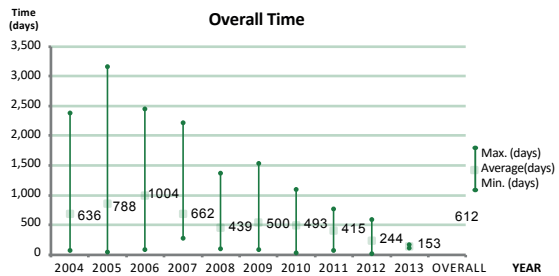


Chart 5. Total time of the legal proceedings brought to the CRM-SE (2004-2013)



Presence of lawyers

In the investigations, 25 of the accused doctors requested legal counsel and, in the PEP, 22 doctors had support of lawyers. The lawyer's presence in the inquiry phase is associated with success ($p < 0.001$), be the lawyer representing the complainant ($p = 0.01$) or representing the accused doctor ($p < 0.001$). Yet, in the PEP phase, lawyers are associated with success only as a representative of the accused ($p < 0.001$).

Discussion

The large increase in the number of investigations from 2004 to 2013, with an average of 10.8% per year, called our attention. This scenario may reflect the revolution in the right to information that has been occurring in recent years. Today, the population has more access to their rights, not to mention the evolution of legal and scientific knowledge and also the way the medical profession is seen today.

Conscious citizens are now more likely to fight for their rights, endorsed as they are by the Código de Defesa do Consumidor (Consumer Protection Code), the New Brazilian Civil Code, special civil and criminal courts, among others. This progress, however, did not result in the growth of the number of PEP, which remained virtually constant over the period considered [14,15]. According to Silva et al, *despite the increase in complaints, many of them don't have theoretical and legal grounds that would justify those complaints, showing trivialization and disrespect for the medical profession* [16]. This way, the authors show that the ease of access to justice can generate an increasing the number of inconsistent complaints which do not evolve to PEP and, consequently, do not result in penalties.

The processes, in general, begin with complaints submitted by the Regional Council of Medicine (complaint *ex officio*), an identified complainant or by the Medical Ethics Committee of any institutional body or health establishment. An inquiry is established after that first step [12].

This survey found that patients themselves were the ones who most complained about doctors in Sergipe (40.3%) even considering all complaints ex officio (35.1%). Santos et al. [17] evaluated the complaints which were made between 1999 and 2009 to the Conselho Regional de Medicina da Paraíba (CRM-PB - Regional Council of Medicine of Paraíba) and found out that, unlike the results of this study, complaints to that CRM were made mainly by families (32.0%), followed by the Prosecutor's Office (19.7%) and the CRM-PB (15.1%), while patients themselves were only in fifth place (8.8%). These results already show that local aspects should be considered on preventive measures. Comparing the results, it is worth highlighting the few complaints made by the CRM-SE itself in a period of ten years: Only 4 (1.9%) -, whereas the CRM-PB made 22 complaints (15.1%), which may indicate, by inference, less supervisory activity of the CRM-SE.

Harmful practices to patients can be characterized as incompetence, recklessness or negligence. They configure exactly what we call "culpable crime", that is, the one which is premeditated and shows intention of committing an infraction. Conceptually, however, some violations are not limited to only one of these three wrong doings, reason why they should be evaluated according to their specificity [18]. In this study, the reported infractions were the most diverse, predominantly related to medical documents, death, and relationship between doctor and patient.

The Occupational Health Certificate (ASO – Atestado de Saúde Ocupacional) and the discharge papers were the main reason for complaints. These documents, in the perception of the patients, create conflicts because they assume that their rights were constrained by the medical reports. This

result related to medical-legal documents in Sergipe emerges as the main reason for complaints to the CRM-SE but it differs from other states where this aspect, although present, is not significant [10,17,19].

Fujita and Santos [19] also consider the change in the scale of priorities of our society as a factor that has been influencing the practice of medicine, seeing how legal actions are being started by patients who feel harmed in their rights. This change is reflected in the current trend of legalization of medicine in Brazil. According to Udelsmann, *the tendency to institutionalize the "industry of compensation," a deformed copy of existing models from more developed countries. Doctors do not have legal training but should begin to look at it with interest if they are to continue to practice and survive in the job market* [20].

The second major reason for complaints are deaths, which, according to assumption of the complainant, could had been prevented, under the argument that the attending physician was at fault. The defense of the doctor, on the other hand, was always based on medical records and on the medical literature, which usually indicates risks and complications inherent in the procedures and the course of the pathologies that led to the death.

As for the doctor-patient relationship, the third largest cause of complaints, it is known to be a complex process, which requires efforts from both sides and that, although essential to humane treatment, it is difficult to build. This difficulty stems from several factors, among which stands out the communication – essential tool to establish the relationship between professional and patient. Lack of communication skills is precisely the triggering element of conflicts that, at a later time, will culminate in the complaints cited literally as "difficulty in the doctor-patient relationship".

Most cases have occurred, when assessing the claims in Sergipe, at the triad composed of public service, clinical and elective. This result does not follow a pattern in other states where there are similar studies. The triad, in the CRM- Bahia (2000-2004) was public service, surgical and urgent / emergency. In Goiás (1992-1997), the most frequent was the dyad private and surgical, and in the Federal District (1992-1997), public and surgical [10].

After the complaint is established an inquest, that can lead to archiving, conciliation or establishment of ethical and professional process. PEP, in turn, may result in archiving or punishment of the accused doctor [12].

In the evolution of the administrative process, it is noteworthy that only 9.1% of investigations progressed to PEP. Fujita and Santos [19] analyzed data from the CRM of the Goiás state between 2000 and 2006 and obtained a ratio of 35% of growth for PEP, which may demonstrate little consistency of complaints in Sergipe, or even misuse of the CRM as a mere referee organ of medical action in order to, later on, give consistency to the allegations in the civil courts. The trials' spheres (civil, criminal and ethics) are autonomous, but interpenetrating. Knowing this, some patients use the result of ethical judgment to influence the outcome of the civil trial, which, economically speaking, is more interesting to the complainant [18].

The medical records are essential for the evaluation of the complaint. They are the first documentation requested by judging bodies. The medical record consists of a set of standardized documents in which are recorded the service and patient care, and serves both to complainants as to the accused, appearing as the main medical defense piece. However, sometimes the quality of the annotations made is weak because of the poor description of the service as well as the illegible writing, which undertakes a proper judgment of the facts. Whereas their responsibility for the record is mandatory, non-transferable and that he himself produced the poor notes, the doctor loses thus the best chance to defend himself. Without this defense option in the CRM-SE, doctors and their supporters resorted to testimonial evidence combined with the medical literature, which then become the main defense of the doctor [21].

The punishments established by the Law 3.268/57, still in effect, consist of: confidential private warning, public censure in an official publication, suspension of professional practice for up to 30 days and loss of medical license. Appeals can be submitted to the Federal Council of Medicine after the end of the inquiry as and also at the completion of the PEP, if a party does not accept the outcome of the trial in the CRM [12].

Given the results of the trials in CRM-SE during the study period, there were cases where a party did not feel satisfied and appealed to the CFM, which resulted in 18 applications, 12 of inquiries and 6 PEP. Regarding the appeals to the inquiries, of the 12 requested, the CFM maintained the decisions of the Regional Medicine Council in 11 cases, and only one appeal, whose initial result was archiving, had its result amended by the CFM and the PEP was then introduced.

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Of the 29 PEP judged by CRM-SE, 13.8% had their results changed by the CFM. Among these 29 cases, six had their results disputed and appealed to the CFM: Five were appeals from doctors who that had been punished by the CRM-SE, of which three were acquitted and the other two had their sanctions maintained by the CFM. The sixth appeal was submitted by the complainant because the doctor had been cleared by the CRM-SE, and the CFM in new trial, changed the result, penalizing the doctor. Finally, from the 18 actions brought by the CFM five were successful, which is equivalent to changing decision in 27.8% of appeals, a very high number, suggesting possible poor quality of work in the conduct of the proceedings.

In this period of ten years, punishments occurred in only 3.7% of the open cases, none of them with a maximum penalty (cancellation of professional practice), but only thirty days suspension. Bitencourt et al 2007 10 also did not identify cassation of professional practice in the period 2000-2004 by the CRM of Bahia. These results may suggest how light are the penalties applied by the various CRM in the country. Also noteworthy is the great void existing between the suspension of thirty days and the permanent suspension of professional practice, which may show the need for further gradual penalties between them to better fit the offence to its penalty. Reason for the Bill 437/2007, authored by Senator Maria do Carmo Alves, Sergipe, in order to establish new and intermediate disciplinary punishments to those already existing in the medicine councils [22].

Regarding the length of time of a process it is noticeable its decrease over the years. The time of an inquiry reached in 2006 the highest recorded average – 829 days, or two years and three months - in order to then develop positively and with greater speed until 2013 when that time was reduced to an average of 153 days or less than one semester. The total proceedings time followed a downward trend observed in the duration of inquiries over the years, because in 2006 the average was 1,004 days (two years and nine months) and in 2013 was reached the average of 153 days. Another point to note is the average time, considerably high, for the trial of an appeal by the CFM: 530 and 424 days for appeals to inquiries and PEP, respectively.

The legal counsel in actions of the CRM, when self-defense is expected, is controversial. Because judging chambers of medical councils are formed by boards of doctors, language and discussions require great technical and scientific knowledge in the area. Thus, if the lawyer does not have affinity with the area, the counsel will not add much to the defense of the doctor [20]. No previous studies showing an association between legal counsel and success in the ethical trials of doctors. In the present study, however, the statistical analysis shows this relationship as positive, except when representing the complainant in the PEP. These results can consolidate the importance of legal counsel in the medicine councils.

There were 3,380 active physicians registered with the CRM-SE on December 31, 2013. Whereas 337 were involved in processes analyzed in this study, this number represents 9.97% of the professionals in the state of Sergipe. Statistically, this is quite a significant number, which needs attention from the CRM, policymakers and especially coordinators of medical courses in the preparation of new professionals, given the worrying growth of complaints each year.

The average age of the accused professionals was around 40 years in almost all researchs. However, the latest research has registered a change of this range from 40 to 50 years. This change may reflect the aging of the offending medical population, indicating a possible generational relationship. This may show a better ethical training of new graduates in the last decades and the greater need to update the older generations [10,17].

The predominant sex was male, counting for 73% of the cases. Among the 14 professionals punished in the period, only three women were included. Probably, women give more importance to current regulations, better elaboration of medical and legal documents, more organized and descriptive medical records, besides managing to have good doctor-patient relationship, practicing a more humane and empathic medicine. These results follow a national trend [10,16,19,23].

Contrary to what many might think, doctors who just graduated, supposed to be inexperienced and insecure, are not the most reported. According to Santos et al. [17], only 16.2% of physicians reported in Paraíba between 1999 and 2009 had less than 10 years of experience since graduation, about the same percentage found in this study (17.8%).

Gynecology and obstetrics was the specialty with the highest number of reported complaints against doctors, confirming results of similar previous research. In Santa Catarina, the specialties which had more complaints were obstetrics and gynecology, anesthesiology, orthopedics and occupational medicine [23]. In Bahia, they were obstetrics

and gynecology, general surgery, anesthesiology, orthopedics and medical clinic [10]. In Goiás, gynecology and obstetrics, general surgery, occupational medicine, medical clinic, in that order [19]. in most of the work, the fact that gynecology occupies the top of the list of complaints is due to surgical procedures which may be necessary and require higher added risk, such as death or postoperative complications [23].

The occupational medicine, a characteristically clinical specialty, also stands out among the most denounced, not only in Sergipe, but also in studies conducted in Santa Catarina and Goiás. It is no wonder that the first cause of complaint to the CRM-SE is due to disagreement or medical documents irregularities produced by doctors, such as the ASO and the dismissal examination. The increased access of the population to its rights produces the false impression that patients are entitled to everything, and the medical document produced whose content does not benefit in any way the evaluated patient – especially when it comes to financial benefit – and generate discomfort may result in litigation.

Final considerations

This study recorded the increasing speed in legal procedures in the resolution of cases by the CRM-SE over the years, with the noticeable decrease in the time of trial in the course of those surveyed ten years. It also proves that, contrary to assumptions in the literature about this matter, what is an unprecedented finding: a statistically significant association between legal counsel in the CRM-SE and the success of the trial, with the exception of the representation of cases reported to the PEP.

The limitations of this study involve the lack of definitive response about the future continuation of the rise in average age of reported doctors, which would show higher correlation with the generation of physicians, not only with age, and could seek answers to this phenomenon. This assumption highlights the need for longer follow-up of these investigations and ethics investigations.

It is important to stress, on the application of punishments, the great void existent between the thirty days suspension and the permanent suspension of professional practice, which may show the need for further gradual penalties between them, to better match the offence to its punishment. However, it is worth mentioning the softness of the punishments applied by the CRM-SE, which had no penalty of loss of medical license in that period of ten years and only one penalty of suspension for thirty days registered, despite the seriousness of the facts alleged.

As a critic, there is the smallest number of complaints made by the CRM-SE itself (*ex officio*) in a period of ten years: only four, which may indicate the weak performance of CRM-SE as a supervisory institution, especially considering all visible and glaring failures of the public health system, cause of good part of the complaints made by the population, the media and also by the very content of the complaints.

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