Ethical judgment in Rio Grande do Norte between 2000 and 2015

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Abstract

With the increasing lawsuits against physicians, whether in the civil, administrative or criminal sphere, the judicialization of medicine has become increasingly common. Therefore, it is essential that medical professionals know the current reality and are prepared to face it. Based on this principle, this study investigated the archives of the Conselho Regional de Medicina (Regional Council of Medicine) for the State of Rio Grande do Norte in order to raise complaints received, investigations, prosecutions and judgments as well as disciplinary penalties applied between 2000 and 2015. After analyzing the data, it was observed that a higher rate of male physicians were reported, and a small number of penalties applied. The research concludes that it is necessary to invest in the prevention of errors through quality and continuous medical education in order to maintain a good relationship between professionals and patients.

Keywords: Medical errors. Health's judicialization. Ethics, medical.

Resumo

Julgamento ético no Rio Grande do Norte entre 2000 e 2015

Com os crescentes processos contra médicos, seja na esfera cível, administrativa ou criminal, a judicialização da medicina tem se tornado cada vez mais comum. Portanto, é fundamental que o profissional de medicina conheça a realidade atual e se prepare para enfrentá-la. Partindo desse princípio, este estudo investigou os arquivos do Conselho Regional de Medicina do Estado do Rio Grande do Norte a fim de levantar as denúncias recebidas, sindicâncias, processos instaurados e julgados e penas disciplinares aplicadas entre 2000 e 2015. Após análise dos dados, observou-se maior índice de médicos homens denunciados e número reduzido de penas aplicadas. A pesquisa conclui que é necessário investir na prevenção do erro mediante educação médica continuada e de qualidade, a fim de conservar boa relação entre profissional e paciente.

Palavras-chave: Erros médicos. Judicialização da saúde. Ética médica.

Resumen

Juicio ético en Rio Grande do Norte entre 2000 y 2015

Con los crecientes procesos judiciales contra médicos, ya sea en la esfera civil, administrativa o penal, la judicialización de la medicina se ha vuelto cada vez más común. Por lo tanto, es fundamental que el profesional de medicina conozca la realidad actual y esté preparado para enfrentarla. Partiendo de este principio, este estudio investigó los archivos del Conselho Regional de Medicina (Consejo Regional de Medicina) del Estado de Rio Grande do Norte con el fin de recolectar las denuncias recibidas, indagaciones, procesos instaurados y juzgados, y sanciones disciplinarias aplicadas entre 2000 y 2015. Después del análisis de datos, se observó un mayor índice de médicos varones denunciados y un número reducido de sanciones aplicadas. La investigación concluye que es necesario invertir en la prevención de errores a través de la formación médica continua y de calidad, a fin de conservar una buena relación entre profesional y paciente.

Palabras clave: Errores médicos. Judicialización de la salud. Ética médica.

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Research

Medicine aims to prevent disease and protect health and life. And when we talk about health, we must evaluate it according to its biopsychosocial context focused on humans, who are susceptible to pain and morbidity. Thus, physicians must address simultaneously the biological, psychic, and social aspects in order to promote a healthy environment. These are the challenges faced by the medical craft [1,2].

Any other action opposed to the practice of caring or healing can lead to wrongful detriment. The first sanctions on physicians were regulated in Mesopotamia by the Hammurabi Code (1790 -1770 BC), the first document to address medical error [3]. In Brazil, the Civil Code, the Penal Code, the Código de Ética Médica (CEM) (Code of Medical Ethics), and specific legislation governing federal, state, and municipal civil servants are the legal instruments that address inappropriate professional conduct. Therefore, physicians can be tried concurrently in the civil, criminal, administrative, and ethical courts [4].

The current commercialization scenario of medical practice, with intense overspecialization, numerous short-term consultations, and wrongful health plan practices only contributes to the deterioration of the doctor-patient relationship. This adverse context may also lead to medical error. Guilt – the basis for investigating the liability of physicians, can be attributed to medical schools that inadequately train professionals; to physicians themselves, who do not seek professional update and development in order to keep up with scientific evolution; and unsatisfactory working conditions. Articles 951 and 186 of the Brazilian Civil Code come into the picture as prerogatives for such imputation, adopting the subjective theory – voluntary action, harm to the patient, and causal relation; and the objective theory, when there is prejudice, but not necessarily guilt [1,4-6].

It is necessary to bring up the definition of medical error, as described by França: *a form of inadequate professional conduct that implies a technical non-compliance, capable of producing damage to the patient's life or health, characterized as malpractice, negligence or recklessness* [7]. A bad physician is one who performs procedures without the required skill, either by unpreparedness or lack of theoretical knowledge. But those who are reckless make hurried, unwise decisions and take risks even if they know they are not prepared or lack scientific knowledge. Negligence is characterized by inaction towards the patient in need of care, in other words, inertia or omission [8,9].

Making mistakes is human, but in health care, medical errors are not tolerated by the general population. A study published in 2016 showed that medical error was the third leading cause of death in the United States in 2013, while preventable adverse effects came first [10,11] – caused by prolonged hospitalization and its possible sequelae, complications resulting from medication use, and injuries followed by infection.

It is essential to understand the judicialization of medical error, which seeks to give voice to victims of misconduct, minimizing their pain and suffering. The media generally expose cases of prejudice allegedly arising from medical malpractice, encouraging the community to seek indemnification so that the culprit and the reason behind the error are found as a way to exercise its citizenship. Nevertheless, given the extensive trauma suffered by patients, the portion of physicians effectively reported or investigated is still small [12].

Errors that cause the death or compromises the health of a patient can result in civil and criminal liability. In addition, medical error is exposed to society in court, which analyzes the consequences following an act of commission or omission, and the causal relation, ultimately reaching a verdict [13].

Based on the point of view of doctors, the media, and society, it is important to establish the causes of medical error and prevent a negative impact on their careers and society, because, nowadays, the general population has wide access to information pertaining medical errors, which have increased considerably and often been treated sensationally, leading to the blame and punishment of the alleged culprit without due judgment. Doctors usually have trouble accepting their mistakes, as they feel intimidated by the defamation in the media and fear institutional punishment, such as indemnification. Conversely, society feels insecure, losing confidence in doctors, which weakens the doctor-patient relationship, one of the pillars of medicine since Ancient history [14,15].

Method

This is a documentary study based on a quantitative approach, which has used as reference the archives of the Regional Council of Medicine of the State of Rio Grande do Norte (Cremern). Data collection started once the study was approved by the Comitê de Ética em Pesquisa (CEP) (Research Ethics Committee) of Potiguar University (UnP), in compliance with the specifications of the Resolution

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set forth by the Conselho Nacional de Sauder (CNS) (National Health Council) 510/2016 [16].

Data was collected by Cremern's claim department following express authorization granted by the president of the institution. The sample included all the complaints received, investigations, lawsuits filed and tried, and disciplinary penalties applied between 2000 and 2015. For statistical analysis and graphing, the total number of complaints received and investigations tried, as well as all the penalties imposed during those 16 years were used as variables. Qualitative data about the doctors reported and their specialties were excluded. Data was analyzed using SPSS version 22.0 software and, for the management of variables, central tendency measures were adopted, such as mean, percentage, and standard deviation (SD).

Results

Between 2000 and 2015, a total of 1,219 complaints were received, an average of 76.19 per year (SD=25.54); with 2010 showing the lowest number of complaints (37; 3.03%); and 2015, the highest (120; 9.84%). From the complaints presented, 778 investigations were conducted, with an average of 49.25 per year (SD=28.12) (Table 1).

Table 1. Complaints and penalizations, Rio Grande do Norte (2000-2015)

Complaints received	1.219
Investigations filed	947
Investigations tried	788
Lawsuits	215
Lawsuits tried	138
Acquittal	107
Confidential warning	10
Confidential reproach	18
Public reproach	5
30-day suspension	3
Banning	0

947 investigations were instituted, involving 1,225 male doctors and 485 female doctors (Table 2). After the trial for Ethical-Professional Proceedings (Processos Ético-Profissional – PEP), penalties were applied; 107 professionals (6.25%) were acquitted, an average of 6.31 (SD=3.02) per year; 10 (0.58%) were given a confidential warning, an average of 0.56 (SD=0.89) per year; 18 (1.05%), confidential reproach, an average of 1.13 (SD=1.02); 5 (0.29%), public reproach, an average of 0.31 (SD=0.60); and 3 (0.17%), a 30-day suspensions, an average of 0.19 (SD=0.40). There was no banning at this time, as shown in Table 1.

Table 2. Investigations based on the gender of doctors; Rio Grande do Norte (2000-2015)

Year	Male	Female	Investigations filed
2000	34	12	36
2001	34	10	40
2002	35	4	35
2003	36	15	48
2004	36	17	44
2005	29	14	31
2006	52	16	53
2007	47	20	55
2008	52	8	34
2009	55	26	49
2010	223	114	73
2011	135	73	82
2012	84	29	90
2013	56	24	56
2014	173	60	114
2015	144	43	107
Total	1.225	485	947

Discussion

Fifteen years ago, the term "judicialization of medicine" would be considered unrealistic, but today, it is very common. The doctor-patient relationship is complex, given the attributes of the profession, which deals with health, the body, and life. As a result, indemnification claims are common for patients seeking financial compensation for damages caused by alleged medical errors. Many times, such errors are not proven during trial, and concurrent fault of doctor and patient may be evident, or even the sole fault of the latter, resulting from improper conduct and practices during or after therapeutic procedures [4].

According to the National Council of Justice [17], between 2014 and 2017, approximately 83,728 lawsuits involving medical errors in the country were filed. The democratization of access to justice, the proliferation of medical and law schools, the consolidation of consumer rights, the dissemination of information and the increase in patient demand for medical services also contributes to this situation [4].

As far as the financial loss caused by lawsuits, even if doctors are not convicted, legal expenses, including the fees charged by lawyers, experts, and technicians, vary from 100 to 200 minimum wages [17]. Moreover, the amounts related to the convictions

are quite high. The highest amount granted by the Superior Tribunal de Justiça (STJ) (Superior Court of Justice) was R$ 830,000.00, in the case of a patient who underwent surgery to heal a clavicle fracture and later presented complications caused by general anesthesia, leaving her in a vegetative state [18].

Medical doctors are advised to protect themselves from expanding lawsuits by taking out liability insurance, which is not something widely recommended by most medical entities, as they claim that such practice would further encourage legal litigation. Therefore, physicians find themselves in a situation of considerable vulnerability, so it becomes necessary to know the reality and be prepared to face it [3,18].

Considering the statistical survey conducted in 2018 by the Conselho Federal de Medicina (CFM) (Federal Council of Medicine) [19] regarding medical demography in Brazil, the proportion of male and female doctors in Rio Grande do Norte remains the same, as compared to 2015. That year, there were 3,031 registered male physicians and 2,233 female physicians across the state, while in January 2018, there were 3,249 male and 2,543 female.

Table 2, which shows how the number of male physicians involved in PEP outnumbered the number of female physicians during the 16-year period analyzed in this study, highlights that the distribution by gender matches the highest number of male physicians. registered with Cremern. That is, there are more male physicians registered and more male physicians reported. However, in proportional terms, the number of female physicians reported is noticeably lower, with a total of 81 women (24.7%) and 246 men (75.3%) involved in PEP between 2000 and 2015 [19].

According to the new Código de Processo Ético-Profissional (CPEP) (Code of Ethical-Professional Proceedings) (Resolution CFM 2.145/2016) [20], it is possible to analyze the legal proceedings to which a physician is exposed when being reported. A formal complaint can only be filed with the Conselho Regional de Medicina – CRM (Regional Council of Medicine) once the patient, the doctor, and the institution where the doctor works are questioned. Then, a preliminary investigation procedure is opened. A counselor is assigned to prepare a report that includes all the facts gathered and the analysis of possible violations against the CEM.

Upon the completion of the report, an investigation can be filed, proposing the termo de ajustamento de conduta (TAC) (conduct adjustment agreement), conciliation, or PEP compliance. Once the proceedings are initiated, the trial proceeds behind closed doors at the CRM. The acquittal of the accused, or the application of penalties provided for in Article 22 of Law 3,268/1957 are possible outcomes [21]. According to article 92 of the CPEP, the trial takes place in the presence of the parties and their respective lawyers, CRM members, a legal advisory member of CRM, and officials responsible for the disciplinary proceedings of the Court of Ethics [20].

Still on the outcome of the inquiry, the CPEP, in its first chapter, "Proceedings in general", deals with the TAC and conciliation [20]. According to Article 19, section IV, TAC is the legal act whereby a person takes on the responsibility to eliminate offense or risk by adapting his or her behavior to legal and ethical requirements. Conciliation, according to Article 18, section III, will only be permitted in cases that do not involve serious injury, sexual harassment, or death of the patient, being dependent upon what the investigation advisor proposes. In addition, any monetary adjustment is prohibited [20]. It is worth emphasizing that the TAC is only possible when the complaint is *ex officio*, that is, the complainant is the CRM itself. As for conciliation, in order to be effective, there must be a complainant, since the measure presupposes that the complainant and the accused reach an agreement.

Another important point is how counselors decide upon the penalty to be carried out. During the session, the rapporteur and the reviewer cast their votes with the other counselors, with a minimum of 11 votes required. Once the result is analyzed, the penalty will be based on the subjectivity of the infraction and the culpability of the accused, if applied. There is no criteria defined by the CPEP that characterizes the penalty for each specific occurrence [20].

Therefore, the penalty is subjective, based solely on the judgment of the counselors. This bias is one of the causes for discrepancy between the number of acquittals and penalties handed down by the CRMs of each state. In order to standardize the decisions of several regional councils, the creation of a binding effect [22] could be proposed, which would significantly reduce divergent disciplinary penalties for similar facts.

A survey conducted by the Conselho Regional de Medicina do Estado de São Paulo (Cremesp) (Regional Council of Medicine of the State of São Paulo) on lawsuits against doctors between 2001 and 2011 shows divergent data regarding the number of PEP filed with Cremorne. In São Paulo, there was a 180% increase in the number of doctors charged and 300% of the PEP in progress. In Rio Grande do Norte,

there was a 25% drop in the number of doctors found guilty, and an 83% increase in PEP opened during the 16-year period covered by this research [23].

During the period analyzed, 107 doctors were acquitted by Cremern (77% of the 138 tried). Only 36 (26%) suffered penalties, which ranged from confidential warnings (n=10; 7.2%), confidential reproach (n=18; 13%), public reproach (n=5; 3.62%), and 30-day suspension (n=3; 2.17%). There were no cases of banning. Compared with the increasing number of registrations in the Cremern, from 2,375 in 2000 to 5,264 in 2015, the penalties applied to the PEPs tried are insignificant.

As far as the prevention of medical errors, it is necessary to understand its multifactorial trait, which encompasses issues such as quality and continuing medical education; good doctor-patient relationship; evidence-based medicine; periodic evidence and revalidation of specialty titles; dissemination of medical ethics during conferences, among others [8]. In view of the increased number of complaints and investigations, the need to invest in the quality of education is evident, which applies not only to undergraduate programs but also to continuing education. Evidence-based medicine, based on recent manuals designed for each area of specialization, must be encouraged in all undergraduate and graduate programs, and continuously promote professional development [24].

A study conducted in 2007 by Bitencourt and collaborators [8] concluded that most medical errors are due to negligence. Thus, measures are required to improve the doctor-patient relationship, such as dealing more broadly and emphatically with medical ethics in undergraduate programs, and disseminating the theme during medical conferences, adapting the approach according to each specialty. It is necessary to invest in continuing education courses, through which federal and regional councils can improve the knowledge of professionals. Such multidisciplinary practices would address situations, conflicts, and ethical dilemmas most common in everyday life, while promoting a more humanistic vision and valuing the technique, which could bring professionals and medical bodies closer together.

For the last few years, Cremern has invested in continuing medical education, even making class materials available on the council's website. However, the effectiveness of this measure initially implemented in Rio Grande do Norte, and now available to all regional councils across the country, must be evaluated, as the number of complaints and PEPs filed continues to grow.

As Table 2 shows, between 2000 and 2015, the complaints arising from possible medical errors increased. This increase was proportional to the number of professionals entering the labor market, because there was a similar growth in the number of new professionals registered with Cremern, although there is no survey available on the number of medical graduates in Rio Grande do Norte during the 16-year period included in this research.

To avoid the insertion of false professionals and standardize the registration of specialists across the country, the Registro de Qualificação de Especialista (RQE) (Specialist Qualification Registry) was implemented. It is up to physicians to be properly registered with the CRM, according to Article 17 of Law 3.268/1957 [21]. Doctors can only legally practice medicine, in any branch or specialty, after registering titles, diplomas, certificates or letters with the Ministry of Education and Culture, and with the Regional Council of Medicine representing the area where they will be working [21]. Resolution CFM 1.974/2011 [25], which deals with medical advertising, makes it explicit the obligation to advertise services properly by stating name, specialty, and both CRM and RQE registration numbers. In addition, the new CEM, which came into force on April 30, 2019, in its Chapter XIII, Article 117, obliges physicians to include, in any kind of professional advertisement, name; registration number with the regional council, including the state where the registration was done; and RQE, when displaying their specialty [26].

Medical residency needs to be expanded and promoted. Many young professionals, soon after graduation, enter the job market without going through a residency program, applying to multiple jobs, especially as ER doctors covering long shifts, which can lead to physical and emotional wear. The commodification of medical work generates labor overload that facilitates the occurrence of errors.

The stress physicians undergo while working in multiple jobs, and the demand for an increased number of visits to decrease the request for exams, focused on greater employer profit, really affect the doctor-patient relationship, increasing the number of errors and consequent PEPs. Patient, in the full exercise of their citizenship, no longer accept adverse results and often question why their treatment was unsuccessful. The media always encourages them to seek judicial or extrajudicial indemnification, sometimes even labeling as "medical error" faults

committed by non-medical professionals, simply because they occurred in a health care setting.

Once a medical error is identified, it is necessary to evaluate the work structure where it happened. Sometimes accountability is misguided and ignores the exploitation of medical professionals by health plans, the state, cooperatives, and sometimes by colleagues themselves. The precariousness of tertiary care, especially in inland cities, induces recurring practices among municipalities, such as investing in ambulances for the transfer of simple, resolvable cases from basic care units or regional hospitals to larger medical centers, which results in crowded emergency rooms and corridors taken over by stretchers. As Neves and Siqueira [27] point out, in these cases, the ethical responsibility for services is not restricted to the medical director only, but involves other decision-making levels, such as the unit's director, municipal and state health secretaries, and the Ministry of Health.

According to an article published online by BBC News Brasil [28], in 2018, approximately three medical errors were filed per hour across the country, and this increasing judicialization of health has been fostering the medical insurance market. The search for such insurance is advised against by CFM [29], since this type of protection, besides actually contributing to increase the number of civil liability actions, does not exempt the doctor from the penalties provided for in the CEM.

Better qualification of medical schools and professional development are expected to contribute with the decrease of lawsuits filed with regional medical councils. Doctors need to be better qualified and treat patients the way they would like to be treated themselves, focused on the humanization of medicine.

Final considerations

The statistical survey presented by this research includes the total number of complaints received by Cremern and the penalties applied during the period studied. It was not possible to conduct a qualitative analysis based on specialty, since a considerable number of professionals did not register their RQE with the CFM. This situation might change with the obligation of ratification based on the approval of the new CEM, approved in 2018 and in force since 2019 [26].

The RQE registration must be effectively implemented and requested by regional medical councils, as it gives patients the assurance that the doctor has been professionally acknowledged by the CFM. The RQE mandatory rule became effective in 2012, through CFM Resolution CFM 1,974/2011 [25]. The completion of the CEM update on August 15, 2018 has enabled the registration of specialists to be normalized.

Investing in the prevention of error and, consequently, lawsuits requires academic training with solid knowledge of medical practice, as well as professional practice with respect to ethical standards, associated with the broad dialogue with patients about the medical act proposed and performed, while respecting their autonomy. The recognition of the rights of the patient was consolidated by Resolution CFM 1,805/2006, which states in article 1: *Physicians are allowed to limit or suspend procedures and treatments that prolong the life of terminally ill patients, suffering from severe or incurable illness, respecting their will and that of legal representatives* [30].

D'Avila [31] had already recommended that doctors record the information about the procedures performed, communicate by using accessible language, maintain a good doctor-patient relationship, demand good working conditions, and keep themselves up to date.

Regarding the penalties applied during the study period, there were a large number of acquittals: 77% of all cases tried. During the 16-year period analyzed, considering the two most severe penalties, Cremern suspended the license of three doctors and there were no cases of banning. In general, the penalties applied in Rio Grande do Norte were milder than those applied by Cremesp [23]. It is worth considering whether this discrepant behavior results from corporatism or unfounded complaints. A second hypothesis would be to formulate criteria to avoid unnecessary investigations and reverse the picture.

Many ethical-administrative proceedings have been instituted resulting in the acquittal of accused and prosecuted physicians, which points to a high number of PEPs that could be resolved with TAC or conciliation. A comparison between the report and additional criteria would solve the problem, speeding up the review of the complaint and significantly reducing the number of lawsuits filed.

It is worth noting that during the period covered by this study, more male doctors were reported, and although most of those registered at Cremern are male physicians, there is a big discrepancy in comparison to the number of female physicians reported. We suggest further discussion of this phenomenon in other works that seek to point out the reasons why men tend to make more mistakes, also clarifying which medical specialties are most involved in complaints.

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