Revista Bioética
Print version ISSN 1983-8042 | On-line version ISSN 1983-8034

Rev. Bioét. vol.29 no.1 Brasília Jan./Mar. 2021

Principlism in medical practice and ethical-professional lawsuits

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Abstract

This study aims to show the importance of the bioethical principles of Beauchamp and Childress, contributing to reiterate them in medical practices to reduce the exorbitant numbers of professional lawsuits brought about by iatrogenesis. Furthermore, the text tries to elucidate the phases these litigations undergo to give more information on the subject to the medical community. To this end, this research carries out a bibliographic review encompassing the Code of Medical Ethics, the Code of Ethical-Professional Litigation, as well as practical and modifiable resources applied to bioethical principles. We conclude that, besides being fair and beneficial to the patient, the practice of ethics-based medicine also serves to protect professionals from misinterpretations regarding their conduct.

Keywords: Codes of ethics. Civil rights. Bioethics. Principle-based ethics.

Resumo

Principialismo no exercício da medicina e em processos ético-profissionais

Este estudo objetiva mostrar a importância dos princípios bioéticos de Beauchamp e Childress e reafirmá-los na prática médica a fim de diminuir os números exorbitantes de processos ético-profissionais impetrados por iatrogenia. Além disso, busca-se elucidar as fases do processo de modo a informar a comunidade médica sobre seu andamento. Para tal, realiza-se atualização bibliográfica pautada no Código de Ética Médica, no Código de Processo Ético-Profissional e em guias práticos e dinâmicos aplicados aos princípios da bioética. Conclui-se que o exercício da medicina pautado na ética, além de ser justo e benéfico ao paciente, é também modo de resguardar o profissional de possíveis interpretações equivocadas sobre sua conduta.

Palavras-chave: Códigos de ética. Direitos civis. Bioética. Ética baseada em princípios.

Resumen

Principialismo en la práctica de la medicina y en los procesos ético-profesionales

El objetivo de este estudio es mostrar la importancia de los principios bioéticos de Beauchamp y Childress y reafirmarlos en la práctica médica, con el fin de reducir la exorbitante cantidad de procesos ético-profesionales provocados por la iatrogenia. Además, se busca dilucidar las fases del proceso ético-profesional para informar a la comunidad médica. Para ello, se realiza una actualización bibliográfica con base en el Código de Ética Médica, el Código de Proceso Ético-Profesional y guías prácticas y dinámicas aplicadas a los principios de la bioética. Se concluye que la práctica de la medicina basada en la ética, además de justa y beneficiosa para el paciente, también protege al profesional de posibles malas interpretaciones sobre su conducta.

Palabras clave: Códigos de ética. Derechos civiles. Bioética. Ética basada en principios.

Research

The authors declare no conflict of interest.

This article is motivated by the high number of ethical lawsuits to which doctors have been answering. Although these disputes can be avoided by respect for the patient, a measure that seem to have been "forgotten" by professionals, and in this sense it is time to reiterate them. The Code of Medical Ethics (CEM) [1] stands as a good basis for understanding and implementing such measures, avoiding ethical-professional lawsuits (EPL).

However, it is clear that the literature on the medical-legal theme, on the CEM [1] and on the Code of Ethical-Professional Litigation (CEPL) [2] is insufficient to provide guidance on this topic. This is because medicine and law bear little resemblance with each other. Besides this gap, it appears that, despite an obvious demand, there are no practical or dynamic guides promoting the application of bioethical principles to avoid legal actions. Thus, this study brings together all these concerns, providing a source of information for the medical profession and offering ethical grounds for medical practices.

Historically, ethics studies have stemmed from barbarities such as the Lübeck disaster in 1930, the Tuskegee study (untreated syphilis) in 1932, and the crimes committed during World War II under the guise of scientific progress [3,4]. The gaps in these studies, however, make it clear that what the Greeks understood as a moral philosophy required a more actionable perspective. Since the term "bioethics" first appeared and a specific field of knowledge was created, numerous codes and studies have been published. But only in 1979, in the classic work by Beauchamp and Childress, *Principles of biomedical ethics* [5], the basic principles governing contemporary bioethics were described: beneficence, non-maleficence, autonomy, and justice.

This poses the question: why continue discussing the morality of the medical profession if it has already been described? The answer lies in the mismatch between ideal and actual medical practices. In a context of extreme judicialization, these principles enable doctors and health professionals to protect themselves, respecting the patient's right for proactivity in the care process, treating them in a dignified way, seeking beneficial therapies, always considering the fine line between therapeutic advancement and processes that harms quality of life. Doctors' daily lives are filled with adversities and unpredictable outcomes that stand beyond scientific control and, under conditions of uncertainty, one must learn how to make moral decisions.

From the patient's point of view, the attitudes of professionals are not always transparent and, in this sense, their dissatisfaction can be justified. While legal actions are necessary as a way to police and report negligence, imprudence and medical malpractice, the number of claims associated with patient dissatisfaction regarding healthcare has been significant in the last years. To reduce these numbers, the principles of bioethics must be reiterated and put into practice. Simple adjustments to the conduct of professionals, based on these principles, would go a long way towards changing the patient's view of healthcare services.

Moreover, health workers often find litigation and its different phases confusing, and this tends to make them feel more insecure and anxious about the situation. Thus, a simplified guide about how such procedures work based on the CEPL [2] would be useful to help the medical community.

This is an extremely important topic for the practice of medicine, and this article aims to analyze the incidence of professional lawsuits ccording to data from the Superior Court of Justice (STJ) in Brazil. Based on this analysis, we also discuss ethics in medical practices to understand the reasons for the exacerbated number of cases. To this end, the article establishes a relationship between the legal and the bioethical approach, seeking to clarify most of the theme's issues and elucidate the EPL's legal course.

Materials and Methods

This study is a bibliographic review carried out during the first half of 2019. The data source was the STJ database, including legal proceedings brought forward from 2000 to 2014 [6]. Also analyzed were the CEM [1] and the CEPL [2], both available on the of the Federal Council of Medicine (CFM) website, as well as relevant articles in the field of ethics and bioethics, available in the Scientific Electronic Library Online. After analysis, we included relevant articles according to their approach and significant statistical data.

Data from the Superior Court of Justice

Iatrogenic practices are still quite frequent. According to law firm Assis Videira[6], data from the STJ indicate a substantial increase – above 300% – in the number of legal actions due to medical errors between 2001 and 2011, besides an increase of 180% in convictions. In 2014 alone, 299 cases were opened, 173 sentences were delivered, and 1,212 cases were in transit in the state of Minas Gerais[6]. Among the most cited adverse consequences are death, aesthetic damage, need for further surgery, and loss of organ or organ function. Among specialties, the ones with most cases in the STJ are gynecology/obstetrics, orthopedic trauma, and plastic surgery[6].

From 2013 to 2015, lawsuits increased by 11.2% in Minas Gerais, with 50.2% defendants being acquitted[6], indicating a growing and fearful phenomenon in the area: medicine as the main target of this "industry"[7]. According to Miguel Kfouri Neto[8], 80% of the actions against doctors are dismissed, which evidence an intent to protect the patient who demands reparations for moral damages by way of profit, since the association between certain outcomes and the exercise of medicine is often not taken into consideration, and it is not uncommon for the natural evolution of the patient's condition to be mistakenly interpreted as negligence.

The consequences of judicialization (financial losses, damage to name and honor, exposure to the sensationalist press) show that one needs to regard it as a serious matter, taking definite steps to prevent it. In this study, the analysis of the most frequent lawsuits and complaints led to the conclusion that the reiteration and understanding of ethical principles as drivers of medical practice comprise one of the most important forms of prevention. In this sense, besides benefiting the patient, an ethics-based medicine protects professionals from misinterpretations about their conduct.

Beneficence

One of the fundamental principles of the CEM states that *the doctor will maintain absolute respect for the human being and will always work for his benefit, even after the patient has died. Doctors are sworn never to use their knowledge to cause physical or moral suffering, to exterminate human beings, and to allow or cover up attempts against human dignity and integrity*[9]. In the same vein, the student invokes the Hippocratic Oath during the medical course: *I will use those dietary regimens which will benefit my patients according to my greatest ability and judgment, and I will do no harm or injustice to them*[10].

Aiming at the patient's well-being, these declarations should be part of the daily life of all health professionals. Simple practical examples of beneficence can be observed when the doctor pays attention to patients and the signs they manifest, or when the doctor understands what patients voices – both in terms of what the latter decide to show and what they merely imply, considering the social and cultural scenario of the individual in question. In case of a mutual disagreement, the physician's duty is to advise the patient to follow the path with more advantages, maximizing benefits and minimizing harms. Balancing beneficence and paternalism, physicians must maintain their authority, preserving knowledge and taking responsibility for their decisions. Patients, on the other hand, must make their choice according to the information that has been made available as well as their personal values[11].

Non-maleficence

The doctor must avoid causing harm to the patient, a principle from the Hippocratic aphorism *primum non nocere* (first, do no harm). In respect to Ancient history, it is interesting to mention that, before Hippocrates, Socrates argued that people who did evil did so because they did not know how to do good[12]. Applying this idea to the practice of medicine, we can say that the professional who acts in contradiction to the principle of non-maleficence – and consequently harms the patient's health – shows ignorance and lack of knowledge[12].

Certain therapies and diagnostic actions can cause discomfort or harm to patients. Thus, it is up to professionals to protect themselves by assessing the real need for a procedure. Generally, reflection on beneficence focuses on the decision to perform a certain intervention, while the principle of non-maleficence refers to the possibility of abstaining from or limiting it. As an ethical impasse stemming from abstention, the question of double-effect should be considered: "should I cause some harm in order to

 http://dx.doi.org/10.1590/1983-80422021291450

obtain a greater benefit?" A classic example involves the high risk of treatment for Hodgkin's disease. In this case, the fact that without treatment the patient has little chance of survival leads one to conclude that the principle of non-maleficence is relative [13].

Discussing this principle is an extensive and complex endeavor. Another important aspect is the right to a dignified death, which is still taboo, and for this very reason should be widely debated. The role of doctors is undoubtedly to cure, focusing their diagnostic and therapeutic actions on the patient's needs; however, it is also their duty to recognize the limited and finite character of each being. Therefore, part of this professional's journey involves talking openly with families in order to question therapeutic obstinacy. "Do no harm," in this case, means to save the patient from a survival through machines and without any quality of life [14].

Autonomy

In article 31, CEM prohibits the physician from *disrespecting the patient's or the patient's legal representative's right to freely decide on diagnostic and therapeutic practices, except in case of imminent risk of death* [15]. "Autonomy" here means the possibility to choose, without internal or external coercion, between the presented alternatives. Except when there is an imminent risk of death, patients must have complete freedom to decide what procedures they are willing to undergo, transferring the right of choice to their legal representatives when they cannot choose for themselves.

To respect patient autonomy, doctors must remember that the sick have a voice: anyone in control of their mental faculties has the right to choose their treatment, and in no way should such a person be subjected to negligence, discrimination, violence or cruelty. Decisions must be made together with patients or, in some cases, with their legal guardians, considering all possible points of view and accepting that the chosen course of action is subject to change.

It is extremely important to register all the information in the medical record, taking note of the adopted course of action to allow for future consultation, if necessary. Furthermore, all procedures should be authorized by a full informed consent form [16], with every step of the procedure being explained to the patient and their family members or guardians, even when the health professional's suggested treatment ends up being refused.

Justice and equity

It is difficult to distinguish the principle of justice from the principle of equity, since both derive from the ethical obligation to treat each individual according to what is morally correct, giving each person what they are due. To be ethical, in this sense, is to act and work towards a healthy doctor-patient relationship, regardless of cultural, social, financial or religious aspects. To be just is to impartially offer knowledge and resources, without providing these valuable assets only to specific groups. It is important for patients to have a sense of the professional's dedication and interest in their stories, receiving the attention they are due [17].

The materialization of these principles in medical practice is a delicate issue, since the social application of justice and equity is still a far cry from present-day Brazil. In this sense, equitable care will only cease to be utopian when society becomes less unequal [17]. Until then, medical practice must find ways to adapt and meet certain standards of conduct.

Professional lawsuit

Even doctors who act according to CEM principles can be sued, as every patient who feels harmed has the right to seek justice through an internal investigation. Legal proceedings may be opened by the CFM or by the Regional Council of Medicine (CRM), as a way to assess the allegation and, if necessary, move forward with an ethical-professional action [18]. If the professional has acted in accordance with ethical principles and nevertheless the internal investigation goes ahead, it is advisable to limit one's responses to the complaint itself, explaining the event while providing all the evidence necessary to develop a brief [19]. This evidence encompasses documents, justifications and up to five witnesses, assembled with the aim of providing as much information as possible to prevent the establishment of the legal action [19]. The law does not requires the presence of a lawyer, but at this point it is important to contact a specialist to prepare one's defense and present evidence.

The internal investigation is analyzed by a specific chamber; for it to be instituted, there must be a written or verbal complaint, containing the full identification of the complaint's author. The complaint is then directed to the CRM, where it is evaluated by a magistrate, and it can be archived in case of plaintiff withdrawal or at the discretion of the Council chamber, as long as it is not a case of alleged serious bodily injury, sexual harassment or patient death. In such cases, the investigation will be assessed in accordance with the Penal Code [20], and under no circumstances will anonymous reports be accepted. Ethical-professional responsibility is independent from criminal responsibility, meaning that even if the Penal Code [20] is applied in the trial, the legal action will proceed normally and the doctor will be subject to punitive measures in the professional sphere [18].

With the internal investigation, the magistrate will appoint an internal-investigation advisor who will present a conclusive report identifying the involved parties, describing the facts, correlating events with possible CEM infractions and finally indicating whether or not the code was violated [18]. This report will be forwarded for analysis with the aim of proposing one of the following outcomes: conciliation; consent decree; archival (if no evidence of violation is identified); establishment of a legal action (if evidence of CEM violation is indeed found), combined or not with a proposal for precautionary interdiction [18].

Conciliation between the parties can only occur in cases unrelated to serious bodily injury, sexual harassment or patient death, and must be proposed by a council member or another member of the chamber. No conciliation proposal will be allowed after approval of the conclusive investigation report. If a proposal is brought forward, no appeal will be allowed after its approval by the investigation chamber. If conciliation is unsuccessful, the procedure will resort to a consent decree [18].

The consent decree is an official act by which individuals or legal entities recognize they have committed an offense against individual or collective ethical interests, assuming, before a legitimate public body, the commitment to eliminate the offense or risk by adapting their behavior, in compliance with legal and ethical requirements [18]. This confidential agreement establishes the physician's commitment to comply with mandatory clauses, imposes criteria for proper behavior, establishes the suspension of the internal investigation in accordance with statutory deadlines, and defines methods for monitoring the assumed goals and obligations [18]. CRM is responsible for monitoring compliance with the consent decree, whose failure to comply implies the opening of an legal proceeding. The doctor who adheres to a consent decree will be prevented from signing another agreement of this kind for a period of five years [18].

The precautionary interdiction of the professional whose action or omission is generating harm or risk of harm to the patient or the population may occur only after a majority vote by the CRM board. Interdiction implies total or partial impediment to practice medicine, becomes effective immediately, and may only be lifted after final judgment. It is valid for the entire national territory and must be published in the Official Gazette as well as in communication means belonging to the medical boards. This publication must include the identification of the involved parties, and the healthcare establishments where the doctor carries out activities must also be informed. The judgment of the legal action must take place within six months, with a single six-month extension being allowed [18].

Once established, the lawsuit cannot be extinguished by applicant withdrawal – in this case, the process will continue regardless (*ex officio*). Denounced physicians are informed by an arraignment letter, a document that have their full name, home or professional address, purpose of the arraignment, deadline, and place for presentation of the brief. As we have already discussed, this will be an opportunity for the accused to offer documents and justifications, specifying the evidence and appoint up to five witnesses. Illicit evidence, that is, evidence that violates constitutional or legal norms, will be inadmissible [18].

Subpoenas are then forwarded to witnesses, involved parties and lawyers. The document must contain a description of the subpoenaed person, a note of acknowledgment and the place and time of the pre-trial hearing, to which all must attend and will start after identifying and qualifying all parties. At the end of the hearing, a ruling is discussed among council members. Upon reaching a conclusion, the ruling is made with the exclusive

presence of the involved parties and the defense, as well as the members of the CRM, a member of the CRM's legal counsel, and operational employees of the Court of Medical Ethics [18].

The penalty inflicted on the medical professional (if any) is decided by a vote by CRM or CFM council members. Possible disciplinary penalties are the following: 1) confidential warning in private notice; 2) confidential reprimand in private notice; 3) public reprimand published in the official press; 4) suspension of professional practice for up to 30 days; 5) CFM revocation of license to practice medicine [18].

The first two sentences are private (society at large is not informed of the penalty). They will be formally communicated to the offending professional and recorded in the medical record referring to the infraction. The last three are published in the respective Official Gazette publications of the state in question, the Federal District and the Country, in widely circulated newspapers, and on the CRM website. They are also included in the medical record of the offending doctor, in order to inform society that the professional has been subjected to an ethical condemnation. In the case of the last two sentences (suspension and revocation), the doctor's professional and identity cards will be seized. When professional practice is revoked and this penalty is corroborated by the CFM, the doctor can no longer practice medicine in Brazil. However, upon receiving the sentence, professionals who are innocent or dissatisfied with the penalty may appeal to the CFM [19].

The punishment for ethical violation prescribes in five years, counting from the date the CRM was made aware of the fact. An internal investigation or lawsuit that has remained inactive for more than three years will be archived *ex officio* (without request by the involved parties) or at the interested party's request [18]. Except in case of revocation of professional practice, rehabilitation may be petitioned by the doctor to their respective CRM after eight years of serving the sentence, as long as the professional has not suffered another penalty during that period [18].

Final considerations

The growth in medical lawsuits points to the need for understanding and exercising principlist bioethics. This means to act consistently in benefit of patients, avoiding harm, respecting their rights, and seeking equity. Considering the complexity of medical practice, measures must be taken to ensure an increasingly ethical healthcare. By strict observance of these principles, professionals will be protected from legal actions in response to their behaviors. Nevertheless, to maintain composure if the action is indeed brought forward – with consequences ranging from warnings to revocation of professional license –, it is crucial to understand its phases and general course.

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Received: 1.7.2020
Revised: 1.28.2021
Approved: 1.29.2021

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