

Overview of physicians submitted to ethical proceedings in Paraíba, 2010–2020

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Abstract

This study analyzes the profile of physicians reported to the Regional Medical Council of the State of Paraíba and the outcomes of professional ethical proceedings conducted between 2010 and 2020. Based on anonymized data provided by the regulatory authority, the following variables were analyzed using a qualitative and quantitative approach: number of proceedings and convictions, type of sanction imposed, physicians' age group, years since graduation at the time of judgment, medical specialties, the presence or absence of a complainant as the plaintiff in the proceedings, and the presence or absence of legal counsel representing the physician. Most sanctioned physicians were men, with a normal distribution regarding age and years since graduation, and without a registered medical specialty. Regarding the conviction rate, only 20.51% of the physicians reported were ultimately found guilty, reinforcing the regulatory authority's cautious approach to avoiding frivolous or unwarranted convictions.

Keywords: Liability, legal. Legal process. Ethics, professional.

Resumo

Panorama dos médicos julgados eticamente na Paraíba, 2010 a 2020

Este estudo analisa o perfil de médicos denunciados no Conselho Regional de Medicina do Estado da Paraíba e o resultado de processos ético-profissionais entre 2010 e 2020. Com base em dados anonimizados, disponibilizados pela autarquia de fiscalização, foram analisadas, de forma qualiquantitativa, as seguintes variáveis: quantidade de processos e condenações, tipo de pena aplicada, faixa etária dos profissionais, tempo de formação no momento do julgamento, especialidades dos profissionais, existência ou não de denunciante no polo ativo do processo, existência ou não de advogado na defesa do médico. Em sua maioria, os condenados são homens, com distribuição normal em relação a idade e a tempo de formação e sem especialidade registrada. Em relação ao índice de condenação, apenas 20,51% dos médicos denunciados são efetivamente condenados, o que reforça a cautela autárquica em evitar condenação frívola e banalizada.

Palavras-chave: Responsabilidade legal. Processo legal. Ética profissional.

Resumen

Panorama de los médicos juzgados éticamente en Paraíba, 2010-2020

Este estudio analiza el perfil de los médicos denunciados ante el Consejo Regional de Medicina del Estado de Paraíba y los resultados de los procesos ético-profesionales entre 2010 y 2020. Con base en datos anonimizados proporcionados por la entidad reguladora, se analizaron, mediante un enfoque cualitativo y cuantitativo, las siguientes variables: número de procesos y condenas, tipo de sanción aplicada, grupo etario de los profesionales, tiempo transcurrido desde la graduación al momento del juicio, especialidades médicas, existencia o no de denunciante como parte actora del proceso y existencia o no de abogado en la defensa del médico. En su mayoría, los médicos condenados son hombres, con una distribución normal en cuanto a la edad y al tiempo de formación, y sin especialidad registrada. En relación con la tasa de condena, solo el 20,51% de los médicos denunciados fueron efectivamente condenados, lo que refuerza la cautela de la entidad reguladora para evitar condenas frívolas o banalizadas.

Palabras clave: Responsabilidad legal. Proceso legal. Ética profesional.

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In professional practice, physicians are liable to three types of responsibility: civil, criminal, and professional ethics. Civil liability obliges physicians to repair damages improperly caused because of professional conduct. Criminal liability, also called penal liability, subjects physicians to criminal justice for the commission of defined offenses, such as criminal infractions.

The Judiciary is responsible for investigating facts related to civil and criminal liabilities, while the hierarchical structure of the Councils of Medicine—the Federal Council of Medicine (CFM) and the Regional Councils of Medicine (CRM)—is responsible for issues related to professional ethics liability, as per the Code of Medical Ethics (CEM)¹. Thus, it is understood that physician practice is subject to broad oversight and judgment by both the Judiciary and the Councils of Medicine.

In the sphere of professional ethics liability, the CRMs are responsible for receiving, investigating, and judging all complaints against medical professionals, within the scope of each federative state where the physician is registered, at the time of the punishable act or its occurrence. Thus, when reported, physicians are subject to investigation of the complaint, which basically consists of two phases: the administrative inquiry and the initiation of professional ethics proceedings, as per regulation established by the Code of Professional Ethics Procedure (CPEP)².

The professional ethics proceeding is the manifestation of one of the most important functions of professional oversight councils: peer judgment. This administrative judgment aims to ensure that the accused professional is judged according to the dictates of ample defense and adversarial proceedings, to, at the end, declare them innocent or guilty of the accusations, as per article 91² and following ones of the CPEP.

Since 1957, the CFM and the CRMs have operated in Brazil under a system of state decentralization, as they are not to be confused with established public entities, since they are legal persons of public law with their own legal personality, with guaranteed administrative and financial autonomy.

Law 3,268/1957 establishes, in its art. 15, “d,” that one of the main functions of CRMs is to

*know, appreciate, and decide matters concerning professional ethics, imposing the applicable penalties*³. The duty-power of the CRMs/CFM is to judge registered medical professionals, in order to analyze whether their conduct aligns with the deontological aspects of the profession, so as to avoid eventual harm to the community⁴.

The ethical proceedings involving physicians follow the regulations provided for in the CPEP², being initiated with the filing of a complaint and the opening of an administrative inquiry, a preliminarily fact-finding investigation into any indications of an ethical violation. The complaint can be initiated upon request of an interested party (patient, family member, legal entity, specialty society, health insurance provider, Public Prosecutor’s Office, Civil Police, or others) or it can be initiated ex officio, when the CRM of the locality where the event occurred, with or without a request, assumes active jurisdiction sua sponte, that is, there is no “external” complainant, as per article 14 of the CPEP².

Traditionally, CRMs registered complaints as ex officio when they originated from public organs that did not have their own legal personality or in the event that the complainant requested an assessment of a certain life event by the Council, without, however, seeking effective participation as a complainant. In other words, sometimes the “reporter” was merely a body or person that desired a position from the CRM/CFM on a potential ethical offense, but had no specific interest in the penalization of the professional, only an indirect interest.

The administrative inquiry phase—equivalent to a police investigation in the criminal sphere—seeks only to find sufficient cause for its conversion into a professional ethics proceeding, that is, the materiality of the fact and indications of authorship. In this initial investigative phase, there is neither ample defense nor adversarial proceedings, as it is an inquisitorial procedure; thus, there is no need for a hearing with the professional for conclusion of the administrative inquiry. However, it is necessary to emphasize the importance of this pre-procedural phase, as the judgment on the administrative inquiry report will guide the entire eventual evidentiary stage,

with indication of potential violated articles and description of the correlation with the acts under investigation, thus binding all subsequent phases of development of the litigation.

The conclusive administrative inquiry report, duly substantiated, is submitted for consideration of the administrative inquiry chamber, which may: dismiss the case due to unsubstantiated accusation, convert it into an ethical proceeding—including the proposal for a precautionary suspension of medical practice, to be assessed by plenary session of the CRM—propose and ratify the conciliation of the parties, ratify the conduct adjustment agreement, or initiate an administrative proceeding to investigate the disabling disease of the physician, if applicable.

After the administrative inquiry review chamber decides to initiate a professional ethics proceeding, the initial opinion must include the facts and the classification of the eventual ethical offense(s), based on the CEM in force; there is appointment of an evidentiary counselor who will coordinate the evidentiary stage, in which the parties, now referred to as complainant and respondent, have equal opportunities to present evidence for prosecution and defense.

Once the evidentiary stage is concluded, after the parties present their final arguments, a rapporteur counselor is appointed, who will be responsible for drafting a report after a detailed analysis of the case files. After receipt of the rapporteur counselor report, the judgment is scheduled and held in a setting with full privacy to preserve proceeding confidentiality, permitting only the presence of the parties and their attorneys (lawyers), whether by means of an in-person or virtual meeting.

The disciplinary penalties applicable by the CRMs to their members are those provided for in the items of art. 22 of Law 3,268/1957³: a) confidential warning in a private notice; b) confidential censure in a private notice; c) public censure in an official publication; d) suspension of professional practice for up to 30 days; and e) revocation of professional practice *ad referendum* of the CFM. In case any penalty is imposed, an appeal can be filed by any of the parties.

With the objective of determining professional responsibility, ethical defense in

the ethical-professional proceedings does not need to be provided by a lawyer, according to Binding Precedent 5, which establishes that *the lack of technical defense by a lawyer in the administrative disciplinary proceeding does not violate the Constitution*⁵. Thus, professionals can present their own defense, without the requirement of a constituted technical defense.

Complaints against physicians in the state of Paraíba have progressively increased over the years. According to records of the Internal Affairs Department of the Regional Council of Medicine of the State of Paraíba (CRM/PB), between January 1, 2010 and December 31, 2020 there were 312 professional judgments.

This increase in ethical-professional judgments in the last decade, whose characteristics as to sociodemographics and technical-scientific training are unknown, justifies the relevance of the present study in analyzing the profile of the reported professionals. We believe that, based on the analysis of the data found, educational measures could be implemented to prevent failures, decrease complaints, and thus improve good medical practice.

The proposal is to use a literature review and a qualitative and quantitative analysis to analyze the profile of the actors involved in the proceeding phase, that is, the physicians reported and judged within the scope of the CRM/PB between January 1, 2010 and December 31, 2020. The methodology consists in a descriptive retrospective study, based on categorical and numerical data related to the variables of professionals judged and/or convicted by the CRM/PB in the indicated period. To this end, documents and judgment minutes concerning the proposed period were analyzed, after prior processing and anonymization of the data by CRM/PB.

This study was previously authorized by the CRM/PB and, pursuant to art. 1, V, of the National Council of Health (CNS) Resolution 510/2016⁶, it was not submitted to the research ethics committee (REC) and National Commission for Ethics in Research (CONEP) system, as the data were previously aggregated by the CRM/PB and made available to the authors without the

possibility of identifying the subjects involved in the ethical-professional proceeding (EPP).

Regional Council of Medicine of the State of Paraíba: reality

The CRM/PB is currently considered a medium-size a Council of Medicine, as it has the 14th largest medical population in Brazil, the highest medical density in relation to the total population in the Northeast region, and the 11th medical density in Brazil⁷.

Considering the time frame between 2010 and 2020, it is necessary not only to show the current factual situation but also the situation at the beginning of the time series. However, given the scarcity of research on the issue, we used as a basis the first study on the issue published by the CFM in partnership with the Regional Council of Medicine of the State of São Paulo (CREMESP) in 2011⁸ and the data from 2020⁷; the comparative profile of the medical class is presented in Table 1.

Table 1. Comparative profile of the medical class between 2011 and 2020

Profile of the medical class in Paraíba	2011	2020
Number of registered professionals	4,886 (15th in the country)	8,194 (14th in the country)
Ratio of physicians/100,000 inhabitants	1.30 (16th in the country)	2.04 (11th in the country)
Men	55,90%	51,50%
Women	44,10%	48,50%
General practitioners	43,50%	43,30%
Specialists	56,50%	56,70%
Mean age	48.8	44.8

Source: Scheffer, Biancarelli and Cassenot⁸; and Scheffer⁹.

The table shows that, in the period of almost ten years, Paraíba evolved in the ratio of physicians per 100,000 inhabitants; however, in terms of changes in the ratio between men/women and general practitioners/specialists, there was little significant change. As for mean age, especially due to the increased number of medical schools in the state—since Paraíba currently has nine medical

programs, with three public and six private—the medical population exhibits a decreased average age, with a reduction of four years in the average age of registered professionals.

Regarding the judicial operation of the CRM/PB, it is important to note that the regulatory authority, in the exercise of its competence and administrative autonomy, judges ethical cases directly in the Plenary Court of the Regional, as no judgment chambers have been created, as per article 11 of the CPEP².

After the above general considerations, the profiles of reported and convicted professionals are presented below.

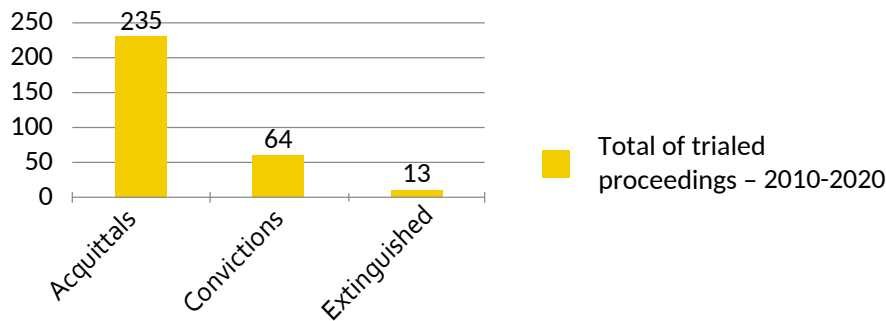
Results

Between January 2010 and December 2020, the CRM/PB judged 222 professional ethics cases, involving 283 physicians. Of these 283 judged physicians, 22 professionals appeared as respondents in more than one proceeding. We observed the following distribution of reported physicians: 261 physicians were respondents in only one proceeding, 18 physicians were respondents in two proceedings, two physicians were respondents in three proceedings, one physician was a respondent in four proceedings, and one physician was a respondent in five proceedings, for a total of 312 occurrences.

Regarding the conversion of judged professionals into professionals convicted in the first instance, conviction occurred in 20.51% of the cases: of the 312 judged professionals, 64 were convicted by the Plenary Session of the Regional Council of Medical Ethics of the CRM/PB; 235 (75.32%) were acquitted; and 13 (4.17%) had their cases dismissed, including cases with a diagnosis of permanent disabling disease, death of the professional, or expired statute of limitations.

Considering proceedings dismissed due to identification of a supervening fact, such as death or diagnosis of a disabling disease, as well as expiration of the statute of limitations, which does not represent an acquittal per se, the number of proceedings judged with a review of medical conduct is reduced to 299 occurrences, with a 21.40% conviction rate, according to the research data.

Graph 1. Number of professionals judged and convicted by the CRM/PB between 2010 and 2020



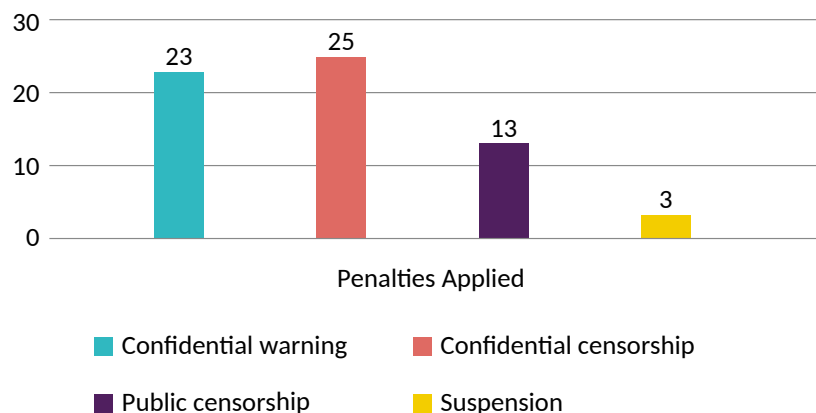
The apparently low conviction rate in proceedings, rather than representing a supposed professional esprit de corps, reinforces the understanding and “prejudice” of medical blame culture and summary professional judgment¹⁰⁻¹². The reports are based on a presumption of professional guilt, so, given the nature of the administrative inquiry and the duty to merely ascertain sufficient cause (materiality of the fact and indications of authorship), the proceedings do not eliminate the presumption of innocence; thus, reported professionals are not automatically convicted.

As for convictions, Law 3,268/1957³ establishes that there are five penalties applicable to physicians: confidential warning in a private notice; confidential censure in a private notice; public censure in an official publication; suspension of professional practice for up to 30 days; and revocation of professional practice, *ad referendum* of the CFM. As for the nature and type of penalties,

Barros Júnior¹³ notes that medical penalties are unconstitutional, as there is no aprioristic correlation between ethical infractions and penalties, while Behrens¹⁴ notes that the flexibility provided by the regulation enables effective adaptation and observance of the principles of reasonableness and proportionality to the concrete case, as established in Law 3,268/1957³, which requires gradation of penalties according to the gravity of the offence.

As for the distribution of penalties applied by the CRM/PB, it was observed that there was a higher incidence of private penalties, understood as those that are not publicized and whose knowledge is restricted to the parties involved in the proceeding and the judges, while public penalties, such as public censure, suspension, and revocation, are published in public notices, the official gazette, local circulation newspapers, and on the internet. That can be apprehended from the following graph.

Graph 2. Penalties applied to convicted professionals



The maximum penalty of revocation, within the scope of the CRM/PB, was not applied in the researched period, a fact also observed in previous studies in the CRM/PB and in other regional federations¹⁵⁻¹⁷. Similarly, the condemnatory distribution is distinct from the profile observed for the Regional Council of Medicine of the State of Pará (CRM/PA), for example, since public penalties (subparagraphs “c,” “d,” and “e”) corresponded to 57.14% of the convictions, while the Paraíba context shows a higher incidence of private penalties (subparagraphs “a” and “b”), corresponding to 75%¹⁸. On the other hand, compared to the study in the CREMESP, there was a high incidence of the revocation penalty¹⁹.

Of the 312 occurrences, in 240 the reported professionals were men, corresponding to 76.92%, while 72 of the respondents were women, corresponding to 23.08%. These data deviate from the distribution of the total number of physicians, as between 2011 and 2020 the ratio of men fluctuated between 55.9% and 51.5%, which denotes a higher absolute and proportional occurrence of professional ethics proceedings against men than women, a fact already observed^{15-17,20}.

Regarding the profile of those convicted, there was a prominence of men, representing 54 out of the 64 total convictions, that is, 84.38% of the number of convicted individuals.

The data obtained regarding the age distribution at the time of judgment show a change compared to the age profile obtained in a study¹⁷ covering the period between 1999 and 2009, in which the largest age group reported was 50 to 59 years (32.4%), and 40 to 49 years (31.3%), while, in the period between 2010 and 2020, the profile is more centered on professionals aged 40 to 49 years (25.33%) and 60 to 69 years old (25.32%).

Synthetically, it can be formalized the following ratio between respondents/convicted individuals distributed among age groups: up to 29 years (2/0), 30 to 39 years (59/10), 40 to 49 years (80/14), 50/59 years (68/17), 60 to 69 years (79/18), 70 to 79 years (21/4), and 80 to 89 years (3/1).

Regarding the time since graduation at the time of judgment, the sample distribution can

be summarized as follows, considering the time since graduation of respondents/convicted individuals: up to 10 years (41/7), between 11 and 20 years (75/14), between 21 and 30 years (71/15), between 31 and 40 years (100/23), between 41 and 50 years (22/5), and between 51 and 60 years (3/0).

Comparing the results obtained in the 1999–2009 and 2010–2020 time frames, there is a slight change in the profile of respondents, with the professionals exhibiting higher experience and practice time. These data reinforce that the aging of the profile of respondents is correlated to a generational issue, and not precisely to the age group¹⁵.

The time since graduation, in principle, is not immediately correlated with the specialty registration. It is important to note that Law 3,268/1957³ establishes that medical professionals, once registered, can practice in any medical specialty. CFM Resolution 1,627/2001²¹ states that medical professionals are complete physicians, so any registered specialty only enriches the professional, without, however, diminishing their technical capacity or limiting their practice in other areas. However, to guarantee the publicizing of up to two specialist registrations, the professional must previously register the title with the CRM and obtain the Specialist Qualification Registration (RQE).

Thus, the disclosure of the medical specialties of the respondents and convicted individuals does not imply an immediate correlation with the alleged ethical infraction, as the professional may practice in any specialty, including one different from the registered one.

There was an asymmetric distribution of specialties between reported and convicted professionals. The areas with the highest number of reports were gynecology and obstetrics (45 respondents), general surgery (24), psychiatry (22), internal medicine (18), and pediatrics (16). Regarding the convictions, it is noted that gynecology and obstetrics had only two convictions, while general surgery presented seven, followed by internal medicine, with four, anesthesiology, also with four, and orthopedics and traumatology, with three.

Other specialties with recorded convictions were acupuncture (1), cardiology (1), cardiovascular surgery (1), oncological surgery (1), coloproctology (1), dermatology (2), homeopathy (1), occupational medicine (1), nephrology (1), and neurosurgery (1).

Some areas presented reports, but not convictions, such as digestive tract surgery, pediatric surgery, thoracic surgery, diagnostic imaging, endoscopy, infectology, family and community medicine, physical medicine and rehabilitation, intensive care medicine, neurology, ophthalmology, radiology and diagnostic imaging, rheumatology, and urology.

Finally, it is observed that the group identified as “no specialty” accounted for 124 reports, of which 34 resulted in convictions—the largest absolute number in both categories. These data indicate that, although certain specialties concentrate more reports, the conviction rate is not necessarily proportional to the volume of reports and, therefore, they reveal relevant variations between areas.

Regarding the means of initiation of the professional ethics proceeding, it was observed that 28 of the proceedings with convictions had a complainant, while 36 of them had no constituted complainant. Regarding the absence of a complainant, it is important to note that the CRM and CFM consider complaints filed by the Public Prosecutor’s Office, Civil Police, ANVISA, AGEVISA, health departments, ethics committees, and other organs and entities to fall under *ex officio*, as they do not actively participate in the evidentiary stage, but merely formulate and report a possibly unethical act and allow the development of the proceeding by the CRM/PB.

Regarding the existence of lawyers as duly appointed defenders of the convicted physicians, it was observed that in 62.5% of cases the professional had technical assistance, while in 37.5% the convicted physician did not have a lawyer, without this representing any procedural nullity. Technical defense is not a mandatory instrument, being guaranteed only in cases of default, as per art. 44 of the CPEP². Regarding the specific context of the CRM/PB, the regulatory authority appoints an *ad hoc* attorney among those previously registered

professionals, as provided for in CRM/PB Resolution 178/2017²².

In the specific case, despite the impossibility of measuring the real contribution of lawyers to the success or failure of proceedings, it is necessary to emphasize that it is not recommended to have a defense without a lawyer, especially specialized defense, even if possible, as *self-defense in law is to law as self-medication is to medicine, a disaster*²³. In the same way that specialized practice is required from medical professionals, a specialized professional should be sought for the conduct of technical defense.

Final considerations

The analyzed data reveal that the CRM/PB physician culpability profile corresponds to male physicians, aged 40 to 69 years, with 31 to 40 years since graduation, not being significant to have a RQE, as the profile of convicted individuals followed the percentage of specialist physicians.

Participation in a medical residency program cannot be confirmed as a factor that interferes with the results, given that, physicians in effective practice in a medical area until April 1989 were permitted to register that specialty without having actually participated in those programs. Thus, considering the average time since graduation of the profile of those found guilty, it is not possible to determine the level of interference of medical residency in relation to the ethical practice of medicine. However, in comparison with the study of Santos, Souza, and Fernandes¹⁷ it was observed that the profile of the reported physician aligns with the same group of people previously studied, with the profile of those reported/convicted having aged along with the studied period.

The major difference between the sexes is also notable. Men represent 80% of those reported and convicted, while women represent only 20%. There was no study on other characteristics related to sex (time since graduation, age, holding of a specialist title, participation in a medical residency program, infraction capitulation, or penalty applied),

which may be the subject of a future study; however, it is evident that female physicians, despite being almost 50% of the medical population in Paraíba, show low representation in the list of defendants in the CRM/PB.

Other highlights include the fact that the respondents are first-time offenders and the low reprehensibility of the medical conduct under investigation, as 75% of the penalties applied correspond to private penalties, provided for in subparagraphs “a” and “b” of art. 22 of Law 3,268/1957³. The application of such penalties, in accordance with the penalty gradation criterion provided for in paragraph 1 of the aforementioned article, demonstrates that, in the vast majority of cases, the infractions committed did not prove major affronts to medical ethics or repeated unethical conduct by a particular professional, as indicated by the low recidivism rate of approximately 7.77%.

It should be emphasized that the judicialization of medicine, a phenomenon that has been growing daily, should not result in a blame culture against the medical profession. Poor medical outcomes do not, for the most part, directly result from physician practice. Factors outside physician control are major contributors to undesirable outcomes, such as endogenous conditions of patients/pathogens and lack of appropriate infrastructure for ethical medical practice—especially in public health care services.

It is true that, since the implementation of the Brazilian Unified Health System (SUS), patient care has improved; however, unfortunately, it is still far from ideal. The statistics on the number of existing beds compared to the minimum recommended by the World Health Organization

provide one of the many indicators of the quality of health care services.

The technical defense of the respondents is recommended in any proceeding within the scope of ethics courts. For physicians, the figure of the lawyer represents security that the decisions made are as fair as possible regarding the conduct indicated as unethical, and the belief that lawyers must obtain acquittal, at any cost, for the client should not be fostered. One of the possible observations on the data obtained in this study is that technical defense was present in few cases and, most likely, in the most complex ones. As stated elsewhere, it is not possible to reliably measure the success of lawyers in demands within the scope of the CRM/PB; however, considering the penalties applied, there was certainly a contribution from them, aiming for justice for the parties in ethical proceedings.

However, the most important point to be demonstrated is that medicine continues to enjoy a good social standing. Its practitioners must have respect, honor, and ethical commitment to the patient. Considering that only a minority of professional ethics proceedings result in conviction by the Regional Court of Medical Ethics of the CRM/PB, it is evident that the rule is still the responsible, prudent, and morally committed practice of the profession. These data do not eliminate the need for permanent institutional oversight; however, they reinforce that the identity of medicine remains founded on values of dignity, responsibility, and public trust, which should continue to guide both the individual conduct of physicians and the corrective operation of the Councils.

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