Medical liability and judicialization in the relationship between doctor and patient

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Abstract

This paper presents a theoretical discussion followed by a proposition about the problem of *excessive judicialization* of the relationship between doctors and patients. It points out the transposition of the power of medicine for law in a process of growth regarding the number of avoidable demands that ignore social debate, favorable to the emancipatory design provided by dialogue and ethical reflection. We discuss medical liability and the *medical power* in an asymmetric structure to the patient regarding a correlation between power and knowledge placed in the speech according to Foucault's approach. Following that, we point out the right to equality, in accordance with human rights, suggesting the implementation of such ideas in the social and medical education in order to value the roles of *patient* and *doctor* as active subjects of the attempt to achieve consensus, aiming to observe the principles of the Universal Declaration on Bioethics and Human Rights.

Key words: Bioethics. Professional responsibility. Professional power. Patient rights. Addresses. Medical education.

Resumo

Responsabilidade médica e judicialização na relação médico-paciente

Neste artigo é realizada uma reflexão teórica seguida de proposição a respeito do problema da *judicialização excessiva* na relação entre médicos e pacientes. É apontada a crescente transposição de poder da Medicina para o Direito, evidenciada no número de demandas evitáveis em desatenção ao debate social, favorável ao desígnio emancipatório propiciado pelo diálogo e reflexão ética. Discute-se a responsabilidade médica e o *poder médico* em uma estrutura de assimetria para com o paciente, tendo em vista a correlação poder e saber, colocados no discurso segundo a abordagem foucaultiana. Aponta-se seguidamente, o direito à igualdade, em conformidade aos direitos humanos, e sugere-se a implementação destas reflexões no meio social e na educação médica para valorização dos papéis do *paciente* e do *médico* enquanto sujeitos ativos da tentativa de consecução de consensos tendo em vista a observância dos princípios da *Declaração Universal sobre Bioética e Direitos Humanos*.

Palavras-chave: Bioética. Responsabilidade profissional. Poder profissional. Direitos do paciente. Discursos. Educação médica.

Resumen

Responsabilidad médica y judicialización en la relación entre médico y paciente

En este artículo es realizada una reflexión teórica seguida de una proposición sobre el problema de la *judicialización excesiva* en la relación entre médicos y pacientes, que apunta al creciente trasvase del poder de la medicina al Derecho, evidenciado en el número de las demandas evitables en desatención al debate social favorable al designio de emancipación a través del diálogo y la reflexión ética. Se discute la responsabilidad médica y el *poder médico* en una estructura asimétrica para con el paciente con respecto a la correlación entre el poder y el saber en el discurso con un enfoque foucaultiano. A continuación, se enseña el derecho a la igualdad conforme a los derechos humanos, y se sugiere la implementación de estas reflexiones en el medio social y en la educación médica para valorización de los papeles del *paciente* y *del médico* como sujetos activos en el intento de lograr un consenso con el fin de observar los principios de la *Declaración Universal sobre Bioética y Derechos Humanos.*

Palabras-clave: Bioética. Responsabilidad profesional. Poder profesional. Derechos de los pacientes. Discursos. Educación médica.

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The *medical liability* issue has been widely discussed in Brazil in the past few years, especially after the increase in the number of lawsuits involving doctors in regular courts.

The quantity of administrative processes has also increased in the scope of ethical and disciplinary proceedings before the regional councils of medicine [1]. This context, in which one can possibly find positive aspects, as it represents the growth of citizenship in the quest for access to justice, can also bring negative aspects when it tends to indicate an *excessive judicialization* of medicine, with growth in the number of avoidable demands upon ethical reflection and dialogue.

This topic is of paramount importance in the bioethical analysis of the physician-patient relationship. To better understand the meaning of this reflection, the meaning given to *liability* will initially be defined so that we can then examine briefly the power, asymmetry and judicialization in the relationship between doctors and patients.

Liability in its moral and legal senses

While morally one can classify the *diligent* doctor as *responsible*, legally you can also adjectivize the *negligent* doctor as *responsible* for negligence. This antagonistic polysemy arises from the substantial semantic differentiation that common sense and the legal area give to the term: as the socially established vocabulary is used, the morally accepted meaning is employed to conceptualize a responsible individual as one who acts with zeal, wisdom, moderation, expertise. There is, thus, the professional who works while caring for the patient and for healthcare and one can morally adjective him as a *responsible physician*.

In parallel, legally the situation may be verified differently, arising from the failure to fulfill a previous obligation – to do or not to do. In the actual case of the doctor, it refers to the circumstance of required confirmation of guilt that will generate, therefore, a duty of reparation. It is in this sense that Cavalieri Filho says that liability *is a successive legal duty, consequent to the breach of the first* [2], the obligation, which is the original legal duty.

If the obligation is breached, the legal liability arises. Thus, the physician who is legally *accountable* is the one who erred; the one that, more precisely, acted with guilt [3], be it characterized as incompetence, recklessness or negligence, and has a duty to respond to such behavior. In this study the expression *medical liability* shall be restricted to the legal semantics, so that *responsible* will be the physician whose duty to indemnify was proven.

The medical liability is an important issue to be observed in the field of bioethics, especially when are proposed, in the doctor-patient relationship, the absence or the macula of the *trust* that is inherent to it. Similarly, it is a theme in bioethics that is surrounded by the legal field, considering that it touches the substantive and procedural laws of the countries where these questions or lawsuits arise. It deserves reflection, still, mainly because it is increasingly present in everyday life in the medical field, which allows its integration within the field of *daily bioethics* or as *bioethics of persistent situations*, in the classifications used by Berlinguer and Garrafa [4], respectively.

According to news from the medical and legal fields [1], there has been a substantial increase in processes in Brazil which discuss the liability of doctors regarding the duty to compensate or not, i.e. in which there is the discussion of the occurrence or nonoccurrence of a medical error to be repaired. It should be noted, moreover, that reparation is due, or rather that medical liability which entails the reparation is found, only in the simultaneous presence of three constitutive assumptions: the *behavior*, which is observed in action or omission; the *chain of causation*, which sets up the connection between the conduct and the possible harm; and the *harm*, that necessarily should be effective.

It is thus necessary to characterize the *culpable* conduct, which, as seen, will be *inexpert* - characterized the practice by action without due knowledge or with disregard to technical standards; *reckless* - identified as risky, hasty, intemperate, or foolish; or *careless* - marked by carelessness, indifference, when, being able to act, the subject does not [5].

Litigation assumes the occurrence of effective damage, compensatable through a process that is justified under the classifications already identified. However, a conflict can also be presumed, caused by a previous failure in communication between the litigants, this being an avoidable lawsuit, because the act in question could have been preceded by a dialogue that is satisfactory to the understanding of the facts, or even by consensus between the parties as to the situation and its possible consequences.

It happens that the possibility of reaching consensus presupposes, beforehand, the attempt to achieve symmetry between the objectors through democratic debate, without hierarchical imposi-

tion, something that is little seen in a relationship where there is an instituted power: the power of medical knowledge.

Medical power in the doctor-patient relationship

According to Foucault, the power relationship is articulated to the speech by setting an underlying dimension of communication between people. It is a relationship between the *power* and the *knowledge* inherent to the discourse itself [6], where the fact of someone possessing an understanding - *knowledge* – is elevated to a condition of power in the given environment that recognizes him as such. In this case, the consequence can be that the assertions emanating from power holding individuals, such as defined by a given society, are presented as *truths*.

The truth, thus constructed and reified, is transposed to the social life in the form of intellectual discourse, initially unquestioned and seemingly intangible. As this juncture, and given the historical observance that, indeed, the power of medicine is rooted in social structures, it is possible to conclude that to their representatives - the physicians - is socially conferred the status that Foucault defines as *the statute of those who have the burden to say what functions as genuine* [6].

This could be seen especially after the modifications undergone by the medicine between the eighteenth and nineteenth centuries, in which scientific and technological breakthroughs that have occurred in a few years brought also a new regimen to medical knowledge [6]. The power of science was related to medicine as it participated in the context of technological developments and came to be seen as something more than just executing the findings or implementing the evolution of scientific practice. Thus, it is observed that also the broader power of the *scientific truth* was included in medical practice, beyond the power of specific knowledge about the objects of their professional competence, embracing in this midst the other areas of the biological sciences.

These new practices, supported by the new power that science has given the medical discourse, echoed directly in the communication with the patient. Medical discourse detains the prerogative of the *meaning*, referred to by Foucault [6], which, when functioning as truth for the society, imposes itself in communicating the relationship with the patient. There would thus be an overlap of the physician's activity in the relationship, with the patient in a lower condition before his power of action and speech.

This goes back to the perception of the insufficient role played by the patient in the relationship. While being the receiver of a *truth* he does not dominate, he is a fragile entity in an asymmetrical context, having less control of the relational situation he experiences. At the same time, the power of truth would be linked to the hegemony of medicine, being presented in the relationship between physician and patient as the power of *medical truth* – a condition that maximizes the asymmetry between the interlocutors.

It should be noted that the understanding of the definition of these *truths* issued by the medical professional as scientific fact is not included in the core of the issue addressed here, since the intrinsic knowledge of medical science is, indeed, a matter for the physician. Such reasoning can also be done in relation to the *truths* that are issued only by the patient, which are, also unilaterally, within his authority. The patient is, if not the only, at least the best judge of his habits, customs, and contacts with external agents, as well as his experience of the disease, given that the same illness might be experienced differently by each person [7].

Differently, this approach is concerned with the way in which this *truth* emanates from the physician in the communication with the patient, especially when one notes the lack of equal opportunity for discussion, questioning and clarification about his state of health or disease – insofar as that asymmetry exists, the power that causes imbalance, reflected in the dialogue, keeps the patient insufficient in the course of communication, and the search for understanding of the situation is hampered, and hence of the subsequent action or inaction, to be held in his body.

This implies that, before issues related to his body, allegedly dominated by himself, the patient would be presented with a situation in which what belongs to him becomes not *his*, since he loses the power to understand it and manage it when he is not given an opportunity for dialogue and understanding that is sufficient to effective decision making. In this sense, the decision about his body becomes strictly under the control of the hegemonic power of medicine, being reflected in the continued dependence of the patient in relation to the figure of the physician, even in moments of decision-making that could be his [8].

One could, therefore, project into the relationship between physicians and patients that which Foucault identified about Medicine and the Law: *the social appropriation of discourses* [9]. It is possible even to classify the situation as similar to what the author defines as *systems of speech subjection* [9]. It is plausible to presume that from this dichotomous and hierarchical condition comes the part of the patient's vulnerability that stems not specifically from being sick. Subsumed in the face of knowledge that he does not dominate and unequal ways of action and opportunity for dialogue, the patient sees himself also vulnerable because he is subjected to a discourse which he has difficulty in appropriating.

As a result, there is a difficulty in having the patient as an effective co-participant on medical decisions in this relationship. This has as a consequence the effect of reduced activity, often just the situation of listener, literally patient. Should he not be given the opportunity to know, understand and act, he becomes a mere spectator, who observes his health care and only answers the questions as they are made.

However, this medical power can be further understood as a means for forming knowledge and producing positive knowledge. According to the same vision inspired by Foucault, the notion of power strictly linked to deterrence is refuted: *What causes the power to remain and to be accepted is that it does not simply weigh only as a force that says no, but that actually permeates, produces things, induces pleasure, forms knowledge, and produces discourse. It should be considered as a productive network which runs through the whole social body much more than a negative instance whose function is to suppress* [6].

This fact makes the development of science and the growth of knowledge in the course of medical evolution to be identified as positive, to the proportion of the benefits they bring to the maintenance of life and health restoration. However, it is worth pointing out that the inexistence of an exactly negative restraint does not imply the inexistence of an indirect imposition of the will of others by the acceptance of truths caused by the other's ignorance.

This having been seen, although one can not say that medicine maintains a repressing power, it must be admitted that the relationship between physicians and patients is undergoing an increasing evolution in search of the emancipation of subjects from hegemonic social settings, such as that which is established in the communication with the physician, which seeks to promote the well being of the patient through the use of his knowledge.

Also, to evolve technologically and scientifically, as it happens with medicine is generally positive; negative would be the occurrence of this evolution in defiance of the ethics that is necessary to human relationships, to the appreciation of the subjects, regardless of their circumstance in this relationship or condition of detention of knowledge. The need to find the balance point in relationships goes back to the idea that the practice of science and ethics can and must go together.

The excessive judicialization of the relationship between physicians and patients

Nonetheless, it is possible to reflect on the attempt to overcome the asymmetry in the relationship between physicians and patients, from the enhancement of patient autonomy, particularly through information and enlightenment that are free of coercion. In this regard, we must remember that in the context of increased *avoidable* litigation in the relationship between physicians and patients it is difficult to arrive at a consensus, or the previous difficulty of dialogue can stem, precisely, from the power asymmetry, the passivity imposed on the patient, both social and historically.

Therefore, when the exercise of autonomy by patients is sullied, understanding is made difficult, particularly in the face of conflicts that are at first dissolvable through communication and consensus. Thus, there are two important perspectives to be analyzed: that which observes the *assertive pursuit* for resolving disputes between physicians and patients by the Judiciary as a process of emancipation through the use of the right of action; and that which observes this *excessive pursuit* as a phenomenon that tends to occupy the Judiciary in the constant solution of failures arising from shortcomings of the relationship between physicians and patients. It is believed that it is possible to place the excessive judicialization of medicine in this last one.

In fact, according to Barroso, the constitutionalist, the phenomenon of judicialization has multiple causes. One of them, which is important to the reflection on bioethics and law, is the democratization of the country, which, of course, praised the sense of citizenship. *Giving a greater level of information and awareness of rights to large segments of the population, which began to seek the protection of its interests before courts and tribunals* [10], this situation

resembles the process of questioning science [11], experienced at the time of the fight for human rights.

In the context of the struggle for equality and other human rights that happened in the second half of the twentieth century, in sequence to the technologization of medicine, emerged both the challenge to the scientific community about the positive effectiveness of the developments in science and technology and new trend of understanding the role of the patient in the relationship with the physician. On this theme, Patrao Neves explains: *At the confluence of scientific-technological development and the new sociopolitical mentality, we find the crisis of the notion of progress as essentially positive and the intensified questioning of science*. *The scientific optimism, common in the 50s, is thus contradicted, and then new abuses against humanity are allowed. Now, with an ever-increasing insistence, the question is not just 'what can we do', but 'what must we do'. The scientific imperative (science and technology) gradually gives way to the ethical imperative* [11].

Embodied in the new ethical and legal support for equal rights, this trend in relation presents the possibility of a new behavior by the patient in face of the physician, since it brings to the relationship the equality of the duty to provide information, with the consequent right of the patient to manifest himself about the decisions, equal to the already present right of the physician. After all, the relationship was between equal subjects that were just in different positions as to knowledge of the matter, amid a circumstance common to both: being involved in a spirit of restoration or maintenance of human health.

In this sense of verification of equality in the status of a person in the relationship, Patrao Neves says: *From a sociocultural perspective we highlight the strength of the human rights movement that renews all areas of human activity through the affirmation of the equality of all men and a similar requirement regarding respect, which at the level of medical practice translates into a new relationship between physician and patient:*

a balanced relationship at the same level, among people who simply find themselves in different circumstances in their lives [12].

The ethical consideration as to openly rethinking medical practice, in addition to the ethical accountability of actions directed to medical care and research, represented this respect to equality, human dignity and the exercise of freedom.

So, the spirit of human rights was intensified in the area of health through a new approach intended to give rise to balance and reciprocity of demonstrations in the relationship between physicians and patients. This approach helped in the necessary attempt to overcome the Hippocratic paternalistic model, which implied the passivity of the patient in all matters involving his health.

In this sense, in view of the Brazilian reality of significant social and educational differences, it is a fact that the greater guarantee of access to justice has a significant role in a social context of necessary emphasis on the struggle to reduce the vulnerability of the population. However, when there is no concomitant search for the reduction of problems through social reflection and enhancement of the emancipatory or proportional dialogue in daily relations, instead of appr6oaching the subjects for the establishment of symmetrical relations, a simply judicial and not social strengthening may be caused.

It is what one understands from the analysis of the assertion by Barroso, who claims that judicialization *involves a transfer of power to judges and courts, with significant changes in language, reasoning and mode of participation of society* [10]. Thus, when one considers a significant part of the increase in disputes arising from the relationship between physicians and patients as *excessive judicialization*, we observe the transposition of the power of medicine to the legal sphere.

Likewise, as the excessive increase in preventable demands is maintained, it is possible that this is an attempt to *repair* a communicative deficiency that is present in the course of centuries in the history of medicine, and that now worsens by the increase of the judiciary power, when not attentive to the emancipatory social design. So in a way that is unfavorable to consensus, physicians and patients, the subjects of a caring relationship, possibly would have become the litigants of a lawsuit.

It could be affirmed that to judicialize the dilemmas of the relationship between physicians and patients is a negative measure, but is it an emergency. This is an important argument and emergency measures are agreed in exceptional incidents. However, it is essential to reflect on whether Brazil is still going through this situation. The answer is probably positive. However, faced with an excessive judicialization, as a forced and misguided attempt to achieve symmetry, while society accepts the overvaluation of the insertion of the Judiciary in the relationship, this emergency measure will become a common practice, being distorted in the transformation of the exception into a rule.

In addition, we started to see the gradual enhancement of *defensive medicine* in medical practice, consistent with the urgent and constant fear by professionals of becoming a defendant in a lawsuit [13]. This proposal leads the physician to a privilege, by observing the patient as a potential litigant at the expense of attention to the care entrusted in the relationship. This perversion of autonomy – both for patients and physicians – generates not only the practice of *defensive medicine* but also an *excessive judicialization*, representing the misuse of the Judiciary rather than the quest for a social resolution of conflicts and the enhancement of the construction of autonomy among pairs. Physicians lose by the misrepresentation of the chosen profession, and patients lose by the distortion of a relationship that is eminently of care for the other.

It is evident that in Brazil there was the influence of the liberal American culture, whose legal system prioritizes the law as a means by which ethical dilemmas are resolved and whose individualist practice has led to this insertion of the process of the Law in Medicine. This profile, which causes the removal of the discussion about substantiation and prioritizes the normative justification plan, culminates in the preference for the regulation of the practices. It is working with an individual legal remedy before understanding the problem and trying to reflect on it in the social sphere, which allows the law to tend to pronounce itself before ethics.

Faced with the certainty that the facts antecede the rules, one can not admit that the norms should precede the facts or, at least, the reflection on the facts. The same goes for the market society that transforms health care in consumption and induces health consumerism.

Medical and bioethics responsibilities discussed socially and academically: final thoughts

Avoiding excessive judicialization means privileging reflection before the legal providence, not electing the judicial process as a guide of social uncertainties or determinant of collective ethical direction. But a question arises: and what would be the way to repair avoidable litigation in the practice of the relationship between physicians and patients, that is not through the coercion of procedural justice?

We believe that the quest for understanding of the contexts in bioethical analysis from its principles achieved legitimate and internationally, and the appreciation of the roles of *patient* and *physician* as active subjects of the attempt to achieve consensus, could contribute to the reduction of avoidable litigations. This is about the valorization of these people, by seeing them as having the right to decide from the freedom that comes from knowledge, as potential carriers of *knowledge* and therefore of *power*, both for effective reflection on the social environment about the theme and about the substantial increase in bioethical discussion in the course of medical education.

Regarding the first suggestion, related to communication gaps or conflicts in the relationship between physicians and patients, it is thought they could be restored or minimized by implementing critical debates both in scientific events, encouraging public participation, and through public hearings, among other means to be suggested and implemented permanently. It is important to note, however, that the major events in which medical liability is discussed in Brazil do not favor the inclusion of the community in the debate, giving greater emphasis to the participation of physicians and lawyers or students of these areas.

A major stimulus for the production of public policies in favor of debate within bioethics also for health issues was the publication in 2005 of the *Universal Declaration on Bioethics and Human Rights*, adopted at a session of the UNESCO General Conference, which brought about fifteen guiding principles consensually constructed and discussed by several countries, mostly focused on ethical issues involving medicine.

Among them Article 5 stands out, which deals with the principle of autonomy and individual liability, which report directly to the present reflection. It is noteworthy here, especially, the respect for the autonomy of the other – the patient – with whom the physician relates to fulfill his professional activity: *The autonomy of individuals with regard to decision-making, on the condition they accept their respective responsibilities and respect the autonomy of others must be respected. For persons unable to exercise their autonomy, special measures must be taken to protect their rights and interests* [14].

So, when the filing of the lawsuit becomes necessary, inevitable to correct issues involving the relationship between physicians and patients regarding the actual situations of medical liability, this will take place by defending the rights and interests of both patients and the medical profession, to the proportion that is concerned with ethics in daily practice.

The second suggestion is directed to college training, the formation process of the physician that must focus not only on technical, but also on ethical issues. The university training is the source from which will arise in the near future, the physicians for the coming decades. As the hodiernal professionals, who are now in the focus of the discussion and of the dispute about the issues of medical ethics and bioethics, students in training must be prepared to undertake their journey safely.

It is understood that it becomes necessary, therefore, to disallow the annihilation of the necessity of learning that is committed to the construction of fundamental ethical values. This need remains, although it presents the possible concern with the dictates of the capitalist medical market and its technicist imposition in detriment of a humanistic perspective. In this sense, the claim is that we must not only seek the importance of professional technical qualification, but also the essentiality of its ethical and moral constitution facing the dilemmas caused by the intense social, cultural, economic, technological and political modifications related to health issues.

Under this view, one points to the importance of considering the symmetry of the relationship between physicians and patients from the medical graduation. It is, above all, at this stage that we note that medical knowledge about the issue needs to be shared, not only because of the legal (the patient's right to information about himself), but also ethical obligation, as Pellegrino and Thomasma add: *The medical knowledge, therefore, is not a private property. It is not intended primarily for personal gain, prestige or power. On the contrary, the profession detains the medical knowledge in trust for the benefit of the patient. By accepting the private of medical education, those who enter medicine become part of an alliance with society – which can not be unilaterally dissolved. Medical students, from the first day, enter a community bound by a moral pact. They accept the privileges of medical education in exchange for the responsibility of the management of medical knowledge* [15].

Therefore, in medical education, is necessary the constant presence of the discussion about the responsibility of the physician in the legal, moral and bioethical senses, as we can already see at some universities in the country. So, one will also be contributing to the search for professional training guided by the essential care to the person in its entirety and autonomy.

This having been seen, it is true that we do not pretend to exhaust the proposals for coping with excessive judicialization or the potential criticism that may be dispensed to it. We suggest, however, that the academic community and civil society both continue to cope with this question. In any event, we believe it is possible to attempt to achieve symmetry in the relationship between physicians and patients, as well as dialogue in order to reach consensus prior to litigation.

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