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Does implicit healthcare rationing impose an unfair legal burden on doctors? A study of Portuguese jurisprudence

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Abstract

Healthcare rationing is inevitable, never more so than during the COVID-19 pandemic. In Portugal, rationing is largely implicit and relies too much on *bedside* decisions, made in stressful circumstances, involving ethical dilemmas and being prone to error. This study uses a qualitative approach by exploring the public records of Portuguese courts for malpractice suits between the years of 2008 and 2019 to ascertain whether the damage suffered by patients in these cases could in any part be attributed to a lack of resources. During this research, we found that a large number of lawsuits against doctors and hospitals might have in fact been the unfortunate result of the constraints of implicit prioritization. We concluded that lawyers and judges must be made aware of the impact of implicit rationing decisions on healthcare professionals, who are judged against a professional standard and an inverse onus rule that places on them a heavy burden of proof.

Keywords

Allocative decision in healthcare, bedside rationing, explicit priority setting, implicit priority setting, medical malpractice

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Introduction

The Portuguese Constitution of 1976 was drafted in the aftermath of both the 1974 *coup d'état*, which ended a decades-long dictatorship, and of the 1975 counter-revolution, which put a stop to the new communist/military revolutionary regime and reinstated democracy in Portugal. The Constitution granted, for the first time in Portuguese history, the right to universal, general and free healthcare and mandated the creation of a national health service. This national healthcare service (NHS) was established in 1979. It has since evolved into a national health *system*, rather than service, because it now includes public–private partnerships and other agreements.

Through a series of constitutional revisions in 1982, 1989 and 1997, it was acknowledged that everyone has the right to healthcare. This right is achieved through a national, *universal* and *general* health system which *tends* to be free.[1] It is *universal* because it covers every Portuguese citizen even if they also have private insurance or any other form of healthcare coverage; it is also extendable to foreigners, on a reciprocity basis, and to migrants, refugees and stateless people.[2] It is *general*, because it comprises integrated healthcare – preventive and curative medicine, diagnosis, rehabilitation and palliative care. It *tends* to be *free* of charge because it is centrally funded, through the general budget, but co-payments – in the form of *moderating taxes* or *fees* – have gradually introduced a means of direct, user-payer financing and rationalization of usage. These *moderating fees* are taxes by nature, albeit on a user–payer logic. These fees account for no more than 1% or 2% of annual healthcare financing,[3] as large groups of people are exempt (all children, pregnant women, the unemployed, the handicapped, blood donors, the police, military and firemen and generally anyone who can prove they do not have the means to pay the fees).

In recent years, healthcare costs have risen dramatically in the industrialized world and Portugal is no exception.[4] The causes are multiple and complex: an ageing population, the rise of chronic and degenerative diseases, technological innovations in diagnostic and therapeutic domains, increasing public expectations and demands, enlargement of insurance coverage and defensive medicine are often listed as the most important factors.[5] This sharp and continuous increase in healthcare needs and demands has become a major concern since healthcare costs have grown faster than overall

1. Cf. Article 64.° of the Portuguese Constitution. An official version in English. Available at: https://dre.pt/constitution-of-the-portuguese-republic.
2. Cf. Law 95/2019 (the *General Law of Healthcare*), 4 September 2019, ELI: https://data.dre.pt/eli/lei/95/2019/09/04/p/dre.
3. Ministério da Saúde, *Nota Explicativa Do Orçamento de Estado Para 2019*, 2019. Available at: https://www.parlamento.pt/Documents/2018/Novembro/NEplicativaSaude.pdf.
4. Jorge de Almeida Simões and others, 'Portugal Health System Review', *Health Systems in Transition* 19(2) (2017).
5. S. Clark and A. Weale, 'Social Values in Health Priority Setting: A Conceptual Framework, ed. by Peter Littlejohns', *Journal of Health Organization and Management* 26(3) (2012), pp. 293–316. Also D. Strech and M. Danis, 'How Can Bedside Rationing Be Justified Despite Coexisting Inefficiency? The Need for "Benchmarks of Efficiency"', *Journal of Medical*

economic growth, jeopardizing the financial sustainability of public health systems. Consequently, healthcare organizations are facing several challenges such as, rising expectations, increasing costs and a deficiency of resources.[6] The shortage of healthcare resources means that it is of great importance to get the best value for money and health policy decision-makers must adopt rationing or priority setting strategies. The importance of rationing is highlighted by the World Health Organization as a prerequisite to universal health coverage.[7] Such rationing or priority setting[8] can occur at the macro or micro level.[9] Macro-allocation includes decisions about how to allocate funds across a range of public goods. Micro-allocation involves bedside decisions about denying a potentially beneficial treatment to patients on the grounds of scarcity. Despite the fervent political and societal debate in recent times, felt most acutely during the COVID-19 pandemic, rationing of healthcare is not new. Traditionally, discretionary models have dominated micro-allocation healthcare resources. Under this 'implicit' method, the mode of rationing is hidden and the responsibility to adopt the measures is entrusted to physicians, who exercise significant autonomy over rationing in a context of rising pressure to contain costs.[10] The criteria to be used to establish patients' priorities are implied, indirect, not clearly expressed and often opaque.[11] These implicit rationing decisions impose a heavier burden on healthcare professionals and foment conflicts and distrusts between them and the public.[12] Waiting lists have been adopted as a widespread means of implicit rationing in Portugal as in most public healthcare systems.[13] In contrast, explicit rationing is based on clearly defined indicators. In Portugal, explicit measures are applied on the demand side through, for example, the regulation of out-of-pocket expenses, co-payments (moderating taxes) and limitation of coverage and

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Ethics 40(2) (2014), pp. 89–93. Also J.L. Dieleman and others, 'Factors Associated With Increases in US Health Care Spending, 1996–2013', *JAMA* 318(17) (2017), p. 1668.

6. A. Mohammad Mosadeghrad, 'Why TQM Programmes Fail? A Pathology Approach', *The TQM Journal* 26(2) (2014), pp. 160–87.
7. World Health Organization, *Health Systems Financing: The Path to Universal Coverage* 2010. Available at: https://www.who.int/whr/2010/en/.
8. Terms we will treat as interchangeable.
9. J. Coast, J. Donovan and S. Frankel, *Priority Setting: The Health Care Debate* (England: Wiley-Blackwell, 1996). Also, R. Klein, 'The Rationing Debate: Defining a Package of Health Care Services the NHS Is Responsible for the Case For', *British Medical Journal* 314 (1997), pp. 506–515.
10. C. Ham and A. Coulter, 'Explicit and Implicit Rationing: Taking Responsibility and Avoiding Blame for Health Care Choices', *Journal of Health Services Research & Policy* 6(3) (2001), pp. 163–169. Also K. Syrett, 'Impotence or Importance? Judicial Review in an Era of Explicit NHS Rationing', *Modern Law Review* 67(2) (2004), pp. 289–304.
11. L.L. Hicks, 'Making Hard Choices', *Journal of Legal Medicine* 32(1) (2011), pp. 27–50.
12. Strech and Danis, 'How Can Bedside Rationing Be Justified'.
13. D. Mechanic, 'Dilemmas in Rationing Health Care Services: The Case for Implicit Rationing', *BMJ* 310 (1995), pp. 1655–1659. Also, K.E. Arnesen, J. Erikssen, and K. Stavem, 'Gender and Socioeconomic Status as Determinants of Waiting Time for Inpatient Surgery in a System with Implicit Queue Management', *Health Policy* 62(3) (2002), pp. 329–41.

triage of patients in emergency services (based on the *Manchester Triage System*[14] the selection of patients is done upon arrival at the hospital, and the waiting time of attendees is defined according to the severity of the health conditions[15]). Explicit rationing also features on the supply side via measures which include: heavy equipment planning (the law regulates the number of inhabitants per unit of some heavy items); human resource management (control of admissions to medical schools – that are exclusively public, through strict *numerus clausus*[16] and establishment of licensing requirements for professional and facilities); regulation of the pharmaceutical market (distribution, prices and reimbursement of medicines are regulated by the government; reimbursed medicines are included in a positive list and reimbursement rates are fixed; denying permission for a pharmaceutical product or a medical device to be used or made available to the public); immunization (only vaccines included in the National Vaccination Programme are provided free of charge for some age or professional groups); and a *New Public Management* model of administration which is characterized by the growth of markets and quasi-markets within public services, empowerment of management and active performance measurement. Given the chronic under financing of the NHS, the explicit rationing measures presented above do not seem sufficient to bridge the gap in the market. Therefore, as in many countries, a 'mixed rationing' method – involving both explicit and implicit priority setting[17] – is the present solution to balancing resources and needs.

Although rationing in Portugal is not explicitly addressed in the political agenda, the theme has once again gained prominence, driven by government efforts to reduce budgetary deficits following the last economic crisis. This pressure to reduce the budgetary deficit was greater than ever during the global financial crisis of 2008. A number of measures aimed at cost containment, improving efficiency and increasing regulation were taken in the wake of the Economic and Financial Adjustment Programme adopted between 2011 and 2014, in order to reach the level of savings in health expenditures

14. A.P. Santos, P. Freitas, and H.M. Gil Martins, 'Manchester Triage System Version II and Resource Utilisation in the Emergency Department', *Emergency Medicine Journal* 31(2) (2014), pp. 148–52.
15. H.M.G. Martins, L.M. De Castro Dominguez Cuna, and P. Freitas, 'Is Manchester (MTS) More than a Triage System? A Study of Its Association with Mortality and Admission to a Large Portuguese Hospital', *Emergency Medicine Journal* 26(3) (2009), pp. 183–86.
16. Access to public higher education in Portugal operates under a *numerus clausus* regime, meaning that for each degree there is a limited number of vacancies. The National Call is managed by the Directorate General of Superior Education (DGES), rather than by Universities themselves. As a consequence, Universities do not have any freedom in establishing the number of vacancies or choosing their students. This is especially true when applied to medical schools, because although Portugal has quite a few private Universities, the Agency for Superior Education Accreditation (A3ES) as never given a license to teach a medical course to a private University.
17. D. Mechanic, 'Dilemmas in Rationing Health Care: The Case for Implicit Rationing', *BMJ* 310 (1995), p. 1655.

established in the Memorandum of Understanding.[18] Portugal is currently under Post Programme Supervision[19] and, according to the WHO, is one of only 4 countries (of the 33 analysed) that reduced public health expenditure between 2000 and 2017.[20] As a result of these measures, the Portuguese health sector currently suffers from disinvestment and is experiencing many disruptions. Modernization of hospitals and obsolete medical equipment replacement is lacking, the public medical workforce, discouraged by poor work conditions are seeking jobs in the private sector and overseas and dental consultations and diagnostic tests are most commonly provided by the private sector, triggering an increase in patient out-of-pocket expenses, which are already 28% of total health expenditures (substantially higher than the EU average of 15%).[21] Therefore, implicit rationing is more present than ever, is conducted by overworked, underpaid professionals in stressful work environments and is prone to error. Healthcare professionals, mainly physicians, feel more intensively the pressure of a lack of resources and often bear the weight of rationing decisions alone.[22]

In this context, there is a rising need for explicit, transparent and socially accepted priority-setting practices. Since the criteria to be used are more direct and open, the results of explicit rationing are more transparent – it is easier to know what and who will be covered and what and who will not be covered. Transparency creates less conflict for providers and puts less strain on provider–patient relationships, while having the added advantage of allowing for the placement of control on costs and quality through the inclusion of more effective provision and exclusion of less effective services.[23] The idea of explicit rationing relies on people understanding that there are simply not enough resources for everyone to have everything, but that is particularly difficult to reconcile with the right to universal, comprehensive and free healthcare enshrined in the Portuguese Constitution, or with the idea of health as a basic human right without distinction of economic or social condition as proclaimed in the Constitution of the World Health

18. J. de Almeida Simões and others, 'Portugal Health System Review', *Health Systems in Transition* 19(2) (2017). Available at: http://www.euro.who.int/__data/assets/pdf_file/0007/337471/HiT-Portugal.pdf (accessed 28 April 2020).
19. Irune Ana Solera López, Catarina Dantas Machado, Julia Lendvai, António Dias da Silva, Rainer Wichern, Giuseppe Carone, Geert Vermeulen, Lourdes Acedo Montoya, Michal Wiktorowicz, Marianne Klumpp, Martin Hallet, Pedro Guedes de Campos, and V. Klyviene, 'The Economic Adjustment Programme for Portugal 2011–2014', Occasional Papers, 2014, ccii, DOI:10.2765/85246>.
20. World Health Organization, *Healthy Prosperous Lives for All: The European Health Equity Status Report*, 2019. Available at: http://www.euro.who.int/en/publications/abstracts/health-equity-status-report-2019.
21. OECD/European Observatory on Health Systems and Policies, 'Portugal: Country Health Profile 2017, State of Health in the EU', 2017, 2–5, DOI:10.1787/9789264283527.
22. M.M. Pinho and P. Veiga, 'Attitudes of Health Professionals Concerning Bedside Rationing Criteria: A Survey from Portugal', *Health Economics, Policy and Law* 15(1) (2020), pp. 113–27.
23. Hicks, 'Making Hard Choices'.

Organization.[24] Nevertheless, we must decide together, as a society, how best to use our resources and agree on clearly defined and stated – that is, explicit – rationing criteria. Some developed countries, such as the United Kingdom, Israel and the Netherlands have already adopted a more open and systematic rationing mode following wide public discussion.[25]

The main objective of this study is to contribute to understandings of the potential burden to doctors where implicit healthcare rationing is prevalent. Namely, we question the extent to which physicians can always be held accountable for their malpractice and how much of the blame can be attributed to health system underfunding.

Method

The present study uses a qualitative approach to explore physician's malpractice suits over the course of 12 years – between 2008 and 2019. We intended to discover whether these malpractice cases were wholly attributable to physicians' errors or whether they could be attributable, at least in part, to resource scarcity in general or with the practice of implicit rationing in particular. This 12-year period would, we hoped, allow us to compare results before and after the austerity measures imposed by the Memorandum of Understanding on the health sector.

The method used in this study consisted of a search in the public records of Portuguese courts for malpractice suits in the period ranging from 2008 to 2019. In Portugal there are few public records of decisions from courts of first instance, so we focused on decisions from appellate courts (i.e. the courts of second instance sitting in Évora, Guimarães, Porto, Coimbra and Lisbon) and the Judicial Supreme Court, the civil and criminal court of last resort. We also explored decisions from administrative courts: because doctors working in state-owned facilities are public employees, the parties can choose to invoke the state's liability, and they do so in administrative courts. Therefore, we searched for decisions from the two existing second instance administrative courts (Central Administrative Courts, North and South) and from the Administrative Supreme Court.

In some cases, Portuguese procedural rules do not allow the parties to appeal to the Supreme Courts (Civil or Administrative), and in those cases, the second instance court is in fact the last resort. In other instances, the case does not go through the second instance, and the Supreme Courts are in fact the second and last instance of appeal: this is known as a *per saltum* appeal. It is also worth noticing that in Portugal, when liability arises from a criminal act and there is a criminal prosecution, civil suits are in most instances a part of the criminal case (this is termed the principle of 'adhesion', found in Articles 71 and 72 of the code of penal procedure).

24. See principles set out in preamble. Available at: https://www.who.int/about/who-we-are/constitution (accessed 28 April 2020).
25. K. Obermann and D.J. Buck, 'The Health Care Rationing Debate: More Clarity by Separating the Issues?', *The European Journal of Health Economics (HEPAC)* 2(3) (2001), pp. 113–117.

We wanted to know whether there were differences in the number and type of malpractice suits before and after 2011 – the year of the beginning of the financial assistance and subsequent 3-year economic adjustment programme to Portugal – and from 2014 – marking the end of the adjustment – to today. According to the statistics provided by the Ministry of Justice,[26] a civil legal case in Portugal takes an average of 13 months to be decided, and another 2 years on average for appeals. An administrative case will take even longer,[27] so we widened our search to 2008.

Our search with the terms medical AND liability[28] between 2008 and 2019 in the public record website[29] identified 36 decisions from the Supreme Court and 48 decisions in total from the 5 Courts of second instance.[30] We also found 21 decisions from the Administrative Supreme Court and 22 judgments in total from the 2 administrative courts of second instance.

When the case number was the same, this meant the case had been heard both by the court of second instance and by the Supreme Courts, and therefore we focused on the latter's decision. This left us with 121 potentially relevant decisions in total. We disregarded all that happened in the context of privately financed healthcare services, as well as all decisions which were not based on the merits of the case, but which rested solely on formal issues or technicalities. Applying these exclusion criteria, we were left with 68 court decisions (Figure 1).

We also wanted to know whether there had been suits against the Portuguese State where a *right to health* had expressly been argued against a rationing decision. Even after widening our search to the Constitutional Court and to the European Court of Humans Rights, notably, we found none.

We read and analysed all 68 selected decisions, and searched for correlations between bedside rationing decisions, poor working conditions and general lack of resources, and the damage that patients suffered. What follows is a summary of the 26 cases where we found such correlations.

Results

Our findings suggest some patterns in the cases described which point to implicit rationing decisions a having been a contributing factor to the harms the patients suffered. We found evidence suggesting that: (i) some small-town hospitals seem to be generally underequipped and understaffed; (ii) complicated cases are sent to central hospitals in Portugal's two major cities (Lisbon and Porto); (iii) equal access to healthcare is questionable since some patients have to travel hundreds of kilometres by ambulance; (iv)

26. Ministério da Justiça, 'Estatísticas Da Justiça', 2019. Available at: https://estatisticas.justica.gov.pt/sites/siej/pt-pt/Paginas/tribunais.aspx (accessed 15 October 2019).
27. Op. cit.
28. In Portuguese, 'médica' AND 'responsabilidade'.
29. Available at: www.dgsi.pt.
30. Some of these decisions came from purely civil procedures and others from criminal procedures where civil liability claims were attached as a consequence of the *principle of adherence.*

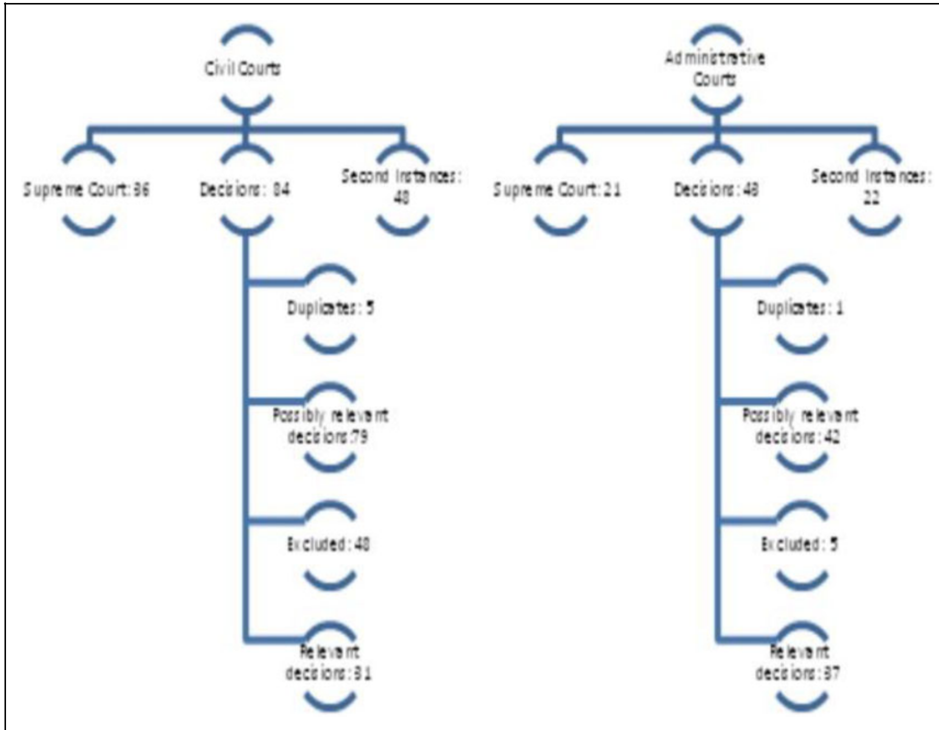

Figure 1. Search process.

emergency services, especially in small hospitals, were sometimes poorly organized, without senior staff or specialists: cf. cases #1, #2, #3, #10, #11, #16, #20, #22, #23 and #26. We also found some evidence that: (v) changes of shifts could cause communication problems leading to misdiagnosis (cf. cases #23 and #24); (vi) obstetricians seem to resist C-sections until the last minute which could cause brain damage or even death of the child and/or, in some cases, of the mother (cf. cases #2, #7 and #9), and finally that (viii) patients deemed 'undesirable' were sometimes sent from hospital to hospital, probably in the context of the highly competitive budget allocation criteria introduced when market-oriented strategies (to improve efficiency) were implemented in public healthcare units (cf. cases #18, #21 and #23).

We found no evidence in any of the cases that a right to health had been argued against a rationing decision (Table 1).[31]

Discussion

This study explores whether medical malpractice suits judged in courts between 2008 and 2019 were wholly attributable to health professionals' errors or whether they can be at least partly attributed to rationing policies. During this period, 26 cases were analysed. In none of these cases was evidence found that a right to health had been argued against a

Table 1. Description of selected malpractice suits.

Case number Date decision Court	Description	Decision
#1 0682/07.1 2 Nov2008 STA	A 12-year-old girl was diagnosed with severe right thoracic adolescent idiopathic scoliosis in October 1994. In June 1995, she was subjected to a Harrington-Luque instrumentation and right thoracoplasty surgical procedure. After the surgery, she was placed in an infirmary which did not have monitoring equipment. The next morning, she was found to be paraplegic, and another surgery was performed to remove the instrumentation. After a number of other procedures, the patient showed little improvement. The claimants believe that a lack of monitoring equipment (which the hospital did not have) and proper surveillance during the night after the first surgery led to vascular and neurological alterations, to progressive ischaemia of the medulla, to a degradation of the patient's clinical condition, and finally to paraplegia	The hospital was found liable and ordered to pay compensation for pain and suffering and future damages
#2 01425/04.8 30 November 2013 TCA-N	A baby boy was born in 1994 by C-section in a hospital in the north region of Portugal, where the mother had been in labour for more than 10 h. After birth, he was transferred by ambulance to the neonatal intensive care unit of a larger, better equipped hospital located about 60 km from the one he was born in. He recovered and was discharged a few weeks later, but his clinical condition degraded in the following months, and he was eventually diagnosed with brain damage caused by perinatal asphyxia. The mother claimed, on behalf of her son, that the damages could have been avoided had the C-section been performed earlier	The doctors and the hospital were found liable and ordered to pay compensation

(continued)

Table 1. (continued)

Case number Date decision Court	Description	Decision
#3 2009/05.9 14 January 2014 TRC	In 1999, a male adult went to the emergency services of a general hospital after a splinter from an axe entered his left eye while he was cutting wood. There was no ophthalmologist present in the emergency room (ER) or proper diagnostic equipment, and the attending general physician performed a simple fluorescein test which revealed a small laceration but failed to detect the presence of a foreign object. The patient was treated with Terramycin antibiotic and discharged. The next day, the patient felt his condition had worsened and went back to the hospital. He was transferred to a larger, better equipped hospital, where the test revealed the splinter was still in his eye and had perforated the cornea, and the doctors decided on a surgery. All the operating room (OR) were full, and the procedure did not begin before 4 more hours had elapses. The patient lost his eye, and claims this was avoidable had he been diagnosed and operated on earlier	Both the doctor and the hospitals were found responsible, the first for wrong diagnosis and the later for organizational failures
#4 093/12 9 May 2012 STA	In 1995, a healthy woman was in labour in a general hospital, waiting for the normal development of an eutocic delivery. There were complications, and she was subject to an episiotomy more than 8 h after she reported the first symptoms, which resulted in severe bleeding and subsequent haematoma. She was not immediately attended to and later developed an infection caused by *Klebsiella pneumoniae* due to poor aseptic conditions. Her condition declined significantly, and the patient underwent two subsequent surgical procedures and was transfused. She blamed the hospital's inefficiency, imprudence and lack	The Court found the hospital partially responsible, citing the French doctrine of *faute de service**

(continued)

Table 1. (continued)

Case number Date decision Court	Description	Decision
	of organization for the pain, suffering and enduring damages she suffered	
#5 0793/09 26 May 2010 STA	In May 1997, a 17-year-old boy was taken to a hospital and diagnosed with acute appendicitis. He was subjected to a surgical procedure to remove the appendix, under epidural anaesthesia performed by a second-year intern. No senior doctor was in attendance, although one doctor popped in briefly during the procedure and instructed the intern to insert the needle until she found resistance. The intern, using a Tuohy needle, perforated the *dura mater* and the patient began to lose cerebrospinal fluid. Only after the dura mater was punctured the attending physician was called to relieve the intern. As a direct consequence of the botched anaesthetic procedure, the patient was left with severe damage to the medulla. The claimants believe the hospital was understaffed and that this was a contributing factor	The hospital and staff were found to have breached the rules of prudence for these types of procedures and were ordered to pay damages
#6 01897/04.0BEPRT 28 June 2013 TCA-N	In 1997, an adult male lost the use of his tongue after being treated for a malignant tumour in his mouth. The doctor immobilized his tongue but failed to intervene after the adequate period of a year. Instead, the patient was left with his tongue immobilized for 3 years and that the damages caused by the delay were irreversible. He also claimed the hospital lacked proper resources and that he was often consulted while lying on a stretch in the corridor	The court decided in favour of the doctors and the hospital, who had claimed in their defence and were able to prove that the patient's drinking habits had impaired his recovery

(continued)

Table 1. (continued)

Case number Date decision Court	Description	Decision
#7 0576/10 24 May 2012 and 19 May 2016 STA	A girl was born in 1998 with severe brain damage caused by perinatal hypoxia. The mother claimed she was denied the C-section she requested when told the foetus was in distress and that the attending physician insisted on vaginal delivery and applied forceps	The staff and hospital had been found liable in the first instance, but the judgment was overturned by the Supreme Court citing lack of adequate proof of causal nexus. The decisions cited previous decisions of the same Court which ascertained that 'childbirth is inherently dangerous'. The claimants later appealed to the plenary of the Court and this Second Supreme Court decision was in their favour
#8 09039/12 13 September 2016 TCA-S	In 2001, an adult man underwent a cataract removal and intraocular lens (IOL) implantation procedure in a specialized hospital. He had been diagnosed in early 2000, but because of the waiting list, the surgery could not be performed sooner. He complained of pain and loss of visual acuity in weeks following the surgery, but it took the hospital more than 3 months to perform the ultrasound which finally detected a dislocation of the retina. This caused blindness, later diagnosed (at a private clinic in Spain) as irreversible. The patient claimed the blindness in his right eye was a direct result of the delayed ocular ultrasound since early detection of retinal detachment of the eye could have prevented it	Following a discussion about the nature of the hospital and staff's liability, the burden of proof of the causation nexus was found to be on the patient, and it was further found that he had not been able to meet it
#9 08411/12 5 May 2016 TCA-S	In 2002, a 37-week pregnant woman was admitted to the emergency services of a general hospital in the early hours of the morning complaining of sudden, severe abdominal pain. She was experiencing uterine tachysystole, and the foetus' heart rhythm was found to be low but she could	The staff and hospital were found liable

(continued)

Table 1. (continued)

Case number Date decision Court	Description	Decision
	not be adequately monitored because the cardiotocogram was unavailable. When monitoring finally became possible, more than 3 h after she had been admitted, the foetus was bradycardic. An emergency C-section was decided on, but it took another 30 min to prepare the OR and to find a surgeon who was available. The child was stillborn and could not be reanimated. The autopsy showed the death was a result of a dislocated placenta and that the child could have been saved if the C-section had been performed sooner	
#10 2104/05.4T 1 October 2015 STJ	In June 2002, a doctor working for a private clinic performed a colonoscopy on an adult woman. The woman felt progressive pain and discomfort in the following days until she had to be admitted to the emergency services of a public hospital, where she was diagnosed with a bladder infection and medicated. The pain aggravated, and the woman again went to the emergency services, where she was left unattended for more than 5 h. She discharges herself and went to a central hospital in a nearby larger city, where she was finally diagnosed with peritonitis caused by a perforation of the intestine during the colonoscopy, which, left untreated, had cause intra-abdominal sepsis. She was subjected to an emergency proctosigmoidectomy, known as Hartmann operation. She was later put on a ventilator in the intensive care unit, and her recovery was slow and painful. When she was discharged, she had to use a colostomy bag for another six months, until the intestine could be surgically	The doctor who performed the colonoscopy, the hospital and the doctors who failed to diagnose the perforation and failed to treat her were all found liable for the damages she suffered

(continued)

Table 1. (continued)

Case number Date decision Court	Description	Decision
	reconstructed. She was left scared and traumatized, and she claims she would have died if she had continued in the care of the first hospital	
#11 1347/04.2 24 May 2011 STJ	In 2002, a young man went to the emergency services of a public hospital complaining of pain in his groin. After 4 h waiting in the emergency infirmary, no proper testing was done, partly because the hospital did not have a urology service and partly because no equipment was available. The patient could have been transferred to a larger hospital, but was instead diagnosed with epididymitis and sent home. Later, he went to another hospital, where surgery was performed, but it was too late to save his left testicle. He claimed that this could have been avoided if a proper diagnosis of testicular torsion had been made, and the operation had taken place earlier	The doctor was absolved of liability, because the claimant failed to prove the diagnosis had been wrong, since epididymitis could have led to the necrosis and subsequent loss of the testicle
#12 01224/06.2BEPRT 22 May 2015 TCA-N	In 2003, a young woman jumped out of a first-floor window of a psychiatric hospital, after being left alone in a room near the window by a nurse. The nurse had allowed her to smoke a cigarette but had left the room to attend to another patient. The woman fractured her skull and suffered long-term injuries as a result of the fall. The claimant sought compensation for damages and alleged a violation of the duty of care and vigilance by the hospital and staff while she was clearly suffering from a psychotic episode	The staff and hospital were able to prove that the degree of liberty the patient had been allowed was adequate in the light of accepted psychiatric practice and the *leges artis*

(continued)

Table 1. (continued)

Case number Date decision Court	Description	Decision
#13 804/03.2 25 February 2015 STJ	In September 2003, a 42-year-old woman complaining of chest pain was admitted to the emergency services of a public hospital, where she was assisted by a female internal medicine specialist who ordered some blood testing – which came back negative for troponin enzymes – and quickly discharged the patient. Back home, the patient suddenly went into cardiorespiratory failure and died in front of her children. She was rushed back to the hospital, but could not be resuscitated. The claimants – her family – argued that the doctor had disregarded obvious signs of myocardial infarction, and had the patient been interned for surveillance and properly attended to, her death could have been avoided. This was a criminal case with an attached civil liability claim, although criminal and civil burdens of proof are notably different	After a complicated and lengthy process, the doctor was found to have acted according to the *leges artis* and was absolved of all – criminal and civil – claims
#14 253/06.0 2 December 2015 TRP	In 2005, a surgical team performing a cholecystectomy on a female patient left a swab inside the patient's abdomen. The patient complained of pain and infection, but only 2 months later managed to convince the hospital to perform a scan which revealed the swab in the patient's duodenum. Surgery was again performed to remove the swab, but the patient's condition worsened. The patient went into shock caused by peritonitis and suffered acute pancreatitis. Although the emergency surgical team was able to save her life, she was left badly scarred and experienced lasting pain and discomfort	The court found a nurse guilty of negligence by failing to account for all the swabs during surgery and the doctor heading the surgical team of rushing the surgery and failing to perform the examinations which would have found the cause of the infection sooner and with less serious consequences to the patient
#15 683/05.5	In 2006, a woman died of sepsis, following undiagnosed acute pyelonephritis. She had been taken by her daughter to the	All the doctors who had examined and subsequently discharged the patient were found guilty of professional

(continued)

Table 1. (continued)

Case number Date decision Court	Description	Decision
9 April 2010 STJ	emergency service of a public hospital three times before, misdiagnosed with cystitis, medicated and subsequently discharged. On the fourth attempt, the patient's condition had deteriorated visibly, and the attending doctor ordered an emergency abdominal computed tomography scan (CAT) scan. The patient was rushed to the intensive care unit and put on antibiotics, but she went into cardiorespiratory failure a few hours later and could not be revived. She died 5 days after the first complaints	negligence contributing to the patient's death
#16 652/06.8 5 February 2013 TRE	In 2006, a young man was rushed to hospital showing signs of acute alcohol intoxication. Friends had told the rescuers that he had also consumed drugs. He had a wound in his forehead. A doctor examined him and ordered blood and urine tests and started an intravenous drip. When she came back to observe him, the test results had not arrived, and she noticed he was unresponsive and had developed a fever. She suspected meningitis and consulted a neurology specialist, who advised a CAT scan. She ordered the CAT scan, by leaving the hand-written requisition inside the appropriate box. The scan was performed more than 4 h later. In the meantime, the doctor ordered the patient be closely monitored, but there were no free beds in the infirmary, and as a result, he was left in the corridor near a door where the doctor could see him. He went into cardiorespiratory failure, but was reanimated and ventilated. When the results of the CAT scan arrived, they showed brain injury and haemorrhaging. The hospital did not have a neurosurgery unit, so the patient had to be	The doctor who had attended to him faced criminal charges, but was acquitted because it could not be proved that death could have been avoided even if she had ordered the CAT scan sooner

(continued)

Table 1. (continued)

Case number Date decision Court	Description	Decision
	transferred to a hospital more than 300 km away by ambulance. When he arrived, more than 4 h later, he was brain dead. He was pronounced dead the following day	
#17 518/06.1 10 March 2013 TRP	A group of doctors and nurses were found guilty of manslaughter after failing to attend to a man rushed to emergency for a suspected heart attack. The patient was left waiting for medical care on a stretcher in the corridor of the hospital's emergency service. The hospital was crowded, and several other patients were complaining of the time they had been waiting. Witnesses claimed there was only one doctor working, while the other was snoring inside a small office while the patient died outside. Another patient heard the nurse saying 'this one is gone' when she checked on the patient hours later and found him already dead. The doctors on duty and the nurse responsible for the triage complained they were understaffed and ill-equipped to deal with the unusual number of patients they had to attend to that night – Easter Sunday, 2006 – and that the delay had in fact been so severe there was an uprising in the waiting room and the police had to intervene	The doctors also claimed that the patient had been assigned the yellow code priority by the triage nurse, but they had to attend to three other patients with a higher, orange code, priority
#18 5072/07.4 23 May 2013 TRL	In 2007, a man was found unresponsive on the street. The emergency services rushed him to a nearby central hospital. They suspected a traumatic brain injury, because the man was bleeding from an incision on his head, as well as from the mouth and ears. Upon arrival at the hospital, the emergency services related their provisional diagnosis	The doctor was accused of manslaughter: the public attorney claimed she had failed to perform a routine neurological examination and to order a CT scan sooner. Although it was also proved that the result of the toxicology examinations she had ordered upon admittance, as well as the performance of the scan had been delayed by the

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Table 1. (continued)

Case number Date decision Court	Description	Decision
	to triage, and the man was subsequently sent to the emergency room with a triage bracelet that signalled a very urgent situation. The doctor on call, realizing the patient smelled of alcohol, sutured the injury on his forehead and placed him in observation. His condition deteriorated, and he slipped into a coma. The doctor ordered a CT scan, which indeed revealed bleeding in the brain, and he was rushed to surgery but died on the operating table	hospital services, the doctor was indicted and ordered to stand trial for manslaughter
#19 105/08.0 21 May 2013 TRE	In 2008, emergency services were called to the rescue of a 71-year-old man who was found to be suffering from an acute pulmonary oedema. The rescuers stabilized the patient and transported him to the nearest hospital's emergency service, where they left him in the care of the physician on call. The patient was stable, and the doctor decided to discharge him after a few hours. He had no one to pick him up, so he was taken home by ambulance. He suffered another crisis a few hours later, and a relative called for emergency rescue. The rescuers found him in cardiorespiratory failure and were unable to reanimate him	The doctor who had discharged him was charged with manslaughter. She claimed in her defence that she is a general practitioner and not a specialist, that the emergency service had seen more than 150 patients that day and that she had been working a 24-h shift and was extremely tired after attending to more than 50 patients. Nevertheless, she was found guilty
#20. 201/08.3 26 March 2014 TRP	In 2008, in a public hospital in the north of Portugal, a doctor, working 36-h a week plus a number of overtime hours as part of a surgical team specially set up by the Ministry of Health to diminish waiting lists, performed ligation and stripping procedures on a 27-year-old man suffering from venous bilateral insufficiency. During the procedure, there was an accidental laceration of the femoral vein with heavy haemorrhaging. The patient was transferred to a central	The court found that the doctor was distracted during surgery and that he had failed to perform adequate pre-surgery examinations, for example, an Eco Doppler test

(continued)

Table 1. (continued)

Case number Date decision Court	Description	Decision
	hospital and his life was saved by an emergency bypass procedure but suffered permanent damages	
#21 1645/08.6 30 April 2014 TRP	A boy was diagnosed with achondroplasia at birth. An associated foramen magnum stenosis was diagnosed in January 2008, after the boy had been experiencing breathing problems for many months, and the condition demanded surgical cervicomedullary decompression. Nevertheless, the orthopaedist who followed the boy failed to perform the surgery. In late 2008, the boy suffered cardiorespiratory failure and was rushed to hospital on four different occasions. The emergency doctors on call came from different hospitals and all failed to check the patient's history or to coordinate with the boy's physician. The last cardiorespiratory failure was severe and left the boy with permanent brain damage caused by anoxia. This was a criminal case	The court found (against the counsel of medical experts) that although there was a lack of coordination between the various doctors who attended to the boy and the diagnosis and surgery had been protracted, it could not be proved to be the relevant standard that these circumstances had caused the damage since achondroplasia is a complex and severe medical condition
#22. 35/11.8 21 February 2017 TRE	In 2009, an adult male was admitted to the emergency department of a public hospital of a small town in the south of Portugal, complaining of abdominal pain. He was an alcoholic, former drug addict, previously diagnosed with Hepatitis C. He was discharged, but was later found unresponsive lying on the ground and rushed to the emergency department again. The attending doctor saw a wound in his head, but suspecting intoxication, he ordered the patient to be transferred to the psychiatry unit of a central hospital more than 200 km away. Once there, the	Both doctors who had previously attended to the patient faced criminal charges, but claimed the traumatic brain injury was not present when they observed him and could have occurred during transportation. They were acquitted

(continued)

Table 1. (continued)

Case number Date decision Court	Description	Decision
	psychiatrist quickly diagnosed him with withdrawal syndrome, did not order a CT scan or any other tests, and transferred him back to the first hospital. Upon arrival, although the patient was agitated and lapsed in and out of consciousness, the doctor decided to transfer the patient by ambulance to the central hospital of the city he lived in, another 600 km away. When he arrived, a CT scan was finally performed. It revealed cerebral haemorrhage. Emergency surgery was performed to relieve the pressure, and the patient's life was saved, although he subsequently stayed in the hospital for more than a year and suffered permanent damage to his brain function	
#23. 371/11.3 7 January 2016 TRE	In 2010, while on holiday, a deaf-mute, mildly cognitively impaired woman fell head first more than 3 m onto a rock. She was immobilized and rushed to the nearby hospital, where multiple radiographic exams were performed. The tests did not reveal any serious injuries, but she soon began to show difficulty in moving her legs, and another doctor thought she should be seen by a neurologist. There was a change in shift, and the new doctor did not call a neurologist and after a few hours' observation decided to discharge the patient. A few days later, the patient was admitted to the same hospital and a CT scan revealed a fracture of the C-5 vertebrae. She was transferred to a larger hospital 200 km away and underwent surgery. In the subsequent months, she was transferred from hospital to	The orthopaedist who had discharged the patient a few hours after the fall was absolved of the manslaughter charges but found liable for some of the damages

(continued)

Table 1. (continued)

Case number Date decision Court	Description	Decision
	hospital, her condition worsened and she died as a result of a respiratory infection and acute anaemia	
#24. 124/13.4 6 November 2018 TRE	In 2013, a 78-year-old male died while in the care of a public hospital where he had been admitted complaining of chest pain. After triage, the situation was deemed very urgent and cardiothoracic emergency procedures were ordered. The hospital was not equipped with echocardiography equipment or personnel, but the available electrocardiogram and haemogram tests revealed alterations pointing to cardiopathy. A change of shift occurred and the new doctor either failed to recognize this or did not have access to the results (this was not clear) and discharged him after a few hours. The patient was found dead in his home a few hours later: his aorta has ruptured	The defendants – both the doctors who had attended to the patient – were pronounced (ordered to stand trial) for manslaughter, even though they argued the hospital was ill-equipped and that the hospital administration should have organized the emergency service more efficiently
#25. 564/13.9 24 February 2016 TRC	In 2013 a 14-year-old boy died of meningitis caused by *Haemophilus influenzae* in the care of the paediatric emergency department of a public hospital. He had been rushed to the emergency department shortly after lunchtime with a very high fever and was triaged as a very urgent case. The doctor in charge of the service saw the boy 1 h later, and again after a few more hours. She wanted to discharge the patient, claiming he had the flu, but as the mother strongly opposed, she transferred him to an infirmary and the care of a nurse. She had ordered microbiological testing by late afternoon. That night, the	The doctor was absolved of liability due to a lack of evidence that death could have been prevented had the patient been diagnosed earlier

(continued)

Table 1. (continued)

Case number Date decision Court	Description	Decision
	young man suffered a cardiorespiratory failure, fell into a coma, and was transferred to an intensive care unit where he died the next morning. The results of the microbiological tests were ready only after the patient's death. This was a criminal case – where the presumption of innocence rule applies	
#26 0813421 12 November 2008 TRP	In 2001, a woman died at home, having been discharged from the small-town public hospital where she had been rushed to by ambulance after a car had struck her. The emergency doctor was accused of manslaughter, because he had failed to perform a number of examinations which would have diagnosed the fracture of several vertebrae, which later caused hypovolaemic shock and death. The doctor acknowledged that he was stressed and did not take the time to talk to the patient, and as a result did not know she had been thrown 3 m in the air and had landed on some rocks, and that, if he had known, he would certainly not have discharged her and would instead have transferred her to a central, better equipped hospital	In spite of these finding these circumstances attenuating, the doctor was convicted

Note 1: Meaning of initials of Civil Courts: STJ: Supremo Tribunal de Justiça (Judicial l Supreme Court); TRL – Tribunal da Relação de Lisboa (Court of Second Instance, Lisbon); TRP – Tribunal da Relação do Porto (Court of Second Instance, Porto); TRC: Tribunal da Relação de Coimbra (Court of Second Instance, Coimbra); TRE: Tribunal da Relação de Évora (Court of Second Instance, Évora); TRG: Tribunal da Relação de Guimarães (Court of Second Instance, Guimarães).
Note 2: Meaning of initials of Administrative Courts: STA: Supremo Tribunal Administrativo (Supreme Administrative Court); TCA-S: Tribunal Central Administrativo Sul (Administrative Court of Second Instance, South); TCA-N: Tribunal Central Administrativo Norte (Administrative Court of Second Instance, North).
Note 3: Leges artis, or *secundum artis legis*, is the Latin phrase used in continental medical law, doctrine and jurisprudence to mean 'according to the law of the art'. The 'art' referred to in the phrase is medicine. In common law, there is a similar concept, the professional standard. The leges artis – or professional standards – are set by the various Specialty Colleges of the Portuguese Medical Board. For details, see note 38. *Note 4:* *Gabardo and Hachem, 2010.[31]

rationing decision. These findings seem to suggest that the public is not sufficiently alert to the implicit prioritization that happens in the NHS and/or has become accustomed to a less than optimal service. Notwithstanding, the results indicate some correlation between the implicit method of healthcare rationing practiced in the Portuguese NHS and patients' damage. Actually, the results suggest that small-town hospitals suffer from a lack of equipment and staff and, as such, complicated clinical situations are redirected to central hospitals; Portuguese patients have unequal access to treatments; communication problems between the staff may lead to variation in medical practice that raises questions about the quality, equity and efficiency of resource allocation and use, and have important implications for healthcare and health policy[32]; strong resistance from obstetricians to resort to C-sections sometimes leads to brain damage or even death; and finally, there is evidence of *cream skimming*, since hospitals sometimes choose patients for some characteristic(s) other than their need for care.[33]

Furthermore, our results reveal that physicians themselves, when faced with costly and emotionally draining malpractice suits or even criminal charges, tend not to invoke the lack of conditions in which they work or the stresses they are subject to in their defence. This leads us to believe that the problems are pervasive and enshrined in the working culture and that healthcare professionals may feel trapped inside the system. Another possible explanation is that the proof of causation between the harms suffered and the rationing decisions are actually too difficult, especially in the light of the type of responsibility mechanisms – a responsibility based on risk, in some cases, on a contract, in others – that usually apply and that invert the burden of proof. We acknowledge however that our data are insufficient to prove these hypotheses. Further research is necessary to ascertain whether our explanations are more than speculative, but this research will require access to data which is not easily available to the public. Nevertheless, this issue has very recently begun to enter the public sphere, especially since the Portuguese Medical Association has increasingly called attention to a clear relationship between medical negligence claims, lack of resources and poor working conditions.[34] A group of doctors working in particularly busy and underfunded public hospitals have stated publicly that under current conditions they are not able to offer even the most basic standard of care, and as such they decline responsibility for the harm that

31. E. Gabardo and D.W. Hachem. Responsabilidade civil do Estado, faute du service e o princípio constitucional da eficiênciaadministrativa. In: A.D. de Mello, Guerra, L.M.F. Pires, M. Benacchio (Orgs.). *Responsabilidade civil do Estado: desafios contemporâneos* (SãoPaulo: Quartier Latin, 2010), pp. 155–201.
32. A.N. Corallo and others, 'A Systematic Review of Medical Practice Variation in OECD Countries', *Health Policy (Amsterdam, Netherlands)* 114(1) (2014), pp. 5–14.
33. D.L. Friesner and R. Rosenman, 'Do Hospitals Practice Cream Skimming?', *Health Services Management Research* 22(1) (2009), pp. 39–49.
34. 'Ordem Justifica Processos Contra Médicos Com a Falta de Recursos' (Portugal: Sic Notícias, 2019). Available at: https://sicnoticias.pt/saude-e-bem-estar/2019-11-05-Ordem-justifica-processos-contra-medicos-com-a-falta-de-recursos.

patients might suffer.[35] Hospital administrators around the country have been offering their resignations in protest against the lack of resources.[36]

Despite all this, it is important to note that Portuguese culture is not one of malpractice litigation, as compared to America, for example. However, we are beginning to see some changes and in the future, there will likely be more civil and criminal actions against doctors, which will in turn further increase healthcare costs.[37] A recent study showed that past successful medical malpractice claims are strong predictors of future claims and that having as few as one successful claim in the previous 5 years nearly quadruples the likelihood of a claim in the next 5 years.[38]

One key strength of our study is the novelty of its approach. As far as we are aware, this is the first attempt to explore the relationship between scarcity of resources, implicit rationing and medical malpractice liability.[39] Its second strength is that our analysis of cases extends over a long period of time (12 years). However, as is common in any research, we acknowledge that our study has limitations. First, the Portuguese judicial system is complicated and slow moving. We had set out to identify differences in the number and type of malpractice suits before and after 2011 – the year of the beginning of the financial assistance and subsequent three-year economic adjustment programme to Portugal – and from 2014 – marking the end of the adjustment – to the present day.

35. Francisco Romão Pereira, 'Médicos Pedem Escusas de Responsabilidades Na Urgência Do Hospital Santa Maria', *Observador*, 7 November 2019. Available at: https://observador.pt/2019/11/07/medicos-recusam-se-a-assumir-responsabilidades-na-urgencia-do-santa-maria. Also M. Do Santa Maria Denunciam Falta de Condições Na Urgência', *Expresso*, 7 November 2019. Available at: https://expresso.pt/sociedade/2019-11-07-Medicos-do-Santa-Maria-denunciam-falta-de-condicoes-na-Urgencia.
36. 'Administração Do Hospital de São João Demite-Se', *Diário de Notícias*, 9 January 2019. Available at: https://www.dn.pt/pais/administracao-do-hospital-de-sao-joao-demite-se-10417861.html. Also, 'Presidente Do Centro Hospitalar de Leiria Demite-Se Devido a Falta de Recursos', *Público*, 6 March 2019. Available at: https://www.publico.pt/2019/03/06/sociedade/noticia/presidente-centro-hospitalar-leiria-demitese-devido-falta-recursos-1864361; and 'Presidente Do Conselho de Administração Do Hospital de Gaia Renuncia Ao Cargo Com Efeito Imediato', *Expresso*, 1 April 2019. Available at: https://expresso.pt/sociedade/2019-04-01-Presidente-do-conselho-de-administracao-do-Hospital-de-Gaia-renuncia-ao-cargo-com-efeito-imediato.
37. D.N. Lakdawalla and S.A. Seabury, 'The Welfare Effects of Medical Malpractice Liability', *International Review of Law and Economics* 32(4) (2012), pp. 356–369.
38. B. Black, D.A. Hyman, and J.Y. Lerner, 'Physicians with Multiple Paid Medical Malpractice Claims: Are They Outliers or Just Unlucky?', *International Review of Law and Economics* 58 (2019), pp. 146–157.
39. We are not aware of any other studies that followed this approach, in Portugal or elsewhere. We did find two interesting studies, one from Finland cf. K.M. Kimmel, 'Challenges in Regulating Priority Setting in Healthcare: A Finnish Perspective on the Lawmaker's Dilemma', *Medical Law International* 19(2–3) (2019), pp. 136–158 and another one from Switzerland cf. – Brigitte Santos-Eggimann, *Is There Evidence of Implicit Rationing in the Swiss Healthcare System?*, 2005 with similar propositions.

However, the most recent facts we could find dated back to 2013, which made this comparison unviable. Unless the state of Portuguese justice changes soon – which is unfortunately not likely – it will take another 5–10 years before such an analysis can be made. Second, most decisions were purely or largely technical. The Portuguese superior court only decides *de jure*, and even in the courts of second instance most of the facts are filtered to include only those which the court decided were relevant, are only summarized and put into the 'proved' and 'not proved' groups, and the details are lost. Lastly, there are no public records of first instance decisions or court session transcriptions where we could have found the unfiltered particulars as they were put forward by the parties. We wanted to ascertain facts; instead, we were buried in long – often repeated – legal arguments mostly about the *legesartis*[40] and the burden of proof. It is our contention that these drawbacks are offset by the contribution of this study.

Conclusions

When facing malpractice suits, physicians will always be held to the professional – *leges artis* – standard,[41] and the actions and interventions that the law requires are set without regard to cost.[42] This places an unfair burden on healthcare professionals who have to make rationing decisions with unfortunate results: the obligation to prove that other professionals faced with the same circumstances would have made the same rationing decision. The malpractice standard precludes any consideration of cost constraints.[43] The law and the courts are not prepared to accept that in the present context of scarcity of resources there might be a decrease in the care provided in response to financing concerns or understaffing of services. This has resulted in decisions against physicians in malpractice suits that should, instead, have taken into account or given sufficient weight to the stressful circumstances of forced bedside rationing decisions that overworked physicians sometimes had to make in understaffed hospitals. These decisions were very often the result of prioritization measures that are implicit and casuistic rather than clear, transparent and general.

40. *Leges artis*, or *secundum artis legis*, is the Latin phrase used in continental medical law, doctrine and jurisprudence to mean 'according to the law of the art'. The 'art' referred to in the phrase is medicine. Cf. B.A. Koch (ed.), *Medical Liability in Europe* (Berlin, Boston: DE GRUYTER, 2011), DOI:10.1515/9783110260168>. Some authors have argued that the concept is outdated. Cf. K. Kraetschmer, '"Lege Artis"—An Outdated Concept in Modern Medicine?', *European Journal of Health Law* 21(2) (2014), pp. 119–122. In common law there is a similar concept, the professional standard. The *leges artis* – or professional standards – are set by the various Specialty Colleges of the Portuguese Medical Board.
41. P.H. Schuck, 'Malpractice Liability and the Rationing of Care', *Texas Law Review* 59(8) (1981), pp. 1421–1427. PMID: http://www.ncbi.nlm.nih.gov/pubmed/11650624.
42. J.J. Frankel, 'Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures', *Yale Law Journal* 103(5) (1994), p. 1297.
43. M.A. Hall, 'The Malpractice Standard under Health Care Cost Containment', *Law Medicine and Health Care* 17(4) (1989), pp. 347–355.

It is argued that the courts have a responsibility to the medical profession and to the public in general, and they must take into account the circumstances in which decisions are made and how they might influence physicians' performance and outcome. Lawyers and judges must be made aware of the impact of rationing decisions and consequently on the burden that implicit prioritization places on healthcare professionals. Defence teams must reflect this knowledge and courts must lower the standard of the *leges artis* in some cases: the professional standard is very dependent on *a spare no expense* logic that is unfortunately not the reality in tax-payer financed healthcare systems like that in Portugal, particularly after the 2008 global crisis.[44] It is worth mentioning that this does not mean that citizens must now accept a lower standard of care or that physicians are not to be held accountable for their actions. In fact, healthcare rationing methods and/or criteria are hardly a matter for courts alone to decide and the involvement of courts in access to healthcare problems is widely debated internationally.[45] Even in countries in which there is a fundamental or constitutional right to healthcare, as is the case in Portugal, Germany, Brazil or the United Kingdom, the courts tend to decline to interfere in rationing choices made by the corresponding national health services.[46] In the United Kingdom, for instance, courts have in several cases asserted the right of NHS managers to take difficult rationing decisions even though these result in patients being denied treatment that could have benefited them.[47] In Germany, however, the Constitutional Court's 2005 *Nikolaus decision* stated that the constitutional 'right to health' allows patients to challenge decisions that withhold reimbursement of treatment excluded from public funding because of insufficient evidence of effectiveness, or when the condition is life-threatening or even no alternative treatment is available and there is an indication that the treatment could benefit the patient.[48] Nevertheless, courts have struggled to apply this recommendation.[49] The implication that the *Nikolaus decision* might have on future central rationing decisions may be disturbing because it involves the judicialization of

44. L. Giovanella and K. Stegmüller, 'The Financial Crisis and Health Care Systems in Europe: Universal Care under Threat? Trends in Health Sector Reforms in Germany, the United Kingdom, and Spain', *Cadernos de Saúde Pública* 30(11) (2014), pp. 2263–2281.
45. C. Flood and Aeyal-Gross, 'Litigating the Right to Health: What Can We Learn from a Comparative Law and Health Care Systems Approach', *Health and Human Rights* 16(2) (2014), pp. E62–E72.
46. D. Wei Liang Wang, *Can Litigation Promote Fairness in Healthcare? The Judicial Review of Rationing Decisions in Brazil and England* (London: London School of Economics and Political Science, 2013).
47. C. Newdick, 'Health Care Rights and NHS Rationing: Turning Theory into Practice', *Revista Portuguesa de Saúde Pública* 32(2) (2014), pp. 151–157. Also, K. Syrett, 'Courts, Expertise and Resource Allocation: Is There a Judicial "Legitimacy Problem"?', *Public Health Ethics* 7(2) (2014), pp. 112–122.
48. S. Ettelt, 'Access to Treatment and the Constitutional Right to Health in Germany: A Triumph of Hope over Evidence?', *Health Economics, Policy and Law* 15(1) (2020), pp. 30–42.
49. Op. cit. Also, A. Bohmeier and others, 'Die Umsetzung Des Nikolaus-Beschlusses Durch Die Sozialgerichtsbarkeit: Fortentwicklung Und Widersprüche Zu Den Vorgaben Des BVerfG', *Wege Zur Sozialversicherung* 3 (2009), pp. 65–77.

politics[50] and is reflective of the tension between two often conflicting principles: the right to healthcare and distributive justice (dependent on evidence-based medicine).[51]

In conclusion, prioritization in healthcare is an ethical problem before it is a judicial, economic or political one. Against the background of rising healthcare costs, the ethical task is to define the basis for a social consensus that secures the most important social values. We should ensure that healthcare is always value for money, that priority-setting is minimal, but that when it is indispensable the most vulnerable are not the ones left to pay the price of rising costs and inefficiency. These are choices that society must make as a whole, but they are inevitable and urgent. For that they must be legitimate as well as ethical,[52] and therefore they must be made through the democratic process.

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50. C. Landfried, 'The Judicialization of Politics in Germany', *International Political Science Review* 15(2) (1994), pp. 113–124.
51. R. Cookson, 'Principles of Justice in Health Care Rationing', *Journal of Medical Ethics* 26(5) (2000), pp. 323–329.
52. A. Dawson and M. Verweij, 'Public Health and Legitimacy: Or Why There Is Still a Place for Substantive Work in Ethics', *Public Health Ethics* 7(2) (2014), pp. 95–97.