CONSIDERATIONS ON MEDICAL CIVIL LIABILITY IN BRAZIL

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1. Medical civil liability: historical origins and contemporary context

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1.1. Historical roots of the liability of the healthcare professional

Medical civil liability has ancient roots dating back to Babylonian civilization. Between the 18th and 17th centuries B.C., during the first Dynasty of Babylon, King Hammurabi enacted the Code of Hammurabi, which already contained express provisions on the liability of healthcare professionals. In that normative context, liability was of an objective (strict) nature, grounded in the retributive logic of "an eye for an eye, a tooth for a tooth," so that any analysis of the professional's fault was disregarded for the purpose of imputing the duty to make reparation.[2]

In parallel, scholarship notes that between the 5th and 4th centuries B.C. the teachings of Hippocrates prevailed in ancient Greece, whose contribution was decisive for the evolution of medical science. Hippocrates grounded the practice of medicine in reason and scientific observation, inaugurating an ethical-moral paradigm that made the patient's health the physician's foremost obligation. From this legacy was born the celebrated Hippocratic Oath, still used as a deontological reference today.[3]

The notion of medical fault began to be outlined precisely in that Greek period, in tune with the Egyptian tradition that equated physicians with priests. However, these professionals were subject to capital punishment if they violated the mandatory rules imposed upon them. It was only with the Roman "Lex Aquilia," in harmony with the principle of "neminem laedere" (to harm no one), that fault became a condition for professional liability, although still within a rather severe context that allowed the death or deportation of a physician who committed a culpable error.[4]

Illustrative of this conception is the fragment of Ulpian recorded in the Digest (1, 18, 6, 7), according to which the physician should not be charged with the death outcome itself, but only with what he had done through lack of skill. This passage shows that, already in Roman law, the professional was liable for culpable conduct without, however, assuming the duty to cure the patient's illness.[5]

1.2. The Industrial Revolution and the advancement of medical science

Medicine underwent a significant transformation after the first Industrial Revolution, which began in England at the end of the 18th century. The massive migration to urban centers, brought about by devastating epidemics of tuberculosis, pneumonia, measles, influenza, scarlet fever, diphtheria, and smallpox, generated a scenario of intense mortality that demanded answers from science. Accelerated population growth resulted in large urban agglomerations, with precarious housing and health conditions, which favored the spread of hitherto unknown and untreatable diseases.[6]

This context of sanitary crisis steered technological progress toward the development of medical science. New medicines, equipment, and treatment modalities were gradually created, making it possible to cure various diseases. However, alongside the undeniable benefits afforded by modernity, risks to the life and health of patients also arose, inherent to the very evolution of therapeutic techniques. In this sense, contemporary medicine has become an activity that, by its very nature, involves significant risks.[7]

1.3. The mass scale of care and the transformation of the physician-patient relationship

Pronounced demographic growth imposed the formation of an internal mass market geared toward healthcare. This structural transformation profoundly altered the dynamics

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[2] Cf. Tomé, 2026; Stoco, 2013, p. 717-718.
[3] Cf. Tomé, 2026.
[4] Cf. Tomé, 2026; Kfouri Neto, 2013, p. 58-60.
[5] Cf. Tomé, 2026; Kfouri Neto, 2013, p. 58-60.
[6] Cf. Tomé, 2026.
[7] Cf. Tomé, 2026; Udelsmann, s.d.

between physician and patient, converting the former into a service provider and the latter into a consumer, according to the logic of contemporary consumer relations. The gradual loss of ethical values contributed to depersonalizing this relationship, while patients' growing awareness of their rights broadened the perception of professional failures such as lack of skill, negligence, and imprudence.[8]

These combined factors produced a distancing between the professional and the patient, opening the way for the significant growth of lawsuits based on medical civil liability, a phenomenon especially pronounced in the United States of America. Nevertheless, the most appropriate path has always been prevention, both for the physician and for the patient, who does not seek care for the purpose of obtaining compensation. Prevention presupposes quality medical services, provided with respect and loyalty, in which the patient is treated as a human being and not as a mere customer of a commercial service in the healthcare field.[9]

1.4. The ethical dimension and the imperative of humanization

The contemporary scenario reveals that some professionals who deal with human life and health show insufficient preparation to treat patients with humanity, to fully respect their choices and decisions, and to prevent harm to their rights. Ethical and moral values, although constantly invoked as pillars of peaceful and dignified coexistence, are at times neglected in favor of private interests. The medical professional must guide his conduct by honesty, humility, and humanity, in accordance with the best scholarship.[10]

The relationship between physician and patient must therefore be permeated by solidarity and by the exclusive purpose of preventing, treating, and, when possible, curing human illnesses. A good relationship between the two is a fundamental element, combined with the correct and diligent exercise of the profession, in attention to the specific needs of each patient. It is essential that physicians precisely understand the legal relationship formed from the provision of care, knowing their rights and duties in this bond, in order to properly fulfill the obligation assumed, without causing harm or conflict.[11]

2. Legislation applicable to medical civil liability

2.1. Subjective (fault-based) liability since the Civil Code of 1916

The civil liability of physicians has been provided for in the Brazilian legal system since the Civil Code of 1916, which already enshrined the subjective (fault-based) modality for harm caused during professional activity. Proof of culpable conduct was therefore required in one of the three modalities - imprudence, lack of skill, or negligence - in addition to the demonstration of the causal link and of the actual harm suffered by the patient. This model follows the historical tradition of medical liability built since ancient Greece, when the idea of fault began to be formulated.[12]

2.2. The advent of the Consumer Protection Code

From 1990 onward, the Consumer Protection Code (CDC) came to regulate consumer relations, providing specifically in Article 14, §4, on the civil liability of the self-employed professional, a category that encompasses physicians regardless of the form of engagement. The inclusion of this provision generated scholarly controversy regarding the legislation applicable to errors committed by physicians in their professional practice. Part of the scholarship maintains that conflicts between physician and patient should be governed

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[8] Cf. Tomé, 2026; Stoco, 2013, p. 720; Farah, 2009.
[9] Cf. Tomé, 2026; Kfouri Neto, 2010, p. 34.
[10] Cf. Tomé, 2026; Kfouri Neto, 2010, p. 34.
[11] Cf. Tomé, 2026.
[12] Cf. Tomé, 2026.

primarily by the Civil Code, including with respect to the limitation period for the claim for compensation.[13]

However, the majority view holds that the relationship between physician and patient constitutes an actual consumer relationship and must be governed by the CDC. This is the position consolidated by the Superior Court of Justice (STJ, REsp 731.078/SP, Reporting Justice Castro Filho, 3rd Panel, judged 13 Dec. 2005, DJ 13 Feb. 2006). The CDC represented a milestone for civil liability by benefiting consumers through the facilitation of access to justice, with the possibility of filing the action in the victim's domicile (Article 101, I), the reversal of the burden of proof by the judge (Article 6, VIII), the recognition of the joint and several liability of all members of the supply chain (Article 25, §1), and the guarantee of full reparation of harm (Article 6, VI).[14]

2.3. The Civil Code of 2002 and legislative perspectives

The Civil Code of 2002 maintained the subjective (fault-based) civil liability of the self-employed professional, encompassing physicians, surgeons, pharmacists, dentists, physiotherapists, nurses, and other healthcare professionals. Currently, Bill No. 4/2025 is under consideration, which seeks to amend the Civil Code, maintaining the physician's subjective liability and inserting, if approved, specific provisions on the theory of loss of a chance, an institute widely used in the field of medical civil liability.[15]

2.4. Summary of the applicable legislation

In summary, the physician who practices as a self-employed professional is subject to subjective (fault-based) liability, under Article 14, §4, of the CDC, and Articles 186, 927, and 951 of the Civil Code of 2002. The same rules apply to the professional who provides services under an employment relationship, in groups, or through health plans, the nature of his liability always remaining subjective.[16]

3. Legal nature of the physician-patient relationship

3.1. Contractual character of the relationship

The relationship established between physician and patient is, as a rule, contractual in nature, according to the understanding consolidated by the STJ (REsp 1.104.665/RS, Reporting Justice Massami Uyeda, 4th Panel, judged 9 Jun. 2009, DJe 4 Aug. 2009). It is, however, a contractual relationship endowed with particularities, since its object is a special provision of services that includes ancillary duties, notably the duty to inform, from which the free and informed consent form derives (STJ, REsp 1.540.580/DF, Reporting Justice Lázaro Guimarães, 4th Panel, judged 2 Aug. 2018, DJe 4 Sep. 2018).[17]

The contract between physician and patient is often formed by the patient's mere tacit agreement, although it may be entered into orally or in writing. Exceptionally, the relationship may be extracontractual, that is, without the prior existence of a contract, as occurs when the physician provides care on a public road, during a trip, or aboard an aircraft. The contractual nature of medical liability is a matter long settled in scholarship and case law.[18]

3.2. A "sui generis" service contract

Scholarly controversy persists regarding the classification of this contractual relationship. Some characterize it as a simple service contract. The prevailing view, however, is that it is a "sui generis" service contract, as defined in the Codes of Switzerland and Germany.

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[13] Cf. Tomé, 2026; Farah, 2009; Stoco, 2013.
[14] Cf. Tomé, 2026.
[15] Cf. Tomé, 2026.
[16] Cf. Tomé, 2026.
[17] Cf. Tomé, 2026.
[18] Cf. Tomé, 2026; Dias, 1950, p. 270-273.

According to this conception, the physician is simultaneously adviser, protector, and guardian of the patient, so that the relationship is not limited to the provision of services in exchange for pecuniary consideration, but requires of the professional a professional conscience that goes beyond technical knowledge.[19]

4. Obligation of means and obligation of result

4.1. Conceptual distinction and procedural repercussion

In the service relationship formed between physician and patient, whether contractual or extracontractual, it is essential to identify whether the obligation assumed is one of means or one of result, since this classification has a direct bearing on the allocation of the burden of proof in any lawsuit. An obligation consists of a legal relationship established, as a rule, between creditor and debtor for the performance of a duty that may be to give, to do, or not to do.[20]

In an obligation of means, the debtor undertakes to act diligently, employing all available resources and knowledge, without guaranteeing a specific result. In an obligation of result, by contrast, the professional's diligent conduct is not sufficient; the useful result legitimately expected by the creditor must be achieved. The majority scholarship and case law hold that the relationship between physician and patient gives rise, as a rule, to an obligation of means. This means that the professional is not bound to cure or save the patient's life, but to employ all his technical knowledge and the available resources to care for, treat, and, when possible, promote the cure.[21]

This understanding is supported by the STJ (REsp 1.051.674/RS, Reporting Justice Massami Uyeda, 3rd Panel, judged 3 Feb. 2009, DJe 24 Sep. 2009). The object of the medical contract is not the cure, but the provision of conscientious, attentive care consistent with the advances of science. This is a position also embraced by Spanish scholarship.[22]

4.2. Exception: plastic surgery as an obligation of result

A relevant exception to the general rule is the civil liability of the plastic surgeon. The case law of the STJ, regardless of whether the surgery is cosmetic or reconstructive, classifies this service as an obligation of result, by reason of the commitment to a useful result promised to the patient (STJ, AgInt in AREsp 2506337, Reporting Justice João Otávio de Noronha, 4th Panel, judged 24 Mar. 2025, DJEN 28 Mar. 2025). However, a significant portion of scholarship disagrees with this orientation, arguing that no physician can commit to a specific result, especially given the individual peculiarities of each organism, which may give rise to unforeseeable complications even in cosmetic procedures.[23]

4.3. Repercussion on the burden of proof

The distinction between obligation of means and obligation of result is decisive for fixing the burden of proof. In an obligation of means, it falls to the patient to demonstrate the physician's culpable conduct in order to be entitled to reparation. In an obligation of result, the physician's fault is presumed: once it is shown that the legitimately expected result was not achieved, it will be up to the professional to prove some ground excluding liability. It is important to stress that an obligation of result is not the same as strict liability, since there is no legal provision to that effect. Under Article 14, §4, of the CDC, the liability of the self-employed professional is always subjective (fault-based), even when the obligation is one of result.[24]

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[19] Cf. Tomé, 2026; Dias, 1950, p. 270-273; Cavalieri Filho, 2010, p. 385.
[20] Cf. Tomé, 2026.
[21] Cf. Tomé, 2026; Penteado; Figueiredo, s.d., p. 222; Dias, 1950, p. 274.
[22] Cf. Tomé, 2026; Casado, s.d.
[23] Cf. Tomé, 2026.
[24] Cf. Tomé, 2026.

Thus, the prevailing understanding is that the liability of self-employed professionals is subjective, with presumed fault in the obligation of result and fault to be proven by the victim in the obligation of means. When the obligation is one of result and the intended result is not achieved, the obligation will be deemed breached, giving rise to reparation or compensation. The STJ examines not the exactness of the result, but the attainment of a satisfactory result. The obligation of means, in turn, will require unequivocal proof of the breach of the duty of diligence, normally produced through technical expert evidence.[25]

5. Medical specialties with doubt as to the applicable obligation

5.1. Plastic surgery: cosmetic and reconstructive

The development of science and technology allowed medicine to act also in improving physical appearance, beyond the traditional care for health and life. Scholarship long debated the lawfulness of plastic surgery, since many argued that performing a surgical intervention on a healthy patient would be unlawful, owing to the unnecessary risks imposed on the individual. This was the understanding initially adopted in French case law.[26]

After lengthy discussion, plastic surgery became established as a lawful medical specialty. It unfolds into two modalities: corrective (or reconstructive) surgery, which seeks to correct congenital or traumatic physical deformities, and cosmetic surgery, whose purpose is to correct physical imperfections that bother the patient, with the aim of enhancing his appearance. As to corrective surgery, it is unanimous that the physician's obligation is one of means. As to cosmetic surgery, the controversy persists, with defenders of both positions. In any event, regardless of the surgical modality, when the result actually obtained significantly diverges from that foreseen, with markedly adverse consequences, compensation will be due.[27]

Identifying the purpose of the surgery - whether merely reconstructive or cosmetic - is a fundamental element in determining the applicable civil liability regime. In cosmetic surgery, motivations related to vanity, the attenuation of the signs of aging, the removal of localized fat, and the aesthetic enhancement of the body stand out.[28]

5.2. The anesthesiologist: nature of the obligation and phases of care

The anesthesiologist is an autonomous physician who establishes his own contractual relationship with the patient. Part of the scholarship maintains that this relationship gives rise to an obligation of result, considering that the professional undertakes to anesthetize the patient, suppress pain, put him to sleep, and, after the intervention, revive him without sequelae. However, the majority understanding is that it is an obligation of means, since the anesthesiologist undertakes to act diligently and carefully, without the possibility of ensuring a specific final result.[29]

The service provided by the anesthesiologist is divided into three phases: pre-operative, operative, and post-operative. In the pre-operative phase, the professional must collect relevant data and perform the tests and examinations necessary to determine the anesthetic appropriate for each patient. This stage is especially important given the habitual use of substances such as alcohol and illicit drugs by many patients, a circumstance that requires redoubled caution in choosing the anesthetic procedure. It falls to the anesthesiologist to

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[25] Cf. Tomé, 2026.
[26] Cf. Tomé, 2026; Dias, 1950.
[27] Cf. Tomé, 2026; Rizzardo, 2013, p. 335-337.
[28] Cf. Tomé, 2026; Rizzardo, 2013, p. 335-337.
[29] Cf. Tomé, 2026; Melo, 2013, p. 131.

select and correctly apply the anesthetic, according to recognized techniques, under penalty of liability for any harm.[30]

Any error in the administration of the anesthetic - whether by an inappropriate choice of the route of administration, by the incorrect selection of the substance, by an excessive dosage, or by application at an improper time interval - will give rise to the autonomous liability of the anesthesiologist. This liability will subsist even when the error was committed by an assisting nurse, constituting a case of "culpa in eligendo" (fault in choosing). Harm caused to the patient in the pre- and post-operative phases is the exclusive responsibility of the anesthesiologist.[31]

In the operative phase, the anesthesiologist must remain beside the patient throughout the entire procedure, monitoring his vital signs, under penalty of constituting negligence. Under Resolution No. 1,802/2006 of the Federal Council of Medicine, this presence is a fundamental duty of the professional. Harm occurring during the surgery may be imputed jointly to the surgeon and the anesthesiologist, depending on the form of engagement. If the anesthesiologist is part of the surgeon's team, both will be liable; if he belongs to the hospital's staff, only the hospital will be held liable, unless the order was improperly given or carried out under the supervision of the lead physician.[32]

6. Fault in medical civil liability

6.1. Foundation of subjective (fault-based) liability

The civil liability bearing on the relationship between patient and physician, both in the obligation of means and in the obligation of result, will be assessed by verifying the professional's fault, owing to the incidence of subjective (fault-based) liability. This modality is provided for in Article 14, §4, of the CDC, combined with Articles 186, 927, and 951 of the Civil Code of 2002. All these provisions adopted the theory of fault, requiring proof of imprudent, negligent, or unskilled conduct for the right to reparation or compensation to arise.[33]

The requirement of proof of fault stems from an elementary moral foundation: no one may be obliged to make reparation for harm without having contributed culpably to its production. In Brazilian civil law, fault is termed "culpa lato sensu" (fault in the broad sense), since it encompasses both intent (the intention to cause harm) and "culpa stricto sensu" (fault in the strict sense - conduct without harmful intent, but carried out with imprudence, negligence, or lack of skill). Where any of these modalities is present, the subjective element of civil liability will be established.[34]

6.2. Negligence

Negligence is one of the forms of "culpa stricto sensu," manifesting itself predominantly through omissive conduct. It consists of the lack of the minimum care necessary for the patient, revealing an inattentive posture that allows harm to occur. Illustrating this conduct are the absence of adequate hygiene, the failure to provide the correct medication, and unjustified delay in diagnosis that results in a worsening of the patient's state of health. Negligence is therefore characterized by inaction, indolence, and inertia, representing the failure to observe the duties required by the circumstances.[35]

In the case of a contractual relationship with an obligation of means, the physician is not required to cure, but to act cautiously and diligently. Breach of this duty, when it causes harm, gives rise to the obligation to make reparation for negligence. The physician has a duty to visit

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[30] Cf. Tomé, 2026; Stoco, 2013.
[31] Cf. Tomé, 2026; Dias, 1950.
[32] Cf. Tomé, 2026; Gonçalves, 2013, p. 272.
[33] Cf. Tomé, 2026.
[34] Cf. Tomé, 2026.
[35] Cf. Tomé, 2026; Kfouri Neto, 2013; França, 2013, p. 255.

his hospitalized patients, and breach of this obligation may constitute negligence, unless the professional assigns to another colleague the responsibility of fulfilling this duty. In the case of a shift handover, the physician must wait for the arrival of the replacement before leaving. If he leaves beforehand and the patient suffers harm owing to that absence, so-called "vicarious negligence" will be configured.[36]

Equally instances of negligence are: failing to heed the patient's complaints; prescribing in illegible handwriting that leads to the ingestion of the wrong medication; leaving a foreign object in the patient's body during a surgical procedure; medicating by telephone without examining the patient; presenting a diagnosis without confirming it through complementary examinations; or discharging a superficially examined patient whose illness was not diagnosed and who comes to die or suffer harm as a consequence of that conduct. It is important to stress that negligence is not the same as lack of skill: administering anti-tetanus serum without a prior test constitutes negligence when the physician knows of the need for the test and omits it; it will be lack of skill when the professional is unaware of that technical requirement.[37]

6.3. Imprudence

Imprudence is another modality of "culpa stricto sensu," manifesting itself through commissive, hasty conduct devoid of the caution expected of the professional. The imprudent physician acts in an untimely, senseless, or inconsiderate manner, disregarding the possible harmful consequences of his actions or failing to adopt the minimum required precautions. Imprudence results from unjustified attitudes taken without any prior care, and always has an active character, differing from negligence, which is characterized by omission.[38]

According to scholarship, imprudence frequently derives from lack of skill, since the physician who does not have sufficient preparation or adequate professional capacity, even aware of that limitation, does not refrain from acting. Lack of skill, in turn, occurs when the licensed professional acts as if he did not master the elementary notions of the technique of consulting, diagnosing, or operating.[39]

6.4. Lack of professional skill (imperícia)

Lack of skill is the third modality of "culpa stricto sensu," consisting of commissive conduct arising from a professional technical error. It reveals the physician's deficient technical knowledge, who adopts inadequate conduct contrary to technical standards, whether through absence of knowledge or through lack of preparation. The distinction between lack of skill and imprudence lies in the motivation: when the professional breaches the technical standard out of carelessness, but without aiming at harm, imprudence is configured; when the breach stems from ignorance or lack of preparation, it is lack of skill.[40]

Instances of medical lack of skill are illustrated by the conduct of the obstetrician who, in performing a cesarean section, perforates an organ of the patient, or that of the professional who, in a forceps delivery, causes cranial trauma to the newborn. The Court of Justice of São Paulo recognized this latter scenario as lack of skill (TJSP, Appeal 0101376-11.2009.8.26.0100, 8th Chamber of Private Law, Reporting Judge Theodureto Camargo, judged 12 Nov. 2014, DJe 4 Dec. 2014). Scholarship and case law admit the existence of medical lack of skill because the diploma does not constitute absolute proof of the technical capacity of the legally licensed professional.[41]

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[36] Cf. Tomé, 2026; França, 2013, p. 255.
[37] Cf. Tomé, 2026; Kfouri Neto, 2013, p. 106.
[38] Cf. Tomé, 2026; França, 2013, p. 255; Kfouri Neto, 2013, p. 109.
[39] Cf. Tomé, 2026; Kfouri Neto, 2013, p. 109; Zuliani, 2010, p. 409.
[40] Cf. Tomé, 2026; Rizzardo, 2013, p. 7.
[41] Cf. Tomé, 2026.

6.5. Medical error: concept, classification, and types

Medical error does not have a precise and univocal definition in scholarship, which has always generated divergence as to its exact scope. In January 2024, the expression was replaced by the formula "material and/or moral damages arising from the provision of healthcare services," although the new terminology is also the target of criticism for not encompassing all hypotheses of harm. In a broad sense, medical error may be defined as a failure committed by the professional at odds with technical guidance, in the exercise of the profession, that causes harm to the patient. Scholarship stresses that the concept should not be limited to the exclusive conduct of the physician, but should include any mistake committed in the chain of healthcare service providers.[42]

Medical error may be caused by a personal failure (lack of preparation, deficient knowledge, or absence of skill) or by a structural failure (deficiency of instruments or work resources). This distinction is fundamental for classifying the error as excusable or inexcusable. An excusable error is a justifiable one, which does not stem from culpable conduct, but from the uncertainty or imprecision inherent to medicine itself, such as the mistaken diagnosis of an uncatalogued disease. An inexcusable error, by contrast, is unjustifiable, committed through negligence, lack of skill, or imprudence, and gives rise to civil liability for the harm caused.[43]

Scholarship classifies medical error into three types: error of diagnosis (mistaken identification of the illness), error of procedure (correct diagnosis with an inadequate choice of treatment technique), and error in the procedure (correct diagnosis and technique, but defective execution). As an example of error of procedure, the case is mentioned of the patient with a leg wound who should have received only ointment and dressings but is advised to undergo surgery. Error in the procedure, in turn, is illustrated by an operation performed on a limb other than the one indicated. Only the inexcusable error will give rise to reparation, that is, one that would not be committed by another diligent professional under the same conditions.[44]

Part of the scholarship distinguishes fault (lack of skill) from professional error. Professional error consists of correct medical conduct using an inadequate technique, being considered excusable because it arises from the imperfections of science itself. Lack of skill, on the other hand, constitutes incorrect medical conduct, albeit with an adequate technique, being an inexcusable error subject to reparation. It is also important to distinguish medical error from the unforeseeable accident (a harmful result arising from a fortuitous event or force majeure) and from the uncontrollable result (the natural evolution of an incurable illness). Professional error, also called "technical error," is, as a rule, excusable, given the risk inherent to medicine, and must be gross in order to give rise to liability.[45]

6.6. Error of diagnosis

Diagnosis consists of the medical conduct through which the professional seeks to identify the disease afflicting the patient, in order to determine the appropriate treatment. More than a procedure, it constitutes a medical duty, under Article 32 of the Code of Medical Ethics, which prohibits the physician from failing to use all available, scientifically recognized means of diagnosis and treatment within his reach. Diagnosis comprises the determination of the illness, its causes, characteristics, and effects.[46]

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[42] Cf. Tomé, 2026; Policastro, 2013, p. 2.
[43] Cf. Tomé, 2026; Stoco, 2013, p. 723.
[44] Cf. Tomé, 2026; Stoco, 2013, p. 723-724.
[45] Cf. Tomé, 2026; Cavalieri Filho, 2010, p. 387; Stoco, 2013, p. 724; Aguiar Júnior, 1995.
[46] Cf. Tomé, 2026; Aguiar Júnior, 1995; Rizzardo, 2013, p. 325.

It is not an objective or mathematical procedure, which requires extreme prudence. It unfolds into two main phases. The first is the clinical examination, which comprises the anamnesis (initial collection of data on symptoms, genetic antecedents, and previous diseases) and the physical examination (checking of mucosae, lymph nodes, hydration, temperature, blood pressure, heart and respiratory rate, abdominal palpation, and percussion). The second phase consists of the eventual request for complementary examinations (laboratory or imaging), followed by the comparative analysis between the data collected and the results obtained in order to reach the correct diagnosis.[47]

Where there is doubt about the diagnosis or suspicion of error in the examination performed, the physician must repeat it or supplement it with other examinations. In the case of a wrong diagnosis owing to a defective laboratory or imaging examination, the professional will have a right of recourse against the party responsible for the examination, whose obligation is one of result. Scientific and technological advancement no longer permits diagnosis based solely on the so-called "clinical eye," requiring substantiation in specific examinations with confirmatory reports.[48]

The error of diagnosis may be excusable or inexcusable, and does not automatically result in civil liability. It will be essential to verify the cause that led to the mistake, which may be of a personal or instrumental nature. Diagnosis is an eminently technical procedure, which makes it difficult for the judge to recognize the error without expert evidence, except in cases of gross error. The STJ has already ruled on the subject (REsp 1.662.338/SP, Reporting Justice Nancy Andrighi, 3rd Panel, judged 12 Dec. 2017, DJe 2 Feb. 2018). Scholarship proposes two fundamental criteria for assessing the physician's fault: (i) whether the conduct adopted would be the same as that of another prudent professional under the same conditions; and (ii) whether the physician used all the resources at his disposal to obtain certainty of the diagnosis.[49]

The majority understanding is that an error of diagnosis does not give rise to civil liability, except where it is a gross error, that is, a situation in which the physician did not do what he should and could have done, having the necessary means. The theory of loss of a chance relates to this hypothesis, insofar as the improper use of the available means may prevent the patient from obtaining an improvement in his clinical condition, under Article 5 of the Code of Medical Ethics.[50]

7. The remaining elements of liability: harm and causal link

7.1. Medical harm: types and characteristics

The physician's obligation, as a rule, is contractual and one of means, and his liability is subjective, requiring proof of the culpable conduct that caused the harm, as well as of the causal link between the conduct and the result. The existence of harm as a consequence of medical error is not enough to crystallize the duty to make reparation; it is necessary to demonstrate all the elements of civil liability. Moreover, there is no right to reparation without proof of the injury, which may be of a material or moral nature. Mere annoyances, discomforts, or sufferings do not, in themselves, characterize moral damages, given the absence of a legal basis.[51]

Scholarship qualifies the harm arising from medical activity as iatrogenesis, an expression that designates the pathological alteration caused in the patient by treatment of any

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[47] Cf. Tomé, 2026.
[48] Cf. Tomé, 2026; Stoco, 2013, p. 738.
[49] Cf. Tomé, 2026; Kfouri Neto, 2013, p. 101-102; Stoco, 2013, p. 738.
[50] Cf. Tomé, 2026.
[51] Cf. Tomé, 2026; Stoco, 2013.

nature. The injury may result from the professional's action or omission, lawful or unlawful. Lawful conduct corresponds to unforeseeable situations, or foreseeable yet unexpected ones, which constitute the regular exercise of a right. There is, likewise, the possibility of injuries arising from individual reactions of the organism to the treatment or medication used.[52]

Harm caused by medical errors may be of a pecuniary or non-pecuniary nature. Pecuniary harm is subdivided into consequential damages (expenses with treatment, hospitalization, medications, and home care) and loss of profits (income that the victim failed to earn owing to the harm). Moral (non-pecuniary) damages may occur independently of or concurrently with pecuniary harm, in accordance with Precedent (Súmula) 37 of the STJ. They consist of an injury to personality, encompassing anguish, pain, and suffering that may affect the individual's image. From a constitutional perspective, moral damages constitute a violation of the right to dignity.[53]

In addition to material and moral damages, the victim may be entitled to aesthetic damages which, according to part of the scholarship, are part of moral damages because they alter the person's image. The prevailing view, however, is that aesthetic damages constitute an autonomous right, not included in moral damages. The accumulation of moral and aesthetic damages is admissible when, although arising from the same fact, they are capable of separate assessment (STJ, REsp 910.794/RJ, Reporting Justice Denise Arruda, 1st Panel, judged 21 Oct. 2008, DJe 4 Dec. 2008). According to the STJ, the injuries need not be exposed to third parties in order to be compensable, it being sufficient to prove the degradation of the victim's physical integrity (STJ, REsp 899.869/MG, Reporting Justice Humberto Gomes de Barros, 3rd Panel, judged 13 Feb. 2007, DJ 26 Mar. 2007).[54]

Compensation is measured by the extent of the harm, under Article 944 of the Civil Code, and judges must act cautiously in quantification in order to avoid the formation of a "compensation industry." In the case of aesthetic harm, reparation "in natura" (a new surgery for restoration) must first be sought, and, where this is not possible, the fixing of pecuniary compensation.[55]

7.2. Causal link

The causal link is the legal bond that connects the agent's conduct to the harm produced. The practice of an unlawful act or the existence of a harmful result is not enough for the duty to make reparation to be demanded by the victim. It is indispensable that the harm have as its direct and immediate cause the agent's unlawful conduct. This cause-and-effect relationship is an unavoidable prerequisite for reparation or compensation.[56]

8. Civil liability of the physician for harm caused by the prescription of medications

8.1. Duty to prescribe and therapeutic autonomy

Medical care provided to the patient constitutes a consumer relationship, with subjective liability applying to harm imputed to professional conduct, regardless of whether the care occurs in a hospital or a private practice. The physician is the only professional endowed with the knowledge and technique necessary to decide which medication and dosage are appropriate for each patient, considering individual peculiarities. The Code of Medical Ethics

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[52] Cf. Tomé, 2026.
[53] Cf. Tomé, 2026; Cavalieri Filho, 2010.
[54] Cf. Tomé, 2026.
[55] Cf. Tomé, 2026.
[56] Cf. Tomé, 2026.

establishes that human health is the focus of all the physician's attention, who must act with the utmost care and the best of his professional capacity (Article 2).[57]

In the exercise of his therapeutic autonomy, the physician has a duty to prescribe appropriate treatments and medications to be used by patients. For controlled medications, he must observe ANVISA Ordinance 344/98, whose prescription rules are set out in Article 36. However, the obligation to prescribe correctly is not restricted to controlled substances, encompassing any kind of medication, in order to ensure rational use and prevent harm from inadequate or excessive use.[58]

It falls to the professional to indicate the appropriate medication, prescribing quantity, posology, manner of storage, and duration of treatment, all legibly and with complete information. Harm caused by failures in the prescription - whether as to the product, the dosage, the treatment period, or the manner of storage - may be imputed to the physician. By contrast, use at variance with the prescription (different medication, incorrect dosage, inadequate storage) does not constitute a failure by the professional, provided that he has supplied all the necessary guidance in the prescription.[59]

8.2. "Off-label" prescription and experimental use

A matter of great relevance is the physician's civil liability in prescribing "off-label" medications, that is, for a therapeutic purpose, dosage, or person other than that provided for in the package insert. In this case, the risk is exclusively the physician's, and it is essential that the patient be aware of and freely and informedly agree to such use. Article 46 of the Code of Medical Ethics prohibits the professional from carrying out any procedure without the prior clarification and consent of the patient or his legal representative, except in imminent danger to life. The physician must inform clearly and precisely about the entire treatment, including foreseeable adverse reactions and the possible absence of scientific knowledge about the pharmacological effects in the specific case.[60]

It is important to stress that the patient's free and informed consent does not constitute a ground for the automatic exclusion of the physician's liability for "off-label" use, which must be assessed according to the peculiarities of each case. "Off-label" use differs from experimental use: whereas the former refers to a medication that has already completed the phases of clinical research and had its commercialization authorized for a given purpose, the latter involves a substance that is still in the research phase, without authorization for commercialization. In Brazil, the use of experimental medications depends on the Federal Council of Medicine, under Resolution No. 1,627/2001, given the absence of specific rules authorizing use by patients outside clinical trials.[61]

Under Article 12 of Law No. 6,360/1976, the prescription of medications not registered with ANVISA is not permitted. The physician who prescribes an unregistered medication fully assumes the burden arising from his therapeutic autonomy, especially given the absence of a guarantee of safety and efficacy by the regulatory agency. In addition, the professional must keep constantly updated as to pharmacovigilance alerts, under penalty of being liable for harm caused by the omission to monitor relevant information about drug reactions.[62]

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[57] Cf. Tomé, 2026.
[58] Cf. Tomé, 2026.
[59] Cf. Tomé, 2026.
[60] Cf. Tomé, 2026.
[61] Cf. Tomé, 2026.
[62] Cf. Tomé, 2026.

8.3. Therapeutic freedom and the prohibition of external interference

The Code of Medical Ethics enshrines therapeutic freedom as a right inseparable from professional practice, prohibiting any interference by laboratories, pharmaceutical industries, the management of clinics, hospitals, or health plans in prescriptive conduct. It falls exclusively to the physician responsible for the patient to determine which medications and examinations are necessary, without being subject to external impositions, especially those motivated by economic interests. Harm arising from submission to such impositions will fall on the professional, who is directly responsible for the conduct adopted. The physician must under no circumstances allow such interference, and may formally report the situation to the management of the establishment or directly to the CFM (Federal Council of Medicine).[63]

8.4. Prescription for an allergic patient and post-prescription monitoring

In the case of prescribing medication for an allergic patient, the physician who, at the first appointment, requests that the patient's health information be filled in, including allergies, cannot be held liable if the patient remained silent, including because he was unaware of the existence of the allergy. However, when the patient reports the existence of an allergy or a condition such as diabetes, and the physician prescribes an incompatible medication (for example, a product containing sugar for a diabetic), the professional's liability is evident.[64]

The physician's duty extends to monitoring the treatment after the prescription, both at home and in the hospital, in order to verify the efficacy of the medication and possible adverse reactions. In the case of medications such as penicillin, whose harmfulness is known but whose benefits outweigh the risks, administration to an allergic patient without a prior test constitutes negligence, by the omission to adopt a measure capable of ensuring the safety of the treatment.[65]

8.5. Generic and similar medications and drug interactions

As to the prescription of generic, similar, or reference medication, Resolution No. 391/1999 authorizes the physician, in private services, to prescribe either by the trade name or by the generic name, and must point out, when necessary, the restrictions on interchangeability. The omission of this information may give rise to liability for the ineffectiveness of the treatment. The same logic applies to drug interactions: the prescribing physician may be held liable for foreseeable adverse reactions arising from an unwarned interaction or from concurrent use with other medications without due guidance to the patient.[66]

Article 52 of the Code of Medical Ethics prohibits disrespecting the prescription of another physician, except in a situation of unquestionable benefit to the patient, in which case the fact must be immediately reported to the responsible professional. Any unauthorized alteration of the therapy will violate Article 81 of the same Code, giving rise to administrative and civil liability for the harm caused.fato ao profissional responsável. Qualquer alteração não autorizada da terapêutica violará o art. 81 do mesmo Código, ensejando responsabilização administrativa e civil pelos danos causados.[67]

9. Civil liability of the physician providing services in a hospital

9.1. Acting as an autonomous self-employed professional

The physician, as a self-employed professional, may provide services directly to the patient through a contractual relationship without a bond to third parties. In this case, his

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[63] Cf. Tomé, 2026.
[64] Cf. Tomé, 2026.
[65] Cf. Tomé, 2026.
[66] Cf. Tomé, 2026.
[67] Cf. Tomé, 2026.

liability will be assessed on the basis of professional fault (subjective liability), under Article 14, §4, of the CDC. The patient must prove the physician's culpable conduct, generally through expert evidence, given the judge's technical impossibility of assessing the error, except where it is a gross error. The burden of proof will vary according to whether the obligation is one of means or one of result.[68]

9.2. The legal nature of hospital services

The hospital is a legal entity that, whether for profit or not, provides medical services, paramedical services (medications, facilities, instruments, operating room, ICU, nursing), and lodging to the consumer. It is, therefore, a service provider, subject to the CDC. Lodging services are equivalent to those of the hotel industry, encompassing accommodation, food, and general care. Patient falls on the hospital premises, contaminated food or food at variance with medical prescriptions, and malfunctioning equipment are entirely the strict liability of the hospital.[69]

9.3. Hospital liability for medical errors: the position of the STJ

The most relevant controversy concerns the kind of liability applicable to the hospital when the harm arises from medical error. The nature of the bond between the professional and the hospital must be analyzed: employee, agent, or autonomous. When the physician acts autonomously, in an "intuitu personae" relationship with the patient, the subjective liability provided for in Article 14, §4, of the CDC applies. The same applies to the self-employed professional who uses the hospital's premises for procedures.[70]

The prevailing understanding in the STJ is that the hospital's liability for harm arising from hospital services proper (lodging and paramedical services) is objective (strict). However, when the harm arises from medical services, the hospital's liability will depend on proof of the professional's fault, under Article 14, §4, of the CDC. This orientation is grounded in the understanding that to admit the strict liability of the hospital for medical errors would be tantamount to transforming the physician's obligation into an obligation of result, which is inadmissible given the inexactness inherent to medicine. The STJ has consolidated that the hospital is jointly and severally liable with the physician only when the professional's fault is proven (STJ, REsp 1.145.728/MG, Reporting Justice João Otávio de Noronha, 4th Panel, judged 28 Jun. 2011, DJe 8 Sep. 2011; STJ, REsp 1.662.845/SP, Reporting Justice Nancy Andrighi, 3rd Panel, judged 22 Mar. 2018, DJe 26 Mar. 2018).[71]

A typical case is care in the emergency room, in which the patient seeks assistance without personally choosing or engaging the physician. It is common for hospitals to contract civil partnerships composed of physicians to make up the emergency room's clinical staff, creating the appearance of autonomous legal entities. Nevertheless, the physician's fault must always be proven for the hospital's duty to answer for the harm to arise, since medical conduct, regardless of the contractual modality, is subjective, given that the professional does not ensure a result.[72]

- **Logic of the topic: medical civil liability**

Medical civil liability is structured upon a logic that articulates historical, normative, and principled foundations into a coherent system. The basis of the system lies in the principle "neminem laedere" - the universal obligation not to cause harm to others - which grounds the secondary and successive duty of reparation whenever professional conduct produces injury

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[68] Cf. Tomé, 2026; Aguiar Júnior, 1995.
[69] Cf. Tomé, 2026; Aguiar Júnior, 1995.
[70] Cf. Tomé, 2026.
[71] Cf. Tomé, 2026.
[72] Cf. Tomé, 2026.

to the patient. Subjective (fault-based) liability is the general rule, requiring proof of fault in any of its modalities (negligence, imprudence, or lack of skill), which stems from respect for the professional's dignity and from the understanding that no one may be obliged to make reparation without having contributed culpably to the harm.

The physician-patient relationship is, as a rule, contractual and of a "sui generis" nature, because it transcends the simple provision of services by incorporating ancillary duties of information, advice, and protection. The obligation assumed by the professional is, as a rule, one of means - the physician undertakes to employ diligence, technical knowledge, and all available resources, without guaranteeing the cure. Exceptionally, in plastic surgeries, case law recognizes the obligation of result. This distinction is decisive for the allocation of the burden of proof: in the obligation of means, it falls to the patient to demonstrate fault; in the obligation of result, fault is presumed, reversing the burden.

The system provides for the incidence of the CDC in relationships between physician and patient, which guarantees consumer protection mechanisms (reversal of the burden of proof, full reparation, joint and several liability), without, however, removing the requirement of fault for the self-employed professional. The coexistence of the CDC and the Civil Code forms a framework that protects the vulnerable patient without disregarding the intellectual nature and the uncertainties inherent to medical activity. The hospital is strictly liable for its paramedical and lodging services, but liability for medical errors depends on proof of professional fault, avoiding the artificial transformation of the obligation of means into an obligation of result.

The prescription of medications fits into this logic as an extension of the physician's therapeutic autonomy, who assumes responsibility for all stages - from the choice of the drug to the monitoring of reactions. "Off-label" and experimental use aggravates this responsibility, requiring informed consent without, however, automatically exonerating the professional. The system closes with the recognition that medical error is inherent to human fallibility and to the limitations of science, which is why only the inexcusable error - the unjustifiable, gross one that would not be committed by a diligent professional under the same conditions - gives rise to the duty of reparation.

- **Synoptic table**

Topic	Explanation
Medical civil liability	Secondary legal duty to make reparation for harm caused to the patient as a result of culpable professional conduct, grounded in the principle "neminem laedere."
Nature of the liability	Subjective (fault-based), requiring proof of the professional's fault (negligence, imprudence, or lack of skill), under Article 14, §4, of the CDC and Articles 186, 927, and 951 of the Civil Code of 2002.
Applicable legislation	CDC (consumer relationship) and the Civil Code of 2002. The CDC is applied as the primary statute according to the majority view and the STJ.
Nature of the physician-patient relationship	Contractual, as a rule, and exceptionally extracontractual (care on a public road, during a trip, or aboard an aircraft).
"Sui generis" contract	The relationship transcends a simple service contract, incorporating ancillary duties of information, advice, and protection of the patient.
Obligation of means	General rule. The physician undertakes to act diligently and to employ all available resources, without guaranteeing the cure.

Obligation of result	Exception applicable to plastic surgery (cosmetic and reconstructive), according to the STJ. The professional undertakes to achieve a satisfactory result.
Burden of proof - obligation of means	It falls to the patient to prove the physician's culpable conduct.
Burden of proof - obligation of result	The physician's fault is presumed. It falls to the professional to demonstrate a ground excluding liability. Liability remains subjective.
Negligence	Modality of fault by omissive conduct. Lack of the care, attention, or diligence expected of the professional. Example: delay in diagnosis, leaving an object in the patient's body.
Imprudence	Modality of fault by hasty commissive conduct lacking caution. Example: untimely action that disregards foreseeable risks.
Lack of professional skill (imperícia)	Modality of fault by professional technical error. Deficient knowledge or technical lack of preparation. Example: perforation of an organ during a cesarean section.
Medical error - excusable	Justifiable error arising from the uncertainties and limitations inherent to medical science, without constituting professional fault.
Medical error - inexcusable	Unjustifiable error, committed through negligence, imprudence, or lack of skill, which gives rise to civil liability for the harm caused.
Error of diagnosis	Mistaken identification or absence of identification of the illness. Gives rise to liability only if gross.
Error of procedure	Correct diagnosis, but with an inadequate choice of therapeutic technique.
Error in the procedure	Correct diagnosis and technique, but defective execution.
Professional error	Correct medical conduct with an inadequate technique. Excusable; arises from the imperfections of science.
Medical harm (iatrogenesis)	Pathological alteration caused in the patient by treatment of any nature. It may be pecuniary (consequential damages and loss of profits) or non-pecuniary (moral and aesthetic damages).
Aesthetic damages	An autonomous right in relation to moral damages. Cumulable when capable of separate assessment (Súmula 387/STJ).
Causal link	Legal bond between the agent's conduct and the harm. The harm must have the unlawful conduct as its direct and immediate cause.
Prescription of medications	The physician is liable for failures in the prescription (product, dosage, posology, storage). He must prescribe legibly and with complete information.
"Off-label" use	Prescription for a purpose, dosage, or person other than that provided for in the package insert. Exclusive risk of the physician. Requires free and informed consent, without automatically excluding liability.
Experimental use	Substance in the clinical research phase, without authorization for commercialization. Full liability of the prescribing physician.
Medication not registered with ANVISA	Prescription prohibited (Article 12, Law 6,360/1976). The physician fully assumes the risks.

Therapeutic freedom	A right inseparable from the practice of medicine. Interference by laboratories, hospitals, or health plans in prescriptive conduct is prohibited.
Hospital liability	Objective (strict) for paramedical and lodging services. For medical services, it depends on proof of the professional's fault (STJ).
Hospital-physician joint and several liability	The hospital is jointly and severally liable only when medical fault is proven, under the CDC.
Cosmetic plastic surgery	Obligation of result, according to the STJ. Fault presumed when the satisfactory result is not achieved.
Reconstructive plastic surgery	Obligation of result, according to the STJ, with the same logic as cosmetic surgery.
Anesthesiologist	Obligation of means (majority understanding). Autonomous liability for harm in the pre- and post-operative phases. "Culpa in eligendo" (fault in choosing) for errors of assistants.
Free and informed consent	An ethical and legal duty of the physician. It must encompass diagnosis, prognosis, risks, benefits, and the effects of medications and treatments.
Prevention	The best path to avoid harm and lawsuits. It presupposes quality services, respect, loyalty, and humanity in dealing with the patient.

- **Table of precedents (STJ)**

Precedent	Details and ratio decidendi
STJ, REsp 731.078/SP	Reporting Justice Castro Filho, 3rd Panel, judged 13 Dec. 2005, DJ 13 Feb. 2006. Held that the relationship between physician and patient constitutes a consumer relationship, governed by the CDC.
STJ, REsp 1.104.665/RS	Reporting Justice Massami Uyeda, 4th Panel, judged 9 Jun. 2009, DJe 4 Aug. 2009. Established that the relationship between physician and patient is contractual in nature, as a rule.
STJ, REsp 1.540.580/DF	Reporting Justice Lázaro Guimarães, 4th Panel, judged 2 Aug. 2018, DJe 4 Sep. 2018. Recognized that the contractual physician-patient relationship has as its object a special provision of services, with ancillary duties, notably the duty to inform and free and informed consent.deveres anexos, notadamente o dever de informação e o consentimento livre e esclarecido.
STJ, REsp 1.051.674/RS	Reporting Justice Massami Uyeda, 3rd Panel, judged 3 Feb. 2009, DJe 24 Sep. 2009. Consolidated that the physician's obligation is, as a rule, one of means, not being bound to cure, but to employ diligence and the available resources.
STJ, AgInt no AREsp 2506337	Reporting Justice João Otávio de Noronha, 4th Panel, judged 24 Mar. 2025, DJEN 28 Mar. 2025. Classified the plastic surgeon's obligation as one of result, for both cosmetic and reconstructive surgery.
STJ, REsp 1.662.338/SP	Reporting Justice Nancy Andrighi, 3rd Panel, judged 12 Dec. 2017, DJe 2 Feb. 2018. Examined the error of diagnosis, affirming that

	only gross error gives rise to the physician's civil liability, considering human fallibility and the inexactness of medicine.
STJ, REsp 910.794/RJ	Reporting Justice Denise Arruda, 1st Panel, judged 21 Oct. 2008, DJe 4 Dec. 2008. Admitted the accumulation of moral and aesthetic damages when, arising from the same fact, they are capable of separate identification.
STJ, REsp 899.869/MG	Reporting Justice Humberto Gomes de Barros, 3rd Panel, judged 13 Feb. 2007, DJ 26 Mar. 2007. Established that injuries need not be exposed to third parties to be compensable as aesthetic damages, it being sufficient that physical integrity be degraded.
STJ, REsp 1.145.728/MG	Reporting Justice João Otávio de Noronha, 4th Panel, judged 28 Jun. 2011, DJe 8 Sep. 2011. Consolidated that the hospital's liability for harm from hospital services is objective (strict), but liability for medical errors depends on proof of the professional's fault.
STJ, REsp 1.662.845/SP	Reporting Justice Nancy Andrighi, 3rd Panel, judged 22 Mar. 2018, DJe 26 Mar. 2018. Reaffirmed that the hospital is jointly and severally liable with the employed physician only when professional fault is proven, under the CDC.
STJ, Súmula 37	Admits the accumulation of compensation for material damages and moral damages arising from the same fact.
TJSP, Appeal 0101376-11.2009.8.26.0100	8th Chamber of Private Law, Reporting Judge Theodureto Camargo, judged 12 Nov. 2014, DJe 4 Dec. 2014. Recognized medical lack of skill in the case of an obstetrician who, in a forceps delivery, caused cranial trauma to the newborn.

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