Doctors and the patients' claims Analysis of judicial practice

Lekarze wobec roszczeń pacjentów Analiza orzecznictwa

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KEY WORDS:

- medical doctor
- medical court
- liability

ABSTRACT

Patient rights have an increasingly significant impact on the conditions of therapy and on daily clinical practice. The fact that law might affect the doctor's approach is confirmed in particular by the case law illustrating the claiming attitude of patients. The purpose of this study is to discuss selected verdicts of medical courts which show that it is not always the diagnosis and treatment that the patients complain about. It is important to review those issues in order to include them in the teaching programs for undergraduate and postgraduate students of medicine.

SŁOWA KLUCZOWE:

- lekarz
- sąd lekarski
- odpowiedzialność

STRESZCZENIE

Prawa pacjenta w coraz większym stopniu wpływają na warunki leczenia, a także codzienną praktykę lekarską. Fakt, że prawo może mieć wpływ na zachowanie lekarza jest potwierdzony w szczególności przez orzecznictwo sądowe będące wyrazem roszczeniowej postawy pacjentów. Celem niniejszej pracy jest omówienie wybranych orzeczeń sądów lekarskich pokazujących, że nie zawsze sam proces diagnostyczno-leczniczy jest powodem skarg pacjentów. Istotne staje się omówienie powyższych naruszeń w celu wprowadzenia w szerszym zakresie powyższych zagadnień do programów nauczania studentów medycyny i młodych lekarzy.

Criminal and civil cases Analysis of statistical data

Polish law stipulates three types of liability of medical doctors related to their profession: criminal, civil and professional liability. Criminal liability involves mainly the liability for crimes against life and health, as defined by the Polish Penal Code (PC) (1). In the prosecution and judicial practice, the most frequent charge is exposing the patient to an immediate risk of loss of life or severe bodily injury, i.e. Article 160 § 2 or § 3 of PC, with respect to Article 155 of PC or Article 156 of PC. According to the analysis conducted by the Department of Preparatory Proceedings of the Medical Errors Division of the State Prosecutor's Office, in 2017, prosecutorial proceedings were conducted in 5,678 cases. This means a 15 per cent increase in the number of proceedings form 2016 (4,963 cases). Over 60 per cent of the proceedings referred to patient's death, mainly involving children (2). In 2017, 2,002 cases were concluded with a substantive decision of the prosecutor, including 139 indictments and 2 no contest pleas. In 248 cases, the prosecutor's office refused to initiate proceedings, and in 1,613 cases the proceedings were discontinued (3).

Civil liability in this context is the financial liability of the medical doctor or the healthcare institution for the damage or injury to the so-called legally protected interests, which include life, health, dignity, reputation, image and veneration of the dead. This type of liability results e.g. in the obligation to pay compensation. The analysis of the verdicts of civil courts from the years 2011 to 2017 indicates that in the cases relating to injury or damage caused by healthcare personnel, the value of compensations for non-material damage (pain and suffering) is increasing, rather than the compensations for material damage. The purpose of the compensation for non-material damage is to compensate the patient for the sustained damage and harm. It should be emphasised here that damage and harm may refer not only to physical and mental suffering, but also to that which he/she might suffer in the future due to the medical error. "Compensation for non-material damage is a one-off benefit intended to repair all of the damage and harm done. (…) The legislation does not provide a precise method for determining the value of compensation for non-material damage, leaving the matter to be decided at the judge's discretion based on all circumstances of the case." (4). Determining the compensation for non-material damage, the court takes into consideration all circumstances of the case which have had impact on the damage and harm sustained by the patient, in particular: the degree of permanent health impairment, the duration of illness, suffering, therapy and rehabilitation, age (5) and sex of the patient, the patient's feeling of helplessness

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and the risk of helplessness in the future. The court also analyses the standard of living the patient (6, 7).

It should be noted that apart from the compensation for non-material damage arising from a medical error, the civil court may, pursuant to Article 4 sec. 1 of the Act on patient rights and Patient Ombudsman (APP) (8) award a compensation for non-material damage arising just from the violation of the patient's rights. Financial compensation for a violation of patient's rights might be awarded for the sole occurrence of violation and does not depend on actual personal injury or damage sustained by the affected patient (9). For a failure to inform a patient of removing a healthy vertebral disc instead of the ailing one, the court awarded a compensation of PLN 15,000, indicating that the amount was determined according to the current judicial practice of the Supreme Court and common courts in which financial compensations awarded for injuries arising from violations of patients' rights were within the range of PLN 5,000 – PLN 20,000 (10). The legal protection under the Act on patients' rights includes, apart from a violation of personal rights, as mentioned above, also a violation of the right to the appropriate standard of medical care which might cause mental suffering, discomfort or mistrust in the attending healthcare personnel, even if such violation has not brought any tangible medical damage.

Misconduct and punishment in medical doctors' professional liability

Cases of professional misconduct of medical doctors are examined by medical courts. The legal basis for professional liability of medical doctors is defined in Article 53 of the Act on medical chambers (11) as follows: the medical doctor shall be liable for "violation of the principles of medical ethics and the provisions related to the practice of medical profession." Therefore, there are two types of normative regulations which a medical doctor must not violate under the pain of professional liability: the provisions related to the practice of medical profession [this includes mainly the Act on the profession of doctor and dentist (12)] and the principles of medical ethics [Medical Code of Ethics (13)]. In terms of procedure, the first stage of proceedings related to professional liability of medical doctors is conducted by the District Screener for Professional Liability; if a motion for penalty is filed, the case is taken over by the medical court. The Screener and the medical court judges are medical doctors and dentists with at least 10 years of professional experience. Pursuant to the Act on medical chambers, the first instance is the district medical court, and the appeal instance is the Supreme Medical Court. Since 2010, extraordinary appeal may be lodged against the verdict of the Supreme Medical Court, i.e. filing for cassation to the Supreme Court where the case is examined by professional judges.

Penalties include: admonition, reprimand, financial penalty, ban on performing management functions, and restriction of professional activities. Doctors may also face a suspension of their licence to practice medical profession for up to 5 years, or a permanent revocation of the licence to practice medical profession. Furthermore, doctors whose medical licenses have been suspended or revoked in Poland, may not practice medicine in the entire European Union. The European Parliament and the Council have adopted a regulation on administrative cooperation through the Internal Market Information System (the so-called "IMI Regulation") (14). The proposed solution – the Internal Market Information System – has become a centralised mechanism for online communication to facilitate the exchange of information and the provision of mutual transborder assistance. The IMI System covers a broad range of fields, including the information on the recognition of professional qualifications, i.e. in professions with impact on patient health (15). The court, prosecutor or the professional self-government authority immediately provide information concerning the decision imposing the ban, suspension, restriction or revocation of the licence to practice a given profession and the decision concerning the use of forged documents. The aforementioned information is communicated to the authorities of member states as a warning in the IMI System not later than within 3 days from the decision becoming final. The countries which post the most warnings in the IMI System are Great Britain, Lithuania and Italy. In 2018, Poland posted 71 warnings on medical doctors, 46 in 2017 and 103 in 2016 respectively (16).

Material and methods

The analysis was conducted in the statistical layer (demonstration of the scale) and in the form of descriptions of specific cases. The first part of the analysis concerns the decisions of the OSL in Warsaw in years 2016 to 2018 The Regional Medical Chamber (OIL) in Warsaw gathers more than 32 708 physicians and dentists, of whom 29 237 are active professionals. In the whole country there are 192 thousand physicians and dentists, more than 174 thousand professionally active (17).

Furthermore, this material is significant in how it creates rich factual bases enabling the evaluation of the entire diagnostic and therapeutic process, the decisions made, and the consequences. In this part of the study analysis covered one of the most frequently brought charges among disciplinary prosecutors – the failure of due diligence. In the analyzed cases before the local medical chamber in Warsaw in 2016 out of 55 cases studied failure of due diligence was found in 39 (71%), and in 2017 there were 52 cases in general, with the conviction in 34 cases (65,4%). In 2018, on the other hand, out of all cases heard by the OSL in Warsaw 26 (65%) involved failure of due diligence. It must be noted that among all these cases charges of failure of due diligence brought against family doctors were the subject of only several decisions.

Analysis of NSL rulings was more challenging, as appellate recourse to this board goes from all regional boards (OSLs). In 2016 out of all of 161 NSL cases, failure of due diligence was the charge in 134 (83%). A year later there were 140 cases, with failure of due diligence charged in (72%) (18).

The two cases selected for discussion belong to typical cases arising in OSL. Doctors meet with these types of events in their daily practice. In these situations, the decisions of medical courts have an educational function, and following the court decisions doctors can learn about errors that should be avoided and what are the limits of practicing a profession.

Attitudes of patients and doctors – examples from the case law

1. *Misunderstandings related to lack of access to medical benefits*

The right to medical benefits, as set forth in Article 6 sec. 1 and 2 of the APP is a fundamental right of the patient

and also a source of numerous disputes. Pursuant to those provisions, in the event of a limited ability to provide medical benefits, the patient has the right to a transparent, objective procedure of determining the order of access to the benefits, based on medical criteria. The order of access to specialised benefits in outpatient healthcare financed from public funds, such as rehabilitation treatment, is determined on the basis of waiting lists (Article 20 of the Act on provision of healthcare benefits) (19). The waiting lists are prepared according to "medical criteria" specified in the provisions of the relevant Regulation of the Minister of Health (20). These include: patient's health condition, prognosis, comorbidities affecting the condition for which the patient is to receive the benefit, and the risk of occurrence, persistence or deterioration of disability. In practice, according to the aforementioned criteria, the patient may be classified as an "urgent" or "stable" case. The patient's condition is classified by the doctor issuing the referral (21). If the patient requires urgent medical attention, the doctor add the note "CITO" (urgent) on the referral.

The aforementioned referral became a matter of contention between a medical doctor and a patient which ended with a hearing before the District Medical Court in Warsaw. The patient, aged 65, has suffered for many years from pain related to osteoarthritis. Due to the deterioration of her ailments, she made three appointments with a medical rehabilitation specialist. On the third visit, which took place on 22 June 2017, the patient reported pain which particularly affected her right knee. The doctor identified a Baker's cyst rupture and referred the patient for a treatment procedure – Pulsed Short Wave Diathermy (PSWD) of the right knee joint. The patient then attempted to make an appointment for the rehabilitation treatment in a number of healthcare centres. Severe pain and remote available dates of treatment forced the patient to visit her rehabilitation specialist without making a prior appointment. On 27 June 2017, the patient entered the doctor's office together with another patient in order to ask whether the doctor would add the "CITO" note on her referral in order to enable the patient to undergo treatment quicker. The doctor refused, because in her opinion, there was no medical indication for urgent treatment. However, the patient refused to leave the doctor's office until the note was added on her referral. The doctor asked the patient not to interfere with other patients' appointments. Since the patient would not leave the office, the doctor took her by the elbow and marched her out. The patient presented a different version of the events, emphasising that the doctor was rude to her and forced her out of the office. The patient filed a complaint with the District Screener for Professional Liability on the conduct of the rehabilitation specialist during the visit of 27 June 2017, which took place without a prior appointment. The complaint was subsequently complemented with the patient's written statement of doubts whether the procedures for which the patient was referred by the rehabilitation specialist were advisable, as the complainant had a pacemaker. The patient, attempting to make an appointment for rehabilitation treatment in various healthcare centres, was informed that a pacemaker was an absolute contraindication for PSWD treatment. Consequently, the procedures for which the patient was referred, could not be performed.

The District Screener for Professional Liability conducted a preliminary investigation of the case. A specialist in medical rehabilitation, locomotor system orthopaedics and traumatology was appointed as an expert witness. By the decision of 22 January 2018, The Screener decided to discontinue the investigation with regard to the alleged unethical conduct of the rehabilitation specialist which, according to the patient, took place in the specialist's office on 27 June 2017. The Screener concluded that in view of the available evidence, the allegation of unethical conduct of the doctor could not be confirmed. The rehabilitation specialist faced the allegation that despite knowing that the patient had a pacemaker, she nevertheless referred the patient for a PSWD treatment of the right knee joint, disregarding the contraindications for such procedure and thus exposing the patient to the risk of disruption of the pacemaker and deterioration of health, violating Article 8 of the Medical Code of Ethics in conjunction with Article 4 of the Act on the profession of doctor and dentist, with respect to Article 53 of the Act on medical chambers.

According to the expert witness, there is no other physical therapy treatment for Baker's cyst rupture that would be as efficient as PSWD. However, according to the literature of the subject and the generally accepted opinion, PSWD is contraindicated for patients with pacemakers. Nevertheless, in the expert witness' opinion, more and more patients with pacemakers are undergoing treatment at this time and the rehabilitation specialists are increasingly referring such patients for treatment with pulsed electromagnetic field, such as PSWD. This arises from the fact that, first of all, the modern pacemakers are very advanced devices which are largely protected against the impact of external magnetic and electromagnetic fields, and some have the feature of temporary shutdown. Secondly, more and more devices used for PSWD have safety zones, or limitations (expressed in centimetres). In the expert witness' opinion, such a feature makes them safer. Pursuant to the regulations of the National Health Fund (NFZ), in physical therapy offices the high frequency electromagnetic field treatment devices (such as PSWD) should be properly marked. In the case at hand, the District Medical Court declared the rehabilitation specialist not guilty of the alleged professional misconduct (22).

2. Lack of patient's consent

The condition of legitimacy of medical treatment is a legally effective consent of the patient (or another authorised person). The judicial practice of the Supreme Court indicates a number of important aspects related to the patient's consent. Firstly, before giving his/her consent, the patient must receive the relevant information on the procedure. The patient has the right to obtain information, and the doctor is obligated to provide it. Both the Act on the profession of doctor and dentist [Article 31 (1)] and the Act on patient's rights and Patient Ombudsman [Article 9 (1) and (2)] shall be treated as providing necessary information to the patient as a necessary condition for the patient to express consent to medical intervention. The scope of the doctor's obligation has been considered by the Supreme Court with respect to the necessity of a surgical procedure. The Supreme Court concluded that it is the doctor's responsibility to inform the patient of his/her health condition and the consequences of the procedure, in order to enable the patient to make an informed decision on undergoing the procedure, with full awareness of what he/she is consenting to and what he/she might expect. Secondly, the Supreme Court emphasised that the scope of information provided to the patient depends on the type of the procedure, in particular on whether the indication for the procedure is absolute or relative, whether the procedure is a life- or health-saving treatment, or merely an aesthetic one. Thirdly, the patient giving his/her consent to the medical procedure, assumes the risk, i.e. the direct,

typical and regular complications, the risk of which should be communicated to the patient (23). In practice, those principles are frequently violated. Such violations may be the basis for the medical courts to punish the doctors.

The District Medical Court in Łódź received a motion for penalty for a dentist who, when performing extraction of teeth No. 38 and 48 of the aggrieved party also extracted teeth No. 18 and 28 without the patient's required consent, thus committing a professional misconduct of violation of Article 32 sec. 1 of the Act on the profession of doctor and dentist, and Article 15 sec. 1 sentence 1 of the Medical Code of Ethics. The aggrieved party was referred for extraction of impacted teeth No. 18, 28, 38 and 48 in general anaesthesia. During a consultation in the Department of Craniomaxillofacial and Oncological Surgery, the patient was diagnosed with "mandibular cyst + impacted teeth 48, 38 + reconstruction with bone substitute material". On the date of the appointment, the patient reported to the hospital ward where one of the doctors collected her informed consent to the extraction of impacted lower wisdom teeth (both), enucleation of the cyst around tooth No. 48, and reconstruction with bone substitute material. On the same day, the accused dental surgeon extracted the four impacted teeth and the cyst. The cystic cavity was filled with bone substitute material. The aggrieved patient was discharged home. The hospital discharge report included information on the extraction of the impacted teeth No. 38 and 48. The patient learned of the extraction of tooth No. 38 during an emergency visit to the ER to have the post-extraction site wound of tooth No. 18 dressed, and she learned of the extraction of tooth No. 28 in a non-public outpatient clinic during the removal of dental sutures. In the course of the proceedings before the medical court, the accused dental surgeon pleaded guilty and provided explanations, emphasising that the patient had absolute medical indications for the extraction of all four impacted teeth. Nevertheless, it was uncertain whether such an extensive surgery would be possible to complete within a single procedure. It was likely because of this potential limitation that the informed consent was collected for the extraction of only two teeth. However, the informed consent was collected and information on the risks related to the procedure were provided by another doctor. The accused dental surgeon admitted to not having verified the scope of consent to the procedure given by the patient. During the surgery, the accused dental surgeon determined that the scope of reconstruction would not be as extensive as initially thought and decided to extract all four impacted teeth so as not to force the patient to undergo another procedure in general anaesthesia. However, she did not discuss that with the patient. Furthermore, the accused dental surgeon was absent from the ward when the aggrieved patient was being discharged and had no control over the contents of the hospital discharge report provided to the patient. It should be pointed out here that performing a procedure without the patient's consent is reserved for health- and life-threatening situations. Having considered the case, the medical court had no doubt that the procedure performed on the patient was elective and that the accused dental surgeon violated the scope of the consent given by the patient. In consideration whereof, the medical court declared the dental surgeon guilty of professional misconduct (24).

Discussion of the cases and conclusions

In recent years, the contacts between the patient and the doctor have become peculiar in a number of aspects. The patients know their rights and intend to exercise them. Patients' complains have become commonplace, and the subject matter of those complaints is not limited to issues related to diagnosis and treatment. The decisions of the medical courts cited herein indicate various sources of the patients' discontent. First, the lack of access to benefits, in this particular case to rehabilitation treatment. According to a report by the National Health Fund (NFZ), two years ago, when the incident examined by the District Medical Court in Warsaw took place, over 1 million patients were on waiting lists for rehabilitation treatments. In September 2018, a dedicated website was launched by NFZ where the patients can check the waiting times for the given treatment or procedure and choose the healthcare centre offering the shortest dates (25). In the case examined by the District Medical Court, the patient, in order to reduce the waiting time for the treatment, attempted to obtain an "urgent" referral from her doctor. The patient's discontent arising from the long queue for treatment, and the doctor's attitude resulted in extending the scope of the case to include the erroneous qualification of the patient for PSWD treatment. This case clearly illustrates that the healthcare personnel's knowledge of the treatment options currently available for patients with pacemakers is scant (26).

In the second case examined by the District Medical Court, the cause of the patient's claims was the incorrectly collected consent to teeth extraction. Unfortunately, it is not uncommon in hospital practice for one doctor to collect the informed consent to treatment, another to perform the surgery, and yet another to prepare the hospital discharge report for the patient. It was due to that confusing practice that the operating surgeon failed to notice that the patient had given consent only to the extraction of two impacted wisdom teeth and removed all four. The patient, who was not informed of that, experienced problems with the post-extraction site wound and had to report to the Emergency Room, and then to another dental care institution. Clearly, in many cases the patient's claims arise not from the healthcare personnel's incompetence in diagnosis or treatment, but simply from impaired communication flow.

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