Arch Med Sadowej Kryminol 2021; 71 (1): 1–7 DOI: https://doi.org/10.5114/amsik.2021.104969

archiwum medycyny sądowej i kryminologii

Praca oryginalna
Original paper

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Malpractice-related deaths resulting from failure of due diligence. Decisions of Polish medical disciplinary boards

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Abstract

Aim: The presented cases are related to failure of due diligence found in the binding decisions of medical disciplinary boards in three centres in Poland, showing in what percentage of the cases the patient died, and answering the question of whether the number of deaths changed, and if yes, then why.

Material and methods: The material for this study was collected as a result of the analysis of disciplinary files from 410 final and binding cases before the regional boards in Warsaw, Poznan, and Lodz in 2015–2018, which covers 12.5% of Poland's total caseload.

Results: During the 4 years of decisions studied, one can observe only a minimal downward trend in the number of cases relating to failure of due diligence by physicians in diagnosis and treatment. Patient deaths occurred mainly in such medical fields as surgery, neurology, cardiology, and obstetrics, in 2015–2016 – a total of 28 in Warsaw, 23 in Lodz, and 8 in Poznan.

Conclusions: A reduction in the number of such cases coming up before medical disciplinary boards is primarily the consequence of the growing involvement of the law enforcement/public prosecutors' offices for offences involving medical error. Currently, the legal awareness of Polish patients or, in this case, their families is focused not so much on the fact that a case has to be brought for potential medical error but on which path to take the case so as to win damages, compensation, or an annuity from the physician or from the medical establishment.

Key words: medical error, responsibility, due diligence, ombudsman, medical disciplinary board, patient's death.

Introduction

In Poland medical errors expose the physician not only to civil and criminal liability but also to 'professional responsibility' – in a type of disciplinary proceeding. All the respective proceedings can run concurrently. Criminal and civil proceedings are the province of common courts, while professional liability engages the medical self-government's custody of the due performance of the protection. These proceedings are regulated by the Act on Medical Chambers [1].

For the purposes of professional responsibility, the medical practitioner is governed by 2 normative systems: (medical) ethics and law. Legal norms relate primarily to the exercise of the profession, requiring the physician to do so in keeping with the current state of medical knowledge and such meth-

ods of prevention, diagnosis, and treatment as are available, as well as the principles of medical ethics and due diligence (Article 4 of the Act on the Professions of Physician and Dentist) [2]. Ethical norms, on the other hand, are gathered in the Code of Medical Ethics [3].

Proceedings involving medical practitioners' professional responsibility are brought by the disciplinary prosecutor – Professional Responsibility Ombudsman – who acts either *ex officio* or pursuant to a complaint filed by the patient or the patient's family member. If there is a suspicion that the physician may have engaged in misconduct, the ombudsman files a motion for penalty with the medical disciplinary board. The lawmaker decided to have 2 tiers of medical disciplinary boards: regional medical disciplinary boards (Okręgowy Sąd Lekarski – OSL) in the first instance and the Supreme Medical Disciplinary Board (Naczelny Sąd Lekarski – NSL) on appeal. In both instances these boards are lay courts (literally referred to as 'medical courts' in Poland's statutory framework), with physicians sitting as judges. Hence, Polish legal writers regard professional responsibility as a sort of quasi-criminal regime because in both instances the adjudicating body is outside the hierarchy of common courts.

The professional liability of physicians, however, belong to criminal law in the broad sense of the term [4], because it meets the European Court of Human Rights (ECHR) standard for right of recourse to the court [5]. This right is preserved because against the rulings of the Supreme Medical Disciplinary an appeal-in-cassation can be brought to the Supreme Court, which is staffed by professional judges. The Supreme Court reviews the fairness of such proceedings, accounting for the lay composition of such boards [6]. This is important because some of the penalties available under the Act on Medical Chambers are very severe, sometimes more than the penalties and punitive measures imposed in criminal proceedings. One example is Article 83(1, 7) of the Act on Medical Chambers, providing the penalty of permanent disqualification.

Aim

To a) present the number of cases relating to failure of due diligence found in the binding decisions of medical disciplinary boards in 3 centres in Poland, b) show what percentage of the cases involved the patient's death, and c) answer the question of whether the process has escalated over the 4 years under review, and if yes, then why.

Materials and methods

The material for this study was collected as a result of the analysis of disciplinary files from 410 final and binding cases before the regional boards in Warsaw, Poznan, and Lodz in 2015–2018, which covers 12.5% of Poland's total caseload. The selection criteria of the boards surveyed reflected primarily the numbers of physicians under the jurisdiction of the relevant board. There are 177,893 practising physicians and dentists in Poland. The jurisdiction of Warsaw's regional disciplinary board covers the country's largest medical chamber. This is the Regional Medical Chamber in Warsaw, in which 32,792 physicians and dentists were associated in the relevant period, out of which 29,306 were practising. The other 2 boards – in Poznan (13,807) and Lodz (13,184) – had jurisdiction over medical chambers with half as many members as the Warsaw chamber [7]. These 2 chambers had similar membership figures to each other, which translated into an opportunity for drawing comparisons between the 2 boards and putting the data in the context of the Warsaw board.

Results

The results of the study are divided into 2 parts. I analysed the were figures from disciplinary boards representing the total caseload relating to physicians' failure of due diligence in the process of diagnosis and treatment. Within the 4 years covered by this study, the Warsaw board's total caseload was 209 cases, of which 148 (71%) involved failure of due diligence by physicians (Table I). The largest number of such cases occurred in the first year under study. Those were mainly in the area of obstetrics, cardiology (mainly undiagnosed myocardial infarctions), and diagnostics in Hospital Emergency Departments. The Lodz board's case count, on the other hand, was 129 in the studied period, out of which 77 (60%) involved allegations of failure of due diligence in the process of diagnosis and treatment (Table II). In 2017 the board decided 40 cas-

Table I. Cases before the Regional Medical Disciplinary Board in Warsaw in 2015–2018

Year	Total caseload	Failure of due diligence	Fatality count
2015	60	44 (73%)	14 (32%)
2016	60	42 (70%)	14 (33%)
2017	49	35 (71%)	8 (23%)
2018	40	27 (68%)	7 (26%)

Table II. Cases before the Regional Medical Disciplinary Board in Lodz in 2015–2018

Year	Total caseload	Failure of due diligence	Fatality count
2015	31	19 (61%)	10 (53%)
2016	33	23 (70%)	13 (57%)
2017	40	19 (48%)	9 (47%)
2018	25	16 (64%)	5 (31%)

Table III. Cases before the Regional Medical Disciplinary Board in Poznan in 2015–2018

Year	Total caseload	Failure of due diligence	Fatality count
2015	25	13 (52%)	7 (54%)
2016	8	4 (50%)	1 (25%)
2017	19	9 (47%)	3 (33%)
2018	20	12 (60%)	1 (8%)

es, and almost half involved failure of due diligence (19 cases – 48%), primarily in the fields of surgery and cardiology, as well as occupational medicine. In the period under study the board in Poznan heard the fewest cases – 72, of which 38 (53%) involved failure of due diligence in diagnosis and treatment (Table III). The largest count of such cases occurred in 2015; these cases were related to surgery and emergency medicine.

During the 4 years of decisions studied, one can observe only a minimal downward trend in the number of cases relating to failure of due diligence by physicians in diagnosis and treatment. The year 2018 in the Poznan and Lodz boards is an exception from this rule, showing an upward trend instead. This means that cases of this type continue to be an important element in the work of medical disciplinary boards.

Subsequently, the number of cases heard by medical disciplinary boards in which the physician's failure of due diligence led to a fatality were analysed. Patient deaths occurred mainly in such medical fields as surgery (abdominal), neurology (stroke), cardiology (diagnosis of infarctions), and obstetrics (delayed caesareans). The largest count of such cases occurred in 2015–2016 – a total of 28 in Warsaw, 23 in Lodz, and 8 in Poznan. In the 2 years that followed, on the other hand, each of the boards shows a marked decline in the diligence-related case count involving patient deaths.

Discussion

There can be no doubt that the largest count of cases involving failure of due diligence in diagnosis and therapy by physicians culminating in the patient's death fell in the years 2015–2016. The context is that in the relevant period medical disciplinary boards generally heard the largest number of cases of this kind. This correlation is self-evident and requires no commentary. The more complaints that are filed with the disciplinary prosecutor by patients' families, the more cases before disciplinary boards result – and as can be seen from the first part of the

study, the majority involve failure of due diligence in diagnosis and treatment. For this reason, the probability of a fatality being considered by the medical board is higher.

What is interesting is the dynamics of this process. It must be noted that over the 4 years covered by this study, in each of the medical disciplinary boards one can see a marked decrease in the number of patient deaths. There were fewer cases relating to failure of due diligence in diagnostics and treatment.

The first reason for this decline is the significant organizational change in common courts with regard to the tier at which such cases are heard, especially in criminal procedure. Previously, offences involving physicians (Articles 155, 156, and 160 of the Criminal Code) [8] were prosecuted at the lowest tier of the prosecution service – district prosecutors' offices. Currently, they are dealt with higher on the hierarchical chain – by circuit (Prokuratura Okręgowa) and regional (Prokuratura Regionalna) prosecutors' offices. This is the consequence of how, in 2016 in the 5 regional prosecutors' offices in Gdansk, Katowice, Krakow, Lublin, and Warsaw, independent divisions were created for the investigation, prosecution, and supervision of cases involving medical error, and since October of that year the Investigations Department of the National Prosecutor's Office has operated a dedicated Medical Error Section. Unquestionably, the higher tier employs more experienced prosecutors equipped with more resources with which to handle their cases, which obviously contributes to increased caseloads.

The prosecution service's activity and efficiency comprise a major driver in reducing the medical disciplinary boards' caseloads, because the patient's family no longer have to keep searching for more and more authorities to analyse the cause of death. From the analysis of the Medical Error Section of the Investigations Department at the National Prosecutor's offices it occurs that a total of 4963 proceedings were conducted in 2016 in prosecutors' offices throughout the country against physicians and occasionally other medical staff (e.g. rescuers, midwives). Compared to 2015, this means a 45% increase. In 2017, on the other hand, the count was 5678, which means 15% more proceedings than in 2016 [9]. In 2018 the number of proceedings held was 5739, including 2217 initiated – in 151 cases the matter ended in a plea bargain involving voluntary submission to punishment, and in 211 cases the prosecutor came up with a bill of indictment, which represents 10.6% of all cases handled in 2018 [10].

In cases that are already being handled by a specialist unit of the prosecution service, the patient's family often forego the opportunity to submit the case to a medical disciplinary board, which is another reason for the decline in the number of fatalities in the diagnostic and treatment process conducted by physicians coming up before medical disciplinary boards for analysis. This decline is once again directly linked to the decline in the overall caseload in this type within the medical disciplinary boards under study, because if the case has already reached the stage of criminal proceedings, then the proceedings before the medical board are of no further benefit to the family. Following conclusion of the case in the criminal court, what is most important to the patient's family are the subsequent civil proceedings involving monetary claims against the physician or against the medical establishment, not the proceedings before a medical disciplinary board. It has to be mentioned that in Polish civil procedure a conviction by a criminal court is binding in the civil court (Article 11 of the Code of Civil Proceedings) [11], while the decision of a medical disciplinary board has no such effect.

Another reason behind the declining number of fatalities in medical disciplinary boards' cases involving failure of due diligence by a physician in diagnosis and treatment is the rapid progress in the scientific and technical fields relating to medicine. On the one hand, the development of medicine, including methods of diagnosis and treatment, has caused the rules for dealing with a patient in medical procedures to become technical standards and an objective category. On the other hand, it has to be borne in mind that despite this progress medicine still has to contend with certain phenomena that have not yet been sufficiently explored and explained. For the patient families coming forward with complaints it is difficult to understand that the rules of conduct do not cover extraordinary, surprising situations and cases not met before. Hence, the rules must be referred to the specific case and the doctor's options available in the relevant situation in keeping with the then-current state of medical knowledge. Thus, the decisions of medical disciplinary boards taking this factor into account tend

to be perceived as a desire to shield the profession from responsibility.

Select cases

Cholestasis

The medical disciplinary board heard the case of a patient who had been under the care of an obgyn clinic into the 32nd week of her pregnancy. During that time laboratory tests showed a high level of bile acids, and the patient began to experience skin itching. After CTG the doctor referred the expectant mother to the hospital, where she was admitted with a diagnosis of intrahepatic cholestasis of pregnancy (ICP). During the hospital stay her condition and that of the child were monitored. This involved gynaecological examinations, CTG and auscultation of the child's pulse 6 times per day, and Doppler ultrasound. Drugs were administered – Sylimarol (sylibum), Essentiale (purified EPL), Ursopol (UDCA) – as well as intravenous vitamin C and 5% glucose. In the following days of her stay at the hospital laboratory examinations showed high bile acids – 97.9 μmol/L and 104.9 μmol/L. The patient was given steroids to accelerate intrauterine lung maturation in the foetus, and her physician in charge qualified her for a caesarean due to the increased concentration of bile acids, and she completed the 36th week of pregnancy. The caesarean exposed a thick green amniotic fluid and no vital signs in the extracted child. Despite the resuscitation, no cardiac activity was achieved. The autopsy report showed no developmental anomalies or infection in the foetus, while noting blood stasis in vessels and an inflated umbilical vein.

The Regional Professional Responsibility Ombudsman, as disciplinary prosecutor, charged the obstetrician with having failed – while providing care to the hospitalized patient during the period from 6 November 2013 to 20 November 2013 and 22 November 2013 to 5 December 2013 for ICP and observing an increase in bile-acid parameters to blood levels 10 or even 15 times the maximum permitted levels (depending on the accepted standard being 6.8 or 10 μmol/L), which a had negative impact on the foetus – to accelerate the conclusion of the pregnancy by ordering a caesarean section, which led to a stillbirth. The disciplinary prosecutor qualified this as professional misconduct under Article 8 CME read in junction with Article 4 of the Act on the Professions of Physician and Dentist.

According to the opinions of the experts appointed in the case, no simple correlation between the concentration of bile acids and the risk of stillbirth had been found at that time. Data from the subject literature do not show any maximum limit of bile acids in a pregnant patient giving rise to an absolute indication for completing the pregnancy. Recommendations of the Polish Society of Gynaecologists and Obstetricians recommend completing the pregnancy after lung maturation completes in the 36th to 38th week of pregnancy. The risk of lung immaturity in premature birth has to be balanced against the risk of stillbirth [12]. Any decision in favour of an earlier birth must be based on serious indications (such as a risk to the life of the mother or child), while in the case at hand there were none, according to the experts. The wait-and-see approach was fully acceptable in this case. During her hospital stay the patient was under strict obstetric observation. The physician in charge monitored the patient and the child. Correct pharmacological therapy and intensive monitoring of the child's condition were provided. The disciplinary board cleared the doctor of the charges [13].

Acute lower-limb ischaemia

On 20 August 2015 at around 5.00 p.m., this patient suffered a workplace accident while felling trees, which led to an injury of the knee and left shin. A short time after returning home he began to experience increasing pain in his left leg. A medical-rescue team was called, who transported the patient to the Hospital Emergency Department in M. at around 8.00 p.m. (the medical file was started at 8.05 p.m.). A specialist surgeon was on duty at the ED on that day and examined the patient and ordered X-rays of the chest, pelvis, left thigh, left shin, and ankle joint. After the examination and diagnostics, the surgeon made the correct diagnosis – instability of the left knee, with symptoms of acute lower-limb ischaemia. The patient was administered a tetanus anatoxin, 1000 mL 0.9% NaCl, Ketonal, and Clexane. After the use of a Kramer stabilizer rail, due to the acute skin ischaemia, within less than an hour (at 8.58 p.m.) the doctor referred the

patient to the hospital in S., where a vascular surgeon could help him. After 2 hours in transport, at around 11.00 p.m., the patient reached that hospital. There, CT angiography confirmed the diagnosis of arterial trauma in the left knee. However, due to the absence of the vascular surgeon, who at that time was on leave, the patient was further referred to the specialist hospital in W., where he was operated on at around 3.00 a.m. In the following days, due to his deteriorating condition, an amputation was performed for life-saving reasons. Despite the doctors' efforts, on 24 August 2015, the patient died amid symptoms of multiple organ failure.

The patient's wife filed a complaint with the Ombudsman. The Ombudsman charged the surgeon – on 20 August 2015 – with failure of due diligence in dealing with a patient, consisting of not having referred the patient, with acute lower-limb ischaemia, to the specialist hospital but to the remote hospital in S., additionally without previously making sure the patient would receive the assistance of the vascular surgeon there, thus exposing the patient to delay in the implementation of correct treatment by another couple of hours, leading to the patient's death, viz. professional misconduct under Article 8 MEC and Article 4 of the Act on the Professions of Physician and Dentist in conjunction with Article 53 of the Act on Medical Chambers.

In the board's opinion the defendant surgeon had properly executed his duties. Firstly, in reliance on medical history and the experts' opinion, the board found that the doctor's examination of the patient and diagnosis was correct. Additional examinations were ordered adequately to the patient's condition and without undue delay. Secondarily, due to non-palpable peripheral pulse and loss of sensation from the knee down, as well as decreased temperature of the left foot and lower leg, the defendant doctor was correct in deciding to refer the patient to a specialized centre. The board had no doubt that a patient with such injuries ought to have been referred to a hospital for a vascular and orthopaedic surgical operation. Thirdly, while in the hospital in M. the patient was in a general condition permitting transport to the hospital in S. The defendant doctor ordered the transport on 8.55 p.m., and the patient left the Hospital Emergency Department at 10.00 p.m. because the ambulance was being used for a previous patient and returned to the hospital at 9.45 p.m. Until that time the patient was under constant monitoring by a nurse. From the medical files and the personnel's testimony, it can be seen that while being transported the patient was in a stable condition, conscious, cardiovascularly and respiratorily stable, adequately managed and secured. Hence, there was no necessity of alternative transport, such as Medical Air Rescue. Fourthly, the defendant doctor had no obligation to verify that a vascular surgeon was present in the hospital in S., which, pursuant to its contract with the National Health Fund (NFZ), guaranteed services in the area of vascular surgery for that territory in 2015. In accordance with NFZ guidelines the patient had to be taken to vascular-surgical A&E in S. The board held that the surgeon could not be held responsible for organizational failures due to staff shortages. The board cleared the doctor of the charges [14].

Conclusions

This article discusses the decisions of medical disciplinary boards concerning failure to exercise due diligence in the process of diagnosis and treatment only in cases involving fatalities. Hereby offering only a partial discussion of the problem of medical error, not including the cases of patients suffering permanent injury rather than death. A reduction in the number of such cases coming up before medical disciplinary boards is primarily the consequence of the growing involvement of the law enforcement – public prosecutors' offices for offences involving medical error. Currently, Polish patients and their families are trying to find the easiest and fastest way to bring a potential medical error before court to win damages, compensation, or an annuity from the physician or from the medical establishment.

The 2 cases involving the patient's death in the process of diagnosis and treatment show that in certain clinical scenarios there are no clear medical indications for a specific course of action, and the physician has to act on the basis of experience and intuition. Additionally, they also highlight certain limitations in medical proceedings due to the organizational deficiencies in medical establishments, which should be corrected as soon as possible.

The author declares no conflict of interest.

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Submitted: 20.11.2020
Accepted: 8.01.2021