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MEDICAL MALPRACTICE AND COMPENSATION IN POLAND

DR. KINGA BĄCZYK-ROZWADOWSKA *

INTRODUCTION

1. The Polish health care system has undergone many significant changes recently. The Institutional Health Care Providers Act (*Ustawa o zakładach opieki zdrowotnej*) of August 30, 1991¹ officially repealed the former framework of State health care (*państwowa służba zdrowia*) and paved the way for establishing private activities, including the provision of health care, the pharmaceutical industry, medical supplies, ambulatory diagnostic services, as well as a wide range of hospital services.² However, until January 1, 1999 it was still a taxation-based system in which the majority of medical services were financed by Government sources through budget allocation (made by the Ministry of Finance).³

On January 1, 1999, the Universal Health Insurance Act (*Ustawa o powszechnym ubezpieczeniu zdrowotnym*) of February 6, 1997⁴ came into force, introducing national health insurance (*powszechnie ubezpieczenie zdrowotne*) based on the principles of equal treatment, social solidarity, equal access to health care services, and a free choice of medical care providers. These principles reflected Article 68 of the newly enacted Polish Constitution of April 17, 1997, which vests everyone with the right to have his health protected (Section 1) as well as the right to equal access to publicly-funded medical services (Section 2).⁵

The fundamental idea of the national health insurance was to separate the purchasing of health care services from the delivery of these services (a

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1. Dziennik Ustaw [Journal of Laws] 1991, No. 91, item 408 (Pol.) - as amended.

2. M. Nesterowicz, E. Bagińska, Medical Legislation in Poland, Yearbook of European Medical Law, Lidingö 11 (2005).

3. For more information, see M. Nesterowicz, E. Bagińska, A. den Exter Medical Law, the Hague-London-New York 24 (2002).

4. Dziennik Ustaw [Journal of Laws] 1997, No. 28, item 153 (Pol.).

5. See Kinga Bączyk-Rozwadowska, ODPOWIEDZIALNOŚĆ CYWILNA ZA SZKODY WYRZĄDZONE PRZY LECZENIU 141–142 (2007).

“purchaser-provider split”). A system in which health care was to be contracted seemed to be the best way to encourage competition between medical services providers to bid for contracts with the institutions in charge of financing public health care.⁶ Therefore, the Universal Health Insurance Act established so-called health insurance funds (*Kasy Chorych*),⁷ responsible for collecting premiums from the insured and purchasing medical services by signing performance-based contracts with both public and private health care facilities (hospitals, clinics, medical centers) as well as individual health care professionals (doctors and other members of the medical profession, e.g., nurses, midwives, laboratory assistants).⁸ These contracts determined the type and scope of health care provided, the terms and conditions of rendering services, maximum cost settlement, principles of medical service quality, quality monitoring and control mechanisms, as well as the principles of supervision, documentation, and complaint procedures. In 2003, due to the need to centralize the insurance scheme, health funds (*Kasy Chorych*) were replaced with one state entity called the National Health Fund (*Narodowy Fundusz Zdrowia* (NFZ)). However, no other structural changes were made to the overall arrangement of health care.

The actual national health insurance scheme operates pursuant to the provisions of the Publicly-Funded Health Care Services Act (*Ustawa o świadczeniach zdrowotnych finansowanych ze źródeł blicznych*) of August 28, 2004.⁹ The scheme is still obligatory for almost all citizens (those who are not subject to the insurance mandate may acquire an insurance coverage voluntarily).¹⁰ Eligibility for health care services is thus no longer automatic (as it was in the former taxation system) but is based on the payment of premiums. However, apart from employed persons’ income contributions (up to 9% of the taxable income) and farmers (using a formula based on the estimated uniform rural production), national health insurance can also be financed with income from bank deposits, donations, legacies, and other sources indicated in the Act.

6. *Id.*

7. Under the Universal Health Insurance Act 15 regional health insurance funds (regionalne Kasy Chorych) and 1 industry-specific (sectoral) pool (branżowa Kasa Chorych) were established. Universal Health Insurance Act, Journal of Laws of 1997, No. 28, item 153, as amended. Although they were modeled on the German Krankenkassen (of a Bismarckian type), some elements of their organizational structure reflected the configuration of Polish health care during the pre-war period. See M. Nesterowicz, E. Bagińska, A. den Exter, *Medical Law Monograph*, INT’L ENCYCLOPAEDIA OF L. 65 (2007).

8. *Id.*

9. Publicly Funded Health Care Services Act of 2004 (Dziennik Ustaw [Journal of Laws] 2004, No. 210, item 2135 (Pol.)).

10. See M. Nesterowicz, *PRAWO MEDYCZNE*, 33 (9th ed. 2010).

In return for the premiums, the insurance scheme provides the insured and other people entitled by the statute (minors under the age of eighteen and other family members of the insured, the unemployed, disabled, mothers on maternity leave, veterans, etc.) with a wide range of medical services that cover nearly all areas of health care (diagnosis, therapy, hospitalization, specialist treatment, rehabilitation, as well as sanitary transport, emergency care, and provision of drugs and other medical appliances).¹¹ These services, called standard (guaranteed) procedures, constitute a health care benefit package, and they are rendered free of charge or in return for partial payments by health care providers that become participants of the insurance scheme by entering into contracts with the National Health Fund.¹² Within the scope of insurance, the insured are also entitled—under certain conditions—to medical treatment abroad¹³ and to a whole or partial refund of drugs, medical products, and appliances as well as orthopedic equipment. Highly specialized health care procedures of certain types (e.g. bone marrow and liver transplantations) are financed directly by the Ministry of Health.¹⁴

Health care providers which do not participate in the national health insurance scheme offer medical services for a charge, on a commercial basis. These “non-standard procedures” are accessible to all patients who are interested in them, and they play an important role in the overall health care system, since the accessibility of medical care financed from public sources is, in practice, limited, particularly for specialized treatment.

2. Civil law, with its compensation mechanisms (instruments), is the main source of reimbursement for personal injury, with social security insurance and private health insurance being of secondary importance in this regard.

Social security insurance has functioned on the grounds of the Social Security Insurance Act (*Ustawa o ubezpieczeniu społecznym*) of October 13, 1998¹⁵ as a system independent from national health insurance. This kind of insurance, obligatory for most of the citizens, provides money and

11. See Publicly-Funded Health Care Services Act, *supra* note 9, art. 15 as amended.

12. The detailed lists of medical services covered by the health care benefit package have been published in 13 Ordinances of the Ministry of Health of 28–30 August 2009. See *Dziennik Ustaw* [Journal of Laws] 2009, No. 139, items 1136–1148 (Pol.). Certain medical services are qualified into a standard category by the Ministry of Health according to the statutory criteria listed in Article 31a of the Law of 2004 and the recommendations of the President of the Agency of Accreditation of Medical Technologies. See *supra* note 9, art. 31a.

13. See Marcin Śliwka, *PRAWO MEDYCZNE* 59–63 (Miroslaw Nesterowicz, ed., 9th ed. 2010)

14. See the Ordinance of Ministry of Health of 13 December 2004, concerning highly specialized medical procedures financed by the State; see also *Dziennik Ustaw* [Journal of Laws] 2004, No. 267, item 2261 (Pol.).

15. Official Journal 2009, No. 205, item 1585 - unified text.

other assistance in the case of illness, work disability, maternity leave, and retirement. The benefits are paid by a State entity the Social Security Insurance Administration (*Zakład Ubezpieczeń Społecznych*), which collects premiums from the insured and administers the scheme.¹⁶

Until the introduction of the new health care system in 1999, Poland had a rather limited experience with private health insurance. At present, this kind of insurance, governed by the general provisions of the Civil Code (Article 805 and the following) and the standard terms of insurance, is becoming more and more common and gradually grows in importance.¹⁷ The reason for this growth is the relatively low quality of NFZ services and effectively limited access to public health care, especially to medical services rendered by specialists (long “waiting lists” for more sophisticated treatment).¹⁸ However, private insurance may (and will) serve solely as a voluntary supplement as long as national health insurance is obligatory. Statutory rules would be required to give patients the choice between public (national) and private health insurance, since as long as the former is compulsory, premiums must be paid even if the patient does not make any use of his or her health care benefit package (when he needs a certain kind of medical treatment).¹⁹

I. GROUNDS FOR CIVIL LIABILITY

1. In the event that damage arises from medical malpractice, civil liability may be attributed exclusively to the that has performed the treatment, irrespective of whether it is a participant of the insurance system or not.

There is no possibility to claim compensation from the National Health Fund, because this institution neither provides health care itself (its role is limited to purchasing medical services by entering into contracts with hospitals and doctors) nor it is an owner, co-owner, or a share-holder of a health care facility. However, as a legal person exercising State (offi-

16. See E. Lechnio-Dziubińska et. al., *UBEZPIECZENIA SPOŁECZNE* (2011).

17. See K. Policha, B. Wojno *Aktualne problemy prywatnych ubezpieczeń zdrowotnych*, *PRAWO ASEKURACYJNE* 14 (2008).

18. In practice, private voluntary health insurance functions in two alternative forms: as group-based insurance (common for employers) or an individual health care benefit package. The costs of such insurance depend on the scope of services covered; the price for a standard packet for one person may vary from PLN 60 (15 €) to PLN 600 (150 €) per month. According to statistical data, as of the beginning of 2011 not more than 18% of Poles have entered into a private health insurance contract of any type. *GAZETA METRO*, 28 March 2011.

19. A number of bills have been drafted to regulate the status of private health insurance and its relation to the national health insurance (the latest dating from October 2010). However, none of them has proposed a free choice between the national and private health insurance. The latter is usually to serve as a supplementary cover only. See Dominika Sikora, *Dodatkowa polisa zdrowotna z ulgą*, *GAZETA PRAWNA* No. 206 (2837), 21 October 2010.

cial) authority to ensure and organize health care (in view of Article 68 of the Polish Constitution),²⁰ the National Health Fund may be responsible for damage that results from the lack of proper quality of medical services, inadequate supervision and control over professionals, improper choice of insurance scheme participants (hospitals and doctors), lack of medical services that should have been contracted, etc.²¹ The legal grounds of this liability are the amended Article 417 of the Civil Code (in force since June 17, 2004),²² which constitutes tortious liability for the unlawful acts and omissions of all legal persons exercising State authority. Since this is an objective, risk-based liability, it is not necessary to prove the damage perpetrator's fault to seek compensation.²³

2. Liability for medical malpractice can be either contractual or tortious. What kind of liability regime is applicable in the circumstances of a certain case depends on the status of the doctor (the hospital) and the nature of medical services that have been rendered to a patient.

If health care is provided within the scope of national health insurance, there is no contract between a patient and a hospital or a doctor, since the source of the provider's obligation toward a patient is statutory provisions (regulations of Publicly-Funded Health Care Services Act of 28 August 2004). Consequently, in the case of damage, provisions of *ex delicto* liability are applied exclusively (Article 415²⁴ of the Civil Code, which constitutes liability for the tortfeasor's own acts and omissions, or Article 430²⁵ of the Civil Code, constituting vicarious liability for a fault of a subordinate). A contract between parties (qualified as a contract of rendering services to which provisions of Article 750 of the Civil Code are applied)²⁶

20. Ewa Bagińska, ODPOWIEDZIALNOŚĆ ODSZKODOWAWCZA ZA WYKONYWANIE WŁADZY PUBLICZNEJ, 287 (2006); Mirosław Nesterowicz, *Glosa do wyroku Sądu Okręgowego w Lublinie z 4.IV.2002 r.* (IC 656/99), [Commentary on the Judgment of the Regional Court in Lublin], PRAWO I MEDYCYNĄ 127–128 (2004/3).

21. Bagińska, *supra* note 20, at 287; Nesterowicz, *supra* note 20, at 127–128.

22. Law of 17 June 2004 (Journal of Laws 2004, No. 162, item 1692), amending the Civil Code (Law of 23 April 1964; Journal of Laws 1964, No. 210, item 2135). Section 1 of the amended Article 417 states: "The liability for damage caused by an illegal act or omission in the course of the exercise of public authority rests on the State Treasury, a local authority or any other legal person who exercises an authority conferred upon it by law." Ewa Bagińska, *Poland* (Ewa Bagińska trans.), in EUROPEAN TORT LAW: BASIC TEXTS 131 (Ken Oliphant & Barbara C. Steininger eds., 2011) (citing Civil Code art. 417 (Dziennik Ustaw [Journal of Laws] 1964) (Pol.)) [hereinafter Bagińska, Pol. Civ. C.].

23. See Bagińska, *supra* note 20, at 286–287; K. Bączyk-Rozwadowska, *supra* note 5, at 196.

24. Article 415 states: "Any person who by his fault has caused damage to another person is obliged to redress it." Bagińska, Pol. Civ. C., *supra* note 22, art. 415.

25. Article 430 states: "A person who on his own account entrusts the performance of an act to a person who at the performance of the act is under his control and has a duty to abide by his instructions is liable for any damage caused by that person's fault in the course of performance." *Id.* at art. 430.

26. Article 750 states: "The provisions of mandate [Articles 734 - 749] shall apply respectively to contracts on performance of services not regulated by other provisions." THE POLISH CIVIL CODE., 135

is concluded only when a patient receives treatment outside the insurance scheme, at a private clinic or a doctor's office. The breach of that contract may then give rise to the provider's *ex contractu* liability (according to Article 471²⁷ or Article 474²⁸ of the Civil Code).

However, in most malpractice cases provisions of tortious liability are applied. According to case law and doctrine, a doctor who causes personal injury (a bodily impairment and/or health disturbance) not only performs his contractual obligations improperly but, at the same time, acts inconsistently with the general duty of care by which he is bound, regardless of the legal relationship with a patient.²⁹ *Ex contractu* liability is then in concurrence with tortious liability and, pursuant to Article 443 of the Civil Code, the injured is entitled to choose legal grounds for seeking indemnity.³⁰ In practice, patients prefer the *ex delicto* regime because of the wider scope of damages,³¹ including compensation for a non-pecuniary loss³² and the statute of limitations, which is far more convenient for a claimant (especially after the latest amendment of Article 442¹ of the Civil Code).³³ The plain-

(O. A. Wojtasiewicz, trans., D. Kierzkowska, ed., 2000), [hereinafter O. A. Wojtasiewicz, *The Polish Civil Code*]. Under this contract on performance of services a health care provider is obliged to perform treatment with due care and diligence required by the medical profession. He then guarantees medical attention free of faults and mistakes, and is not responsible for failure to achieve a certain result (a successful treatment or cure). M. Nesterowicz, *supra* note 10, at 75. Compare M. Sośniak, *CYWILNA ODPOWIEDZIALNOŚĆ LEKARZA*, 30 (1st. ed., 1968).

27. Article 471 states: "The debtor shall be obliged to redress the damage resulting from the non-performance or improper performance of the obligation unless non-performance or improper performance were due to the circumstances for which the debtor is not liable." Wojtasiewicz, *supra* note 26, at 136.

28. Article 474 states: "The debtor shall be liable, as for his own acts and omissions, for acts and omissions by the persons with the assistance of whom he performs the obligation, as well as the persons whom he entrusts with the performance of the obligation. The above provision shall also apply where the obligation is performed by the statutory representative of the debtor." *Id.* at 136.

29. In view of doctrine, in the field of medical malpractice contractual duties only strengthen and reinforce the general duty in tort to respect patients' interest in the integrity of the body. Stefan Grzybowski, *Odpowiedzialność cywilna lekarza*, *ODPOWIEDZIALNOŚĆ CYWILNA ZA WYRZĄDZENIE SZKODY* 130, 133 (S. Grzybowski, ed., 1969).

30. Article 443 states: "The fact that the act or omission from which the damage arose constituted the non-performance or the improper performance of a pre-existing obligation does not preclude a claim for damages in tort, unless the pre-existing obligation provides otherwise." Bagińska, *Pol. Civ. C.*, *supra* note 22, art. 443; *see also* the judgment of the Supreme Court of 28 April 1964 (II CR 540/63), OSPiKA 1965, item 197 and the judgment of the Supreme Court of 10 October 1997 (III CKN 202/97), OSN 1998/3, item 42.

31. *See infra* note 144.

32. *See infra* note 144.

33. The Law of 16 February 2007, *Dziennik Ustaw* [Journal of Laws] 2007, No. 80, item 538 (in force since 10 August 2007). Section 3 of the amended Article 442¹ states: "In a personal injury case, a claim shall not be barred before a period of three years from the date on which the injured learned about the injury and about the person obliged to redress it." Section 4 states: "The claims of a minor for redress for damage resulting from personal injury shall not be barred before a period of two years from the date he obtains the age of majority" which is eighteen years. Bagińska, *Pol. Civ. C.*, *supra* note 22, art. 421.

tiff's choice of liability provisions is binding on the court (bearing in mind that only one compensation may be awarded). However, it is not possible to create a "combined" regime which comprises certain (and most favorable for a claimant) elements of *ex contractu* and *ex delicto* liability.³⁴

Civil liability, whether contractual or tortious, may be attributed to a doctor or a hospital when any of these persons' own (faulty) acts or omissions result in damage. However, it may be also a hospital's vicarious liability for injuries caused by fault of its doctors or other medical staff.

3. A doctor who works outside the scope of the NFZ insurance and renders medical services individually, within his own private practice (as an entrepreneur, within the meaning of the Business Activity Freedom Act of 2 July 2004³⁵), bears civil liability for any damage resulting from his negligent conduct. Although there is, as a rule, a binding contract between that doctor and a patient, which gives rise to *ex contractu* liability (pursuant to Article 471 of the Civil Code), in the great majority of cases Article 415 of the Civil Code is applied concurrently. A patient may claim damages in tort even if certain obligations of the doctor laid down in the contract (e.g., the duty to pay additional visits, to perform an operation personally without delegating these tasks to a colleague, etc.) were not fulfilled or fulfilled improperly, provided the breach of these obligations has caused a personal injury.

A doctor who runs his individual private practice and employs medical staff such as assistants, subcontractors, or subordinates (anesthesiologists, nurses, midwives, laboratory assistants, etc.) is liable for the misconduct of the members of that staff, regardless of whether the resulting damage is caused by his own fault. In such cases, liability is objective, based on the principle of risk pursuant to Article 474 of the Civil Code or Article 430 (applied concurrently as delictual grounds). Consequently, a doctor may not be exempt from it by proving that he was diligent selecting his subordinates or that he exercised proper supervision and control over the employed staff. However, a patient who suffered the damage must

34. Case law did make several attempts to create such a combination but this solution was finally disapproved by the Supreme Court. The only possibility is to claim compensation for pecuniary and non-pecuniary loss on appropriate grounds by means of the concurrence of liability if such a possibility in casu exists. In the judgment of 17 December 2004 (II CK 300/04), OSP 2006/2, item 20 cmt. by M. Nesterowicz, the Supreme Court admitted that claiming damages for material loss *ex contractu* (pursuant to Article 471 of the Civil Code) does not exclude the indemnification of pain and suffering (on the grounds of Article 445 of the Civil Code, in conjunction with Article 443) if the results of the improperly performed obligation (defective artificial limbs) are so grave for the injured person that they constitute at the same time a tort as defined by Article 415 of the Civil Code. See also M. Nesterowicz, *Zadośćuczynienie pieniężne ex contractu i przy zbiegu odpowiedzialności deliktowej*, PAŃSTWO I PRAWO 23 (2007/1).

35. Dziennik Ustaw [Journal of Laws] 2007, No. 155, item 1095, art. 4 (Pol.) as amended.

present the evidence of fault (negligence) of an individual perpetrator (a certain member of the doctor's personnel) or at least (as far as Article 430 is concerned) prove the existence of the so-called anonymous fault (fault by an unidentified person).³⁶

4. In the case where a doctor does not work individually but renders medical services in a health care facility, it is necessary to establish whether he performs treatment on the grounds of a contract of employment (as a hospital's employee³⁷ within the meaning of Article 2 of the Labour Code³⁸) or pursuant to a civil law contract (as a so-called independent contractor). The distinction is important, because if damage arises from medical malpractice, different provisions are applied and liability may be attributed to different persons.

4.1. A doctor who works as a hospital's employee is protected under the provisions of the Labour Code. He is then not individually liable for the damage inflicted on patients in the course of treatment and due to his fault (so-called employee immunity, Article 120 § 1 of the Labour Code).³⁹ Consequently, the injured person can pursue his claims only against the health care facility (the doctor's employer, irrespective of whether it is a public hospital, a doctor's cooperative, a medical center, or a private clinic), which is obliged to redress the damage (in full) according to the provisions of the Civil Code. The doctor who caused the damage does not act as a party in the lawsuit and he may appear in the court (if ever) only as a witness presenting evidence of the circumstances of the case.⁴⁰ As case law provides, the exclusion of the doctor's liability towards the patient extends also to the claims of the insurance company, which cannot recourse the

36. Gerard Bieniek, KOMENTARZ DO KODEKSU CYWILNEGO. KSIĘGA TRZECIA. ZOBOWIĄZANIA. TOM I 344 (G. Bieniek, ed., 2002). For discussion of the concept of anonymous fault, see *infra* notes 99–103.

37. Pursuant to Article 44a of the Health Care Institutions Act, an employment relationship is obligatory for doctors—principals of a hospital and heads of a hospital. However, these doctors usually work as employees only part-time, while during the rest of the working time they render medical services as independent contractors. This situation creates difficulties, since in the case of damage inflicted on a patient it may be difficult to establish which of the two capacities of the doctor will be the legal basis for the case against him. See M. Nesterowicz, *Odpowiedzialność cywilna zakładu opieki zdrowotnej za lekarza jako podwładnego*, PAŃSTWO I PRAWO 4 (2008/9).

38. Law of 26 June 1974, Journal of Laws No. 24, item 141.

39. The same rules are applied for doctors who render health care as functionaries (in a function-based relationship) in the armed forces, in the police, or in the prison medical service. M. Nesterowicz, *supra* note 36, at 125.

40. This solution has been criticized by doctrine as being disadvantageous (and, as it is pointed out, unfair) for the injured. See M. Nesterowicz, *Odpowiedzialność cywilna za działania zespołów lekarskich*, MATERIAŁY SYMPOZJUM NAUKOWEGO PRAWO A MEDYCYNA U PROGU XXI w. 50 (M. Filar, ed., 1987).

doctor for the sums paid to the injured person on the grounds of Article 828 § 1 of the Civil Code (*cessio legis*).⁴¹

In the majority of malpractice cases, the injured persons are reimbursed on the grounds of Article 430 of the Civil Code, which constitutes the hospital's objective (risk-based) liability for damage caused by fault (negligence) of a subordinate doctor.⁴² However, if medical care was rendered on a contractual basis, outside the scope of the NFZ insurance, it is also possible to claim damages from a hospital *ex contractu*, pursuant to Article 474 of the Civil Code.

The health care facility which has indemnified the injury (whether on the grounds of Article 430 or Article 474 of the Civil Code) acquires the right of recourse to the doctor. The recourse may be claimed if all premises of the tortfeasor's liability are met, in particular the employee's fault and the extent of the patient's damage (Article 116 of the Labour Code). However, the scope of recourse is limited to a maximum of the threefold monthly remuneration of the employee (Article 119 of the Labour Code). The right to full recourse, which comprises the entire damage, may arise only when the injury was inflicted intentionally,⁴³ when the doctor acted outside the course of treatment (without a functional connection to the execution of his vocational duties⁴⁴), and when the hospital is insolvent or improperly insured (Article 122 of the Labour Code)⁴⁵.

In the aforementioned situations the restitutorial function of compensation and the protection of the employer's (hospital's) interest in being reimbursed prevails over the necessity to safeguard the property of an employee. In order to be successful in claiming recourse (whether limited or

41. See the resolution of the Supreme Court of 7 November 1977 (III CZP 80/77); OSN 1978/5 – 6, item 84. The Supreme Court ruled that the Labour Code is a special act introducing employee protection separate from the Civil Code, and Article 828 of the Civil Code, which constitutes the insuring party's right assignment, is not applied thereto.

42. In view of doctrine and case law, the relation of superiority (dependency) between the health care institution and the doctor exists, even though the latter is independent from a hospital as far as the professional sphere of medical activity (diagnosis and therapy) is concerned. See Bączyk-Rozwadowska, *supra* note 5, at 189. Compare the judgment of the District Court in Lublin of 4 April 2002 (I C 656/99), PRAWO I MEDYCYNA 184 (2004/3), cmt. by M. Nesterowicz; the judgment of the Supreme Court of 13 December 2007 (I CSK 384/07), OSP 2009/2, item 20; and the judgment of the Appellate Court in Lublin of 4 March 2009 (I ACa 12/09), unreported.

43. As case law provides, damage caused by intentional fault is hardly ever a case in the field of medical malpractice. It may appear, e.g. when a doctor refuses to treat or to admit to a hospital a patient in an emergency situation. See M. Nesterowicz, KONTRAKTOWA I DELIKTOWA ODPOWIEDZIALNOŚĆ LEKARZA ZA ZABIEG LECZNICZY, 85 (1972).

44. See the judgment of the Supreme Court of 11 October 2007 (IV CSK 174/07), Przegląd Sądowy 2008/9, 34

45. See also the resolution of the Supreme Court (in a panel of seven judges) of 7 June 1975 (III CZP 19/75), OSN 1976, item 20 and the judgment of the Supreme Court of 11 April 2008 (II CSK 618/07), ZDP 2009, item 41.

full), a hospital must present all the facts that prove the doctor's liability (in particular negligence or another kind of his unintentional fault), demonstrate the scope of the damage and establish the causal link between that damage and the doctor's negligent improper (faulty) conduct. Obviously, if an individual perpetrator cannot be found or if it is impossible to establish his identity (e.g., in the case of anonymous fault), no recourse is possible.

In practice, recourse claims (or suits) are very rare. Damages are usually paid to the injured person by the insurance company that a hospital has entered into a contract with, so there are in fact no grounds for recourse. On the other hand, if a health care provider itself indemnifies the injury, the matter of recourse is usually settled between the parties (the employer and the employee) by means of an out-of-court agreement (unless the employer has renounced the pursuance of this limited indemnity at all). This solution is particularly favorable for the doctor, who may then have his indemnity reduced. Such a reduction is usually made after consideration of all circumstances of the case, in particular the economic status of the doctor, his family's living conditions, as well as his attitude towards professional tasks and obligations. However, the refund a doctor is obliged to pay may not be reduced if the damage was caused intentionally or when the doctor was convicted by a criminal court (with a final verdict) for not fulfilling (neglecting) his vocational duties.⁴⁶

4.2. A doctor who performs treatment in a health care facility on the grounds of a civil law contract (which may be a contract of rendering services within the meaning of Article 750 of the Civil Code or a contract of granting an order to perform treatment regulated by Article 35 Sections 1–4 of the Health Care Institutions Act of August 31, 1991) is not protected under the provisions of the Labour Code. Consequently, he bears civil liability for any damage inflicted on patients in the course of treatment, pursuant to Article 415 of the Civil Code. Liability of an independent contractor is joint and several with the health care institution with which the doctor has concluded a contract, pursuant to Article 441 Section 1 of the Civil Code⁴⁷ or Article 35 Section 5 of the Health Care Institutions Act (for contracts of granting an order to perform treatment⁴⁸).⁴⁹ As case law provides, it is not possible for a doctor to prove in the malpractice suit that

46. Nesterowicz, *supra* note 10, at 126.

47. Section 1 of Article 441 states: "If several persons are liable for damage caused by a tort, their liability is joint and several." Bagińska Pol. Civ. C., *supra* note 22, art. 441.

48. These contracts are concluded by doctors with a public health care facility as a subcontract to the main contract between the facility and the National Health Fund. Bączyk-Rozwadowska, *supra* note 5, at 145.

49. Nesterowicz, *supra* note 10, at 67.

he contributed to the existence or emergence of damage to a lower or greater extent than the other joint tortfeasor (a hospital or another doctor).⁵⁰ Since Article 441 of the Civil Code (as a *ius cogens* mandatory provision) accepts no exceptions to the joint and several liability, each of the defendants (tortfeasors) should be ready to compensate all the damage sustained by the patient (however, with the right to recourse after the injured is fully reimbursed).⁵¹

In the case of multiplication of possible defendants, patients usually proceed against a health care institution since that sort of party (debtor) makes recovery easier than an individual perpetrator. The institution's recourse against the individual perpetrator is subject to the provisions of the Civil Code, and its scope depends on the circumstances of a given case. Full recourse is possible when damages are paid by a hospital which indemnifies the patient, in spite of the lack of its fault, provided the injury was caused by fault or another kind of negligence on the part of the doctor (Article 441 § 3 of the Civil Code).⁵² However, if the damage resulted from the improper conduct of both a doctor (who, e.g., performed an operation negligently) and the health care institution (which, e.g., did not provide the doctor with the adequate surgical equipment) and only the latter redressed the injury in full, it may demand from the doctor the refund of an appropriate part according to the fault of that person and the extent to which he contributed to the emergence of the damage (Article 441 § 2 of the Civil Code).⁵³

5. Liability of a health care provider may arise in the case where the damage is inflicted on a patient as a result of the improper organization or mistakes in the functioning of a hospital itself. Circumstances of that kind constitute the so-called organizational fault (*wina organizacyjna*), which, as a legal person's own fault, shall not be attributed to a certain member of medical staff (in particular, a doctor) but to the entire health care institu-

50. The judgment of the Supreme Court of 2 December 1970 (II CR 542/70), OSN 1971, item 153 and the judgment of the Supreme Court of 25 August 1978 (III CZP 48/78), OSN 1979/4, item 64

51. The judgment of the Supreme Court of 2 December 1970 (II CR 542/70), OSN 1971, item 153 and the judgment of the Supreme Court of 25 August 1978 (III CZP 48/78), OSN 1979/4, item 64. Compare Bieniek, *supra* note 36, at 398–399.

52. Section 3 of Article 441 states: "A person who redresses the damage for which he is liable in spite of the absence of fault has a right of recourse against the perpetrator if the damage occurred due to the latter's fault." Bagińska, Pol. Civ. C., *supra* note 23, art. 441.

53. Section 2 of Article 441 states: "If the damage resulted from acts or omissions of several persons, the person who redresses the damage may demand reimbursement from the others of the appropriate part depending on the circumstances of the case, in particular the fault of the given person and the degree to which the latter contributed to the occurrence of the damage." Bagińska, Pol. Civ. C., *supra* note 22, art. 441.

tion.⁵⁴ Consequently, the legal grounds for a hospital's liability are, as a rule, Article 415 of the Civil Code (or, less often, Article 416 of the Civil Code if damage is caused by fault of a legal person's agency⁵⁵), in concurrence with Article 471 when the patient was treated on a commercial basis, outside the scope of the insurance scheme (Article 443 of the Civil Code).

As case law provides, the improper organization or malfunctioning of a hospital may appear in many forms.

First, the health care provider can bear liability for a failure to provide patients with a "safe hospital stay."⁵⁶ The hospital should then take all necessary precautions to ensure the expected hygiene and safety standards to prevent risks of any harm. Furthermore, hospital facilities and furnishing ought to be designed in the way that prevents accidents, like slipping on a wet floor or falling off a hospital bed or operating table.⁵⁷ According to case law, the scope of the duty to provide a safe stay depends on the type of health care facility as well as the patient's health condition. For example, a mental hospital is obliged to take special precautions to ensure the total care to the unconscious and mentally disturbed patients to prevent them from injuring themselves (the judgment of the Supreme Court of 19 November 1969, II CR 294/69)⁵⁸ and third parties (other patients, visitors to the hospital, and passers-by; pursuant to the judgment of the Supreme Court of 15 June 1981, I CR 174/81).⁵⁹

The duty to provide a safe hospital stay also includes protecting patients from infections (such as hepatitis B and C, the HIV-virus, staphylococcus, etc.) which may be acquired in connection with the treatment

54. As of 1 January 1999 (in consequence of the reform of the health care system) public health care providers (samodzielne publiczne zakłady opieki zdrowotnej) were granted legal personality and they may bear their own responsibility. Liability for damage incurred in private hospitals may be attributed to a person or institution that runs the hospital (as its founding entity), e.g. a partnership, foundation, legal or physical person, or a religious union. Bączyk-Rozwadowska, *supra* note 5 at 124; see also U. Drozdowska, *Problematyka odpowiedzialności cywilnej zakładów opieki zdrowotnej – wybrane zagadnienia*, RADCA PRAWNY 22 (2002/3).

55. See the judgment of the Supreme Court of 13 V 2005 (I CK 662/04), OSP 2009/12, item 134 and the judgment of the District Court in Szczecin of 26 April 2007 (II CSK 2/07), OSP 2009/1, item 6.

56. According to statistical data, injuries caused by a failure to provide patients with a safe hospital stay result in ten percent of all malpractice suits. Adam Makosz, *Szpitalę płacą coraz więcej za błędy lekarskie*, GAZETA PRAWNA, (July 13, 2010).

57. M Nesterowicz, *Odpowiedzialność cywilna zakładu leczniczego za bezpieczeństwo pacjenta podczas hospitalizacji*, PAŃSTWO I PRAWO 40 (2001/3).

58. OSPiKA 1970, item 249. This case concerned a patient who, due to the lack of a proper supervision of the hospital's staff, managed to jump out of the window and suffered serious injuries. It is important to mention that such behavior was not qualified by the court as a patient's contribution to the damage. See also the judgment of the Appellate Court in Poznań of 28 June 1995 (I ACr 39/95), OSA 1996/7-8, item 36. In this case a patient, who had previously manifested suicidal tendencies, was able to leave hospital on his own and to bring about his death by a train.

59. OSPiKA 1982/11, item 188. This case concerned a mentally disturbed patient who had arbitrarily left hospital and inflicted damage on a passer-by.

(nosocomial infections).⁶⁰ The health care provider is then obliged to maintain the sufficient conditions of the hygiene and asepsis to avoid transmitting contagious diseases and spreading bacteria.⁶¹ This duty includes the use of properly sterilized equipment and appliances,⁶² as well as separating those who are infected or who might be carriers of certain viruses from the rest of the patients treated in the same ward (department).⁶³ In the judgment of the Supreme Court of December 14, 1973 (II CR 692/73),⁶⁴ a hospital was found liable for the damage suffered by a patient who had had his wound infected after surgery (cyst removal). In the court's opinion, the injury (gaseous gangrene) was due to the breach of hygiene standards by the medical personnel who had not dressed the wound in the treatment room but in the sick room, where there had been other patients suffering from serious bacterial infections. Furthermore, the hospital's ward was overcrowded and not cleaned properly (with dirt, dust, and insects in the sick rooms) to provide a safe treatment.⁶⁵ In another judgment of July 10, 1998 (I KKN 786/97),⁶⁶ the Supreme Court admitted that infecting a patient with a contagious disease (hepatitis B) at the defendant's hospital proves that the latter failed to provide this patient with a safe hospital stay. Omission as such constituted negligence for which a hospital was liable on the grounds of Article 415 of the Civil Code. The duty to provide safe treatment also extended to prevention of hospital-acquired infections.

Secondly, a hospital may be responsible for injuries which result from the use of faulty and defective medical equipment. In the judgment of May 11, 1983 (IV CR 118/83),⁶⁷ the Supreme Court ruled that a health care facility was obliged to take special care of its apparatuses, surgical instruments, and other treatment appliances so that they would not be dangerous

60. Nosocomial infections are still a great problem for Polish hospitals, since they concern around 24% of all malpractice suits. Adam Makosz, *supra* note 56. According to statistical data, in the late 1990's, 60% of adult patients and 80% of minors under the age of two were infected with hepatitis B at hospitals. W. Magdzik, *Wirusowe zapalenie wątroby typu „B” jako zakażenie szpitalne, PROFILAKTYKA I ZWALCZANIE ZAKAŻEŃ SZPITALNYCH, MATERIAŁY SYMPOZJUM KIEROWNICZEJ KADRY MEDYCZNEJ* 15 (1997).

61. See the judgment of the Appellate Court in Kraków of 14 October 1992 (I ACr 374/92), OSA 1992, item 44.

62. The judgment of the Supreme Court of 28 October 1983 (II CR 358/83), OSPiKA 1984, item 187.

63. The judgment of the Appellate Court in Wrocław of 28 April 1998 (I ACa 308/98), PRAWO I MEDYCYNĄ 147 (2002/12) cmt. by M. Nesterowicz.

64. OSPiKA 1975, item 94.

65. See also the judgment of the Appellate Court in Lublin of 2 May 2006 (I C 496/04, unreported), concerning a newborn infected with septicaemia (sepsis) due to failure to observe hygiene requirements at the defendant's hospital.

66. Unreported.

67. OSN 1983/12, item 201. This case concerned a patient who had suffered serious burns as a result of the use of a defective electric knife during lung surgery.

either for patients or for the operating team. Therefore, it is necessary for a hospital to undergo periodical check-ups of all equipment, carried out by professional service providers. Moreover, doctors are obliged to exercise *ad hoc* control before each use of the apparatus and medical instruments in order to find any visible defects or faults that may cause an injury.⁶⁸ However, liability of a hospital may not arise if the damage inflicted on a patient results from latent defects that came into being during the manufacturing process (due to faulty construction or use of improper materials) and the doctor who was applying the equipment could not have detected the defects and, consequently, could not have avoided the injury, in spite of being careful and diligent.⁶⁹ Injuries of that kind should be, as a rule, indemnified by the producer, importer, or professional seller of the medical equipment, pursuant to Article 449¹ of the Civil Code, which constitutes a strict product liability regime.⁷⁰

Thirdly, a health care facility may be responsible for the damage caused by an unjustified refusal to admit a patient to the hospital and the delay in rendering necessary medical care (only if, by means of immediate help, the injury could have been avoided) as well as for injuries resulting from lack of a sufficient number of properly qualified doctors (anesthesiologist, surgeons, etc.) and other members of medical personnel (nurses, midwives, laboratory assistants, etc.). The rule is that a hospital, whether public or private, cannot (and has no right to) refuse the treatment and care if a patient requires immediate assistance because of an emergency situation in which his health or life is threatened (Article 7 of the Institutional Health Care Providers Act). In the judgment of December 11, 2002 (I CKN 1386/00),⁷¹ the Supreme Court explained that a refusal to treat a patient and perform a medically justified and necessary operation in a public hospital cannot be a free decision of a doctor. In the court's opinion, such a refusal should always be confirmed by a specialist in the respective field of medicine and described in detail in the patient's medical record. Otherwise, the hospital may be responsible not only for a further deterioration of the pa-

68. See the judgment of the District Court in Lublin of 4 April 2002 (I C 656/99), PRAWO I MEDYCYNĄ 122 (2004/3), cmt. by M. Nesterowicz (concerning a patient who suffered serious burns to his feet and tissue necrosis as a result of the use of a faulty thermophore after a kidney operation). See also Kinga Bączyk-Rozwadowska, *Odpowiedzialność cywilna za szkody wyrządzone pacjentom w związku z użyciem wadliwego lub niesprawnego sprzętu medycznego*, PRAWO I MEDYCYNĄ 57 (2002/11).

69. Nesterowicz, *supra* note 10, at 378.

70. There is a proposal in the doctrine that a hospital should be attributed strict liability (pursuant to Article 449¹ of the Civil Code) for all damages caused by defective equipment, however with the right of recourse to the manufacturer or seller of that equipment. *Id.*

71. Reported in the electronic version - LEX 75348.

tient's health but also for the lack of improvement (losing the chance of improvement) which could have appeared if he had been given the necessary treatment.

Fourthly, an improper organization of a hospital may consist of "technical" faults and mistakes that cause the damage. According to case law and doctrine, an example may be an erroneous identification of a patient which results in performing the treatment (surgery) on a wrong person. In the judgment of 10 December 1952 (C 584/52),⁷² the Supreme Court found a hospital liable for the injury suffered by a patient who had mistakenly had her uterus removed instead of having her uterine cervix sutured following rupture during delivery (which was a routine treatment). The court held that the injury resulted from the improper organization of the hospital, in particular from the mistakes of both a nurse who had prepared and brought the wrong person to the operating room as well as a doctor who had failed to verify the patient's identity, examine her, or check the medical records before a sophisticated operation. Another example of a technical mistake that may give rise to hospital liability for improper functioning is a disorder (disarray) in medical records which resulted in a long-term, compulsory, and burdensome treatment of a patient who, in fact, did not suffer from tuberculosis but had been mistakenly handed the results of another patient's diagnostic test by a member of the hospital's staff and then treated as a person suffering from it (the judgment of the Supreme Court of 4 July 1969, PR 179/69).⁷³

6. Civil liability of health care providers coexists with civil liability (third party) insurance. Since 2007, this insurance has been obligatory for all health care providers (whether public or private hospitals, doctors, or other members of medical staff) that render medical services on the grounds of contracts concluded with the National Health Fund (pursuant to Article 136 (b) of the Publicly-Funded Health Care Services Act). Liability insurance is also compulsory for independent contractors who render health care in hospitals pursuant to contracts of granting an order to perform treatment on the grounds of Article 35 of the Institutional Health Care Providers Act. In each of the aforementioned cases, liability insurance is a necessary premise (a prerequisite) of entering into a contract to perform treatment and, consequently, becoming a participant of the health insurance

72. PAŃSTWO I PRAWO 366 (1953/8-9).

73. OSN 1970, item 71 cmt. by M. Nesterowicz.

scheme. The scope and conditions of both kinds of insurance are regulated in a detailed manner in the Ordinances of the Minister of Finance.⁷⁴

An even newer solution is compulsory liability insurance for all doctors that render medical services in Poland pursuant to the amended Article 48(b) of the Physician's and Dentist's Professions Act (*Ustawa o zawodach lekarza i lekarza dentystry*) of December 5, 1996⁷⁵). Since January 1, 2010, these doctors have been obliged to have insurance coverage, irrespective of whether they run an individual or a group private practice (in a form of a partnership, doctors' cooperative, etc.) or work in a public or private health care facility (a hospital, medical centre, clinic, etc.). The only exceptions are doctors who render medical services exclusively on the grounds of a contract of employment as employees within the meaning of the Labour Code (Article 48(b) Section 2 of the Physician's and Dentist's Professions Act). As previously mentioned, they do not bear civil liability for the damage inflicted on patients in the course of treatment, and Article 120 of the Labour Code provides them with sufficient legal protection.⁷⁶

The scope and terms of the new liability insurance are regulated in a detailed manner in the Ordinance of Minister of Finance of 26 April 2010.⁷⁷ According to its provisions, the insurance covers all injuries inflicted on patients due to the faulty acts and omissions of an insured doctor, provided the damage is caused in the course of treatment and within the doctor's vocational duties (§ 1 of the Ordinance).⁷⁸ There is no possibility for an insurance company to limit its duty to pay indemnities in the insurance contract (§ 2 point 3 of the Ordinance). The minimum insurance sums have been established with respect to the types of medical specialization.⁷⁹

74. See the Ordinance of 23 December 2004 (concerning compulsory liability insurance of health care providers concluding contacts of granting an order to perform treatment). *Journal of Laws* 2004, No. 283, item 2825; see also the Ordinance of 28 December 2007 (concerning compulsory liability insurance of health care providers). *Journal of Laws* 2008, No. 3, item 10.

75. *Dziennik Ustaw* [Journal of Laws] 2008, No. 136, item 857 (Pol.). Article 48b was amended by the new Law on Medical Chambers of 2 December 2009 (*Dziennik Ustaw* [Journal of Laws] 2009, No. 219, item 1708).

76. The Announcement of the Secretary of State M. Twardowski of 25 January 2010 (concerning the compulsory liability insurance of doctors who render medical services exclusively on the grounds of a contract of employment).

77. *Dziennik Ustaw* [Journal of Laws] 2010, No. 78, item 515 (Pol.). The Ordinance came into force on 12 June 2010.

78. The exclusions of the insurer's liability, enumerated in § 2 points 1–4 of the Ordinance, concern e.g. injuries to property, injuries resulting from contractual indemnities a doctor is obliged to pay, injuries inflicted on patients after the suspension of the right to perform treatment, and injuries resulting from vis maior incidents and acts of terror. *Id.*

79. The minimum insurance sums are as follows: the PLN equivalence of 100,000 € for doctors who specialize in oncology and clinical oncology, anesthesiology, gynecology and obstetrics, intensive care, urology, neurology, laryngology and otolaryngology, emergency medicine, ophthalmology; the

The idea of obligatory insurance for all health care providers is of significant importance and should not be underestimated. Since currently all doctors and institutional health care providers, both participants and non-participants of the health insurance scheme, have coverage, the goal to provide patients and health care professionals with a sufficient protection (offered by complex liability insurance) seems to have been achieved.

II. LIABILITY BASED ON FAULT

1. In all fields of medical malpractice, civil liability is based on fault. As previously mentioned, fault may be a necessary premise of a doctor's or hospital's liability for their own acts and omissions which cause the damage. If fault is committed by a member of medical staff (in particular, a doctor), it may constitute a prerequisite of that hospital's vicarious liability, even when it appears in its objective-like form of the so-called anonymous fault.

Fault usually consists of negligence (*niedbalstwo*), which is defined as failure to work with due care and diligence while treating a patient. The doctor's conduct is negligent if, according to the current state of medical knowledge, a doctor has not exercised due care required by the profession.⁸⁰ Apart from negligence, fault may involve any kind of carelessness, lack of skill, inadequate attentiveness, imprudence, or insufficient knowledge. The study of case law proves that a doctor's or hospital's fault may, in particular, consist of performing an obviously unnecessary operation or treatment⁸¹; rendering medical care without required qualifications, unless there is an emergency situation (the judgment of the Supreme Court of October 9, 1945, C I 188/45⁸²); prescribing improper drugs (the judgment of the Supreme Court of 3 December 1958⁸³); leaving surgical instruments in the patient's body after an operation (the judgment of the Supreme Court of 25 February 1972; II CR 610/71⁸⁴); or omitting necessary care or diagnostic tests (the judgment of the Supreme Court of 10 March 2006; IV CSK 80/85⁸⁵). In the judgment of 29 September 2000 (V CKN 527/2000),⁸⁶ the

PLN equivalence of 50,000 € for dentists and dental surgeons; and the equivalent of 25,000 € for remaining doctors.

80. B. Lewaszkiwicz-Petrykowska, *Wina lekarza i zakładu opieki zdrowotnej jako przesłanka odpowiedzialności za szkody wyrządzone przy leczeniu*, PRAWO I MEDYCYNA 125 (1999/1); M. Sośniak, *supra* note 26, at 122; M. Nesterowicz, *Kontraktowa*, *supra* note 43, at 84.

81. The judgment of the Supreme Court of December 10, 1952, C 584/52.

82. Zbiór Orzecznictwa SN 1945-46, item 18.

83. PAŃSTWO I PRAWO 200 (1960/1).

84. Nowe Prawo 1349 (1973/9). The case concerned a patient, who had suffered an injury as a result of a small piece of bone forceps being left in his skull (epicranium) after a brain operation.

85. OSP 2007/1, item 11.

Supreme Court held that it was a doctor's fault to have accidentally severed a healthy organ (common hepatic duct) during an operation in the abdominal cavity (a removal of cholecystis). The rule is that damage as such may not burden a patient and cannot be treated as a risk which a patient accepts while giving his valid consent to surgery (the judgment of the Supreme Court of 9 January 1971, II CR 421/71).⁸⁷

The standard of due care is objective in nature, oriented towards what is expected in medicine as required at the time of the treatment.⁸⁸ In practice, the courts in medical malpractice suits establish the scope of doctor duties and the desired standard of care (which is an abstract model of an experienced, diligent doctor of a respective medical discipline) and compare it to the conduct in question, taking into consideration all relevant circumstances of the given case, like the time and place of performing the treatment, the urgency of the procedure, the condition of the patient, etc.⁸⁹ The required duty of care is then related to medical specialization. Therefore a specialist-standard ought to be applied if any doctor (whether an expert in a certain field of medicine or not) undertakes treatment requiring specialized knowledge and skills, unless there is a case of emergency.⁹⁰

The standard of care has been set at a high level because of the professional nature of doctor and hospital activity (according to Article 355 § 2 of the Civil Code, which requires higher diligence standards from all professionals) and the object of this activity, which are the most precious human interests such as human health and life. In the judgment of October 29, 2003 (III CK 34/02)⁹¹ the Supreme Court stated that a doctor was obliged to perform treatment in accordance with the highest due care that could be required from a professional in view of current medical knowledge. The doctor's fault may then consist in a failure to exercise the highest diligence that is possible in the course of certain medical procedures and treatment of the diseases of particular types (the judgment of the Appellate Court in Kraków of October 12, 2007, I ACa 920/07).⁹²

As case law also points out, the standard of care that medical professionals should observe ought to be the highest possible since the conse-

86. OSN 2001/3, item 42.

87. M. Nesterowicz, *PRAWO MEDYCZNE* 45 (7th ed., 2005).

88. *Id.*

89. *Id.*

90. See the judgment of the Supreme Court of 9 October 1945 (C I 188/45), *Zbiór Orzecznictwa* 1945-46, item 18. In this case a patient died after having haematoma removed by gynecologist instead of a qualified surgeon. The court found the operation unnecessary and medically unjustified since there had existed some other, less radical, ways to treat haematoma.

91. OSP 2005/4, item 6.

92. *PRAWO I MEDYCZYNA* 124 (2010/1).

quences of a doctor's conduct may be serious, far-reaching, and sometimes irreversible (the judgment of the Appellate Court in Kraków of March 9, 2001, I ACa 124/01⁹³). It is then irrelevant whether the source of the doctor's obligation to perform treatment is a contract or a statutory provision. A duty to observe high standards of care is always the same (identical in content), because a patient is at all times entitled to professional care based on the standard of an experienced physician in a respective medical discipline. Also, financial considerations cannot modify this duty, because once the doctor-patient relationship exists, it remains the same whether the services are rendered gratuitously or for an ordinary payment.⁹⁴ However, the requirements to observe high standards of care cannot lead to the imposition on doctors such duties that are impossible to be performed in practice. In view of case law and doctrine, this solution would mean the doctor's *sui generis* liability based on the principle of risk, which obviously contradicts the nature of the medical profession (the judgment of the Appellate Court in Warszawa of March 3, 1998; I ACa 14/98).⁹⁵

Fault usually exists in a form of negligence, but it may also appear as gross negligence.⁹⁶ As case law provides, *dolus* [intent] (whether *directus* [purpose] or *eventualis* [knowledge of consequences]) appears but sporadically in medical malpractice suits. In the doctrine, a distinction is also made between fault which concerns medical aspects of a doctor's activity (e.g., lack of sufficient knowledge and skills, imprudence and negligence) and fault of another kind (lack of a proper supervision over the patient, an unjustified refusal to render medical services, performing treatment without the patient's consent, etc.).⁹⁷ However, as a rule, a certain degree of fault or its type does not have to be proved, since *culpa levissima* (the slightest fault) is sufficient to attribute liability to either a doctor and a hospital in the *ex delicto* regime.⁹⁸ On the other hand, in the case of *ex contractu* liability, any contractual exclusion of intentional fault is invalid, pursuant to

93. Przegląd Sądowy 132 (2002/10).

94. Nesterowicz, *supra* note 10, at 86.

95. Wokanda 1998, item 10. In this case, a newborn who had suffered from pneumonia was infected with hepatitis B during his blood transfusion. The defendant's hospital proved its due diligence by showing that the blood for the plaintiff had been purchased from a blood donation centre, stored in accordance with all necessary procedures and transfused with sterile, single-use equipment by qualified medical staff. The court admitted that an omission to check the blood's quality could not constitute the hospital's fault (negligence) because the donation centre was obliged to supply "safe blood", free of viruses. However, compensation was granted on the grounds of the principle of rightness (*boni mores*) and equity, pursuant to Article 419 of the Civil Code, derogated in 2004.

96. The judgment of the Supreme Court of 22 March 1973 (I CR 73/73), unreported; Mirosław Nesterowicz, *Commentary on the judgment of the Appellate Court in Lublin of 1 February 2006* (I C 213/04), PRAWO I MEDYCYNĄ 128 (2009/4).

97. Nesterowicz, *supra* note 10, at 81.

98. B. Lewaszkiewicz-Petrykowska, *supra* note 80, at 125.

Article 473 § 2 of the Civil Code. Furthermore, any stipulation which limits a doctor's or hospital's liability for negligence (*culpa levis*) should be deemed null and void as contrary to law and the principles of rightness (*boni mores*) and equity (*zasady słuszności*) on the grounds of Article 58 § 2, Article 353¹ and Article 385³ point 2 of the Civil Code.

2. Since fault is a subjective premise of civil liability, proving it requires a thorough analysis of an individual perpetrator's decision concerning his unlawful conduct (an act or omission). In particular, a court should verify whether a doctor could have avoided causing damage if he had performed the treatment with due care and diligence required in the circumstances.⁹⁹ However, in the field of medical malpractice, a prerequisite of fault may be fulfilled even if the subjective fault mentioned above is missing. According to the theory of anonymous fault (*wina anonimowa*), in the case where it is impossible to determine the damage perpetrator for whom a hospital is vicariously liable, the latter may be attributed liability provided that the damage has been caused by negligence of an unidentified member of the hospital's staff (a doctor, a nurse, a laboratory assistant, etc.).¹⁰⁰ Since in such cases fault is assumed without identifying damage perpetrator, evidence of unlawfulness of a certain medical conduct is effectively sufficient to claim damages.¹⁰¹

The concept of anonymous fault is of significant importance because it simplifies proof of fault for those plaintiffs who otherwise could have serious problems with receiving due indemnity. Therefore, anonymous fault is applied relatively often in medical malpractice cases. In the judgment of December 29, 1993 (I C 298/92)¹⁰² the District Court in Bydgoszcz found a hospital liable for injury suffered by a patient who had been infected with hepatitis B due to a failure to observe requirements of hygiene by one of its doctors, whose identity could not be established. In the court's opinion, the impossibility to identify the damage perpetrator could not release the hospital from liability (on the grounds of Article 430 of the Civil Code¹⁰³) if it was proved that negligence had existed and resulted in the emergence of that damage. Therefore, it was not relevant which of the

99. *Id.*

100. Nesterowicz, *supra* note 10, at 371; *see also* the judgment of the District Court in Bydgoszcz of 29 December 1993 (IC 298/92), unreported.

101. M. Safjan, PRAWO I MEDYCYNA. OCHRONA PRAW JEDNOSTKI A DYLEMATY WSPÓŁCZESNEJ MEDYCYNY 85 (1998).

102. Nesterowicz, *supra* note 10, at 371.

103. Bieniek Commentary 2002, *supra* note 36, at 343.

doctors had been culpable, provided that the injury had been causally connected with a failure to neglect the professional duties.¹⁰⁴

3. In the field of medical malpractice a distinction is made between fault and medical error (or, more precisely, error in the medical art¹⁰⁵). Both case law and doctrine have defined medical error narrowly, as conduct concerning the professional sphere of a physician's activity, which is diagnosis and therapy inconsistent with medical knowledge accessible to the doctor at the time of treatment (the judgment of the Supreme Court of 1 April 1955, IV CR 39/54).¹⁰⁶ A misconduct which involves other areas of the doctor's performance (different from diagnosis and therapy) cannot be deemed as error. As case law provides, an example is leaving medical instruments in the patient's body after an operation, a breach of requirements of hygiene and asepsis, using defective medical equipment, exposing a patient to an excessive dose of X-ray radiation, mistakes in medical records and documentation, and mistakes in the results of diagnostic tests.¹⁰⁷ However, misconduct as such may also give rise to civil liability of a doctor or hospital if all premises of that liability have been *in casu* fulfilled.¹⁰⁸

Error in the art of medicine in the aforementioned, narrow, meaning is an objective category (as some authors point out—an objective component of fault¹⁰⁹), which does not refer to a person who commits it or to the circumstances of the given case. As such, error does not determine the provider's liability *per se*. If the doctor is to be made liable, his wrongdoing should be, at the same time, negligent. In the case where there is no negligence, liability for error may not arise, even if damage exists and is causally connected with the doctor's improper conduct. In view of case law, there are, in particular, no grounds for the doctor's liability if a healthy patient,

104. Compare the judgment of Supreme Court of 26 May 1994 (II CRN 244/94), unreported; see also the judgment of the Supreme Court of 21 November 1974 (II CR 638/74), OSPiKA 1975, item 108 and the judgment of Supreme Court 17 April 1974 (II CR 13/74), OSPiKA 1974, item 207, adjudicated on the grounds of art. 417 of the Civil Code (in the wording preceding the amendment of 17 June 2004).

105. There is an ongoing dispute in doctrine concerning the notion of error. See Kinga Bączyk-Rozwadowska, *Błąd lekarski w świetle doktryny i orzecznictwa sądowego*, PRAWO I MEDYCYNĄ 5 (2009/3). Compare M. Nesterowicz, *Kontraktowa*, *supra* note 43, at 78; Agnieszka LISZEWSKA, *ODPOWIEDZIALNOŚĆ KARNA ZA BŁĄD W SZTUCE LEKARSKIEJ*, 24 (1998); Zdzisław Marek, *BŁĄD MEDYCZNY. ODPOWIEDZIALNOŚĆ ETYCZNO-DEONTOLOGICZNA I PRAWNA LEKARZA*, 35 (2007).

106. OSN 1957/1, item 7.

107. For example, in the judgment of 17 February 1967 (I CR 435/66), OSN 1967, item 177, the Supreme Court ruled that an infringement of the duty to apply rules of asepsis during surgery could not be considered an error because observing such rules constituted an essential obligation of all members of the hospital's staff and had not required special medical knowledge.

108. This distinction was made before the Civil Code came into force (in the mid 1950's) when case law admitted that a hospital could be vicariously liable for a doctor only when the latter had committed an error, while liability for negligence of another kind might be attributed only to an individual doctor. See Bączyk-Rozwadowska, *supra* note 5 at 55.

109. Nesterowicz, *supra* note 10, at 79-80.

manifesting symptoms of a certain disease, is mistakenly diagnosed with an illness and the following treatment is not detrimental to that patient (the judgment of the Supreme Court of December 8, 1970; II CR 543/70¹¹⁰). A similar ruling could be passed if, for example, an injury occurred as a result of anatomical abnormalities which could not be predicted before an operation and also in the case when the current state of medical knowledge made it impossible for the doctor to diagnose a rare illness, as yet not described in the literature.

4. In the case when certain medical misconduct is subject to both civil and criminal proceedings, there is no duty to establish negligence twice. Pursuant to Article 11 of the Code of Civil Proceedings of November 17, 1964,¹¹¹ if a doctor was convicted of a criminal offense, factual findings concerning his faulty conduct which served as grounds for the final sentence of the penal court are binding for a civil court in the following civil proceedings.¹¹² Therefore, if negligence (as a fault which justifies the tortfeasor's criminal liability) has already been established by the criminal court, the civil court takes for granted the fact that a tort (*delict*) has been committed and, consequently, establishes only the existence of a causal link (probability) and the damage and also ascertains the scope of compensation. In the criminal case of August 19, 1953 (IK 295/53)¹¹³ adjudicated in the last instance by the Supreme Court, the lower courts established fault of an obstetrician who had left the hospital during his working hours while his patient was going through a complicated childbirth. Lack of proper, highly qualified medical care and continued supervision had resulted in a rupture of the uterus, excessive bleeding, and the patient's death, for which the doctor was found criminally liable. Omission as such constitutes a delict of civil law and could serve as grounds for a compensation claim (of the family members of the deceased, pursuant to Article 446 of the Civil Code).

However, if the criminal proceedings have not been finished yet, but the ascertainments that have already been made may influence the settle-

110. OSN 1970, item 137.

111. Law of 17 November 1964, (Dziennik Ustaw [Journal of Laws] 1964, No. 43, item 296 (Pol.) - as amended.

112. Criminal liability of doctors (and other members of medical staff) is governed by the general provisions of the Penal Code (Law of 6 June 1997; Journal of Laws 1997, No. 88, item 553 - as amended), concerning unintentional crimes and offenses against life and health (Chapter XIX of the Penal Code). There is no special model of "medical liability," except in Article 192, which penalizes performing treatment without the patient's consent; Articles 150 and 151, concerning euthanasia; Articles 152-153, involving voluntary and involuntary abortion; and Article 157a, which concerns prenatal injuries. See M. Filar, LEKARSKIE PRAWO KARNE 84 (2000).

113. PAŃSTWO I PRAWO 381 (1954/2).

ment of a civil case, the civil court can (and, in practice, usually does) suspend the proceedings until the final judgment of the criminal case. The same situation occurs when criminal proceedings have not been started yet.

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It is also worth mentioning that when a criminal action fails (*e.g.*, the proceedings are discontinued due to the death of the perpetrator), civil litigation is still able to proceed and, as case law proves, may influence the burden of proof that a plaintiff is obliged to carry. In the judgment of the Supreme Court of 23 July 2004 (III CK 0071/03)¹¹⁵ the fact that a doctor had been found guilty of the criminal offense of exposing a patient to the direct danger of losing his life or suffering from a significant bodily impairment (Article 160 § 2 and § 3 of the Penal Code) served as grounds for determining causality in a civil litigation suit. In particular, it is possible to presume the existence of a causal link between the perpetrator's faulty conduct and the damage (pursuant to Article 231 of the Civil Code) even if a criminal court has not *in casu* established causality in a way that is required by Article 361 § 1 of the Civil Code (and – as such – is binding for the civil court by virtue of Article 11 of the Code of Civil Proceedings).¹¹⁶

III. BURDEN OF PROOF AND CAUSATION

1. The general rule is that a patient is burdened with proving damages, fault and a causal connection between the faulty conduct and damages (Article 6 of the Civil Code). However, in the field of medical malpractice, these strict requirements have been lowered by case law in order to be more convenient for a claimant. Otherwise it would be too difficult (if not impossible) to establish negligence and to explain whether the damage re-

114. The judgment of the Supreme Court of 27 November 1961 (II CR 1043/60), OSN 1963/2, item 35.; *see* M. Jędrzejewska, K. Weitz, *KODEKS POSTĘPOWANIA CYWILNEGO. CZĘŚĆ PIERWSZA. POSTĘPOWANIE ROZPOZNAWCZE*, T. I, 118-119 (T. Ereciński, ed., 2009).

115. Unreported. In this case a patient died one day after he had left hospital. The reason of his sudden death was a rupture of an abdominal aortic aneurysm which was not diagnosed properly by a rentgenologist (error in diagnosis) and, consequently, not treated at all by a cardiologist (therapeutical error).

116. In the discussed case the rentgenologist was found guilty of causing a direct threat to the patient's life (which is only a formal offense that does not require the result of faulty conduct of an accused) but not for the death itself. However, the mere fact of conviction allowed the civil court to assume that there had been a causal link between the rentgenologist's faulty conduct (error in diagnosis) and the death, and, consequently, that the death of the patient had caused a significant worsening of the living standards of the closest members of the family members of the deceased (secondary victims entitled to compensation on the grounds of Article 446 of the Civil Code).

sulted from the doctor's wrongdoing or whether the issue was only the progression of the patient's initial disease.¹¹⁷

1.1. While in the *ex contractu* regime the defendant's fault (concerning his own act and omissions) is statutorily presumed on the grounds of Article 471 of the Civil Code,¹¹⁸ no such statutory presumption exists for tortious liability. However, in the *ex delicto* regime the doctor's or hospital's fault and/or causation may be established by means of a factual presumption (indirect evidence). According to Article 231 of the Code of Civil Proceedings, the court is allowed to determine fault if, after taking into consideration the findings that were previously made, it is possible to draw the conclusion that such fault really exists. In other words, fault must be obvious in view of all circumstances of the case, unless there is evidence to the contrary. From that point of view, factual presumption serves as *prima facie* evidence, quite similar to the *res ipsa loquitur* ("things speak for themselves") rule adopted in common law jurisdictions.¹¹⁹

Prima facie evidence is usually applied by courts in medical malpractice cases concerning a hospital's failure to provide patients with a safe hospital stay, in particular, the so-called sponge cases and healthcare-related (nosocomial) infections involving hepatitis B or C, staphylococcus and the HIV-virus.

As for the first category, the court deems negligence obvious when it establishes that surgical instruments (probes, needles, forceps, etc.) or pieces of any tampons, plugs, or bandages were left in the patient's body during an operation, irrespective of what object was ignored (forceps, probes, and needles are treated in the same way as tampons, plugs, or bandages, which are more likely to be overlooked due to their absorptiveness).

In the case of infections, the provider's fault and/or causation is presumed on the grounds of the breach of a duty to observe the rules of hygiene and asepsis while treating a patient. In the judgment of January 11, 1972 (I CR 516/71)¹²⁰ the Supreme Court ruled that if the patient's death had been preceded by the negligence of doctors and other medical staff during surgery and the pre-operation period (failure to verify the patient's blood group, lack of blood supplies for complicated surgery in the abdo-

117. See the judgment of the Appellate Court in Kraków of 14 October 1992 (I ACr 374/92), OSA KR II, item 44; compare the judgment of the Supreme Court of 13 June 2000 (V CKN 34/00), unreported.

118. See Wojtasiewicz, *supra* note 27, at 136.

119. Compare Marcin Śliwka, *Ciężar dowodu w procesach medycznych – między domniemaniami faktycznymi a dowodem prima facie. II. Domniemania faktyczne a dowód prima facie*, ARCHIWUM MEDYCYNY SĄDOWEJ I KRYMINOLOGII 4 (2004/1).

120. OSN 1972, item 59.

minal cavity, lack of sufficient qualifications of an anaesthesiologist, etc.), the court might deem causal link established on the grounds of factual presumption, provided that a conclusion could be drawn that the current medical knowledge exclude such a connection.¹²¹

However, according to latest case law, hospital infections are not deemed self-evident. It is necessary for a plaintiff to prove the existence of a certain act which has been inconsistent with the requirements of hygiene and asepsis.¹²² It may be, for example, the improper sterilization of medical instruments (the judgment of the Supreme Court of October 28, 1983, II CR 358/83)¹²³ and apparatuses (the judgment of the Appellate Court in Gdańsk of June 26, 1992, I ACr 254/92)¹²⁴, faulty disinfection or clean-up of the hospital premises which is a source of dust and dirt in the hospital ward (the judgment of the Supreme Court of 14 December 1973, II CR 692/73).¹²⁵

In the judgment of April 28, 1998 (I ACa 308/98)¹²⁶ the Appellate Court in Wrocław established that the defendant's dialysis center had not taken necessary precautions to minimize the risk of transmitting infections. In particular, there were no separate rooms and dialysis apparatuses for patients, who could be infected with hepatitis and HIV or might be carriers of AIDS and jaundice. Besides, multiple-use equipment had been applied. The conclusion was that, in such circumstances, not only was fault evident, but also a causal link between the defendant's negligence and the patient's damage (infection with AIDS and hepatitis B) could be presumed without proof. Since the defendant did not succeed in proving to the contrary, the claimant was granted compensation.¹²⁷ In the judgment of February 9, 2000 (I ACa 69/00)¹²⁸ the Appellate Court in Kraków applied indirect evidence, taking into consideration the fact that the injured person had been treated in the ward at the time when a significant number of patients (10 %) were infected with hepatitis B and the defendant's hospital had not undertaken any measures to isolate them and, consequently, to prevent the spread

121. Compare the judgment of Appellate Court in Kraków of 14 October 1992 (I ACr 374/92), OSA 1992, item 44.

122. See B. Janiszewska *Praktyka sądowa w sprawach cywilnych a zakażenia szpitalne* -część I, PRAWO I MEDYCYNA (2009/2).

123. OSPiKA 1984, item 187.

124. OSP 1993/10, item 195.

125. OSPiKA 1975, item 94.

126. PRAWO I MEDYCYNA 147 (2002/12),cmt. by M. Nesterowicz.

127. An appeal of the defendant (dialysis centre) was dismissed by the Supreme Court (the judgment of 13 June 2000, V CKN 34/00).

128. Wokanda 1998, item 7.

of the virus. The hospital ward had therefore become a “source of epidemics.”

1.2. As for causality, Article 361 § 1 of the Civil Code requires an adequate causal connection between faulty acts or omissions and the damage.¹²⁹ The theory of adequate causality assumes that a person liable to pay compensation bears liability only for normal consequences of his acts or omissions from which the damage has resulted. Normal effects are those which generally occur in similar circumstances; it is not important whether the same result appears every time.¹³⁰

However, in medical malpractice cases it is not required for the causality to be determined “in a certain manner.”¹³¹ According to case law and doctrine, it may be sufficient to establish “probability of a high degree (the highest possible *in casu*)” that a doctor’s or hospital’s faulty conduct caused the damage in question.¹³² The dominant opinion is that as far as the human body is concerned, certainty hardly ever exists, thus the requirements to prove it seem neither real nor justified.¹³³ Therefore, the plaintiff should not be required to prove in what way and at what exact moment he became infected, since such proof has usually not been possible in practice.

129. This provision is said to be original with respect to other countries, since it states *expressis verbis* that adequacy is a criterion of normative evaluation of the results of a certain event (conduct). Z. Radwański, SYSTEM PRAWA CYWILNEGO. PRAWO ZOBOWIĄZAŃ. CZĘŚĆ OGÓLNA, 255 (3rd. ed., 1981). Compare Andrzej Koch, ZWIĄZEK PRZYCZYNOWY JAKO PODSTAWA ODPOWIEDZIALNOŚCI W PRAWIE CYWILNYM 155 (1975).

130. In order to establish adequate causation it is necessary to find out first whether the hypothetical elimination of a certain act or conduct (event A) would eliminate the existence of the damage (fact B). If the answer is affirmative, causal connection between the conduct and the damage is deemed established (A is a *conditio sine qua non* of B). Second, it should be verified whether event A is a condition that generally (in view of statistical data, general or specialized knowledge in a certain domain) gives rise to the result B. The estimation is made *ex post*, on the grounds of all the established facts and ascertainties that were previously made during the proceedings. *Id.*; see also Bagińska, Pol. Civ. C. *supra* note 22, at 516.

131. M. Nesterowicz, E. Bagińska, A. den Exter, MEDICAL LAW 50(2007).

132. Compare the judgment of the District Court in Wrocław of 11 December 1998 (I C 299/97), cited by M. Nesterowicz, PRAWO MEDYCZNE 307 (7th ed., 2005). Any particular percentage rate is not required; however, the probability should be of the highest extent possible (as opposed to “absolute” certainty). In medical malpractice cases, the standard of proof of causal link between the improper conduct and the damage is then lower in comparison to other areas of civil liability. The courts have not made any general rules that apply to the estimation of “probability”; they rather decide on a “case by case” basis and use different terminology, *e.g.* “probability of high degree” (the aforementioned judgment of the District Court in Wrocław of 11 December 1998; I C 299/97), “sufficient dose of probability” (the judgment of the Supreme Court of 17 June 1969, I PR 74/67; OSN 1968/2, item 26) or “prevailing probability” (the judgment of the Supreme Court of 5 July 1967, II CR 165/69, OSPiKA 1969/7 – 8, item 155).

133. The judgment of the Appellate Court in Katowice 20 October 2006 (I ACa 966/06; LEX 269615). In this case compensation was claimed by a patient who had her kidney removed and had been infected with staphylococcus as a result of negligent post-operation care.

In the judgment of June 13, 2000 (V CKN 34/00)¹³⁴ the Supreme Court ruled that medical knowledge, due to its imperfection, cannot provide satisfying answers to each question which concerns the human body.¹³⁵ Many factors may have an influence on the existence of damages, and it is necessary for a court to establish to what extent a doctor's or hospital's fault may be a probable cause of this damage when compared to other reasons (e.g., independent development of the disease). However, the evidence that factors other than the doctor's negligence could have resulted (but did not have to result) in the injury shall not release the doctor or hospital from liability. As doctrine provides, even in the case of either multiplication of such reasons or the increased risk of treatment—resulting, for example, from the patient's health condition—the provider's liability cannot be excluded if at least one of the factors that caused the patient's injury was that doctor's or hospital's negligence or any other kind of fault (a lack of knowledge, imprudence, etc.).¹³⁶

Moreover, in medical malpractice cases the burden of causality is, in practice, not only lowered (by replacing the requirement of "absolute" or "exclusive" certainty with the premise of probability of a high degree) but it may be reversed as well, particularly in the area of healthcare-related infections. The courts, aware of the difficulties a plaintiff has to face to prove a causal link between faulty conduct and the damage, deem probability established on the grounds of factual presumption, according to Article 231 of the Code of Civil Proceedings. In the judgment of January 22, 1998 (II UKN 465/97)¹³⁷ the Supreme Court ruled that a high degree of probability may be also presumed (by means of indirect evidence), provided this presumption is a logical conclusion derived from properly established facts that serve as the premise of such a presumption.¹³⁸ Thus, in order to be exempt from liability, the defendant doctor or hospital should rebut the probability or at least impair it by showing that there had been some other probable reasons for the patient's injury.¹³⁹

134. LEX 52689.

135. Since the court not only lowered the burden of proof but also reversed it, the defendant hospital, in order to be exempt from liability, had to rebut the probability or at least impair it by showing that there had been some other probable reasons for the patient's injury. Reversal as such has been common in malpractice cases concerning hospital-acquired infections. See the aforementioned judgment of the Supreme Court of 11 January 1972 (I CR 516/71).

136. Nesterowicz, *supra* note 10, at 96.

137. OSNP 1999/1, item 24.

138. Compare the aforementioned judgment of the Supreme Court of 11 January 1972 (I CR 516/71).

139. Compare the aforementioned judgment of the Supreme Court of 13 June 2000 (V CKN 34/00)

In view of case law and doctrine, it is not necessary for a causal connection (probability) between negligent conduct and the injury to be direct (like in a typical sponge case, where a medical instrument is left in the patient's body) since indirect intermediate causality may also serve as a prerequisite of a valid compensation claim (e.g., when the improperly performed operation causes the necessity to operate again and during the next operation an injury appears).¹⁴⁰ In the judgment of November 4, 1960 (II CR 411/59)¹⁴¹ the Supreme Court assumed that there was a normal causal connection between a lack of proper supervision on the part of the defendant's hospital and an accident which had occurred when a mentally disturbed patient jumped out of the window. In the Court's opinion, the fact that the cause of the patient's injury was remote was of no relevance, as long as the result thereof (severe bodily impairment of a patient) could be qualified as normal in view of Article 361 § 1 of the Civil Code.

This view has been confirmed in the judgment of the Supreme Court of June 17, 2009 (IV CSK 37/09).¹⁴² The Court ruled that physicians who neglected to examine a one-year old baby closely enough, which resulted in the failure to diagnose cerebral palsy and a two-year delay in starting the necessary treatment, were liable for the further deterioration of the patient's health even though the doctors' fault was not the direct reason of the injury. The Court explained that cerebral palsy, which had appeared as a consequence of organic brain damage, was not causally connected with the doctors' negligent omission. However, a failure to make a correct diagnosis was the indirect reason for diminished (by 20%) chances of the child's health improvement.

IV. COMPENSATION

1. While on the grounds of contractual provisions it is only possible to claim compensation for pecuniary loss¹⁴³, the *ex delicto* regime provides the injured with a wide scope of compensation for personal injury, including pecuniary and non-pecuniary loss for the injured himself (Articles 444–445 of the Civil Code)¹⁴⁴ and, in the case of his death, for secondary vic-

140. *Id.*

141. OSPiKA 1962/9, item 251.

142. OSP 2010/9, item 93 cmt. by M. Nesterowicz.

143. However, in the view of academic doctrine it seems necessary to make it possible for the injured to claim compensation for a non-pecuniary loss also in the *ex contractu* regime. See M. Saffjan, *NAPRAWIENIE KRZYWDY NIEMAJĄTKOWEJ W RAMACH ODPOWIEDZIALNOŚCI EX CONTRACTU IN: ODPOWIEDZIALNOŚĆ CYWILNA. KSIĘGA PAMIĄTKOWA KU CZCI PROFESORA ADAMA SZPUNARA* 255 (M. Pyziak-Szafnicka, ed., 2004); M. Nesterowicz, *supra* note 10, at 20.

144. Judgment of the Supreme Court of 13 June 2000 (V CKN 34/00), *PRAWO I MEDYCYNA* 22 (2005/2).

tims (immediate members of his family) and for pecuniary loss only for those whom he had a statutory duty to support or voluntarily and permanently supported (Article 446).¹⁴⁵ The Polish Civil Code does not limit the amount of damages that should be paid for a personal injury. Therefore, a doctor or a hospital found to be liable has to indemnify the patient for any and all damage which results from negligent treatment. Any contractual limitations are deemed invalid (pursuant to Articles 58 and 353¹ of the Civil Code).

2. A pecuniary loss has to be compensated in full, according to Article 361 § 2 of the Civil Code (comprising *damnum emergens* and *lucrum cessans*). A patient may claim a single-payment indemnity for medical care costs and loss of income (Article 444 § 1 of the Civil Code) and, when his disability is permanent, periodical payments in the form of annuity (Article 444 § 2 of the Civil Code).¹⁴⁶

Medical care costs are interpreted broadly as all necessary expenses incurred by the patient as a result of the injury, including consultations with the best specialists,¹⁴⁷ an expensive treatment abroad,¹⁴⁸ and the necessary medical equipment and drugs which are not covered by the health insurance scheme.¹⁴⁹ As case law provides, these are also costs of transport to a health care facility (for consultations, rehabilitation services, further auxiliary tests, etc.); expenses resulting from visits to a hospital paid by relatives; and costs of home medical care and assistance rendered by a nurse, social worker, etc.¹⁵⁰ However, in order to receive compensation, a patient should prove that the aforementioned costs are justified (in view of medical knowledge) and necessary to alleviate the personal injury he has sustained. What is more, the injured is the only person entitled to make a claim even if medical care costs were *in casu* borne by third parties (the patient's rela-

145. See Ewa Bagińska, *Roszczenie o zadośćuczynienie na podstawie art. 446 § 4 kodeksu cywilnego na tle doświadczeń europejskich*, KOMPENSACJA SZKÓD KOMUNIKACYJNYCH. NOWOCZESNE ROZWIĄZANIA UBEZPIECZENIOWE 138 (K. Ludwichowska, ed., 2011).

146. Section 1 of Article 444 states: "In the case of bodily injury or damage to health, damages shall include all costs arising therefrom. Upon the request of the injured person, the person obliged to redress the damage shall pay the sums required for the costs of medical treatment in advance and, if the injured person becomes disabled, he shall also pay the sums required to train him for an alternative occupation in advance." Section 2 states: "If the injured person completely or partially loses his ability to work or if his needs increase or his future prospects are diminished, he may demand an appropriate annuity from the person obliged to redress the damage." Bagińska, Pol. Civ. C. *supra* note 22, art. 444.

147. The judgment of the Supreme Court of 26 June 1969 (II PR 217/69), OSN 1970/3, item 50; the judgment of the Appellate Court in Katowice of 26 November 1991 r. (III APr 75/91), OSA 1992/6, item 38.

148. The judgment of the Supreme Court of 13 December 2007 (I CSK 384/07), unreported.

149. The judgment of the District Court in Katowice of 12 December 2003 (II C 911/01/05), PRAWO I MEDYCYNA 122 (2005/12).

150. The judgment of the Supreme Court of 21 March 1973, OSPiKA 1974, item 183.

tives, members of his close or closest family, statutory or factual guardians, etc.).¹⁵¹

Upon the demand of the patient, the doctor or health care institution liable for the damage should, in advance, deposit the sum needed to cover the costs of treatment. In the judgment of the Supreme Court of December 13, 2007 (I CSK 384/07)¹⁵² the Court ruled that the right to claim an advance payment arose irrespective of whether the injured person was entitled to medical services within the scope of the health insurance scheme and whether he was at all able to incur these costs by himself, at least partially. In the court's opinion, the only condition to make such a claim is to present evidence that a certain kind of treatment (or medical services), qualified as a sub-standard procedure not covered by the NFZ insurance, is *in casu* necessary and justified in view of current medical knowledge. Therefore, a health care provider cannot be obliged to make an advance payment when it has been proved that all the costs of medical care are incurred by the National Health Fund or the Ministry of Health (if highly qualified procedures financed by the State are concerned¹⁵³).

As for annuity, an original solution of Polish law is that it may be awarded in three circumstances: when the victim has completely or partially lost his ability to work, when his needs have increased, and when his future prospects have been diminished.¹⁵⁴ Any of these conditions, whether alone or concurrent with the others, entitles the injured to make a claim.

Claims for annuity are relatively frequent in medical malpractice cases, due to the unique nature of personal injury. In the case of December 12, 2003 (II C 911/01/05)¹⁵⁵ the Appellate Court in Wrocław granted an annuity for the increased needs (PLN 700 per month; 175 €) of a patient who had suffered serious injuries as a consequence of the unnecessary removal of the lower part of his large intestine and pelvirectal sphincter (*fistula*). While estimating the amount of damages, the court took into consideration the costs of purchasing necessary somatic and anti-depressive drugs; expenses for periodical consultations with psychiatrists and psychologists (due to his breakdown and depression); costs for a special low-fiber diet

151. The judgment of the Supreme Court of 4 July 1969 (I CR 116/69), OSN 1970, item 82.

152. Unreported. This case concerned a minor who had suffered serious injury (right hand paresis) as a result of a negligently performed delivery. He proved that an advance payment was necessary to cover the costs of an expensive operation in Texas (USA) as well as all the expenses for transport and accommodation. The court found the claim justified. Compare the aforementioned judgment of 26 June 1969 (II PR 217/69).

153. See the aforementioned Ordinance of Ministry of Health of 13 December 2004 (concerning highly specialized medical procedures financed by the State).

154. See Judgment of the Supreme Court of 13 June 2000 (V CKN 34/00).

155. PRAWO I MEDYCYNA 122 (2005/2).

and vitamins; and the costs of additional clothes, bed clothes, and sanitary equipment not refunded within the NFZ insurance.

As case law provides, the increased needs usually serve as grounds for an annuity claimed by minors. In the aforementioned judgment of June 17, 2009 (IV CSK 37/09)¹⁵⁶ the Supreme Court ruled that if due to the doctor's negligence (an omission to diagnose cerebral palsy early enough to start proper treatment in time), the patient had lost his chances for health improvement, the main goal of the annuity for increased needs was to redress a pecuniary loss which involved higher, continuous expenses (for rehabilitation, physiotherapy, professional indoor care, consultations with specialists, etc.) that would be incurred in the future for a defined or undefined period of time.

When the damage is evident but there are some difficulties with estimating its scope (because rehabilitation is still in progress or the treatment has not been completed) the court may grant, at its discretion, an amount of money which it deems appropriate in view of all circumstances of the relevant case (pursuant to Article 322 of the Code of Civil Proceedings). Detailed and precise findings that prove the extent of pecuniary loss are then not always necessary, which makes this legal solution advantageous for claimants. Therefore, Article 322 of the Code of Civil Proceedings is applied in a significant number of malpractice cases, in particular those that concern annuity.¹⁵⁷

Furthermore, if the injured is granted either a single-payment indemnity or an annuity (or both), the defendant may be liable for further loss that may appear in the future as a result of the same event. This legal principle adopted by case law is to prevent a possible a future claim from falling under what is known in common law countries as the statute of limitations.¹⁵⁸

According to the prevailing view of case law and doctrine, accident insurance benefits received by the injured from social security insurance are deducted from the amount of compensation awarded by the civil court on the grounds of Article 444 of the Civil Code (*compensatio lucri cum damno*).¹⁵⁹ However, no deduction can be made in the case where a patient

156. OSP 2010/9, item 93.

157. The judgment of Supreme Court of 25 November 1999 (II CKN 476/88), Nesterowicz, *supra* note 10, at 100-101.

158. *See, e.g.*, the judgment of the Supreme Court of 12 April 1970 (III PZP 34/69), OSN 1970, item 217.

159. A. Śmieja, PRAWO ZOBOWIĄZAŃ-CZEŚĆ OGÓLNA. TOM 6 680 (A. Olejniczak, ed., 2009); A. Szpunar, ODSZKODOWANIE ZA SZKODĘ MAJĄTKOWĄ. SZKODA NA MIENIU I OSOBIĘ, BYDGOSZCZ 85 (1998).

(or a person acting on his behalf) voluntarily concluded an accident insurance contract (known in Polish as *NW*) with a commercial insurer (Article 829 of the Civil Code). The opinion is that a person who takes care of his interests and pays premiums to have better protection against certain risks or events should not be treated in the same way as the injured who was not so provident (the rule of *compensation lucri cum damno* is then not applied).¹⁶⁰

3. Unlike the situation concerning material damages, compensation for a non-pecuniary loss is at the court's discretion. Therefore, even in the case where all necessary premises of the defendant's liability have been met, it is up to the court to decide whether a patient should be indemnified for pain and suffering. If a claim is deemed justified, the court may grant an amount which is appropriate to the damages in question.¹⁶¹ A reimbursement is made exclusively in the form of a single-payment, pursuant to Article 445 of the Civil Code.¹⁶²

There are no statutory rules concerning the assessment of damages for pain and suffering; thus, in this area, the courts make decisions on a case-by-case basis, taking into consideration all relevant circumstances and referring to the directives offered by case law and doctrine. According to these directives, the scope of compensation should depend, first of all, on the extent of the non-pecuniary loss (the degree of pain and suffering).¹⁶³ Further relevant criteria are the severity of physical and moral consequences of the injury, the victim's age, degree of the tortfeasor's fault, duration of the disease, patient's prospects for future personal and professional life, and the possibility of further health deterioration.¹⁶⁴

160. *Id.*; see also the judgment of Supreme Court (PSiAPIUS) of 23–24 April 1965 (III PO 3/65); OSN 1965/12, item 198.

161. The judgment of the Supreme Court of 15 September 1999 (III CKN 339/98), OSP 2000/4, item 66. As case law provides, a claim for moral damages can be dismissed only when the degree of pain and suffering is minor (the judgment of the Supreme Court of 23 January 1974, OSPiKA 1975, item 171). Furthermore, each decision of the court, whether awarding or refusing moral damages, should be based on objective criteria and well-grounded in the motives of the judgment. A Szpunar op. cit., 79.

162. Section 1 of Article 445 states: "In the cases specified in [Article 444], the court may award to the injured person an appropriate sum as compensation for non-pecuniary harm." Ewa Bagińska, *Roszczenie o zadośćuczynienie na podstawie art. 446 § 4 kodeksu cywilnego na tle doświadczeń europejskich*, KOMPENSACJA SZKÓD KOMUNIKACYJNYCH. NOWOCZESNE ROZWIĄZANIA UBEZPIECZENIOWE 138 (K. Ludwichowska, ed., 2011).

163. The resolution of the Supreme Court of 8 December 1973 (III CZP 33/73), OSN 1974/9, item 45.

164. Nesterowicz, *supra* note 10, at 104; M. Wałachowska, ZADOŚCUCZYNIENIE ZA SZKODĘ NIEMAJĄTKOWĄ 127 (2007).

In the judgment of the District Court in Bydgoszcz of July 19, 1999 (I C 1150/98)¹⁶⁵ the court granted moral damages to a woman who, after being misdiagnosed with breast cancer, had undergone a medically unjustified removal of both breasts. While estimating the scope of damages, the court took into consideration the age of the patient (twenty-four), the lack of medical grounds for surgical procedures, the irreversibility of the injury, the emotional shock, mental distress, necessity to be treated by psychiatrists and neurologists (due to severe depression), as well as further consequences of the disfigurement of the body for the patient's private life: the inability to work for a long time, isolation, divorce, etc.

The behavior of a person liable for the redress of damage may also influence the extent of compensation for a non-pecuniary loss. In the judgment of January 9, 1978 (IV CR 510/77)¹⁶⁶ the Supreme Court admitted that it might be possible to increase the scope of the indemnity when a health care institution did not take any measures to provide the injured (a woman who suffered a serious bodily impairment during delivery) with the appropriate advice and assistance. In the Court's opinion, such an attitude of the defendant's hospital to the injured person added to the damage (pain and suffering of the patient), so granting a higher amount of compensation seemed justified.

In addition, the transitory nature of pain and suffering does not make it impossible for a patient to claim compensation for a non-pecuniary loss. In the judgment of March 20, 2002 (V CKN 909/00)¹⁶⁷ the Supreme Court ruled that the mere fact that moral damage had not existed at the time of the judgment did not exclude a successful compensation claim. In addition, a reimbursement may be claimed by a person who is not aware or does not seem to be aware of the moral harm because of his mental disturbance or age.

Both Polish case law and doctrine are not likely to apply percentage schemes and average remuneration rates for the degrees of permanent bodily injury. In the judgment of the Appellate Court in Kraków of February 18, 1998 (I ACa 715/97)¹⁶⁸ the court held that such "guidelines" might be

165. OSP 2002/4, item 59 cmt. by M. Nesterowicz. *Compare* other cases concerning unnecessary treatment or operation—the judgment of the Supreme Court of 24 February 2005 (V KK 375/04), PRAWO I MEDYCYNĄ 125 (2006/1), cmt. by J. Wyrembak; the judgment of 4 July 1969 (I PR 178/69), OSN 1970/4, item 71.

166. OSN 1978/11, item 210. This case concerned a woman who had suffered rupture of the pubic symphysis during delivery. After the injury had appeared, she was not offered any support by the hospital; in particular, she was given no psychological assistance and no directions concerning further medical treatment.

167. PRZEGLĄD SĄDOWY 141 (2003/4) cmt. by K. Bączyk.

168. OSA 1999/2, item 7.

helpful to settle claims for moral damages but, as not very comprehensive, they could not be decisive. In particular, a comparison between an amount of compensation for non-pecuniary loss and an average remuneration rate may not be made automatically without taking into consideration all relevant circumstances of the case in question, such as the direct results of the damaging act (any bodily impairment, or mental disturbance), further deterioration of the patient's health, the emotional attitude to the sustained damage, and any permanent results thereof. The court made this distinction because compensation for a non-pecuniary loss is given as a special kind of damage which is usually not easy to estimate (the judgment of the Appellate Court in Białystok of 9 April 1991, I ACr 53/91)¹⁶⁹.

Recent case law suggests that damages for a non-pecuniary loss serve the purpose of compensation. The principle of a moderate award for pain and suffering, which required the compensation to correspond with the standard conditions of living of an average member of society,¹⁷⁰ has fortunately lost its importance and is applied as a subsidiary criterion or it is not taken into consideration at all. In the precedent-setting judgment of March 10, 2006 (IV CSK 80/85)¹⁷¹ the Supreme Court ruled that the main factor which should be taken into account while estimating the quantum of damages was the degree of pain and suffering. The principle of moderate compensation might be then applied as a supplementary one, provided its application does not interfere with the compensatory function of moral damages.

Since the courts follow this new direction, the amounts of moral damages have become slightly higher lately. For example, in 2006 minors who had suffered cerebral palsy as a result of negligent treatment during their delivery were awarded around PLN 300,000 (75,000 €)¹⁷², and in late 2009 and 2010 the courts used to grant not less than PLN 500,000 (128,205 €) to compensate this kind of injury.¹⁷³ However, in 2011 as much as PLN

169. OSA 1992, item 50; *see also* the judgment of the Supreme Court of 28 VI 2005 (I CK 7/05), LEX 153254.

170. The judgment of the Supreme Court of 24 June 1965 (I PR 203/65), OSPiKA 1996/4, item 92.

171. OSP 2007/1, item 11 cmt. by M. Nesterowicz. In this case a twelve-year-old girl was negligently diagnosed with kidney cancer. She underwent chemotherapy and one of her kidneys was immediately removed. The actual disease was very rare but could have been diagnosed if further examination (biopsy) had been ordered.

172. *See* the judgment of the Appellate Court in Poznań of 8 February 2006 (I ACa 1131/05), unreported.

173. According to statistical data, cases concerning injuries sustained in connection with delivery give rise to 37% of all malpractice suits. Adam Makosz, *supra* note 56.

900,000 (225,000 €) was awarded for that specific kind of injury.¹⁷⁴ As for hospital infections, while in the late 1990s compensation for infection with hepatitis B amounted to PLN 5,000 (1,300 €) for adult patients and as much as PLN 8,000 (2,000 €) for minors; and PLN 20,000 to 50,000 (5,130 € to 12,820 €) for hepatitis C. Accordingly, in 2000 to 2010 these amounts were doubled or even tripled (e.g., in 2010 the average compensation for a non-pecuniary loss resulting from hepatitis C amounted to PLN 375,000, which is equivalent to 93,750 €).

While a claim for redressing material damages devolves upon the heirs (according to the general rules of succession law), a claim for compensation for a non-pecuniary loss, due to its personal nature, expires with the death of the injured. However, this rule is not applied when a person responsible for the redress of damage has acknowledged the claim in writing or when a suit was filed before the death of the injured (Article 445 § 3 of the Civil Code).¹⁷⁵ The inherited claim should then be accepted by the adjudicating court in the same amount as it would have been the injured person's at the time of his death. The fact that the heirs have their own claims resulting from the death of the patient (as secondary victims, on the grounds of Article 446 of the Civil Code) is of no importance and may not influence any court's decision.¹⁷⁶

4. If a patient dies as a result of medical malpractice, indemnity may be sought by secondary victims on the grounds of Article 446 of the Civil Code. As it was already mentioned, they can pursue up to two claims for pecuniary loss as well as a claim for a non-pecuniary loss. The kind of claim and, consequently, the scope of compensation depends on the circumstances of the case, in particular the nature and intensity of the relationship between the claimant and the deceased.

First, the persons with respect to whom the deceased had a statutory duty of maintenance (according to the provisions of the Family and Guardianship Code¹⁷⁷) may claim the so-called compulsory pension from the doctor or hospital obliged to redress the damage, irrespective of whether the injured himself had *de facto* fulfilled this duty before he died (Article 446 § 2 Sentence 1 of the Civil Code). This group of secondary victims

174. The judgment of the Appellate Court in Kraków of 2 March 2011. Apart from moral damages, the court granted an annuity of PLN 4,800 (1,200 €) and a single-payment indemnity for medical care costs amounting to PLN 9,500 (2,375 €), GAZETA PRAWNA (3 March 2011).

175. Compare the judgment of the Supreme Court of 25 March 1975 (II CR 53/75), LEX 7682.

176. Gerard Bieniek, KOMENTARZ DO KODEKSU CYWILNEGO. KSIĘGA TRZECIA. ZOBOWIĄZANIA. TOM I 611 (G. Bieniek, ed., 2008).

177. The Law of 25 February 1964, Journal of Laws 1964, No. 43, item 296 - as amended.

comprises descendants and ascendants of the patient, his brothers and sisters, spouse, adopted parent and adoptee as well as other kin.

Other persons related to the deceased can be awarded the so-called facultative pension if the patient, before his death, voluntarily and permanently (but without a legal obligation) supplied them with means of maintenance. However, the rule is that a court grants such a pension at its discretion, after having established that the claim is justified in view of the principle of rightness (*boni mores*) and equity (pursuant to Article 446 § 2 Sentence 2 of the Civil Code). It is then necessary to consider all circumstances of the case, in particular the personal and economic situation of the claimant after the death of his maintenance supplier (breadwinner). The Civil Code offers no definition of “other persons closely related to the deceased,” but according to case law and doctrine this group comprises brothers and sisters of the deceased, his parents and children, as well as a person in a *quasi*-marital relationship (a partner), and certain other persons. There is a rule that *de facto* relations, not family ties, should be decisive to deem a person “closely related” in terms of Article 446 § 2 of the Civil Code.¹⁷⁸

Both obligatory and facultative pensions should be calculated in accordance with the needs of the claimant as well as the financial possibilities and potential earning circumstances of the deceased. The health care provider liable for the damage is obliged to pay the annuity for the period of the likely duration of the maintenance duty.¹⁷⁹ According to doctrine and case law, there is no possibility to award one joint pension for all secondary victims who are entitled to it. A claim for annuity is personal by nature, and the court should decide about each claimant separately, considering all relevant circumstances of the case.¹⁸⁰

Second, the closest members of the family of the deceased may claim an appropriate single-payment indemnity, pursuant to Article 446 § 3 of the Civil Code, if the death of the injured resulted in a considerable deterioration of the former’s living standards.

The Civil Code neither gives a definition of the closest family members nor explains who may belong to this group. According to case law and doctrine, this category comprises of parents and children of the deceased and other persons related to them, such as close and remote ascendants and

178. Z. Radwański, A. OLEJNICZAK ZOBOWIĄZANIA-CZĘŚĆ OGÓLNA. ZARYS WYKŁADU, 257 (2009).

179. A. Cisek, KODEKS CYWILNY. KOMENTARZ 801 (E. Gniewek, ed., 3rd ed. 2008)

180. *Id.*

descendants as well as in-laws.¹⁸¹ The Supreme Court found that a person entitled to a single-payment indemnity may also be an aunt or an uncle¹⁸² who had been keeping the household for the deceased, an illegitimate child brought up by grandparents as a foster child,¹⁸³ and a step-mother who had taken care of her step-son since the earliest days of his life.¹⁸⁴ The dominant view is that the notion of family should be interpreted broadly as describing not only legal but also actual relations between persons living in the same household, provided this relation is serious, constant, and stable (family *sensu largo*).¹⁸⁵

As case law provides, a single-payment indemnity aims at rewarding that kind of pecuniary loss which has not been covered (or may not be covered) by an annuity awarded on the grounds of Article 446 § 2 of the Civil Code. These are, in particular, broadly interpreted material damages (a pecuniary loss) that are difficult to evaluate, like the worsening of the economic situation of the claimant, loss of possibility of either improving his living conditions in the future or fulfilling the intended life goals (if e.g., after the death of a family breadwinner an adolescent child has to give up his studies in order to start working gainfully to support his family or help them with the household).¹⁸⁶ The rule is that a court should apply only objective criteria to verify whether such a pecuniary loss exists and whether it results from the death of the closest family member. The mere subjective feeling that the claimant's living standards have deteriorated may not merit compensation.¹⁸⁷

181. A. Szpunar, WYNAGRODZENIE SZKODY WYNIKLEJ WSKUTEK ŚMIERCI OSOBY BLISKIEJ 156(2003); Kinga Bączyk-Rozwadowska, *Roszczenia odszkodowawcze rodzin poszkodowanych pacjentów po nowelizacji kodeksu cywilnego* (art. 446 § 4 k.c.), PRAWO I MEDYCYNĄ 32-33 (2010/2).

182. The judgment of the Supreme Court of 31 May 1938; Zbiór Orzecznictwa SN 1939, item 100.

183. The judgment of the Supreme Court of 5 August 1970 (II CR 313/70), OSN 1971/3, item 56.

184. The judgment of the Supreme Court of 10 December 1969 (III PRN 77/69), OSN 1970/9, item 160. There is a question whether a person in a quasi-marital relationship and, in particular, a partner of the same sex may be qualified as the closest member of family within the meaning of art. 446 § 3 of the Civil Code. See Bączyk-Rozwadowska, *supra* note 181, at 33; A. Daszewski, *Od stosownego odszkodowania do zadośćuczynienia pieniężnego za krzywdę dla najbliższych członków rodziny zmarłego*, PRAWO ASEKURACYJNE 20 (2008/4).

185. Bączyk-Rozwadowska, *supra* note 181, at 33.

186. Before the Civil Code was amended with Article 446 § 4 (discussed below), an indemnity for the deterioration of living standards used to cover also some elements of a non-pecuniary loss. In particular, the courts assumed that the death of a little child resulted in a deterioration of the living standards of his parents not only when it caused actual material loss. The parents' pain and suffering also impaired their everyday activity and, consequently, affected the possibility of improving their living conditions in the future. See Radwański, *supra* note 178, at 258; the judgment of the Supreme Court of 13 May 1969 (II CR 128/69), OSPiKA 1070/6, item 122; the judgment of the Supreme Court 15 October 2002 (II CKN 985/00), unreported.

187. The judgment of the Supreme Court of 4 November 1980 (IV CR 412/80), unreported.

The indemnity for the deterioration of living standards can be sought by secondary victims, irrespective of any other claims these persons are entitled to make, in particular on the grounds of Article 446 § 2 and § 4 of the Civil Code. However, it is up to the court to decide whether the persons in question should *in casu* be awarded and in what amount.

Third, the new provision of Article 446 § 4 of the Civil Code (in force since August 3, 2009) entitles the closest members of family to claim compensation for pain and suffering resulting from the death of the injured. Each member of the family is allowed to pursue this claim separately, independently of the others and irrespective of whether he has been granted an annuity or single-payment indemnity for a considerable worsening of their living standards.¹⁸⁸

Moral damage suffered by secondary victims is mostly of a psychological nature since it involves all negative feelings and experiences of the closest family member after the death of the injured person. As doctrine provides, it may be psychological pain, emotional shock or breakdown, feelings of sadness, hopelessness and loneliness, as well as a loss of meaning of continued existence.¹⁸⁹ In light of this view, moral damage sustained by the closest members of family can also involve helplessness, perplexity, loss of support and assistance in household activities, feeling of lost hope, and loss of motivation to overcome the hardships of everyday life.¹⁹⁰ However, it is not necessary to prove that a plaintiff has suffered a certain type of illness or mental disease (e.g., neurosis, depression or another kind of mental disturbance) that has been confirmed by a doctor in a respective field of medicine. Determining the existence and scope of such damage requires taking into consideration all relevant circumstances of the case and making a thorough analysis of the individual situation of the claimant. Since the latter may (and usually will) be subjective and likely to overestimate his non-pecuniary loss, the court should establish that the pain and suffering are real and of the kind that would render compensation justified.¹⁹¹

Since Article 446 § 4 of the Civil Code is a new regulation, there arises a question about establishing adequate causality between the death of the injured and the moral damage suffered by the closest member of the family in question. Both life experience and medical science acknowledge that the death of the closest relative usually results in serious moral harm: emotion-

188. Kinga Bączyk-Rozwadowska, *Roszczenia odszkodowawcze rodzin poszkodowanych pacjentów po nowelizacji kodeksu cywilnego* (art. 446 § 4 k.c.), *PRAWO I MEDYCYNĄ* 28 (2010/2).

189. *Id.* Compare M. Wałachowska, *Wynagrodzenie szkód poniesionych na skutek doznania wstrząsu psychicznego spowodowanego śmiercią osoby bliskiej*, *PRZEGLĄD SĄDOWY* 46 (2004/7-8).

190. See the judgment of the Supreme Court of 25 July 2000 (III CKN 842/98), *LEX* 513/57.

191. Bączyk-Rozwadowska, *supra* note 181, at 29.

al distress and breakdown, which may also manifest itself in a form of certain mental diseases. It is then probable that the courts will find probability of high degree sufficient to justify a claim for compensation based on Article 446 § 4 of the Civil Code or will require only a *conditio sine qua non* to be established with certainty. The necessity of providing secondary victims with a sufficient legal protection as far as compensation is concerned may also make the courts assume the existence of pain and suffering without any proof, only on the grounds of the close relation between the claimant and deceased (especially in the case of spouses and parents-children relationships).

All of aforementioned claims based on Article 446 of the Civil Code are secondary victims' own claims. They may be pursued irrespective of whether a certain family member is an heir of the deceased (in view of provisions of succession law) or not. These claims are also independent of the claims of the injured person himself and from the remuneration that he had been awarded before he died.¹⁹²

5. Moral damages are not limited to situations where, as a result of medical malpractice, a patient suffers a personal injury within the meaning of Articles 444 and 445 of the Civil Code. Pursuant to Article 4 Section 1¹⁹³ of the new Law on Patients' Rights and Patients' Ombudsman of November 6, 2008¹⁹⁴, it is possible to claim compensation for a non-pecuniary loss when a patient's rights have been infringed even if the patient has not sustained any bodily impairment or health disturbance at the same time. The object of protection under the Law on Patients' Rights is not human life and health as such but a special category of non-material interests of a patient: his privacy, dignity, personal autonomy, and freedom to decide about the integrity of the body.¹⁹⁵ However, Article 4 requires an infringement of the patient's rights to be faulty and causally connected with acts or omissions of a doctor or a hospital.¹⁹⁶ If these premises are fulfilled, the court may, at its discretion, award moral damages on the grounds of Article 448 of the Civil Code.¹⁹⁷ It is not important whether the liability of a doctor

192. *Id.*

193. Section 1 of Article 4 states: "A person harmed by a negligent breach of his rights as a patient may claim pecuniary compensation for non-pecuniary harm in an action based on Article 448 of the Civil Code", Bagińska, Pol. Civ. C. *supra* note 22, art. 4.

194. Dziennik Ustaw [Journal of Laws] 2008, No. 52, item 417 (Pol.) - as amended.

195. See the judgment of the Supreme Court of 29 May 2007 (V CSK 76/07), OSN 2008/7-8, item 9 cmt., M. Wałachowska.

196. M. Nesterowicz, *Zadośćuczynienie pieniężne za doznaną krzywdę w „procesach lekarskich”*, PAŃSTWO I PRAWO 17 (2005/5).

197. Article 448 states: "In the case of an infringement of personal interests, the court may, independently of other measures necessary to remove the results of the infringement, award the injured person an appropriate sum as compensation for non-pecuniary harm or may, at his request, award an

or a hospital is *in casu* tortious (pursuant to Article 415 or 430 of the Civil Code) or contractual (pursuant to Article 471 or 474 of the Civil Code), since Article 4 concerns all health care providers, irrespective of their status (public or private) and the form in which they render medical services.¹⁹⁸

As case law provides, compensation for a non-pecuniary loss may be granted, in particular, for performing treatment without the patient's valid consent, even if the medical procedures were carried out properly (*lege artis*) and resulted in the improvement of his health.¹⁹⁹ However, if a doctor's conduct performed without the patient's consent has caused a bodily impairment or a health disturbance, the injured person can either claim compensation for pain and suffering on the grounds of Article 445 of the Civil Code or he may pursue his claims for moral damages using Article 4 (in conjunction with Article 448 of the Civil Code), indicating the mere infringement of his right to decide about the integrity of his body. Thus, in view of case law and doctrine, the relation between Article 445 of the Civil Code and Article 4 is deemed an alternative concurrence of liability provisions.²⁰⁰

Furthermore, the patient is allowed to seek indemnity for being treated without his consent if a certain kind of treatment was necessary to save his life or prevent him from serious disability. This view was confirmed by the Supreme Court before the enactment of the Law on Patients' Rights, in the judgment of October 14, 2005 r. (III CK 99/05).²⁰¹ In this case, a claimant was diagnosed with kidney cancer, and the only possible method to treat and save her life was a resection of that kidney. The operation was performed *lege artis*, but without the patient's consent; the doctors presumed that the consent had existed, taking into consideration the necessity of the treatment and the fact that the patient, aware of the danger, would have certainly agreed. The Supreme Court ruled that a claim for moral damages could be justified also in the case where a certain medical treatment or an operation had been carried out without the patient's consent.²⁰² In another

appropriate sum to a social cause chosen by him. Art. 445 § 3 shall apply." Bagińska, Pol. Civ. C., *supra* note 22, art. 448.

198. M. Wałachowska, USTAWA O PRAWACH PACJENTA I RZECZNIKU PRAW PACJENTA. Komentarz 11 (M. Nesterowicz, ed., 2009); Nesterowicz, *supra* note 10, at 17.

199. The judgment of the Appellate Court in Warszawa of 31 March 2006 (I ACa 973/05), LEX 252827.

200. Nesterowicz, *supra* note 10, at 32.

201. OSN 2006/7-8, item 137 cmt. by M. Świdorska, K. Bączyk-Rozwadowska and B. Janiszewska.

202. Compare the judgment of the Supreme Court of 14 November 1972 r. (I CR 463/72), NOWE PRAWO 1975/4, 585 cmt. by M. Nesterowicz.

precedent-setting judgment of October 27, 2005 (III CK 185/05)²⁰³ the Supreme Court ruled that a statement (declaration) in which Jehova's witness objected to any kind of blood transfusion was binding on a doctor (or hospital), provided that the patient's will had been expressed consciously and clearly enough to eliminate any doubts about the patient's intentions. In the court's opinion, since the law protects the patient's autonomy and freedom to decide about the integrity of the body, irrespective of the motives for refusing treatment, a lack of patient consent to medical procedures of a certain kind is always binding on the doctor. Consequently, treatment or surgery carried out against the patient's will always renders the doctor's conduct unlawful and justify the patient's claim for compensation.

According to doctrine, the mere knowledge about the necessity of treatment and the dangers connected with the omission to take certain precautions does not exclude the duty of the doctor (hospital) to respect the autonomy of the patient and his freedom to decide about the integrity of the body.²⁰⁴ Furthermore, the above mentioned circumstances may not justify any medical procedure carried out without the patient's consent, since such conduct remains illegal as long as the patient has no desire to be treated. However, two questions arise: whether in similar cases moral damages should be awarded in lower amounts and whether a claim for compensation could be found by the court to be contrary to the principles of rightness (*boni mores*) and equity and, as such, not taken into consideration at all.²⁰⁵

6. Compensation for both pecuniary and non-pecuniary loss may also be claimed in criminal proceedings.²⁰⁶ The injured, as a civil law claimant (and in case of his death, secondary victims—persons closest to the injured²⁰⁷), is allowed to attach a so-called adhesion claim (*powództwo adhezyjne*) to the criminal prosecution on the grounds of Article 62 of the Code of Criminal Proceedings (*adhaeret causae criminali*).²⁰⁸ However, the

203. Biuletyn SN 2006/2, item 9.

204. See M. Świdarska, ZGODA PACJENTA NA ZABIEG MEDYCZNY 15 (2006).

205. Compare Wałachowska, *supra* note 198, at 26 and Nesterowicz, *supra* note 10, at 138.

206. The proceedings consist then of two parts. One of them is a criminal action that aims at attributing criminal guilt to the perpetrator and convicting him. The second part is a civil litigation which goal is to reimburse the loss sustained as a result of a criminal delict. See P. Mierzejewski, KOMPENDIUM PRAWA KARNEGO 205 (2010).

207. According to Article 115 § 11 of the Code of Criminal Proceedings, a person closest to the injured is his spouse, ascendant or descendent, siblings, a person related by affinity (an akin of the same line or degree), adopter or adoptee and a person in a quasi-marriage relationship. See CODE OF CRIMINAL PROCEEDINGS art. 115 (Dziennik Ustaw [Journal of Laws] 1997, No. 89, item 555 (Pol.) – as amended).

208. Law of 6 June 1997, Journal of Laws 1997, No. 89, item 55. Article 62 of the Code of Criminal Proceedings states: "Until the judicial proceeding in the main trial are commenced, the injured person may bring a civil action (adhesion claim) against the perpetrator to have his damage, sustained as a direct result of the criminal offense, compensated in criminal proceedings." *Id.* at art. 62. However,

injured party may claim compensation only for those pecuniary and non-pecuniary losses that result directly from the criminal offense committed by the accused.²⁰⁹

The rule is that a person who makes an adhesion claim is exempt from the duty to pay an admittance fee (*wpis*), which is generally required to initiate civil proceedings.²¹⁰ If the claim is accepted by a criminal court (wholly or even partially), these costs are awarded at the expense of the accused (pursuant to Article 643 of the Code of Criminal Proceedings). The civil claimant would bear them only when the adhesion claim was dismissed (pursuant to Article 644 § 1 of the Code of Criminal Proceedings).

In practice, the injured person hardly ever initiates adhesion proceedings. Medical malpractice cases are complicated, time-consuming, and more expensive than criminal litigation, since they usually require expert opinions (especially when the injuries sustained by a patient result from errors in the medical art).²¹¹ In criminal proceedings, priority is given to the perpetrator's criminal liability, which ought to be established as quickly as possible in order to fulfill the repressive and preventative function of penal law. Thus, there is a high probability that the criminal court leaves the adhesion claim unrecognized, pursuant to Article 415 § 2 and § 3 of the Code of Civil Proceedings. The decision as such is obligatory when the accused has not been convicted, the evidence revealed during the trial is found insufficient to adjudicate adhesion claim, and any supplement thereof causes excessive lengthiness of the proceedings.²¹²

V. PROFESSIONAL LIABILITY OF DOCTORS

Except for civil and criminal liability, doctors, as members of medical chambers (*izby lekarskie*),²¹³ may also bear professional liability for con-

there is no possibility to initiate adhesion proceedings if the same claim for compensation is either subject to other litigation, e.g. a civil one (*lis pendens*), or has already been concluded with a final valid decision (*res iudicata*).

209. According to doctrine, it is impossible to claim compensation for a mere non-pecuniary loss. P. Mierzejewski, *KOMPENDIUM PRAWA KARNEGO* 20 (2010). Compare J. Gajewski, *PRZEBIEG PROCESU KARNEGO*, 147 (2008).

210. According to the provisions of the Law on Costs of Civil Court Proceedings of 28 July 2005 a plaintiff is to make a payment of 5% of the amount of damages he claims, however not less than PLN 30 (7,5 €) and not more than PLN 100,000 (25,600 €). See *Dziennik Ustaw* [Journal of Laws] 2005, No. 167, item 1398 (Pol.); see also J. Jodłowski et. al., *POSTĘPOWANIE CYWILNE* 300-310 (6th. ed. 2009).

211. The average time to decide a case is two to four years for less complicated cases (where there is no cassation to the Supreme Court). However, it may even be eight to ten years for more difficult cases concerning errors in the medical art, in which a medical expert opinion is usually required.

212. See P. Mierzejewski, *supra* note 205, at 207; J. Gajewski, *supra* note 209, at 148.

213. Regional medical chambers and the Central Medical Chamber are institutional manifestations of doctors' professional 'self-government.' They supervise the performance of the medical profession by carrying the disciplinary proceedings, represent the interests of doctors, adopt the rules of medical

duct contrary to the principles of ethics and medical deontology²¹⁴ and the breach of provisions concerning the performance of the medical profession (*przewinienie zawodowe*), pursuant to the regulations of Chapter 5 of the new Law on Medical Chambers of December 2, 2009²¹⁵.

Disciplinary proceedings are carried by regional medical courts (composed of three judges) and the Supreme Medical Court of Professional Liability, which adjudicates in the second instance (in a panel of three to five members, including a judge of the Supreme Court as chairman).²¹⁶ Under certain conditions, an appeal (the so-called Extraordinary Appeal) may be made to the Supreme Court.²¹⁷ No petition of the injured patient (*pokrzywdzony*) is required, since the proceedings are initiated upon a motion of a disciplinary commissioner (*rzecznik odpowiedzialności zawodowej*), who acts as the prosecutor and is responsible for conducting preparatory proceedings.²¹⁸ In the case where the same professional misconduct is subject to a civil or criminal litigation, the medical court is allowed to suspend its proceedings until civil or criminal proceedings are finished if their result may influence the disciplinary judgment.²¹⁹ The medical court (in the trial) or disciplinary commissioner (during the preparatory proceedings) may also initiate mediation between the accused doctor (*obwiniony*) and the injured patient. A mediator is a doctor appointed for this function by the medical chamber of the locality where the doctor practices his profession.

ethics and take care of physicians' professional education and the development of vocational skills. Medical chambers also grant the doctors the right to practice the medical profession; they are also the keeper of the register of doctors who have been permitted to perform treatment. M. Nesterowicz, E. Bagińska, A. den Exter, *Medical Law Monograph*, INTERNATIONAL ENCYCLOPAEDIA OF LAWS 35(2007).

214. Principles of ethics and medical deontology are embodied in the Code of Medical Ethics (Kodeks Etyki Lekarskiej) of 2 January 2004, adopted by the 7th Extraordinary National Congress of Physicians. The Code determines standards of performing the medical profession, principles of medical practice, doctor's duties towards the patient and the population as a whole, mutual relations between doctors, and the principles of scientific research and medical experiments. See M. Nesterowicz, E. Bagińska, A. den Exter, *Medical Law Monograph*, INTERNATIONAL ENCYCLOPAEDIA OF LAWS 64 (2007).

215. Dziennik Ustaw [Journal of Laws] 2009, No. 219, item 1708 (Pol.).

216. M. Nesterowicz, E. Bagińska, A. den Exter, *Medical Law Monograph*, INTERNATIONAL ENCYCLOPAEDIA OF LAWS 64 (2007).

217. An extraordinary appeal to the Supreme Court may also be lodged against a valid judgment regarding professional liability by the Minister of Health and the President of the Central Medical Chamber. M. Nesterowicz, E. Bagińska, A. den Exter, *supra* note 216, at 65.

218. These proceedings consist of making all the ascertainments and investigations necessary to explain the circumstances of the alleged professional misconduct. If the commissioner finds punishing a doctor for a certain professional misconduct justified, the latter is charged and consequently interrogated. M. Filar, S. Krześ, E. Marszałkowska-Krześ, P. Zaborowski, *Odpowiedzialność lekarzy i zakładów opieki zdrowotnej*, 281 (2004).

219. M. Nesterowicz, E. Bagińska, A. den Exter, *supra* note 216, at 64.

Medical courts may exclusively issue the following penalties: a warning, a reprimand, a fine, a suspension of the right to practice as a doctor for a period ranging from six months to three years, and a deprivation of the right to perform the profession. The sentence of the court (a convicting judgment), together with the doctor's name and medical license number is added to the public Register of the Disciplinarily Punished Doctors and Dentists held by the Central Medical Chamber.²²⁰ However, as case law provides, if a doctor is found guilty, the court may, in certain circumstances, decide not to award a punishment.²²¹

In the case where the doctor has been found innocent or the procedure has been quashed as a result of an Extraordinary Appeal or as a result of proceedings being resumed, the doctor is entitled to claim compensation from the regional medical chamber.

No proceedings on professional liability may be initiated if three years have elapsed since the commitment of the act.

CONCLUSION

As for attitudes and concerns about the existing compensation system, the first thing which requires approval is the current tendency to assure better protection of the non-material interest of patients by, on the one hand, awarding higher sums for a non-pecuniary loss and, on the other, providing additional grounds for moral damages under the Law on Patients' Rights. The other good solution is the complex liability insurance, which is compulsory for all health providers, whether or not they participate in the national health insurance scheme.

However, despite some moderation concerning the burden of proof, the requirement of the doctor's or hospital's fault is still troublesome for the injured. The situation of patients who suffer injuries where no one is guilty (so-called medical accidents) is particularly difficult. After the amendment of the Civil Code of June 2004, they may not claim damages on the grounds of the principle of rightness (*boni mores*) and equity any more (derogated Article 419 of the Civil Code). Besides, malpractice suits are still long and expensive, while their result is usually uncertain and not

220. The rules of holding a Register of the Punished Doctors were laid out in the Ordinance of Minister of Health of 13 July 2010 concerning the form and procedures of holding of the Register of the Disciplinarily Punished Doctors and Dentists and the way of executing the final judgments of medical courts (Journal of Laws 2010, No. 130, item 884).

221. See the judgment of the Supreme Court of 18 February 1994 (I PN 1/94), OSNAPiUS 1994/1, item 16. Compare Filar, et al., *supra* note 218, at 281.

easily predicted. There is an increasing number of cases every year,²²² because patients are more aware of their rights and prone to claim reimbursement if these rights are not observed. Therefore, an introduction of a *no-fault* liability regime in Poland may be taken into account. The existing systems of that kind could serve as good examples, especially the Swedish No-Fault Patient Insurance (NFPI) and the French scheme which combines elements of fault and no-fault liability. It seems that implementation of a *no-fault* compensation system, at least for medical accidents in Poland, is the best possible solution to improve the mechanisms of damage compensation and to prevent the spread of a potential malpractice crisis.²²³

222. According to statistical data, in 1991 there were 260 (reported) claims concerning medical malpractice and 80 of them were adjudicated in favor of the plaintiff. In 1999, this number increased to 968 (in 509 of them compensation was granted). As for the last ten years, it is estimated that there have been around 1,500 malpractice suits annually. Adam Makosz, *supra* note 56.

223. However, there is a bill of November 2010 which proposes a no-fault compensation scheme for injuries resulting from so-called medical misfortune (*niepowodzenie lecznicze*). The draft defines medical misfortune as an activity concerning diagnosis, therapy or application of medical products which is inconsistent with requirements of current medical knowledge, provided it results in infections, bodily impairment, health disturbance, or the patient's death. According to the proposed bill, medical misfortune claims are to be adjudicated by independent district commissions in special, simplified procedures that will be less formal, less expensive and much quicker than civil law suits. See E. Kowalewski, M. Wałachowska, M. Śliwka, *Kompensacja szkód wynikłych z „błędów medycznych”*. *Ocena projektowanych rozwiązań prawnych*, PRAWO I MEDYCYNA 22 (2010).

