Anna Wszołek
ORCID: 0000-0003-2539-6542

Factors potentially enhancing medically unjustified malpractice claims in Poland

Streszczenie

Czynniki potencjalnie zwiększające liczbę medycznie nieuzasadnionych roszczeń z tytułu błędów medycznych w Polsce
Lekarze w Polsce coraz częściej sygnalizują, że muszą bronić się przed nieuzasadnionymi zarzutami o błędy medyczne. Mając w perspektywie skazanie lub zapłatę wysokiego odszkodowania, nawet jeśli objętego ubezpieczeniem, czują niepewność. Z jednej strony doniesienia o postępach w medycynie i konsumpcyjne podejście do usług przyczyniają się do obrazu nieograniczonych możliwości w opiece zdrowotnej. Z drugiej informacje nagłaśniające przypadki szokujących zaniedbań i wysokich odszkodowań wzmacniają przekonanie, że niepomyślności w leczeniu są efektem błędów. Artykuł rozważa zmiany w relacji lekarz– pacjent oraz inne potencjalne czynniki, które mogą wpływać na liczbę roszczeń z tytułu błędów medycznych i skłonność pacjentów do ich dochodzenia.

Słowa kluczowe: błąd medyczny, błąd lekarski, opieka zdrowotna, relacja lekarz–pacjent, roszczenia pacjentów, obowiązek informacyjny.

1. Introduction

High technological development, globalisation and current accessibility of goods raised the bar of customers' expectations towards the quality of products and services, also in the medical area. Mistakes, while rationally

admissible, are less welcome. However perception of patient as a consumer and using the notions of 'customer', 'client' or 'user' are being considered in the Polish literature, such context remain controversial[1]. Medicine, like other fields of science, has made a tremendous progress over the last few decades. There has been a significant development in diagnostic and therapeutic techniques, as well as a complete transformation of the shape and means of providing healthcare services. Instead of treating patient by a single doctor, a whole team of specialists participate in the process. Although medicine has significantly increased its effectiveness, it still possess a trait of unpredictability, incomparable to other scientific areas, such as for example chemistry.

Like biological sciences, medicine deals with the study of phenomena occurring in living organisms, in this case human bodies. Due to the multitude of factors and their variability, it is difficult to foresee unequivocally how a specific patient will react to a particular medical procedure. Certainly, on a research basis some trends and correlations can be observed but at that point it is impossible to completely exclude patient's individual risk. Recognition of the difficulty to assure patient's recovery became an argument supporting the doctor's obligation to act diligently rather than to deliver fixed results. Such approach is accepted in the Polish doctrine[2]. Unfortunately doctors signal more and more often that they have to face and defend themselves against unfair medical malpractice allegations[3]. Having the perspective of being convicted or paying high compensation, even though covered by insurance, they feel insecure which influences their work and private life. This article concerns factors potentially enhancing medically unjustified malpractice claims in Poland and it is a part of the research project on the topic

[1] M. Gałązka, *Pojęcie pacjenta*, [in:] M. Safjan, L. Bosek (ed.), *System Prawa Medycznego*, vol. 1, *Instytucje prawa medycznego*, Warszawa 2018, pp. 533–534.

[2] K. Bączyk-Rozwadowska, *Błąd lekarski jaki obiektywny element winy lekarza*, [in:] E. Bagińska (ed.), *System Prawa Prywatnego*, vol. 5, *Odpowiedzialność prywatnoprawna,* Warszawa 2021, pp. 239–240, with the literature referred to therein.

[3] I. Dudzik, *Nie traktujcie nas jak przestępców*, "Medical Tribune" 5/2022, https://bit.ly/3KhbHjB.

of legal protection of doctor's reputation as a party to unjustified medical malpractice proceedings[4].

2. Doctors' perspective on malpractice claims

During my research I conducted an overview survey among 102 volunteer doctors on their attitude towards patient claims arising from alleged medical malpractice in Poland. The questionnaire grouped volunteers by years of experience, type of their specialisation and practice in a private or public entity. The doctors were asked to answer six questions in total. For the topic of this article particularly relevant were two questions. The first one was meant to establish whether doctors find some of the patient's claims unreasonable: "Do you think that some patients' claims for medical error are made wrongly or for frivolous reasons (recklessly)*? *For example due to a failure to distinguish between the error and the unfortunate consequences of the procedure beyond the doctor's control; due to a desire to exploit the situation in order to obtain high compensation/redress or other."[5]. The group of respondents was able to choose between numbers 1-5 on a linear scale, where number 1 meant "definitely no" and number 5 meant "definitely yes". It is notable that only 8 persons answered negatively choosing number 1 or 2, which means indeed a lot of asked doctors (92,16 %) find some of the patients' claims wrong or frivolous. It also needs to be indicated that the wording used in the questionnaire, even if sometimes reflecting legal nomenclature, referred to the common understanding of terms.

The second question was addressed only to the respondents whose answer to the previous question (question number 3 in the questionnaire) was neutral or positive: "If you marked any of the answers 3–5 in the previous question 3, please indicate what you consider to be wrongful or frivolous reasons for patients' medical error claims". This question

[4] Research work funded from the 2018–2023 science budget as a research project under the 'Diamentowy Grant' programme.

[5] Translated from Polish.

was open, therefore the answers varied. Certainly, the doctors pointed out claims made when there was no actual medical malpractice on their part. Going further and analysing the reasons for presenting such claims, there were mentioned among others: a lack of understanding of various issues related to the treatment process resulting from a lack of basic medical knowledge, ignorance of the medical indications and the medical procedure in a given case, as well as excessive, unrealistic expectations of patients. Also, the doctors signalled patients' failure to understand that every medical procedure involves a greater or lesser risk concerning health and life, depending on the type of disease case and the patient's clinical condition.

It is important to bear in mind that doctors, like members of any other profession, are not always willing to admit they committed an error. They may even be unaware that such an error occurred. It should therefore be underlined that the mere belief of a doctor that he or she has acted correctly and without error does not automatically mean this is in line with the facts. It has to be stated that indeed there are many cases of errors in medicine which cause patient suffer serious injuries. These cases with all due respect deserve to be compensated. However, not all adverse effects are caused by medical malpractice. Even though a medical procedure was carried out in accordance with the up-to-date medical knowledge and fully correct, there might occur some negative consequences, including death of the patient. Nevertheless it is rather undeniable that only other doctors, specialists in the discipline, can properly assess the conduct in question. Therefore it might be appropriate to encourage an objective and impartial assessment of the factual basis of the case before filing a civil lawsuit or notification of possible criminal offence against doctor.

It is also worth emphasising that medical malpractice cases are exhaustive for a number of reasons. In addition to the unpleasantness on both patients' and doctors' side, there is length of the proceedings, costs, sometimes infamous media publicity and the overall financial burden on the healthcare system. For example according to a study conducted in the US, in a medical practice of about 40 years doctors spend on average 10.6% of

the time, which is around 4 years, having an open malpractice case[6]. This has also been pointed out in the German literature, where the duration of only preliminary proceedings is approximately 1–2 years[7]. Unfortunately it is rather difficult to find up-to-date and comprehensive data on this matter in Polish literature. Older data indicates about 4 years and up to 10 years in more complicated cases[8]. The longer proceedings the more stress and anxiety for doctors who are sometimes unable to normally deal with their day to day work. It also affects doctor's family, especially when criminal proceedings are in progress. Long-lasting proceedings are also disruptive for the patients.

3. Factors potentially enhancing medical malpractice claims

There are many potential reasons why patient decides to challenge doctor's actions in the court or in other way. The most simple answer would be because they suffer injuries from a medical procedure. In this case bigger number of claim would mean a bigger number of medical malpractice. Unfortunately such direct conversion cannot be made easily because there is no exact data on the number of medical errors occurred in Poland each year. Moreover not all cases and complaints are considered in favour of patients. Sections below present factors which from my perspective are the most probable to influence the number of malpractice claims in Poland.

3.1. Complication vs. medical malpractice

Medical malpractice in Polish literature is strongly related to the notion of 'error'. An ambiguity of this word gives several options for interpretation,

[6] S.A. Seabury, A. Chandra, D.N. Lakdawalla, A.B. Jena, *On Average, Physicians Spend Nearly 11 Percent Of Their 40-Year Careers With An Open, Unresolved Malpractice Claim*, "Health Affairs" vol. 13, no 1/2013, pp. 111 and 115–116, https://doi.org/10.1377/hlthaff.2012.0967.

[7] K. Ulsenheimer, K. Gaede, *Arztstrafrecht in der praxis*, C.F. Müller 2021, p. 7.

[8] Uzasadnienie do rządowego projektu ustawy o zmianie ustawy o prawach pacjenta i Rzeczniku Praw Pacjenta (druk sejmowy nr 3488).

one of them being colloquially an act that brings negative outcome for someone. In the situation where the outcome of medical procedure is negative for the patient he or she may associate it with doctor's error[9], however not necessarily it equals medical malpractice. In such context even the slightest deviation from the patient's expectation may be seen as negative and become a reason to question doctor's actions[10]. Some authors rightly in my opinion indicate that the word of error itself brings more complications to this already complicated matter and therefore they propose a use of different terms[11]. However I agree that it has no legal value for the topic of doctor's liability, 'medical error' has a technical meaning and may be helpful in addressing the category of cases related strictly to medical professions and healtcare. Nevertheless, it is worth noticing that terminology might influence the misunderstandings on the difference between doctor's acts which cause patient's damage, and the damage independent from doctor's acts.

There is a divergence between 'complication', 'therapeutic failure', and 'malpractice'/ 'error'[12]. From medical perspective complication is "a distinct disorder that arises as a result of, *inter alia*, another disease, surgery, medical errors", while therapeutic failure is defined as "cases in which, despite the correct treatment appropriate to the disease, the patient's health may deteriorate or even patient may die"[13]. In this case it might be said that a complication is a broad notion which covers any disorder caused by an external factor independent of the original disease. Therefore a complication might be caused by medical malpractice or other factors, while a therapeutic failure is not a consequence of medical error. In other words a patient may suffer an injury after undergoing

[9] M. Boratyńska, P. Konieczniak, *Prawa pacjenta*, Warszawa 2001, pp. 135–136.

[10] T. Tołłoczko, *Błąd lekarski. Spojrzenie klinicysty*, "Prawo i Medycyna" 5/2000, pp. 49–50.

[11] M. Boratyńska, P. Konieczniak, *Prawa*…, pp. 135–139. In contrary: M. Sadowska, *Zapobieganie błędom medycznym w praktyce*, Warszawa 2019, p. 37.

[12] The meaning of these terms vary in Polish.

[13] K. Woźniak, *Błąd medyczny*, Katedra Medycyny Sądowej UJ CM, Kraków 2014, cited after: Judgement of the Court of Appeal in Gdańsk of 9.06.2020 r., V ACa 89/20, LEX nr 3052839, (translated from Polish).

a treatment and no doctor will be responsible for it. Reports of new therapies and medical advances raise patient's expectations and hopes which not necessarily meet the reality and capabilities of medicine in particular case. It was noted in older literature that a large proportion of the number of complaints is derived from the common knowledge of treatment capabilities[14]. Nevertheless if something works for person A it does not automatically work for person B and some complications based on individual predispositions may occur. However it is in accordance with the common-sense that doctors have no unlimited capabilities, sometimes it may be difficult for patient or family to take in.

On one hand the above-mentioned terminological differences might seem meaningless. From patient's perspective indeed, what most relevant is that his condition may not improve or may deteriorate regardless the fact that the medical procedure was undertaken appropriately and with all due care. Complications are independent of adherence to the established medical standards and procedures. The medical malpractice is only one of the factors that may be the reason for a complication. Understanding and acceptance of this fact by patients might save doctors from being easily blamed. On the other hand the nomenclature is significant for the communication between the parties, both doctors-patients and doctors-lawyers. This matters especially regarding the duty to inform about foreseeable complications of the procedure in order to avoid resulting from it possible misunderstandings.

3.2. Changes in doctor-patient relationship and delivering health care services

Over the centuries there has been a significant change in the relationship between patients and doctors. One of the major changes is moving from a paternalistic model to ones that respect patient's autonomy. For many centuries doctors enjoyed authority because of their medical knowledge. Being a doctor required training available only to a few people, therefore

[14] Z. Marek, *Błąd medyczny*, Kraków 1999, pp. 20–21.

respecting their skills patients followed their recommendations and did not participate in the decision-making process[15]. This changed after World War II as the significance of the individual human being in society and the importance of the autonomy raised.

Paternalism in its etymology comes from the word 'pater' meaning father[16]. It refers to the authority of the father over his children, or more broadly subordinates, which materialises in governing their lives and imposing rules and limits. According to G. Dworkin it is "the interference with a person's liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests or values of the person being coerced"[17]. In a doctor-patient relationship it manifests with doctor's kind of protective behaviour towards the patient. The doctor possessing necessary knowledge have a superior position and therefore knows what stands for patient's best interest. This way the patient was excluded from the decision making process and the doctor determined the treatment. The doctor treated patient to the best of his abilities, while the patient trusted he would be cured.

In the second half of the 20th century, safeguarding the interests of an individual person became central to legal and philosophical discussions[18]. It was obvious that what happened during the II World War should never be repeated, therefore human rights were strongly emphasised in the international arena. The technological revolution in the field of biology and medicine in the 1960s, which led to an interest in the morality of research and the development of bioethics in the United States, played an important role in distinguishing patient rights[19]. New

---

15 T. Brzeziński, *Etyka lekarska*, Warszawa 2011, pp. 45–46.

16 L.J. Thompson, "paternalism", Encyclopedia Britannica, https://www.britannica.com/topic/paternalism.

17 G. Dworkin, *Paternalism*, "The Monist" vol. 56, no 1/1972, http://www.jstor.org/stable/27902250.

18 The most notable example is the adoption of The Universal Declaration of Human Rights in 1949 (General Assembly resolution 217 A), https://www.un.org/en/about-us/universal-declaration-of-human-rights.

19 J. Bujny, *Prawa pacjenta. Między autonomią a paternalizmem*, Warszawa 2007, p. 38, with the literature referred to therein.

approach to the topic of medicine and treatment did not align with the paternalistic relationship model between doctor and patient.

In 1972, R. Veach proposed four concepts of the patient-doctor relationship: priestly (paternalistic), engineering, collegial and contractual[20]. The last three may be collectively named as partnership models as they form an opposition to the paternalistic one. Twenty years later, a new proposal emerged distinguishing between paternalistic, informative (corresponding to the engineering one), interpretive and deliberative model[21]. The notion of autonomy, which represents the possibility of self-determination is central to models being in opposition to paternalism. T.L. Beauchamp and J.F. Childress point out that there are two fundamental conditions that must be met in order to speak of autonomy. These are the liberty – an independence from controlling factors, and the agency, which constitutes an ability to act intentionally[22]. The inclusion of patient's autonomy in the treatment process has to be assessed without doubt as positive. A fundamental manifestation of respect for the patient's autonomy is the requirement of the conscious consent to the medical procedure, which implies the patient's willingness to undergo a treatment. According to some Polish authors changing the relationship and basing it on the partnership model removes a part of the responsibility from the doctor, thus it establishes a greater balance between him and the patient[23]. Clearly this is the right direction for the partnership in medicine.

As mentioned above cultivating patient's autonomy resulted in development of different kinds of relationship models, moving in the direction of more and more consumer – service providers one. In this sense the US seems to be quite close to such approach[24] which comes probably

---

[20] R. Veach, *Models for ethical medicine in a revolutionary age*, "Hastings Center Report" vol. 2, no 3/1972, https://doi.org/10.2307/3560825.

[21] E.J. Emanuel, L.L. Emanuel, *Four Models of the Physician-Patient Relationship*, "JAMA" vol. 267, no 16/1992, pp. 2221–2226, DOI:10.1001/jama.1992.03480160079038.

[22] T.L. Beauchamp, J.F. Childress, *Principles of Biomedical Ethics*, New York–Oxford 2019, p. 100.

[23] T. Brzeziński, *Etyka*…, p. 47.

[24] M. Balicki, *Prawa pacjenta – wybrane zagadnienia*, [in:] *Szkoła Praw Człowieka: teksty wykładów*, Helsińska Fundacja Praw Człowieka, Warszawa 1996, p. 315.

from the general legal culture of that country. On one hand Poland seems to be moving slowly towards this direction too and so patients expect healthcare services be like any other. On the other hand they remain still more attached to some peculiarities of this extraordinary situation of entrusting life and health to another person[25]. There is no place in today's world for imposing one's will on another person that is capable of managing their own life and excluding them from decision making process[26]. However 'Both the autonomy of the patient and that of the doctor are to be subordinated to the needs of the patient, to his or her well-being, not the other way around. It is not autonomy but the person that is the absolute value. The dignity of the person is not to be reduced to his or her freedom only.'[27].

Another significant change was the transition from a single-doctor healthcare to a collaborative treatment by a team of specialists. Together with new research in medicine and the development of technology, treatment has become more accessible to a bigger number of patients. Building an efficient healthcare system started to be one of the pillars for countries policies. Today healthcare services are a chain of actions undertaken by different medical practitioners and specialists, who participate in the process. It is rather rare one single person to be responsible for the whole treatment. The complexity of the relationships between the parties and services provided has its reflection in the legal perspective[28]. Unfortunately the number of patients, scarcity of the resources comprising funds, professionals and equipment result in difficulties in providing services to everyone at an adequate level. Limited time per person and

---

[25] M. Anczewska et al., *Pacjent, klient, czy… – określenia preferowane w psychiatrycznej opiece zdrowotnej*, "Psychiatria Polska" no 1 (2011), p. 41, cited after: B. Kmieciak, *Definicja pacjenta*, [in:] R. Kubiak, L. Kubicki (ed.), *System Prawa Medycznego*, vol. 1, *Pojęcie, źródła i zakres prawa medycznego*, Warszawa 2018, p. 160.

[26] A. Coulter, *Paternalism or partnership? Patients have grown up—and there's no going back*, "BMJ" no 319/1999, p. 719, DOI:10.1136/bmj.319.7212.719.

[27] T. Biesaga, *Elementy etyki lekarskiej*, Kraków 2006, p. 74 (translation from Polish).

[28] Z. Banaszczyk, *Elementy zobowiązaniowego stosunku medycznego*, [in:] M. Safjan, L. Bosek (ed.), *System Prawa Medycznego*, vol. 1, *Instytucje Prawa Medycznego*, Warszawa 2018, pp. 327–340.

collaborative healthcare depersonalised and loosened the bond between doctors and patients. Moreover healthcare ceased to be an individual matter, but treated more globally considers also whole societies.

Doctor-patient relationship is inherently characterised by a certain intimacy. Intercourse with human life and health on a daily basis, makes the medical profession unique in some sense. Paternalism has been an integral part of medicine for centuries and not necessarily need to be judged negatively, as long as it is only implemented to a limited and solidly justified extent. The notion of paternalism identified with coercion by many philosophers has taken on a definitely negative overtone[29]. What should be condemned are aggressive attempts to exert influence on patients or exclusion from the decision making process. Paternalism understood as mentoring and guidance may have in my opinion a positive outcome, when linked to respect. Instead, focusing merely on formalities and fulfilment of contract or statutory requirements puts treatment on a par with other services, which in my opinion does not lead to the satisfaction of patient's true interest. Here comes the difference between a pure contractual, consumer relationship between doctor and patient based only on formal obligations, and the true partnership where the doctor is more of a counsellor and a spark of positive paternalistic approach remains.

3.3. Deterioration of the image of doctors

One of the factors influencing propensity to sue might be a general deterioration of the image of profession. This would be mostly because of media and their one-sided broadcasts on medical malpractice. Generally negative and shocking information attracts more attention, therefore these stories are of particular interest to media. Repeated reports on fatal cases, unethical behaviour and high compensations might convey a sense that these kinds of incidents are common. On the other hand pieces of news reporting outstanding achievements in medicine might create an

[29] N. Fotion, *Paternalism*, "Ethics" vol. 89, no 2/1979, pp. 191–198, cited after: M. Zatoński, *Czy paternalizm wobec dorosłych jest uzasadniony?*, Warszawa 2000, p. 21.

image of unlimited possibilities, which is kind of a paradox. Public Opinion Research Centre[30] carried out couple of surveys regarding perception of medical profession in the Polish society.

In a survey on the prestige of professions conducted in 1995, the profession of medical doctor occupied the second position in the hierarchy (only university professor was higher) regardless the respondents' level of education. In the 2019 survey 80% of respondents indicated again that they held doctor profession in high esteem[31]. Thus, it can be said that this profession is generally perceived as prestigious by the entire Polish society. When it comes to assessing professional honesty and integrity doctors performed worse. In 1998, only half of those surveyed believed that doctors try to provide the best possible care for the patient, and only a quarter thought that doctors pay a lot of attention to patients[32]. In 2001, the majority of interviewed patients felt that they had been treated appropriately by doctors and nurses during their treatment, objections were usually minor[33]. Regarding opinions on medical errors and trust in doctors[34], the research comparing years 2001 and 2014 revealed that in both years patients, despite experiencing a medical error, predominantly trust doctors. There has also been an increase in the proportion of people (31% in 2001 and 41% in 2014) who responded they had encountered a medical error or lack of due diligence. At the same time, the vast majority of respondents (71%) felt that these situations rarely or never occur. The newest report from 2023 shows that 70% of the Polish society finds doctors as competent, 63% believe they are committed to their work and they care to help patients[35]. In comparison a survey carried out by BioStat

[30] Pol. Centrum Badania Opinii Społecznej – CBOS.

[31] M. Omyła-Rudzka, *Które zawody poważamy?*, Komunikat z badań CBOS, Warszawa 2019.

[32] *Uczciwość i rzetelność zawodowa*, Komunikat z badań CBOS, Warszawa 1998.

[33] W. Derczyński, *Opinie o stosunku do pacjentów w placówkach opieki zdrowotnej*, Komunikat z badań CBOS, Warszawa 2001.

[34] M. Omyła-Rudzka, *Opinie o błędach medycznych i zaufaniu do lekarzy*, Komunikat z badań CBOS, Warszawa 2014.

[35] M. Omyła-Rudzka, *Opinie na temat funkcjonowania systemu opieki zdrowotnej*, Komunikat z badań CBOS, Warszawa 2023.

in 2018 showed that only 43% of people believed that doctors were committed to their work[36],

However each of the above surveys presents slightly different perspective on doctors profession, they might give some general indication regarding perception of doctors in the Polish society. It seems that an overall opinion about doctors is positive and patients trust them. This may signify that there is no correlation between trust and favourable perception of doctor and there are other factors which drive patients to sue. Doctors admit sometimes they can suspect from patients behaviour that a certain person might cause trouble in the future. Another possibility is that only some particular groups of patients, with certain characteristics are prone to complain. In such case hypothetically the propensity to sue might depend for example on the gravity and risk of the procedure or the severity of damage. Further research on this matter for Poland would be necessary. Interesting results were shown by a study conducted in the State of New York in 1991[37]. Of the 1133 adverse events selected in the study, only 280 were the results of medical errors. In contrast, the number of patients who suffer serious, disabling injuries each year as a result of clearly negligent medical care apparently exceeded the number of patients who choose to pursue their claims. Perhaps it would be accurate to say that, for some reason, patients for whom medical errors are not at all obvious are more likely to pursue claims there. If this was the case also in Poland, then it might again be a signal of necessity to focus on assessing the actual occurrence of a medical error before starting the proceedings.

[36] Raport *Lekarze w badaniach opinii społecznej 2018*, Ośrodek Studiów, Analiz i Informacji Naczelnej Izby Lekarskiej, https://nil.org.pl/uploaded_images/1575629945_raport-lekarze-w-badaniach-opinii-spolecznej-w-2018-roku.pdf.

[37] A.R. Localio et al., *Relation between Malpractice Claims and Adverse Events Due to Negligence – Results of the Harvard Medical Practice Study III*, "New England Journal of Medicine" vol. 325, no 4/1991, DOI:10.1056/NEJM199107253250405.

3.4. Doctors behaviour towards patient

As observed in the studies in the U.S. patients and their families who were already dissatisfied with the attitude of their doctors for some reason are more likely to pursue claims arising from adverse events[38]. For example, a prior disregard for the patient, his or her questions or concerns and limited communication of information can lead to possible claims in the event of an adverse event. When it comes to the occurrence of an adverse event, having previous negative experience may cause patient suspects some misconduct or simply wants to payback. Also, doctor's behaviour after an adverse event might play a role, whether the doctor is keen to inform and explain everything to the patient. Due to many difficulties arising from legal and procedural matters in case of an adverse event patients prefer an early disclosure with apology and they are more inclined to forgive doctors rather than initiate legal proceedings[39]. Working on the project and this article[40] involved consultations with several lawyers representing patients in medical malpractice cases. Some of the lawyers shared an insight it is often that patient decides to consult them because at the previous stages of treatment, before an allegedly adverse event occurred, doctors behaviour had been disparaging or disrespectful. This may indicate that also in Poland doctors behaviour towards patient is an important factor for patient's decision to claim.

Going through the survey conducted on doctor's attitude towards patients' claims arising from alleged medical malpractice[41], it seems there is a common point for many answers, namely a lack of understanding or simply misunderstanding between the parties – doctors and patiens.

---

[38] G.B. Hickson, E.W. Clayton, P.B. Githens, F.A. Sloan, *Factors that prompted families to file medical malpractice claims following prenatal injuries*, "Journal of the American Medical Association" vol. 267, no 10/1992, pp. 1359–1363.

[39] L. Berlin, *Will saying "I'm sorry" prevent a malpractice lawsuit?*, "American Journal of Roentgenology" vol. 187, no 1/2006, pp. 10–15; T.H. Gallagher, D. Studdert, W. Levinson*, Disclosing harmful medical errors to patients*, "New England Journal of Medicine" vol. 356, no 26/2007, pp. 2713–2719, DOI:10.1056/NEJMra070568; E. Jackson, *Medical Law: Text, Cases, and Materials*, Oxford 2019, p. 166.

[40] See Introduction to this article on page 1.

[41] See p. 2 of this article.

Without doubt patients have the right to be informed about what might happen to them and doctors have an obligation to respect this right. Lack of medical knowledge on patient's side and some kind of superiority feeling on doctor's side cannot be an excuse to narrow down the scope of information or to exclude the necessary explanation. Staffing constraints and therefore limited time for patients may seem an obstacle to fulfil this duty, nevertheless it seems that the way patient is treated by the doctor is one of the factors potentially influencing patient's decision to question doctor's conduct in case of an adverse effect. However this does not guarantee there will be no claims, doctors should find time, willingness and patience to provide patients with an accurate information. This enhances a sense of being cared and respected and can thus may reduce patients' propensity to sue.

On the other hand patients should exercise their rights and actively seek all the necessary information and explanation they need from doctor to make a conscious decision. Instead, it happens that patients try to challenge validity of their written consent for the procedure[42] by stating that they were under pressure and did not understand everything, while not even having asked for clarification. Such situations can be very frustrating for doctors, because regardless fulfilling their duties they might become a party to the court proceedings and have to defend themselves. The feeling of injustice and helplessness enhance suspiciousness and distrust towards patients too. Mutual distrust between doctors and patients creates a vicious circle in this sense.

3. Summary

It is rather difficult to point out only one main factor that influences the number of medical malpractice claims and complaints against doctors. More likely it is a mix of several elements. According to the survey of doctors, the majority finds some of the patients' claims are made wrongly

[42] For example see Judgement of the Polish Supreme Court from 18 September 1999 r., II CKN 511/96, LEX no 453701.

or for frivolous reasons. These would be the claims made where no actual error was commited. In the survey doctors pointed out among others excessive, unrealistic expectations of patients, incomprehension of various treatment related issues and ignorance of the medical indications or necessity to undertake a medical procedure which result later on in unjustified claim. The above mentioned factors on one hand may be perceived as generally contributing to the number of patient's claims and complaints, but at the same time they may influence those particular cases of unjustified claims.

Changes in doctor-patient relationship on one hand positively raised awareness of patients' rights and means available to protect their interests, therefore patients are naturally willing to take action in case of infringement or adverse event possible. On the other hand moving towards more contractual approach brings in my opinion more formality, demands and coldness, which does not help to build confidence necessary in this kind of relationship. The data presented in the section 3.3. seem to deny the deterioration of doctors image in the Polish society and lack of trust towards the profession. Nevertheless cases lost by the patients somehow ended up in the courts, which might be explained by patient's trust that lasts unless no adverse event occurs. Particularly important in making decision to sue or file a complaint might be the way patient was treated before and after an adverse event, whether doctors provide a proper explanation, shows due respect and communicate openly about occurred complications. Patient's negative experience may contribute to the unjustified suspicion of medical malpractice or even desire for punishment in the extreme case. However it is quite difficult to capture, high sums of compensation and lawyers interests in this type of cases may also be considered in my opinion as enhancing medical malpractice.

In order to diminish unjustified claims I find healthy and respectful doctor – patient relationship especially important. On one hand, patients may comfortably and with openness share their doubts and thoughts which help them in making their decision with confidence. This can strengthen the patient's positive attitude towards therapy, so that he or she is able to achieve better results. On the other hand, a doctor working in a friendly atmosphere, without the constant feeling of fear that

a patient is lurking for his or her mistake in order to take advantage, also has a more positive attitude towards patients their job. Certainly doctor needs to focus not only on the medical procedure itself but care to treat patient with due respect and politeness, which includes providing information and explanation. Having healthy approach to the process of treatment and mutual expectations may limit the necessity of applying law in it's extreme – at the court. Nevertheless this cannot eliminate all the unfair claims, as the marginal cases of bad faith still remain.

Bibliography

Balicki M., *Prawa pacjenta – wybrane zagadnienia*, [in:] *Szkoła Praw Człowieka: teksty wykładów, Helsińska Fundacja Praw Człowieka*, Warszawa 1996.

Banaszczyk Z., *Elementy zobowiązaniowego stosunku medycznego*, [in:] M. Safjan, L. Bosek (ed.), *System Prawa Medycznego*, vol. 1, *Instytucje prawa medycznego*, Warszawa 2018.

Bączyk-Rozwadowska K., *Błąd lekarski jako obiektywny element winy lekarza*, [in:] E. Bagińska (ed.), *System Prawa Prywatnego*, vol. 5, *Odpowiedzialność prywatnoprawna*, Warszawa 2021.

Beauchamp T.L., Childress J.F., *Principles of Biomedical Ethics*, New York–Oxford 2019.

Berlin L., *Will saying "I'm sorry" prevent a malpractice lawsuit?*, "American Journal of Roentgenology" vol. 187, no 1/2006.

Biesaga T., *Elementy etyki lekarskiej*, Kraków 2006.

Boratyńska M., Konieczniak P., *Prawa pacjenta*, Warszawa 2001.

Brzeziński T., *Etyka lekarska*, Warszawa 2011.

Bujny J., *Prawa pacjenta. Między autonomią a paternalizmem*, Warszawa 2007.

Coulter A., *Paternalism or partnership? Patients have grown up—and there's no going back*, "BMJ" no 319/1999, DOI:10.1136/bmj.319.7212.719.

Derczyński W., *Opinie o stosunku do pacjentów w placówkach opieki zdrowotnej*, Komunikat z badań CBOS, Warszawa 2001.

Dudzik I., *Nie traktujcie nas jak przestępców*, "Medical Tribune" no 5/2022, https://bit.ly/3KhbHjB.

Dworkin G., *Paternalism*, "The Monist" vol. 56, no 1/1972, http://www.jstor.org/stable/27902250.

Emanuel E.J., Emanuel L.L., *Four Models of the Physician-Patient Relationship*, "JAMA" vol. 267, no 16/1992, DOI:10.1001/jama.1992.03480160079038.

Gallagher T.H., Studdert D., Levinson W., *Disclosing harmful medical errors to patients*, "New England Journal of Medicine" vol. 356, no 26/2007, DOI: 10.1056/NEJMra070568.

Gałązka M., *Pojęcie pacjenta*, [in:] M. Safjan, L. Bosek (ed.), *System Prawa Medycznego*, vol. 1, *Instytucje prawa medycznego*, Warszawa 2018.

Hickson G.B., Clayton E.W., Githens P.B., Sloan F.A., *Factors that prompted families to file medical malpractice claims following prenatal injuries*, "Journal of the American Medical Association" vol. 267, no 10/1992.

Jackson E., *Medical Law: Text, Cases, and Materials*, Oxford 2019.

Kmieciak B., *Definicja pacjenta*, [in:] R. Kubiak, L. Kubicki (ed.), *System Prawa Medycznego*, vol. 1, *Pojęcie, źródła i zakres prawa medycznego*, Warszawa 2018.

Localio A.R., Lawthers A.G., Brennan T.A., Laird N.M., Hebert L.E., Peterson L.M., Newhouse J.P., Weiler P.C., Hiatt H.H., *Relation between Malpractice Claims and Adverse Events Due to Negligence – Results of the Harvard Medical Practice Study III*, "New England Journal of Medicine" vol. 325, no 4/1991, DOI:10.1056/NEJM199107253250405.

Marek Z., *Błąd medyczny*, Kraków 1999.

Omyła-Rudzka M., *Które zawody poważamy?*, Komunikat z badań CBOS, Warszawa 2019.

Omyła-Rudzka M., *Opinie o błędach medycznych i zaufaniu do lekarzy*, Komunikat z badań CBOS, Warszawa 2014.

Raport *Lekarze w badaniach opinii społecznej 2018*, Ośrodek Studiów, Analiz i Informacji Naczelnej Izby Lekarskiej, https://nil.org.pl/uploaded_images/1575629945_raport-lekarze-w-badaniach-opinii-spolecznej-w-2018-roku.pdf.

Sadowska M., *Zapobieganie błędom medycznym w praktyce*, Warszawa 2019.

Seabury S.A., Chandra A., Lakdawalla D.N., Jena A.B., *On Average, Physicians Spend Nearly 11 Percent Of Their 40-Year Careers With An Open, Unresolved Malpractice Claim*, "Health Affairs" vol. 13, no 1/2013, https://doi.org/10.1377/hlthaff.2012.0967.

Tatoń J., *Filozofia w medycynie*, Warszawa 2003.

Thompson L.J., *paternalism*, "Encyclopedia Britannica", https://www.britannica.com/topic/paternalism.

Tołłoczko T., *Błąd lekarski. Spojrzenie klinicysty*, "Prawo i Medycyna" no 5/2000.

Uczciwość i rzetelność zawodowa, Komunikat z badań CBOS, Warszawa 1998.

Ulsenheimer K., Gaede K., *Arztstrafrecht in der praxis*, C.F. Müller 2021.

Veach R., *Models for ethical medicine in a revolutionary age*, "Hastings Center Report" vol. 2, no 3/1972, https://doi.org/10.2307/3560825.

Zatoński M., *Czy paternalizm wobec dorosłych jest uzasadniony?*, Warszawa 2000.

Case

Judgement of the Polish Supreme Court from 18 September 1999 r., II CKN 511/96, LEX no 453701.

Abstract

Doctors signal more and more often that they have to face and defend themselves against unfair medical malpractice allegations. Having the perspective of being convicted or paying high compensation, even though covered by insurance, they feel insecure. Reports on outstanding medical advancements together with today's consumerism implement a sense of unlimited possibilities in healthcare. On the other hand information publicising shocking cases of negligence and high compensation creates an image that if something goes wrong during treatment, it is doctor's fault. This article considers changes in doctor-patient relationship and other potential factors which might influence the number of medical malpractice claims and the propensity of patients to sue.

Keywords: medical malpractice, medical error, healthcare, doctor-patient relationship, patient's claims, duty to inform