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# No Fault Insurance Systems in Polish Law and in Other European Legal Systems

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New models of simplified liability regarding the medical injuries have been created for several years. They are commonly referred to as *no fault insurance systems*. In the herein article, the author discusses two European models: a Swedish model, which is based on compulsory patients' insurance, and a French model, the provisions of which describe the liability cases based on *fault* and *no fault* principles, with a complementary solution of subsidiary state liability resulting from social solidarity. Next, the author presents the Polish solutions, along with the damages and reimbursement claiming procedures, involving the Voivodeship Investigation Commissions procedure, which has been in force since Jan. 1. 2012. The article also outlines the legal situation of patients and their insurers, along with the doubts connected to the interpretation of the legal regulations in force. Furthermore, the present work characterizes the medical event insurances and their legal character (initially compulsory – now voluntary). Finally, the author compares the Polish solutions with the Swedish and French systems, indicating the potential course of the development of the Polish law.

**Keywords:** medical events liability, no fault insurance, medical insurance, civil liability insurance, medical malpractice, third party insurance, injuries resulting from medical events.

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## 1. Genesis of the no fault systems

In many European Union states, a need of introducing a new system of compensation regarding the therapy-related injuries has arisen. The dynamic development of medical knowledge means that the traditional civil liability model, based on the fault principle, does not lead to full compensation of the patients' claims. In some cases it is hard to prove the doctor's malpractice, or even failures within the scope of organization in case of the therapeutic subject. Besides the scope of protection, so called medical events have been the case here – incidents which are quite rare, not related to the patients' status, thus not included in the scope of the risk the patient would accept, when signing a consent related to the medical procedures<sup>1</sup>.

On the other hand, an increase in awareness of the injured patients and rise in the number of court cases may be observed. Waiting time related to the settlement, or even awaiting first hearing is prolonged. Evidence problems are the reason why the patients (even after a long period of court proceedings) may not receive their damage

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<sup>1</sup> Lt. M. Nesterowicz, *Ubezpieczeniowe i gwarancyjne modele kompensacji szkód wyrządzonych przy leczeniu*, [Insurance- and Guarantee-based Therapy Injuries Compensation] *Prawo Asekuracyjne* 2002, No. 2, p. 13; K. Bączyk-Rozwadowska, *Odpowiedzialność za szkody wyrządzone przy leczeniu*, [Responsibility for the Injury Inflicted During the Therapy] Toruń 2007.

payments<sup>2</sup>. A large part of the provisions established by the court is used to cover the cost of court proceedings or remuneration of the litigation legal representatives.

Considering the inconveniences presented above, many propositions have been made, within various European legal systems, aiming at creating a more effective scheme of repairing the injuries that have to be sustained by the patients due to therapy<sup>3</sup>. According to one of the concepts, not only shall undesirable effect of the medical procedures be a burden for the patient, the related effect shall also be imposed on the state. Another assumption places an emphasis on the need of introducing, liability based on risk or equity principles, should any medical malpractice injury occur. Numerous authors stress the fact that there is a need of adjusting the civil liability insurance policies in force to the existing medical malpractice liability system, or even a need of introducing new insurance for the patient, or creating special guarantee funds. Another proposed solution was to implement a new type of compulsory insurance – insurance for the patients. Each of the medical subjects should be then obliged to insure the patients. This insurance would be used, should a defined impairment for the patient occur, without the fault on the side of the doctor or the therapeutic subject. The exception would refer to injuries caused intentionally or by flagrant malpractice of the perpetrator of the damage, and then damages would be paid by the guarantee fund. This fund would be created by the hospitals themselves, by paying relevant insurance contribution, whereas, at the moment when the patient's claims are met, the fund would gain a right to submit a recourse for the responsible subject. Proponents of the discussed concept sometimes pointed out to the fact that the new insurance would ultimately be too burdensome financially for the hospitals, hence the contributions shall be paid individually by the patients themselves.

Contemporary *no fault compensation systems* are based on an assumption, according to which should the specific subject be responsible, there is no need of proving his fault. Considering this feature, the systems described above are commonly known as systems of compensating the damage regardless of fault. They still require the proof of injury, its size and causal relationship between action and failures to perform made by the given subject (doctor, medical facility), and the injuries which are the cause for the patient's suffering.

Another feature of the *no fault compensation system* is visible in the simplification of the procedures, the aim of which is to repair the damage by handing off the procedures related to the proceedings or opinions about the raised claims to independent organs or bodies: Commissions, Bureaus, Funds. The model of the proceedings carried out differs, depending on the country. In some states the procedure is carried out in writing, in some it is assumed that the patient – claimant needs to play an active part in the process; character of the decision made during the proceedings carried out in front of the Commission is not unified as well – it is either treated as a binding one or solely as an opinion in the legal dimension,.

Out of a variety of systems, the Swedish model is particularly interesting, since it is based on additional *first party insurance*, and the French system, in which the civil liability of the doctors and therapeutic subjects, who obligatorily need civil liability insurance, has been connected with the guaranteed liability of the state, according to the

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<sup>2</sup> P. Caine, *Atiyah's Accident Compensation and the Law*, London–Dublin 1993, pp. 401 and further.

<sup>3</sup> R. Elgie, T. Caulfield, M. Christie, *Medical Injuries and Malpractice*, Health Law Journal 1993, No. 1, s. 97.

equity principle. These standards have become a model for the subsequent European legislation, particularly the Belgian Act on compensation of damage resulting from medical events and the Polish Act on Patient's Rights and Patient's Rights Advocate, which offers provisions related to so called medical events.

### **2. Swedish no fault insurance model**

Swedish medical malpractice injury liability model is not based on modification (expansion) of the rules of liability in question, it is rather on obligatory insurance of the medical facilities made for the patients (No Fault Patient Insurance – NFPI or first party insurance)<sup>4</sup>.

This insurance was created in the 1970's, on the basis of an agreement made between the National Association of the County Councils, which is responsible for the organization and provision of medical service within the Swedish territory, involving a consortium of the 4 largest insurance companies. At first, the insurance was obligatory solely in case of so called public healthcare. Doctors who ran their practices privately, as well as non-public therapeutic agents, could be involved in the memorandum at their own discretion, which led to varied situations of the patients, depending on the subject which carried out the therapeutic activities. Starting from Jan. 1<sup>st</sup> 1997, the insurance has also covered the injuries caused to the patients due to provision of healthcare at private and public hospitals. They are administered by the county councils. This means, according to the new legal regulations, that insurance for the patients has become an obligatory insurance for all of the subjects which render health services within the Swedish territory. On the basis of that, the patient who is not a Party of the insurance agreement has a right to submit a direct claim to the insurance company, with which the insuring party signed an agreement. The injured person, in order to receive the benefits from the NFPI insurance company, does not need to prove fault of the patient or the medical facility. If the injury has been incurred as a result of wilful misconduct or gross negligence of those subjects, the insurer who has paid the benefit to the patient may submit a recourse claim for the direct originator of the damage.

NFPI insurance scheme includes, according to the rules, injuries that happened during the therapy and hospitalization of the patients, caused by the persons performing a medical profession (doctors, nurses, midwives, physical therapists, laboratory diagnosticians). The issue of therapy is quite widely understood. Not only does it include procedures which are strictly medical, but also the prevention diagnostics, palliative and hospice care, medical experiments, as well as the use of drugs and pharmaceutical materials and ambulance services.

The responsibility of the insuring party within the scope of NFPI, even though it is much wider than in case of classic civil liability insurances, has no absolute character<sup>5</sup>. In order to make the insurer obliged to pay the benefits, injury, health problems or death of the patient must take place in the conditions defined by the Act. The damages will be granted then for:

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<sup>4</sup> More information on that issue: *No Fault Compensation In the Health Care Sector*, Vienna – New York 2004 and related references.

<sup>5</sup> A. Merry, A. McCall Smith, *Errors, Medicine and the Law*, Cambridge University 2004; *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation and Compensation*, New York 1991.

- any injuries throughout the therapeutic process, which could have been avoided, should the doctor have used other method of therapy or should he have conducted it in other way,
- injuries resulting from using defective or ineffective equipment or medical products,
- injuries related to incorrect diagnosis,
- injuries resulting from hospital infections,
- injuries resulting from hospital infections, or from wrongfully administered or prescribed medication,
- injuries, which have been caused by so called hospital accidents.

Out of all of the above categories, hospital accidents seem to be the most interesting one. This category includes cases when the person was injured as a result of sudden and unforeseen circumstances, which are beyond the scope of the undertaken medical actions and are unrelated to the patient's health status and/or individual properties of his organism. Such cases usually include falling out of the bed or down the stairs, when the patient is being transported between two different health facilities. In case of the Swedish model, injuries caused by the defective medical products, equipment and medical devices have been included in a separate category. Body injury as well as the patient's health deterioration may be caused by defective medical or hospital equipment, or by improper use of that equipment during the medical examination, provision of care or conducting the therapy.

The Swedish system also provides for exceptions – circumstances which are excluded out of the scope of insurance protection. This means that NEFPI does not include injuries resulting from the breach of the patient's rights, including particularly the events in which the patient did not receive the information related to his health status and within the scope of provided benefits, lack of patient's consent for potential therapy or breach of the medical privilege. Additionally, a specific case of disorder of psychological health resulting from therapy or hospital treatment has been excluded here, even when it has emerged when the assumed treatment method turned out to be ineffective, such as chemotherapy in case of the neoplastic processes. The situation when given actions were to be undertaken immediately, or the patient's life could have been endangered or the patient may have been seriously injured is yet another independent case. These situations may be qualified as actions, the aim of which was to save the patient's life. Repairing such injuries can be realized via civil prosecution.

At the moment when the injury occurs, the patient has an option of selecting the compensation system to be used in claiming damages. He may enter the court way, showing prerequisites of civil liability of the originator of the injury or use the NFPI system. If the NFPI system is selected, requesting the damage repair, then solely the patient may make that choice. Should the patient be dead, the family members, who have been injured, may indirectly claim damages. These persons may require reimbursement of the incurred costs related to therapy and burial, within the scope corresponding to the local customs, along with a single-time damages payment. NFPI system also provides limits for the damages: for each of the events, the value is as much as 1000 times multiplicity of so called base value, and 200 times multiplicity in case of the individual patients. The base value is, currently, as much as EUR 4000.

If the injury is caused by a subject, who, against its obligation, has not concluded an insurance agreement for the patients, the benefit is paid from a special fund, created for that purpose, which has a recourse claim against the injuring party, directly responsible for the injury. The Fund is established on the basis of the assets transferred by the

Association of Patient's Insurance Companies, created by all of the insurance companies, which offer this type of insurance policies.

Swedish NFPI model has become a model for similar compensation systems used in the Scandinavian countries: Denmark (1992), Norway (1988) and Finland (1987).

### 3. French Medical Malpractice Injuries Liability Model

Despite the fact that a variety of solutions, including those referring to the Swedish model exist, the French legislation has adopted an expansive model of medical damage compensation, which covers the following issues:

- traditional liability on the side of the doctor or medical facility, based on the fault rule,
- no fault system,
- guarantee-based liability of the State, based on the equity.

The French liability model related to the injuries caused by medical malpractice is thus varied, depending on the reason for occurrence of the damage, and on its character<sup>6</sup>. Liability of the doctor may be based on fault, but no fault system is also being used. All of that is related to a single type of insurance – Civil Liability Insurance. Contrary to the Swedish system, the French solution does not feature a new type of insurance for the patient – guaranteed liability based on equity has been used instead (*la solidarite nationale*)<sup>7</sup>.

French Medical Malpractice Injuries Liability Model has been regulated in detail by the March 4<sup>th</sup> 2002 Act, which covered the patient's rights, along with the quality of the services offered within the Healthcare system. Liability based on the fault rule is of the fundamental relevance. The doctor is particularly obliged to carefully act, within the scope required from a medical professional. The person who is providing the health services is responsible for diagnosis errors, therapy errors or prognosis errors and for the injuries occurring due to the breach of patient's rights. Tightened liability which is set independently from the fault, should a nosocomial infection be the cause, and in case when the injury is caused by use of defective medical equipment. In the situations described above, it is assumed that obligation of the therapeutic object is treated as an obligation of result, and may be contained within the definition of widely understood obligation of providing safety to the patient, throughout the therapy. Liability based on equity is applicable within the scope of so called therapeutic risks, when:

- injury is a result of involuntary action or omission of the doctor or other person who is a member of the medical personnel,
- injury is a result of so called medical accident/event,
- nosocomial infection occurred, being the cause of the patient's death or permanent disability exceeding 24% of permanent injury,
- should so called pure therapeutic risk be the case, if the injury is a result of medical intervention in unusual circumstances (state, when the patient's life is endangered).

In all the cases indicated above, the State Damages Bureau Dealing with the Medical Incidents (ONIAM) is obliged to pay the damages to the injured persons. ONIAM's scope of responsibility is being successively expanded. Regardless of the obligations of repairing the injuries related to therapy and hospitalization, ONIAM also pays the bene-

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<sup>6</sup> S. Carval, R. Sefton-Green, *Medical Liability in France (w:) Medical Liability in Europe*, Berlin – Boston 2011, pp. 207 and further.

<sup>7</sup> Information related to the solutions used within the French legislation has been derived from the research carried out by the University of Tours and from the conferences related to the problem of medical law, which took place in France, at the beginning of 2014.

fits in case of the injuries caused by infection with HIV or hepatitis B resulting from transfusion. On the other hand, the classic civil liability of the doctors and therapeutic subjects, has been subjected to be covered with obligatory civil liability insurance.

The act regulating the patient's rights has introduced a two-way system, which makes it possible to meet the damages claims of the patients. The injured person may use the out-of-court conciliation procedures or pursue his claims via civil or administrative way. The conciliation procedure has unified character and is related to all cases presented above, regardless of the facts whether the damages have been incurred in private or public health facility. Its aim is to define the existence and basis for liability for the specific subject. Amicable settlement of the disputes is realized by the Regional Conciliation Commissions, which have been created for that purpose.

#### 4. Polish medical events liability system

The Polish medical liability system is based on the civil liability, in a classic understanding, which is dependent on the principle of fault, and on civil liability related to the medical events, which is present should an action or omission occur, in case when these actions or omissions are not compliant with the current state of medical knowledge. This division has led to introduction of two types of medical insurance policies: Civil Liability insurance, which is obligatory in case of the medical liability, along with medical events insurance.

Amendment of the Act on Patient's Rights and Patient's Rights Advocate is of fundamental significance here, along with the Act on Obligatory Insurance, Insurance Guarantee Fund and Polish Motor Insurers' Bureau<sup>8</sup>. These legislative regulations specify the detailed rules and mode of setting the damages and reimbursement in case of so called medical events. They entered into force on Jan. 1. 2012. The new system, which so far has been unknown within the Polish law, is based in the Swedish Patient Insurance model. The new system constitutes an attempt of solving the problem of the increasing number of claims of the injured persons against the healthcare institutions. However, the newly adopted system is not perfect, as it has created a lot of doubts regarding the option of interpreting the regulations<sup>9</sup>.

The legislature, defines the medical event in a detailed way in the initial provisions of the act, resigning from the term of medical error that has been used earlier (Art. 67

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<sup>8</sup> Amendment made on Apr. 28. 2011. (Dz. U. [Journal of Laws] 2011, No. 113, item 660). It is going to be referred hereinafter as the "patient's rights act" or abbreviated into "pat. righ."

<sup>9</sup> More information on that issue: E. Kowalewski (ed.), *Kompensacja szkód wynikłych ze zdarzeń medycznych* [Compensation of injury resulting from medical events]. *Problematyka cywilnoprawna i ubezpieczeniowa*, [Problem of civil law and insurance] Toruń 2011 and included interesting texts by the authors; E. Kowalewski, *Obowiązkowe ubezpieczenie pacjentów z tytułu zdarzeń medycznych* [Obligatory patient's insurance due to medical events], *Wiadomości Ubezpieczeniowe* 2011, No. 1, p. 3 and following pages.; M. Serwach, *Ubezpieczenia z tytułu zdarzeń medycznych w teorii i w praktyce* [Medical events insurance – theory and practice], *Prawo Asekuracyjne* 2012, No. 4, p. 4 and following pages.; By the same author: *Problematyka zdarzeń medycznych w praktyce orzekających komisji* [Issue of medical events in the practices carried out by the investigation commissions], *Wiadomości Ubezpieczeniowe* 2012, No. 4 and *Dopuszczalność odstąpienia przez podmioty lecznicze od umowy ubezpieczenia z tytułu zdarzeń medycznych, jej rozwiązania lub zmiany*, [Admissibility of withdrawal from the insurance agreement by the medical institutions due to the medical events, along with termination and amendments of such agreement] *Prawo Asekuracyjne* 2013, No. 1, p. 3 and following pages. Lt. E. Kowalewski, W. Mogilski, *Istota i charakter ubezpieczenia pacjentów z tytułu zdarzeń medycznych*, [Nature and substance of patients' insurance covering the medical events] *PA* 2012, No. 1, p. 13 and following pages.

a, section 1.). In a response to the objections of the medical circles, representatives of which indicated that the “medical error” term has been incorrect, since it has been suggesting that fault or negative action was placed in the hands of the responsible subject, the criticized term has been replaced with a term of “medical event”. This change is hard to be considered a success, since the term “medical event” is semantically quite wide, and were it not for the detailed definition of the statutory term, most of the cases which occurred at the medical facility could be classified as a medical event.

According to the provisions made by Art. 67 a section 1 of the Patients’ Rights Act, medical event is understood as infecting the patient with a pathogen, causing bodily injury or health impairment or death, all of which would result from the following procedures, which are not compliant with the current state of medical knowledge:

- diagnosis, should it have been a cause of improper medical treatment, having an impact on development of the disease,
- therapy, including surgical procedures,
- using therapeutic products or medical products.

As it stems from the literal interpretation of the rule, the basic premise deciding on possibility of occurrence of liability for the medical event is an occurrence of the defined injury, resulting from actions which are not compliant with the current medical knowledge. The definition mentioned here does not directly indicate fault of the medical facility. The Act assumed that the fact whether the fault of the specific subject exists or not, within the scope of assumed medical event liability, had no meaning whatsoever. It seems though, that introducing the requirement related to the decisions which are not compliant with the medical knowledge means, that even despite lack of the need of proving the fault, in practical terms most of actions will have that specific character. In most cases, the actions which are not compliant with the current medical knowledge, will constitute at least for malpractice. Besides, the possibility of infecting the patient with a pathogen will be sometimes an evidence of so called “organizational fault” of the medical facility.

One shall also consider the fact that the legislator points out a possibility of occurrence of irregularities not only within the therapeutic process, but also at the stage of diagnosis or at the stage of using the therapeutic products. In practical terms doubts may arise, whether the specific situations are included in the semantic field of that term. A typical example of that may include bodily injury or health impairment caused by faulty equipment. It seems that in many cases, specific instruments may be classified as medical products. Besides, if such equipment has been used within the therapeutic process, bodily damage or disorder of health may be interpreted as events caused by improper therapy. The assumed interpretation expands the responsibility for the medical events, since the non-conformity requirement regarding the actions of the responsible subject, compared to the current medical knowledge would be an indication of stress placed on the decisions which are strictly medical. Analogous doubts may occur, should the therapy be rejected. On the one hand though, the regulations of the act are applied in case of the medical events resulting from provision of health services, on the other, rejection of therapy may constitute an action which is not compliant with the current medical knowledge, particularly in the cases when the doctor makes an improper decision due to incorrect diagnosis. Then we may speak of a diagnosis, which has delayed the therapy proper, having an impact on the development of the disease.

**5. Liability for occurrence of a medical event – scope of application**

The legal regulations of the Patient's rights act are used in case of the medical events, which result from provision of health services at the hospital, in line with the act regulating the therapeutic activities. The indicated act defines hospital as a business establishment of the therapeutic subject, in which the subject carries out its therapeutic operations, such as hospital services (Article 2, section 1, subsection 9). As it is specified by the regulations, the implemented definition is lacking clarity. It is even more complicated because of the division into business establishments of the medical facilities and medical facilities that are not treated as businesses, and by maintaining the term of independent, public healthcare facilities.

The Patient, or his statutory representative is the subject authorized to submit a request for investigating the medical event in a form of infection, bodily injury or health disorder, and in case when the patient is dead, his inheritors take over this role. Patient is defined as every person who uses healthcare services, or asks for provision hereof by a subject which provides these services or by a person who is working in a medical profession, *inter alia* hospital, nurse, midwife or other subject which is providing health services<sup>10</sup>.

The granted permissions for submitting a claim for damages or reimbursement for the patient, who is treated as the Party which has been directly injured, is the most natural solution. However, a provision which grants a right to claim damages for the inheritors, is quite controversial. The amendment defining the responsibility for the patient's rights has been introduced into the regulations of the Patient's Rights Act. The indicated act grants some entitlements to the patient, defining his rights, and it also grants some entitlements to the patient's relative, patient's statutory representative or even to the patient's guardian<sup>11</sup>. No provision specifies the entitlements for the patient's inheritors, even in the cases when wilful breach of the patient's right to die in peace and with dignity, possibility of requesting a proper amount of money for the indicated social initiative, on the basis of the Article 448 of the Civil Code, which is granted to the spouse, relatives by blood or in-laws, to the second degree in straight line or to the statutory representative.

These issues are described analogously by the latest legal acts, which entered into force on Jul. 1. 2011, including the Act on Medical Activity<sup>12</sup>, and other regulations, particularly those, which are contained in Acts such as Act on Professions of Doctor and

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<sup>10</sup> This definitions of a patient is introduced by Art. 3, section 1, subsection 4 of the Nov. 6. 2008 Act on Patient's Rights and on the Patient's Rights Advocate (Dz. U. [Journal of Laws] 2009, No. 52, item 417).

<sup>11</sup> Close relatives are defined as the spouse, relative by blood or relative by affinity to the second degree in a straight line, statutory representative, a person who shares living with or a person indicated by the patient. Besides the entitlements stemming from the regulations of the Patient's Rights Act, this subject also has a right to receive the information on the patient's health status when the prognosis is not favourable, however the doctor limits the scope of the provided information. The guardian is a person who is, without a statutory obligation, taking care of the patient, who would require such care, regardless of his age, health status or psychological condition. Statutory representative of the patient has a basic right to accept the medical services and to receive information describing the patient's health, regarding the person of whom he takes care.

<sup>12</sup> This Act provides that, should the patient's status deteriorate, in a way that patient's life is in danger, or should the patient die, the person indicated by the patient or his statutory representative needs to be immediately informed about such an event (Article 28, section 1, subsection 1). The Right to be discharged at own request is granted to the patient or to his statutory



Dentist, or Act on Provision of Healthcare Financed from the Public Assets<sup>13</sup>. Out of all of the medical acts, solely the discussed amendment, which introduces the hospital's liability for the medical event, entitlement to request payment of damages or reimbursement has been granted for the patient's inheritors. As we know, the patient may pass his inheritance both to the statutory heirs as well as the heirs indicated in the testament. The legislator does not specify the heir, so the testament heir may also submit a request, and that heir is not always a member of the testator. This issue is also dubious within the civil dimension. The Act discussed here contains the entitlement to claim damages or reimbursement by the patient's inheritors, while Article 446 of the Civil Code entitles the closest family members (§ 4, § 3) or other relatives (§ 2) to submit similar claims. In practical terms this means that an "unknown person" may be the patient's inheritor. Such a person would be neither the patient's relative nor a family member, but would be entitled to submit a request to the voivodeship commission and to receive benefits due to the patient's death resulting from a medical event. In extreme cases one may imagine a situation, in which a foundation or other legal person, as testament inheritors, or even the Treasury or local government units, as the statutory inheritors, would gain entitlement to submit a respective motion.

And subject which is authorized to carry out the clarification procedures and to issue a relevant report is the Voivodeship Commission which deals with investigation of the medical events<sup>14</sup>. An insurer is also to be involved in the analyzed procedure. When it comes to the rules themselves, the insurer, with which the hospital managing subject signed the obligatory insurance agreement regarding the medical events that occurred during the term of that agreement, is the Party which is to pay the benefit for the applicant. The legal situation is interesting, since most of the hospitals are not insured within the scope of the medical events.

Anyway, the aim of the proceedings carried out against the hospital is to check, whether the event which was the cause of patient's injury, had a character of a medical event. Occurrence of a medical event may lead to both a monetary, as well as a non-monetary damage. In consequence, the Subject which is filing a relevant claim may claim damages which would be used to repair the financial loss and reimbursement, which is to compensate so called harm. In cases when liability for medical events emerges, determining the person who is directly responsible for the injury is of secondary importance. This liability is a liability of the hospital itself, which is represented by the head of the facility in the process of communication with the commission, which investigates the medical event. His responsibility will be considered both in case when the faulty procedures or decisions have been undertaken by the doctor, nurse, midwife, as well as in case, when these decisions have been made by any other subject, which provides health services within the area of the facility. It has not even been specified, whether that person should be working in a medical profession. Similarly, the hospital situation has not been differentiated, depending on the person who caused the injury – whether that person is an employee of the health facility or whether he is a so called contractor. Meanwhile, this issue may be important in case when there is an option of recourse claim

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representative (Art. 29., Section 1, Subsection 2), similarly as it happens in case of the right to refuse the potential autopsy (Art. 31, Section 2).

<sup>13</sup> The Act on Professions of Doctor and Dentists contains detailed provisions regarding the patient's consent, patient's statutory representative, and in case of the medical examination, this entitlement has also been granted for the actual guardian.

<sup>14</sup> Hereinafter referred to as the "Commission".

being issued against the direct perpetrator. The legislature did not notice that issue, probably assuming that all of the benefits stemming from medical events would be covered by the insurance company. In case when the guarantee amount is depleted, or in case when no obligatory insurance agreement exists for the patient, obligation of payment of damages or reimbursement is to be burdening the hospital in which the medical event took place. The lack of proper regulations may create a justified question, whether the medical facility, which has paid the specific benefit for the patient, would be entitled to any recourse claim against the responsible subject. Moreover, it is not relevant, from the point of view regarding the discussed liability, whether we are dealing with action which is not compliant with the current state of the medical knowledge or with the perpetrator's omission. It shall be assumed, however, that should the liability for the medical event arise, a causal relationship must occur between the action which is not compliant with the current medical knowledge and the patient's injuries, such as bodily damage, health disorder or death.

Temporary liability of the medical subject managing the hospital is limited by a double term<sup>15</sup>. The request, aim of which would be to investigate the circumstances of a medical event may be submitted within the term of one year, starting from the day when the person authorized to do so found out about the infection, bodily injury, health disorder or death of the patient. However, the term described above cannot be longer than 3 years, starting from the day when the medical event occurred. The legislature states that the beginning of the term is dependent on the moment of discovering the infection, bodily injury or health disorder, however, when it comes to the inheritors, no such a moment is defined, but a statement "or when a death of the patient took place" is used. Anyway, 3-year term has so called "absolute character". After it expires, one cannot request the investigation of the medical event to be conducted, which does not exclude a civil court way of solving the issue. After this term expires, the patient cannot, effectively, submit a motion in order to investigate the medical event. There are no legal obstacles for the patient to receive damages and reimbursement via the civil procedure, if term of 3 years, starting from the day when the patient discovered the injury and the person who is obliged to repair the damage, has not expired (art. 442<sup>1</sup> § 3, Civil Code)<sup>16</sup>. This right will be granted to the inheritor, who at the same time does not meet the requirements of the Article 446 of the Civil Code. The inheritor of the patient, who at the same time does not belong to the closest family members, will not be authorized to claim reimbursement for the incurred injury via the civil procedure.

Regardless of that, in case of the patient's death, the deadline for placing the request resulting from a medical event does not start until the inheritance procedure is finished (Art. 67c, section 4). The implemented solution means that the medical subject managing the hospital never knows, when the liability for the specific medical event is to expire. Similar doubt arises, when it comes to his insurer. In practical terms, the inheritors may delay the inheritance proceedings by many years, particularly in case when the shared inheritance is a beneficial situation for them. More problems will

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<sup>15</sup> It shall also be noted that, contrary to the provisions of the Civil Code, where an expiration term of the given claim is defined, the discussed Act introduces a deadline for submission of a request.

<sup>16</sup> In case of a person who is a minor, the injury repair claiming period may expire earlier than in 2 years, starting from the moment when that person reaches the age of 18 (art. 442<sup>1</sup> § 4, Civil Code).

emerge in a situation, when the inheritance procedure is being prolonged by the conflicts between the inheritors.

The amount of the claimed damages or reimbursement needs to be indicated by the entitled subject in a request submitted to the voivodeship commission which investigates the medical events. However, the amount of the benefits to be received is strictly limited within the statutory framework. Article 67 section 7 of the Act on Patient's Rights indicates the maximum level of the benefits due (damages and reimbursement). The amount is, within 12 month period of insurance, with a reference to any medical events covered by the insurance, as much as PLN 1 200 000, and in case of infection, bodily injury or health disorder, the amount is smaller – PLN 100 000. In case of his death, the amount constitutes maximally PLN 300 000. In both cases, the amount is related to a single patient. The way this regulation reads means that in this case, we may see an indirectly introduced guarantee amount. Meanwhile, should the indicated amount be depleted, or in case when the obligatory insurance agreement is not made, the medical subject, which manages the hospital, is bound by the results of the investigation carried out by the commission, which means that it is obliged to present its own proposal regarding the payment of the proper benefit for the patient (Article 67 k section 10). If, within the term of 30 days, starting from delivery of the investigation results that indicate the medical event, the managing party does not present its own conditions, it is obliged to pay the amounts indicated in the application, but this amount shall always be contained within the statutory limits. As a result of that, the regulations which define the maximum amount of the benefits paid for the patient or his inheritors, not only may define the range of the amount liability of the insurer, but also apply in case of the medical entity itself. In both cases, presenting a specific proposal or payment of damages or reimbursement does not mean that the claim is accepted for the purpose of claiming damages within the scope of the civil procedure.

### **6. Insurance of the medical subject managing the hospital**

Strict liability of the hospital was to be mitigated by the obligation of having proper insurance<sup>17</sup>. Within the scope of liability for occurrence of a medical event, the insurer is bound by the results of the investigation carried out by the Commission. With the help of the Commission, within 30 days period, starting from the delivery of the investigation results, regarding the medical event, which have been issued as a result of a request for reconsideration of the case or starting from the day of receiving the notification about ineffective expiration of the term, which was needed to submit such an application, the insurer is obliged to present a proposal of damages and reimbursement to the entitled party. This option must be contained within the statutory limits. According to Article 67 k section 9 of the Patient's Rights Act, a presentation of a relevant proposal or payment of the damages or the reimbursement does not mean that the claim would be accepted within the scope of the purpose of claiming damages in a civil procedure.

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<sup>17</sup> Introduction of the new type of insurance has also caused changes in the new regulations of the May. 22. 2003 act, regarding the compulsory insurance, Insurance Guarantee Fund, and the Polish Motor Insurers' Bureau (Dz. U. [Journal of Laws] No. 124, item 1152, with further amendments). In case when the investigation points out that a medical event took place, the insurance company pays the damages or reimbursement due to the compulsory insurance, on the basis of acceptance of the claim of the insured person, stemming from the insurance agreement, resulting from the settlement made with the insured person, final judgement of the court, or in a way defined by the regulations of the Nov. 6. 2008 Act on Patient's Rights and Patient's Rights Advocate (Article 13, section 1).

As a result, submitting the discussed proposal by the insurer will not be an obstacle to questioning the liability of the insurer during the court proceedings<sup>18</sup>.

If the insurer does not present the damages or reimbursement proposal, within the indicated period of time, he is obliged to pay these amounts in accordance with the sums defined by the application. Instead of the stance taken by the insurer, the commission issues a certificate, according to which the application has been submitted to investigate the medical events, sets the amount of damages or reimbursement, and indicates that no proposal has been made by the insurer. Article 67 k section 4 of the Patient's Rights Act is the most surprising, since such a certificate constitutes an instrument permitting the enforcement. In this case, regulations of the section II, of title I of the third part of the Code of Civil Procedure are used.

However, response of the Party which submits that request is of a decisive value here. This subject, within the term of 7 days starting from the moment of receiving the proposal, submits a declaration for the insurer, stating whether the proposal is accepted or rejected. Should the proposal be accepted, another declaration is submitted, according to which the subject drops all the claims regarding damages and monetary reimbursement related to the injury incurred, which would stem from the events which have been established to be the medical events by the commission, within the scope of the injuries which have been found, starting from the day of submitting the application<sup>19</sup>.

The presented procedure, after the investigation carried out by the Voivodeship Commission Investigating the Medical Events the insurer may offer any amount, even a very small one, stating that the injury was insignificant. The applicant may not accept the amount of benefits proposed as a result of the investigation, and the investigation related to the medical event would be virtually insignificant. It is also unclear, which subject, shall cover the costs of the investigation carried out by the commission in a case of rejection of the amount of benefit proposed by the insurer. However, this situation is not described by any of the cases defined by the hypothesis stated by Art. 67 and sec. 3 of the Patient's Rights Act.

As it is pointed out above, insurance related to the medical events has been made compulsory. Many hospitals though, have not concluded a relevant insurance agreement due to the amount of the insurance premiums and lack of financial assets needed to cover these costs. Resulting from that situation, the legislative body has changed the type of these insurance policies – now they are not compulsory, they are voluntary. This change is only temporary. The legislator stated that, starting from Jan. 1. 2013., the insurance was to have compulsory character again. A variety of variants of the new insurance were outlined<sup>20</sup>. Next, that deadline was prolonged until Dec. 31. 2014, in order to extend the optional character of the medical events insurance until Dec. 31. 2015. According to the current solution, this insurance is to become compulsory, starting from Jan. 1. 2016. At the same time it has been stated that conditions of that insurance cannot be random, particularly when it comes to the guarantee amount. The solution proposed by the legislator is to calculate the insurance amount with a reference to all of the events at the hospital,

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<sup>18</sup> In case when the same insurer made the Civil Liability insurance agreement and the patient's insurance agreement with the medical subject.

<sup>19</sup> The declaration submitted by the inheritor, who is representing the remaining inheritors shall be effective against these subjects.

<sup>20</sup> More information on that issue: M. Serwach, *Problematyka zdarzeń medycznych w praktyce orzekających komisji, podmiotów leczniczych oraz ich ubezpieczycieli* [Problem of medical events in practice of the Investigation Commissions], *Wiadomości Ubezpieczeniowe* 2012, No. 4.

results of which are covered by the insurance Agreement in relation with the number of beds and sum of insurance, with a reference made to a single hospital bed. Amount of insurance, related to a single hospital bed, is no less than PLN 1000. Should the medical entity be in possession of accreditation certificate, in line with the Nov. 6. 2008 Act, regarding the healthcare accreditation procedures<sup>21</sup> within the scope of hospital therapy, then the amount of insurance, related to a single hospital bed, is reduced by 10%. Another solution proposed by the legislator is to introduce so called aggregated franchise, integral in an indicated amount which is not smaller than 50% of the total insurance amount. Additionally, it is possible to introduce the third solution into the medical events insurance – proportional contribution of own medical facility, with set value, which is not to be higher than 50% of the insurance fund.

While comparing the solutions adopted in Poland and other European legal systems, particularly considering the Swedish and the French models, one should state that the Polish system has a 'mixed' character. The legislator, by not wanting to expand the scope of responsibility of the medical facilities, and by acting in line with the patients' interest, has introduced patients' insurance based on the Swedish model. However, by changing the profile of this insurance, from obligatory into based on good will, the responsibility has been expanded to the level compliant with the French model. Meanwhile, the adoption of a unified concept and refining the regulations related to the proceedings in front of commission would indeed have a potentially beneficial impact on the situation of all the concerned subjects: patients, medical facilities and their insurers.

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<sup>21</sup> Dz. U. [Journal of Laws] 2009, No. 52, Item 418 and No. 76, Item 641 and 2011, No. 112, Item 654.