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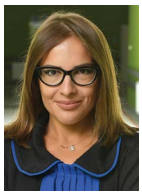
Physician's legal liability for making a patient becomes infected with SARS-CoV-2

Odpowiedzialność prawna lekarza za zakażenie się pacjenta SARS-CoV-2



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Abstract

The coronavirus epidemic, lasting from the end of 2019, which quickly gained proportions and the status of a pandemic, has changed the reality in health care for a long time, not only radically testing the endurance of medical personnel and the efficiency of the health system, but also forcing its significant and immediate rearrangement. In the period of the greatest number of infections, in view of disease outbreaks in healthcare facilities, a decision to limit access to health care services both in a timely justified for health reasons (postponement of scheduled admissions) and in a medically optimal form (telephone medical advice) could expose a patient to negative health effects, even though it was epidemiologically justified. The choice between epidemiological risks and patient's exposure to health consequences due to failure to provide a health care service on time or form was burdening managers of healthcare facilities and their medical personnel. In the light of the above, a decision to provide a health care service as part of hospitalisation was inherently associated with an increased risk of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection during a hospital stay, which justifies the legal analysis of the possibility of classifying SARS-CoV-2 infection as hospital-acquired infections and all legal consequences related to them.

Key words: coronavirus infection, hospital-acquired infection, infection prevention, infection combating

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Introduction

Due to the new epidemiological realities in which it has become necessary to provide health care services of all kinds under the conditions of a pandemic, a dynamic arrangement of the various stages of the process of providing health care services became justified [1]. It was subject to significant changes through the spread of telephone medical advice, transformation of health care facilities into single-name hospitals, creating so-called temporary hospitals, or implementing new standards of medical procedure in the field of preventing and combating severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection. It also turned out to be necessary to limit certain rights of patients, including the right to contact with relatives and access to health care services. According to the Report by the Patient Ombudsman [2], the number of written petitions submitted to this authority

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in September 2020 was 1 063. In the corresponding period of 2019, it was 482. Among the petitions submitted from January to September 2020, 71% was concerning the restriction of the right to health care services or their improper implementation in health care facilities; another 29% was connected with objections against a long waiting time for specialist services, comprehensiveness, and diligence of the health care services provided, as well as limited access to diagnostics. Among the petitions addressed to the Patient Ombudsman's Office and directly to health care facilities, there were also requests for explanations of circumstances of patients' infections with SARS-CoV-2 during hospitalisation caused by another disease. Currently, the first payment requests are recorded in health care facilities, which are an announcement of future civil actions for payment or notifications to law enforcement authorities regarding SARS-CoV-2 infection during a stay in hospital related to routine treatment or elective surgery.

SARS-CoV-2 hospital-acquired infection

Pursuant to Art. 2 sec. 33 of the Act on preventing and combating infections and infectious diseases in humans [3], a hospital-acquired infection is an infection that occurred during the provision of health care services when a disease is not in a period of incubation at the time of or does not occur after providing health care services in the period not longer than the longest incubation period. In the light of the presented legal definition, a hospital-acquired infection may be a consequence of a lack of diligence in performing medical procedures, non-compliance with current medical knowledge, as well as a result of the improper organisation of the process of providing health care services in a health care facility. The risk of coronavirus infection in connection with a stay in a health care facility in 24/7 conditions was associated with several factors.

Firstly, health care facilities did not have a sufficient number of single-person rooms, isolation rooms, airlocks, and other spatial conditions which would allow optimal isolation of patients with suspected infections, especially since the number of so-called asymptomatic patients made every patient a potential suspect of infection, although not everyone exhausted a legal definition of a suspect within the meaning of the Act on preventing and combating infections and infectious diseases in human [4].

Secondly, the specificity of SARS-CoV-2 infection and a significant number of asymptomatic patients supported the use of polymerase chain reaction (PCR) testing method [5], which, thanks to greater sensitivity, can definitely more accurately verify the epidemiological status of a patient, whereas this type of test is not always possible due to the need to immediately provide the patient with emergency medical care. For these reasons, antigen tests have become the more commonly used diagnostic method in hospital emergency departments and emergency rooms [6]. At the same time, a patient who was hospitalised in an emergency mode of hospital admission and was diagnosed and subjected to various types of medical procedures, after disclosing the fact of infection, he or she was subjected to isolation procedures. However, it was not possible to remove the epidemiological effects of his or her diagnosis and treatment in the structure of the entire health care facility in light of the previously performed antigen test of lower sensitivity.

Thirdly, there were frequent cases of testing results, the so-called false negative or false positive ones [7], initially implying a specific procedure which then turned out to be incorrect. Finally, the possibility of coronavirus infection was much more likely than in the case of a typical hospital-acquired infection, in which the particular risk was associated primarily with surgery or other invasive procedures, while in the case of SARS-CoV-2, the possibility of infection was associated with the usual contact with a patient [8], and therefore, it was particularly difficult to avoid, even with due diligence.

Specificity of evidence proceedings in cases for an infection

Pursuant to the provision of Article 6 of the Civil Code, the burden of proving the fact lies with the person who derives legal consequences from it. In the case of lawsuits related to infection with a biological agent, the jurisprudence assumes that it is sufficient for the affected person to substantiate the possibility of a medical error because his or her demonstration of the premises of the responsibility of a health care facility is an extremely difficult and sometimes even impossible task due to the properties of the biological processes involved. The existence of a causal link between a triggering event and damage, as a rule, cannot be certain, as far as human health is concerned, since the links occurring in the field of medicine cannot be reduced to a simple result of one phenomenon from another. Therefore, it would be unrealistic for a significant number of cases to require absolute certainty of the existence of a causal link [9].

An infection of a patient during his or her treatment at hospital may mean that the hospital has not provided the patient with a safe stay. Failure to comply with this obligation usually proves that there has been negligence in maintaining epidemiological standards and it is considered to be an organisational fault of a health care facility [10]. In the case of hospital-acquired infections, hospital's negligence may be assumed as a factual presumption which results in shifting the burden of proving that the infection did not occur as a result of failure to exercise due diligence

or the standards of current medical knowledge to the health care facility which is then required to demonstrate that the infection did not occur as a result of circumstances for which it is responsible [11]. Among the premises justifying the application of a presumption that a patient is infected, the following are mentioned: the fact that a patient was not infected with a pathogen at the time of hospital admission; other cases of infection are discovered at the same time and in the same hospital; negative sanitary and epidemiological assessments, failure to comply with the cleanliness requirements of medical equipment and personnel; a "hospital-acquired" or "community-acquired" type of bacteria causing a disease; no information about the fact that members of patient's family had previously suffered from a disease caused by such infection; the lapse of time from the stay at hospital to the discovery of symptoms of infection, corresponding to the incubation periods of the disease accepted in medicine. In practice, the above-mentioned circumstances are considered to increase the probability of infection of a patient in a specific hospital and, therefore, justify the presumption that the infection occurred in that facility [12].

The assessment of the organisation of the provision of health care services in the time of a pandemic must include both the organisational aspect of the functioning of a health care facility as well as due diligence in dealing with patients. As part of the prevention of the spread of infections, the first thing that can be indicated is the possibility of conducting laboratory screening tests, excluding SARS-CoV-2 infection at the stage of admission to hospital, which, however, is only possible with regard to elective medical procedures and allows for limiting the risk of hospitalisation of an infected person but not its complete elimination. Limiting the possibility of contacts between patients seems justified to the extent permitted by the current conditions of premises of a given health care facility, but the real possibility of ensuring epidemiological safety in this way before the outbreak of a pandemic existed only in infectious wards, where the standard of rooms provided for the arrangement of solitary confinements, which is not required or practised in other hospital wards and has been ad hoc introduced by the legislator in the requirements for the so-called temporary hospitals [13]. A standard of conduct is also using personal protective equipment and the applicable standards of conduct by medical personnel in the field of preventing and combating infections, resulting from the current suggestions and recommendations of relevant entities [8, 14–17]. All methods of preventing SARS-CoV-2 infection in hospitals do not guarantee that the effect would not occur in the form of an infection, but only reduce the probability of its occurrence, so the obligation to prevent this effect is a duty of careful action, not a result.

Conclusions

The assessment of whether a patient was infected with SARS-CoV-2 in connection with a hospital stay has been the fault of a health care facility, will require proving that this type of damage occurred as a result of failure to exercise due diligence or as a result of non-compliance with current medical knowledge. However, if organisational conditions of patient's stay, a diagnostic and treatment process and the conduct of medical personnel are in accordance with the current standards and are not negligent, the occurrence of infection will not result in hospital's liability, because it is not responsible for the result of non-infection but for due diligence in preventing it. Therefore, despite the observance of all procedures and due diligence, an undesirable event may occur, for which no one will bear responsibility. A physician is obliged to use available methods of prevention and treatment; therefore, his or her responsibility is derived from the means at his or her disposal, and this availability should be assessed in terms of medical, organisational, and economic availability. Due to the global nature of the pandemic, medical knowledge about coronavirus infection is global and is subject to dynamic changes, and the subsequent methods of preventing and combating SARS-CoV-2 are universal and widely available, which makes their use largely a global standard to be followed by health care facilities and medical personnel, and the compliance with it will ensure the possibility of exculpation, regardless of whether the prevention of infection is effective in each case.

Conflict of interest

None.

Funding

None.

Streszczenie

Trwająca od końca 2019 roku epidemia koronawirusa, która rychło zyskała rozmiary oraz status pandemii, na długo odmieniła rzeczywistość w ochronie zdrowia, nie tylko radykalnie testując wytrzymałość personelu medycznego oraz wydolność systemu, ale także wymuszając jego istotną, doraźną reorganizację. W okresie największej liczby zachorowań, zważywszy na ogniska zakażeń występujące w podmiotach leczniczych, decyzja o ograniczeniu dostępu do świadczeń zdrowotnych, zarówno w uzasadnionym ze względów zdrowotnych terminie (odroczenie przyjęć planowych), jak i w optymalnej medycznie formie (bezpośrednie badanie względem teleporady), mogła narazić pacjenta na ujemne skutki zdrowotne, będąc wszakże epidemiologicznie uzasadnioną. Wybór między ryzykiem epidemiologicznym a narażeniem pacjenta na konsekwencje zdrowotne z powodu nieudzielenia świadczenia w odpowiednim czasie lub formie obciążał kierujących podmiotami leczniczymi i personel medyczny. W świetle powyższego decyzja o udzieleniu świadczenia zdrowotnego w ramach hospitalizacji była nieodłącznie związana ze zwiększonym ryzykiem zakażenia koronawirusem zespołu ostrej niewydolności oddechowej 2 (SARS-CoV-2) podczas pobytu w szpitalu, co uzasadnia prawną analizę możliwości kwalifikacji zakażenia SARS-CoV-2 jako zakażenia szpitalnego i związanych z tym konsekwencji prawnych.

Słowa kluczowe: zakażenie koronawirusem, zakażenie szpitalne, zapobieganie zakażeń, zwalczanie zakażeń

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