MEDICAL LIABILITY IN ITALY. WALKING THROUGH THE MALPRACTISE PROCESS

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The subjet of my speech evokes the theme of the c.d. “medical malpractice”; a theme of strong media impact, which deserves a more careful reflection and more rigorous interpretation.

It is necessary to carry out an analysis that is not conditioned by the inevitable suggestions solicited daily by mass media.

I thought it appropriate to verify what is a deep personal conviction gained during my professional experience: the spread of the phenomenon of unfounded complaints that has found widespread in our country especially in the 1990s and early 2000.

The figures for the reference period are surprising:

-Forty doctors reported every day, with an average of 15.000 cases for year;

-Every Italian doctor has – in twenty years of activity – 80% of probability of having to face a process.

The categories most at risk are: orthopedics, gynecologists, obstretricians, anesthesiologist, general surgeons.

Only 25% cases of professional misconduct are convicted and three out of four doctors are acquitted.

Very few, them, in proportion the judgments that come to the scrutiny of the Court of Cassation.

This is of absolute importance and, in some respects, very comforting for the citizen, because it shows that the Italian medical class, as a whole, has a high degree of preparation.

On the other hand, the phenomenon of spreading unfounded complaints is disheartening, that end up producing considerable personal costs due to the serious damage to the image and the consequences on personal balance or on the existential level of unjustly prosecuted professionals; without saying, then, the inevitable effects induced by rising costs on health expenditure that is constantly growing.

More in our penal system when a complaints is filed for medical fault due to practice the Public Prosecutor tend to enter in the register of suspects all the doctors listed in the medical records seized; this to prevent the first investigations and, therefore, also the autopsy are not usable against some sanitary that then turns out to be guilty.

The excessive number of criminal complaints has led to another consequence: the use of so-called defensive medicine

The doctor's concern to be subjected to a criminal trial often leads to health:

- or to prescribe visits, examinations and treatments not strictly necessary in the specific case but only for precautionary purposes (positive defensive medicine);
- or to avoid patients or high-risk treatments, adopting abstentionistic attitudes, such as the non-acceptance of patients with rare or extremely complex pathologies (negative defensive medicine).

The use of defensive medicine has obvious negative effects on the health of patients as the doctor does not merely balance risks and benefits for the patient, but is also assesses its own risk of being subjected to criminal proceedings, and is ultimately conditioned by that fear.

One wonders what are the causes of such a high number of complaints and trials against health care workers and such a large number of acquittals.

I would be inclined to believe that there is a marked speculative component and an attempt to exploit the prosecution to obtain substantial compensation, in the belief that the criminal process can give more immediate and effective answers than the exercise of the action in civil.

I believe – however – that this speculative intent fails to explain the scale of the phenomenon.
There is a more subtle and profound reason for modern man's present attitude towars illnes and death.
From the total acceptance of death by primitive cultures we have passed to a pervasive and subtle refusal to die.

In this way, the conviction has been rooted – encouraged also by scientific progress - that medicine cannot but “must” abolish suffering (that is, disease) and in the perspective death.
It has been forgotten that the activity of the health care provider is a means and not a result.

Grounding in the collective consciousness of this misconception gives patients and the members of their families a sense of revenge in the event of failure to heal or death.
In my opinion, this is the reason for the large number of unfounded complaints.

Given this premise on the genesis of the phenomenon, I would like to move on to address the evolution in Italy of the criminal trial for medical responsability in recent decades, starting from the analysis of the conditions for the affirmation of a criminal responsability.

Criminal liability presupposes the violation of a criminal precept.

Normally the legislator expresses judgments of value and criminally sanctions those behaviors that attack the legal goods, that in a certain historical period are considered worthy of inhanced protection.

The doctor must be called to account for his professional conduct when this does not conform to the rules of art, but not all interventions to which healing does not result are relevant to criminal law.

And, indeed, the Italian penal system is conformed to the principle of stricness and determination.

According to these principles to criminaly sanction the diagnostic or therapeutic error of the doctor is necessary that it not only causes damage but also integrates all the details of the crime-fact.

The doctor’s professional responsability involves, indeed, a number of numerous crimes but the two most recurrent indictments in the judicial cases of the professional responsability of the doctor are represented by: manslaughter ad negligent injury.

Reporting the speech in the specific area of our interest we can say that in order for the criminal responsability of health care to arise in addition to the error of diagnosis and therapy two other essential elements are required:

- there must be a causal link between the technical error and the harmful or lethal event;
- it is also necessary for the behaviour of the doctor to be characterised by the psychological element of guilt.

The error may result from omission of the hospital or improper actions and may depend on inexperience, carelessness or negligence, or violations of rules, regulations and disciplines.

The issue of medical guilt has been subject to considerable differences of interpretation and has been the subject of various regulatory interventions.
Before the constitutional recognition of the right to health, the case-law used a yardstick of particular generosity in assessing the guilt of health care.

Starting from a unitary criterion of the concept of guilt – inferable from all the rules of the legal system – valid for both civil and criminal law, much of the doctrine and case law have been deemed applicable, also in the criminal filed, the principle contained in art. 2236 of the Civil Code, which regulates liability for professional negligence in cases where it is necessary to address the resolution of technical problems of particular difficulty and dictates the rule of judgment, according to which the person is liable only if he has acted with intent or gross negligence.

For a long time, therefore, the work of the doctor was evaluated only in cases of gross technical errors, having conformed the judges to the criterion of gross negligence.

With the evolution of medical science and – above all – with the introduction of the Constitutional Charter, which expressly provided for the protection and safeguarding of primary goods such as life and health, this principle of grave guilt has gradually crumbled.

A thesis has taken shape that has argued that the norm of which to art. 2236 of the civil code is an exceptional norm, which derogates from the normal criteria for assessing liability for fault and – therefore – cannot be applied beyond the mandatory cases for which it has been expressly provided.

This rule, therefore, would not apply in the assessment of criminal liability.

And, indeed, with the recognition of the assets life and health at the constitutional level, the jurisdiction has attributed to the doctor a function of guarantee with the correlative obligation to do everithing that science suggests to ensure the patient's health and avoid ill-fated events.

The analysis carried out so far clearly shows an extremely rigorous trend in the assessment of guilty in medical activity:

- considerable rigour in the assessment of negligence and recklessness;

- an almost categorical rejection of the application of the different degree of guilt because of the doctor's inexperience.

The jurisprudential contrasts and the excessive rigour of some interpretations have made to warn the requirement of the partecipation of the legislator,

In 2012 came into force the law “Balduzzi”, with which it was expected that “the practitioner of the health profession who, in carrying out his activity, adheres to the guidelines and good practices accredited by the scientific community does not respond criminally for the slight fault”.

Therefore the law in question excluded liability for slight negligence in the case of compliance with the guidelines and best practices accredited by the scientific community.

It did not, however, specify what those guidelines were.

Therefore, the best-known definition of the guidelines, namely the American Institute of Medicine, wa used.

On the assumption that the Law of 2012 did not bring significant improvements, in 2017 a further legislative amendment took place in the matter: the law “Gelli Bianco” came into force, which introduced innovations aimed at trying to balance the right to health with the right of the doctor to be able to carry out his professional activity with serenity in the exclusive interest of the patient.

In the criminal field, the most important novelty is represented by the introduction in the Code of art. 590 sexies, which in paragraph 2 provides that “If the event (death or injury) occurred due to inexperience, punishability is excluded when the recommendations of the guidelines, as defined and plublished by law, are complied with, or, in the absence of these, good clinical-care practices provided that the recommendations set out in those guidelines are appropriate to the specificity of the specific case”.

Therefore, the Institute of Health has been entrusted with the task of declaring what are the guidelines the observance of which is obligatory for the doctor in order to be able to invoke the cause of non punishable.

As noted by the Doctine, the precise identification of what are the guidelines on the one hand met the needs of certainty not guaranteed by the Balduzzi law, but on the other hand risks leading to the affirmation of a “state medicine” to the detriment of patients themselves.

In the light of the new law, the new cause of non criminality can be applied when the following three conditions are met:

- that the medical profession is guilty of negligence;
- has complied with the guidelines expressly set out in that standard;
- that the guidelines were appropriate to the specific circumstances of the case.

Based on my experience in medical fault trials, the real important novelty introduced with this latest law is represented by the obligation to always appoint, in the judgements of health responsability, a college of at least two consultants: a medical examiner and a medical practitioner specialising in the subject matter of the proceedings.

When I starded dealing with medical misconduct in the late ’90, the Public Prosecutor’s Office used to appoint only a coroner, who – as such – had no direct pratical experience but only theoretical knowledge.

This meant that the medical staff were often referred back to court, which were then acquitted at the outcome of the hearing as in the course of the same defense was able to demonstrate through their consultans specialists and experts in the specific subjet there were no criminal liability issues.

I must say that since the Public Prosecutor's Office has been appointing the specialist at the initial stage of the procedure in one to the coroner, the processes that are already defined in the investigation phase with a measure of archiving are considerably increased.
This avoids unnecessary, lengthy and burdensome judgments.

In conclusion, the different jurisprudential orientations that have occurred over time and the last two regulatory changes within a few years are indicative of how the issue of medical guilt is perennial topical in our country and still has not found a definitive resolution.

I believe that the approach to complaints of medical misconduct must be one of extreme caution to avoid bringing to the attention of the criminal Magistrate events that should find their epilogue in the civil headquarters

It would, however, be good practice before filing a complaint for a medical fault to submit medical records and all medical documentation available to a medical examiner and a specialist in the field in which the damage would have occurred to carry out a preliminary assessment of the existence of criminal liability profiles.

We should never forget the essentiality of the work of health professionals and how patient care needs a serene approach by the doctor, who should have as their only concern to make the best choice for their patient free from any conditioning or fear.