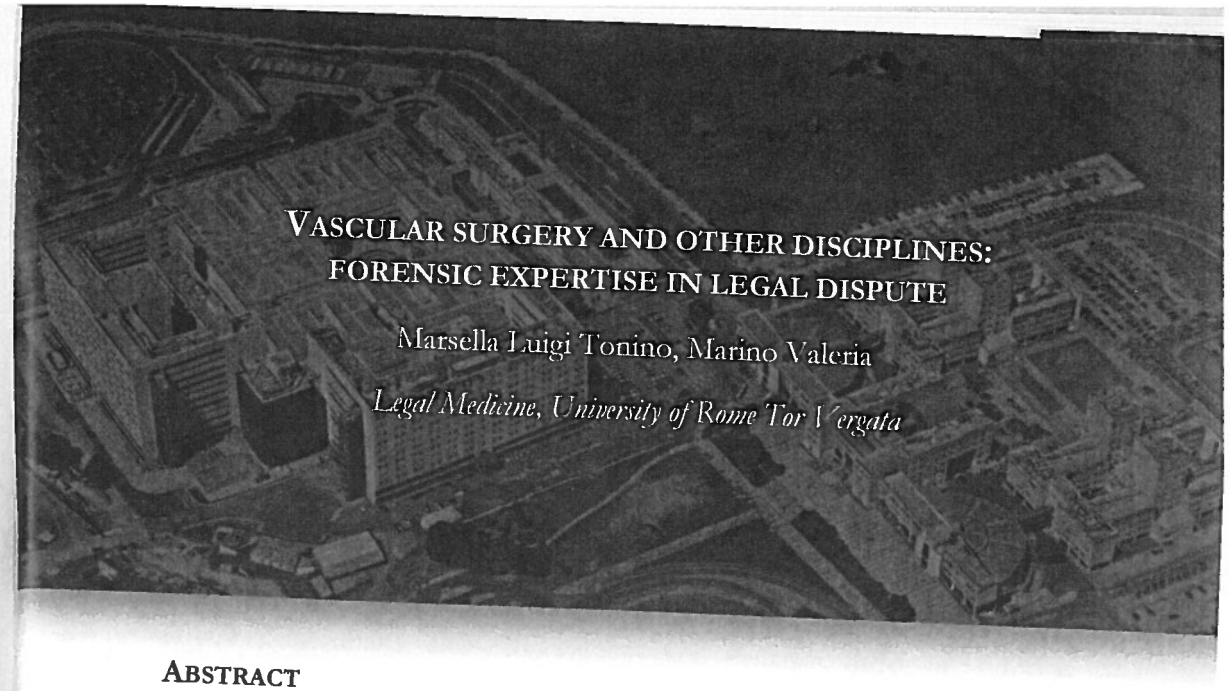

VASCULAR SURGERY AND OTHER DISCIPLINES: FORENSIC EXPERTISE IN LEGAL DISPUTE

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ABSTRACT

The issue of medical liability has taken in recent years an increasing importance, especially in light of recent legislative reforms. It is under this major evolution and change that the issue of so-called "defensive medicine" has gradually gained its own independent relief within the wide national debate on the subject of professional liability. In general, the medical liability system configures a composite and complex as his analysis must take into account not only the doctor-patient relationship, but also of the various relationships that are established between the patient and the many health professionals who contribute in the process of care. Health services, in modern hospitals, in fact, are characterized by being carried out not only by a physician, but by a more systematic collaboration between doctors, and between them and the paramedics. This complex system ensures that in the event of a negative outcome of the medical treatment poses the question of whether, and to what extent, the individual doctor can answer for the wrongful conduct related to other members of the team or the extent to which extend the its duty of care, skill and prudence when it is operating in conjunction with other subjects. With regard then clinical practice, another important hub in the field of medical liability consists of the application of the guidelines in clinical practice and the related implications of forensic. The theme is expressed, with many judgments, the Supreme Court and again, this issue is the focus of much debate, deserving careful examination.

INTRODUCTION

The issue of medical liability has taken in recent years an increasing importance, especially in light of recent legislative reforms. The evolution, both doctrinal and jurisprudential, involved a significant discipline on the subject, which has become increasingly complex and articulated and which has now accumulated a vast bibliography. It is under this major evolution and change that the issue of so-called "defensive medicine" has gradually gained its own independent relief within the wide national debate on the subject of professional liability. Defensive medicine is a "bad medicine" that is expressed in two different ways: from a high set in motion over-performance and diagnostic and therapeutic actions superfluous, the other determines the waiver by the doctor to take a therapeutic complex to avoid a possible litigation. It is commonly sectors "increased risk" (emergency medicine, orthopedics, surgery, gynecology-obstetrics, anesthesia-resuscitation) or characterized by a marked incidence of litigation with repercussions for damages of very high magnitude. The scientific literature concerning the medicolegal implications of Vascular Surgery is relatively low, however, given the insurance premiums for professional liability according to specialty, it can be considered a branch of "high risk" of complaints. The reasons for this data reside on the one hand the very nature of specialties characterized by an intrinsic danger on the other by the complexity of the cases in which the vascular surgeon is to act together, often with other surgical disciplines and not.

In general, the medical liability system configures a compound and complex as his analysis must take into account not only the doctor-patient relationship, but also of the various relationships that are established when a person is the recipient of medical services of all kinds, (diagnostic, preventive, hospital, therapeutic, surgical, aesthetic, etc.) provided by one or more physicians as well as by personnel with other professional. Health services, in modern hospitals, in fact, are characterized by being carried out not only by a physician, but by a more systematic collaboration between doctors, and between them and the paramedics. Whether it's surgical activities, whether it be the care of patients in specific departments, the health activity is a set of pathways and processes of diagnosis and treatment, a combination of

professionalism, autonomy and responsibility of different, interdependent between them.

In order to enable individual professionals to work independently, each according to their skills, and at the same time to cooperate to achieve the end unit of the care and protection of health of the patient, it is essential that health activities are organized in units operational / collaborative. This multi-disciplinary collaboration or cooperation can be effected before or later; in the first case, typical of the surgery group or collaborative, the collaborative contribution of individual health care, whether it be scientific (anesthesiologists, surgeons etc.) or merely auxiliary (nurses etc.), is integrated into each other one temporal context; in the second case, the diagnostic or therapeutic is developed through a series of scientific and technological activities, temporally and functionally successive turns to the achievement of the desired result.

THE RESPONSIBILITY OF TEAM

This complex system ensures that in the event of a negative outcome of the medical treatment poses the question of whether, and to what extent, the individual doctor can answer for the wrongful conduct related to other members of the team or the extent to which extend the its duty of care, skill and prudence when it is operating in conjunction with other subjects.

From a doctrinal point of view the main distinguishing feature of the working relationship is represented by the *principle of trust* that builds on the possibility for each of the team members, to rely on the correctness of the conduct of his colleagues, all required to comply with the precautionary rules of the medical art, that is, to fulfill its performance with due diligence, prudence and expertise, so that every member of the team can do "rely" on the proper execution of the task by every colleague. However, this principle applies in the case of "split duty", that is differentiated according to the specific rules precautionary reference, may not be applicable in the event of *common duties*.

In this regard, the Supreme Court has repeatedly stated that in principle any health should also check the work of other colleagues, by removing obvious errors and not sectoral. According to the Court of Cassation, the single member of the burden is the duty of care and prudence task-related expertise of its relevance, and the obligation to evaluate the work of other

colleagues, although specialists from other disciplines, checking and by removing the errors committed by them if they are amendable with the common knowledge of the average professional[58].

This obligation continues even control the post-operative phase, during which the doctors have an obligation of health surveillance patient. As regards, moreover, the "dissolution of the team operating", if it occurs in a phase of the intervention in which the residual only "requirements of maximum simplicity," is admitted and allows to exclude the blame for negligence (and consequently the incidence which caused the damage) of the doctor who left the team in advance, unless it is a high-risk intervention and that the removal is justified by compelling professional needs.[3]
It is also necessary, in order for a correct assessment of the matter, find the one that is of apical function, both as team leader or primary, with the task of supervising and coordinating the work of other specialists, and to determine to what extent it is legitimate due to primary or team leader is responsible for the performance taken from one of the doctors or health professionals working in a given surgery. The Court's legitimacy has been expressed about saying that the head of the operating team holds a position of security and medical employees of the primary must follow the orders received, with the obligation, if deemed harmful, motivated to express dissent. So if the primary aid and assistant share treatment decisions, together assume responsibility; when instead the assistant or the aid does not share the primary treatment choices, they can go free from liability only if done so to report to the same primary withholding unsuitability or risk choices, could otherwise incur the crime of cooperation crime manslaughter, in art. 113 Criminal Code, since the hierarchical subordination does not justify the failure to distance itself from a practice deemed wrong, having each operator is obliged to express their dissent. [4]

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[58] Cassazione penale IV sezione, sentenza n. 24036 del 26 maggio 2004, stato poi ribadito ulteriormente da Cass. Pen., Sez. IV, 6 ottobre 2006, n. 33619.

THE GUIDELINES IN CLINICAL PRACTICE

Another important hub in the field of medical liability consists of the application of the guidelines in clinical practice and the related implications of forensic. The guidelines and documents produced by scientific societies represent an extremely useful tool in medical practice as they allow rapid transfer of knowledge developed in research to health professionals; They are thus intended to facilitate and support the formation of a clinical judgment that however will be diversified depending on the case concerned. The guidelines, therefore, qualify as *"suggestions for the guidance of health behaviors that need to be put in place in relation to specific cases"* (See., Cass. Pen., Sec. IV, sent. June 14, 2006, n. 24400).

It is up to the doctor, in view of his expertise and his experience, assess the extent to apply in the individual case the recommendations in the guideline reference place that they refer to a situation of the population and should therefore be interpreted with intelligence and applied with adequate judicious.

With regard then to the implications in terms of professional liability in the cases of application of the guidelines in medical practice you can say that in general they "can not provide absolute indications for the appreciation of any responsibility, both for the freedom of treatment that characterizes the activities of a doctor, and because, in some cases, the drafting of the same can be affected by reasons related to the containment of health care costs or because they are objectively controversial and not universally shared. The doctor is required to exercise choice considering the unique circumstances that characterize the case and the specific situation of the patient, respecting his will, beyond the rules crystallized in the medical protocols. "[2]

The theme is expressed, with many judgments, the Supreme Court stating that "*There can be no immunity for the fact that you have followed the guidelines or protocols have been followed if the doctor has not negligently made the choice in concrete was necessary. This, above all, when the guidelines followed are objectively inspired to meet only the needs of 'economic management' or when these become apparent objectively obsolete, outdated, even controversial.* "[2]

The position of security that takes the doctor to the patient shall require it not to respect those directives where they are inconsistent with the requirements of care of the latter. The adhesion of healthcare to these parameters does not eliminate even the discretion inherent in the

judgment of guilt, for which the judge is free to assess whether the actual circumstances' requiring a conduct other than that prescribed in the protocols.

However, more recently there has been a significant turnaround the case law relating to medical professional liability as a result of the application of guidelines which is a crucial reference for defining the boundary between the risk inherent to medical practice and malpractice. In this case, the sentence no. 268 issued by the Fourth Criminal Chamber on 29.01.2013, the Supreme Court ordered that *"Under Article. 3 of Law no. 189/2012, the health care that you follow the guidelines and good practices of the medical treatment, as subject to careful scientific knowledge, respectful of the guidelines formed the same way as solid evidence of diagnostic confidence and free of temptations personalistic, will be held criminally responsible if his conduct is not characterized by mild fault "*. According to the principle mentioned, the conviction for manslaughter against the health professional was annulled by court: for the purposes of application of the rule occurred in favor, pursuant to art. 2, paragraph 2, of the Criminal Code, was, in fact, asked the trial court to review the case to determine if there are guidelines or accredited medical practices related to the execution of surgery in question; if surgery performed has moved within the boundaries marked by the Directives and, if so, whether the execution of surgery there has been negligence or serious.

The Supreme Court canceled and deferred sentence for manslaughter against a surgeon during the surgical procedure designed to correct a herniated disc relapsed, had accidentally cut some patient's blood vessels, causing bleeding from 'fatal. The case was then referred to the Judge about to see if there are guidelines or medical practices accredited and best known of the scientific specialties pertaining to the type of surgical procedure, in order to determine whether it is mild or severe fault.

The practical application of art. 3 of the law 8 November 2012 n. 189 has, therefore, determined the decriminalization of medical professional liability in case of slight negligence only in the event that the health operate within the guidelines marked by virtuous or medical practices, provided that they are accredited by the scientific community, still provided, however, the obligation under Article. 2043 of the Civil Code.

At the same time, however, the guidelines are not regarded as "precautionary rules preconceived", such as falling within the concept of "specific fault" under art. 43 Criminal Code, but must be applied by the doctor when the case requires it.

REFERENCES

[1] E. Roche et Al.: Professional Liability Claims in vascular Surgery Practice. Ann Vasc Surg. 2014 Feb; 28(2):324-9.

[2] Cassazione penale IV sezione, sentenza n. 24036 del 26 maggio 2004, stato poi ribadito ulteriormente da Cass. Pen., Sez. IV, 6 ottobre 2006, n. 33619.

[3] Cass.pen., sez. V, 30 marzo 2005, n. 12275.

[4] Cass. Pen., sez. IV, 16 giugno 2005, n. 22579.

[5] Cass. Pen. Sez. IV, 5 ottobre 2000, n. 13212.

[6] Cass. Pen., Sez. IV, 19 dicembre 2000, n. 1736: "Nell'ambito di una equipe medico-chirurgica, nel caso in cui l'assistente (o l'aiuto) non condivida le scelte terapeutiche del primario che non abbia esercitato il suo potere di avocazione, il medico in posizione inferiore, che ritenga il trattamento terapeutico disposto dal superiore costituire un rischio per il paziente o essere comunque inidoneo per le sue esigenze terapeutiche, è tenuto a segnalare quanto rientra nelle sue conoscenze, esprimendo il proprio dissenso con le scelte dei medici in posizione superiore; diversamente egli potrà essere ritenuto responsabile dell'esito negativo del trattamento terapeutico, non avendo compiuto quanto in suo potere per impedire l'evento".

[7] Cass., sez. IV pen., 29 gennaio 2013, n. 16237.

[8] Cass. Pen., Sez. IV, sent. 11 luglio-19 settembre 2012, n. 35922; in senso conforme, Cass. Pen., Sez. IV, sent. 16 marzo 2010, n. 10454; Cass. Pen., Sez. IV, sent. 23 novembre 2010, n. 8254; Cass. Pen., Sez. IV, sent. 5 giugno 2009, n. 38154; Cass. Pen., Sez. IV, sent. 24 febbraio 2000, n. 6511.

[9] Art. 3 Legge 08 novembre 2012 n. 189 (di conversione, con modificazioni, del Decreto Legge n. 158/2012, recante *"Disposizioni urgenti per promuovere lo sviluppo del Paese mediante un più alto livello di tutela della salute"*): *"L'esercente le professioni sanitarie che nello svolgimento della propria attività si attiene a linee guida e buone pratiche accreditate dalla comunità scientifica non risponde penalmente per colpa lieve. In tali casi resta comunque fermo l'obbligo di cui all'art. 2043 del codice civile. Il Giudice, anche nella determinazione del risarcimento del danno, tiene debitamente conto della condotta di cui al primo periodo".*

Bibliography

[1] Chindemi D., *Responsabilità del medico e della struttura sanitaria pubblica e privata.* Altalex Editore, 2014;

[2] Genovese U., Mariotti P., Zoja R., *Le linee guida e la responsabilità sanitaria Alla luce della Legge "Balduzzi".* Maggioli Editore, 2013;

[3] Mariotti P., Genovese U., *Responsabilità Sanitaria e Medicina Difensiva.* Maggioli Editore, 2013;

[4] Cataldi R. et Al., *La responsabilità professionale del medico tutela civile e profili penali.* Maggioli Editore, 2009;

[5] Fiori A., Marchetti D., *Medicina legale della Responsabilità Medica: Nuovi Profili.* Giuffrè Editore, 2009;

[6] Norelli, Giannelli, Mazzeo, La responsabilità penale nel lavoro medico chirurgico di equipe. Tegete, 2004;

[7] E. Roche et Al.: Professional Liability Claims in vascular Surgery Practice. Ann Vasc Surg. 2014 Feb; 28(2):324-9;

[8] Feola A., Marino V., Marsella L.T., *Medical Liability: The Current State of Italian Legislation.* European Journal of Health Law 2015; 22 (4): 347 – 358;

[9] Tarantino U., Giai Via A., Macrì E., Eramo A., Marino V., Marsella L.T., *Professional liability in Orthopaedics and Traumatology in Italy.* Clinical Orthopaedics and Related Research 2013 Oct; 471(10):3349-57;

[10] Marsella L.T., Eramo A., Marino V., *La responsabilità professionale d'èquipe in ambito chirurgico. Risultati di una ricerca eseguita sulla giurisprudenza civile del Tribunale di Roma.* Jura Medica volume XXIII n. 3/2010;