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МЕДИЧНЕ ПРАВО УКРАЇНИ: ПРОБЛЕМИ ПАЛІАТИВНОЇ ДОПОМОГИ ТА МЕДИКО-СОЦІАЛЬНОГО ОБСЛУГОВУВАННЯ НАСЕЛЕННЯ

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2. Метою надання паліативної допомоги є полегшення страждання хворої людини.

Результати дослідження можуть бути використані у подальшій розробці та вдосконаленні законодавства, що регулює суспільні відносини, які виникають при наданні паліативної допомоги.

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CHOSEN REMARKS ON ABIDING THE PATIENTS' RIGHTS AT THE CARETAKING AND MEDICAL TREATMENT FACILITIES

Sroka T.

Universytet Jagielloński w Krakowie

(m. Kraków, Rzeczpospolita Polska)

On 4 June 2009 the Patients' Rights and the Patient's Rights Spokesmen Act of 6 November 2008 came into force in Poland[1]. The Act determines, inter alia, the rights of the patients, that are vested in them while being provided with medical service. The aforesaid legal act is to be applied to all kinds of medical service and patients, including the persons who are beneficiaries of the so called long term healthcare. It is important to emphasize that due to the progress of aging of the Polish society, the demand for such healthcare rises. If more and more people use the services included in long term health care, the question of abiding patients' rights in caretaking and medical treatment facilities and caretaking and nursing facilities gains more and more meaning.

From the perspective of long term care, as well as palliative care, article 20 of the aforesaid Act is of special importance — it establishes the right of every patient to dignity and intimacy, which include the right to die in peace and dignity. It is rightly argued that this should be interpreted in the light of appropriate provisions of the Medicine Doctors' Ethics Code[2] , especially article 30, according to which "A *practitioner should exercise every effort, to provide humanitarian terminal care and adequate conditions of dying to the patient. A practitioner should ease the suffering of the terminally ill and sustain, as far as possible, the quality of life until its end.*[3]" In this context the regulation of article 20 of the aforesaid act is appropriate: "*the patient in terminal state has the right to medical services providing relief to pain and other suffering*". The doctrine rightly argues that "*easing all suffering, especially unbearable pain is the basic premise of respecting human dignity*[4]". In this context, what is of special importance is providing the proper standard of medical service to the persons in caretaking and medical treatment facilities and caretaking and nursing facilities, so that those services would ease the pain and other suffering on one hand, and on the other — would allow to die in dignity. The mentioned questions are connected to the problems of the so-called persistent therapy, euthanasia, and "do not resuscitate" documents, which are beyond the scope of this study[5].

The practice knows numerous problems connected with respecting the rights of the patient towards the persons using the medical services within the scope of the long tern healthcare. Special attention should be drawn to the question of proper financing of those medical services and supplementary services, as accommodation and boarding of the patients.

According to article 15 section 2 point 6 of the Medical Services Financed from Public Means Act of 27 August 2004[6], the beneficiaries, according to the rules established by the Act, have the right to, inter alia, guaranteed medical services of nursing and caretaking within the scope of long term healthcare. It should be brought to mind that in Poland medical services provided in caretaking and medical treatment facilities and caretaking and nursing facilities are financed within long term caretaking, and not within palliative or hospice care. Simultaneously, the Act in article 31d empowers the health minister to determine, in a regulation, the list of guaranteed services. Such list

of long term health care services is established by the Minister of Health regulation of 30 August 2009 concerning the guaranteed services of nursing and caretaking within long term caretaking[7], which establishes different ranges of services, according to the differentiation between in-house and stationary conditions. From the perspective of the caretaking and medical treatment facilities and caretaking and nursing facilities functioning, the range of guaranteed services provided in stationary conditions is important, and those are — according to § 4 section 2 of the regulation — comprise of: medical services provided by physicians and nurses, general rehabilitation, psychological services, occupational therapy, pharmacological and dietetic treatment, medical products supply and health education consisting in preparing the beneficiary and his family or carers to self-caring and self-nursing in in-house conditions. These services are guaranteed to the patients who gained not more than 40 points in the process of evaluating according to the scale of the level of demand for care[8].

The manner of settling between the service providers and the State Health Fund is connected indirectly with providing the proper amount of guaranteed services. According to § 14 point 7 of *the Chairman of the National Health Fund bylaw no. 84/2009/DSOZ of 11 December 2009 concerning the determination of the conditions of concluding and realizing the contracts pertaining to nursing and caretaking services within long term therapy,* the proper way of settling services included in palliative care is a payment for a person-day unit. On the basis of the contract concluded between the service provider and the National Health Fund the payment rate for a person-day unit is established, according to which the service provider will be paid for every patient that is staying at the caretaking and medical treatment facility or caretaking and nursing facility.

The problem arises when the agreed person-day unit payment is not sufficient to cover the costs of providing all necessary services to the patient on proper level and in necessary scope. Additionally, it has to be brought to mind that the National Health Fund applies different payment rates for different parts of the country[9]. From this arises the threat that the service providers will cut down on the amount of services provided or on the scope of services provided to the patients, due to the lack of cost coverage by the National Health Fund.

The service providers try to gain additional funds to cover the costs of provided medical services, however, those are not always legal. In practice, one can encounter the cases of dividing the medical services into the standard ones, which must be provided to the beneficiary due to his needs and state of health, and the extra-standard ones, which are not in the scope of obligatory services, and as such are not refunded. This differentiation gives the service providers the possibility to acquire additional payments from the patients for extra-standard services. It should be remarked that the Medical Services Financed from Public Means Act of 27 August 2004 requires every patient to be provided with medical services appropriate for his state of health and needs[10]. When it comes to the patients of the caretaking and medical treatment facilities or caretaking and nursing facilities no provisions regulate the question of the standard of services provided, especially those provisions do not divide those services into standard and extra-standard ones — they only state that the services are to be adequate to the state of health and needs. From this a conclusion arises that the minimal and obligatory range of medical services is determined by the health state and needs of the particular patient. The worse the state and greater the needs, the greater the number of services deemed to be appropriate.

It is worth noticing, that the patients of the facilities are usually elderly people, seriously ill, who have problems with exercising even the basic every day activity[11]. In this context, the appropriate range of services, which should be guaranteed to the patients of the caretaking and medical treatment facilities or caretaking and nursing facilities, is very broad and only in extraordinary cases particular services may be determined as extra-standard ones. What is more, an abstract determination of such services is impossible, only determination according to a particular patient is possible. The determination of the exact health state and needs of a particular patient might allow to state, that some services are extra-standard, but solely when pertaining to a particular person. Therefore, creating a catalogue of extra-standard services by the service providers is inadmissible.

The service providers cannot, as well, seek savings by charging the patients with the costs of medicines and health products. There are cases in practice, when the patients are obliged to supply e.g. diapers, dressing materials or anti-sore mattresses. It should be pointed out that according to article 35 of the Medical Services Financed from Public Means Act of 27 August 2004 the service provider, rendering services in stationary conditions, is obliged to ensure his patients with free-of-charge medicines and other medical products necessary to provide medical services. What is more, Minister of Health regulation of 30 August 2009 concerning the guaranteed services of nursing and caretaking within long term caretaking in § 4 section 3 obliges the service providers to supply the beneficiaries free-of-charge, inter alia, medicines in the scope necessary to exercise guaranteed services. From this arises a conclusion that the patient may be obliged to supply by himself only those medicines and medical product that are not the necessary element the services provided[12].

The practice knows another significant problem pertaining to settling between service providers and the national Health Fund. According to § 15 point 2 of *the Chairman of the National Health Fund bylaw no. 84/2009/DSOZ of 11 December 2009 concerning the determination of the conditions of concluding and realizing the contracts pertaining to nursing and caretaking services within long term therapy,* the day of entering the patient into the caretaking and medical treatment facility or caretaking and nursing facility and the day of leaving that facility are taken as one person-day unit. As it is argued in the doctrine, the day of entering and the day of leaving are the most costly days of the patient's stay in the facility[13], while the facility acquires only half of the payment for it, instead of full payment. This situation may, due to financial savings, force the facility to lover the quality or even the amount of services in those days, which of course should not take place. It therefore calls for consideration if the days of entering and leaving should be taken as full person-day units after all[14].

The question of financing board and accommodation is also connected with the problem of financing the medical services provided in stationary conditions. According to article 18 of the Medical Services Financed from Public Means Act of 27 August 2004 the beneficiary, who stays at the caretaking and medical treatment facility or caretaking and nursing facility that provides services 24 hours a day, has to bear the costs of board and accommodation by himself. Nonetheless, the Act establishes the maximum costs of board and accommodation collected from the patients which cannot exceed 70% of the beneficiary's income according to the Social Security Act. It is worth mentioning that the same regulation concerning board and accommodation is found in article 34a section 1 of the Health Care Facilities Act of 27 August 2004, which is a kind of *superfluum.*

In practice on can encounter cases, where the caretaking and medical treatment facility or caretaking and nursing facility breaks the aforesaid provisions. Within that phenomena two situations can be pointed out. The first, where the rate established for a particular patient for board and accommodation exceeds the stated 70% of the beneficiary's income. There is no doubt that this is a breach of the patient's right to acquire the services for proper payment. Such activity of the service providers is illegal.

The second situation is when the caretaking and medical treatment facility or caretaking and nursing facility determines the payment for board and accommodation by percent, on the level in compliance with article 18 of the Medical Services Financed from Public Means Act of 27 August 2004 (70% of the beneficiary's income according to the Social Security Act). Nonetheless the service provider also determines a minimum mount of money, that is the minimum payment for board and accommodation. In this manner the service providers try to ensure to themselves an amount of money that will be sufficient to cover the basic costs connected with the patient's stay at the facility. If the aforesaid amount of money stays within the 70% of the beneficiary's income, there is no problem. When this is exceeded, the situation is different. Such activity of the facility should be taken as illegal, as the Act does not provide any exceptions and in any case the costs acquired from the patients cannot exceed the mentioned limit. This is not changed by the fact that sometimes the payment collected under article 18 of the Act will not be sufficient to cover the existing costs of monthly board and accommodation of the beneficiary.

The financing of board and accommodation is connected with the problem of providing proper meals at the caretaking and medical treatment facilities and caretaking and nursing facilities. Despite the fact, that the beneficiaries bear the costs of the board, very often the meals are not adequate to their age, physiological conditions and state of health. While it should be pointed out that proper board has massive meaning for effective medical procedures application, in fact being an element of applying them properly. What is more, improper food may cause additional illnesses for the patient, e.g. food poisoning, which should be especially avoided by the entities providing medical services. It deems proper for the caretaking and medical treatment facilities and caretaking and nursing facilities to employ nutritionists who would establish individually the kinds of meals for every patient, according to his age and state of health.

The right to decent death is not only the appropriate scope of medical services, adequate for the person in need of long term or palliative care. This right is also connected with the right to the patient being accompanied in the last hours of his life by his relatives or other closest persons. A problem may arise in this aspect. Every facility has a functioning regulation and determined visiting hours. Therefore there is a question whether forbidding the close person from contacting the patient outside visiting hours when the patient is dying would not be a breach of the patients right to die in peace and dignity. It seems that this right — apart from proper living conditions of course — also encumbers the right to support by close persons. J. Ciszewski rightly remarks that *"the respect towards this right means also ensuring the possibility to contact with family and a clergyman. There should also be the possibility to watch over the patient continuously*[15]". According to that, the functioning regulation of the facility should be providing for the possibility of seeing the patient outside visiting hours[16].

1. Unified text — Dz. U. 2009 r. No. 52 position 417 with further amendments.

2. See M. Śliwka in: M. Nesterowicz (edition), *Ustawa o prawach pacjenta i Rzeczniku Praw Pacjenta. Komentarz*, (The commentary on the Patients' Rights and the Patient's Rights Spokesmen Act). Warsaw, pp. 183-184, 2009.

3. Similar regulations can be found in the Ethics Code of the Polish Nurses and Midwives, which in point 7 in the 1st chapter of the special part provides: *"A nurse/midwife should exercise every effort to provide the patient with humanitarian terminal care, decent conditions of dying, with respect to the values the patient believes in."*

4. D. Karkowska, *Prawa pacjenta (The rights of a patient)*, Warszawa, p. 488, 2009, and the remark made by the author: "the lot of humans who die after lengthy suffering is believed to be beneath human dignity"

5. There are, however, opinions according to which the right to proper death includes euthanasia. See Por. M. Świderska, *Prawo do godnej śmierci w świetle nowej regulacji prawnej we Francji*, (The right to proper Heath according to the new legal regulation in France). Prawo i Medycyna 3/2006, pp.111; M. Płachta, *„Prawo do umierania"? Z problematyki autonomii jednostki w sprawach śmierci i umierania*, (Right to die? From the problems of personal authonomy in matters of Heath and dying), Państwo i Prawo 3/1997, pp. 53-64

6. Unified text — Dz. U. 2008 r. No. 164 position 1027 with further amendments.

7. Dz. U. 2009 r. Nr 140 poz. 1147 with further amendments.

8. This evaluation is based on Barthel scale.

9. See http://www.rynekzdrowia.pl/Zdrowie-publiczne/Hospicja-im-tez-przydaloby-sie-wiecej-pieniedzy,12111,27.html

10. What is more the medical services should correspond with the requirements of medical knowledge, and their standard — with the average standard of services provided at the public health care facilities. See M. Śliwka, *Prawa pacjenta w prawie polskim na tle prawno porównawczym. (Patient's rights according to Polish law in comparative context)* Toruń, pp.88-90, 2008

11. This is proved, Inter alia, by the fact that the basic criteria for becoming a patient of stationary long term healthcare is being evaluated 40 or less at the Barthel scale.

12. See J. Nowak-Kubiak, B. Łukasik, *Ustawa o świadczeniach opieki zdrowotnej finansowanych ze środków publicznych. Komentarz*, (The Medical Services Financed from Public Means Act. The commentary) Warsaw, pp.71-72, 2006.

13. See Ł. Wojtusik, B. Maziarz, *NFZ nie płaci za śmierć w hospicjum*, (The National Health Fund does not pay for death in hospice) http://wiadomosci.gazeta.pl/Wiadomosci/1,80708,6341019,NFZ_nie_placi_za_smierc_w_hospicjum.html; see also: http://www.rynekzdrowia.pl/Finanse-i-zarzadzanie/Czy-w-przyszlym-roku-beda-mniejsze-kontrakty-dla-hospicjow,12052,1.html

14. There i salso a suggestion that the service providers should acquire one and a half person-day unit payment for the days of ente ring and leasing. That would also allow getting additional funds. See Wojtusik Ł, Maziarz B, *NFZ nie płaci...*

15. J. Ciszewski, *Prawa pacjenta w aspekcie odpowiedzialności lekarza za niektóre szkody medyczne*, (The patient's rights in the context of the practitioner's liability for medical damage) Gdańsk, pp.55, 2002.

16. See J. Umiastowski, *Prawa pacjenta w stanie terminalnym* (the rights of the patient in a terminal state) In: K. Gibiński (edition), *Prawa pacjenta a postawa lekarza*,(The rights of the patient and the practitioner's stance) Kraków, pp.60, 1996