# Practical Class 10

## Physician's Liability. Clinical Cases.

## Social History of the Patient. Family Anamnesis.

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Conspectus topics (27, 34)

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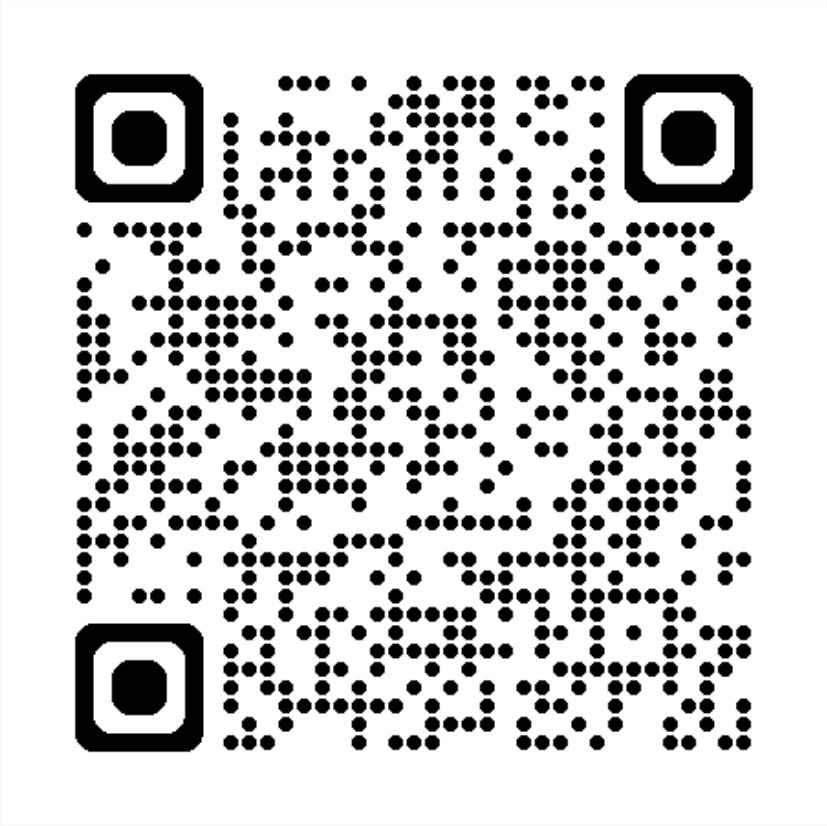
download the presentation from https://tinyurl.com/social-med-class-10

# 15-minutes reading assignment



https://kostadinoff.github.io/learning.html

# Group tasks

https://kostadinoff.github.io/tasks.html

# Outline

1. Prerequisites for Medical Practice
2. Civil Liability
3. Administrative Liability
4. Disciplinary Liability
5. Criminal Liability
6. Clinical Cases — Physician’s Liability
7. Social History — Foundations
8. Structure of the Social History
9. Family Anamnesis

# Prerequisites for Medical Practice

# Legal Prerequisites for Practice in Bulgaria (27)

Before lawful medical practice may commence, four foundational requirements must be satisfied:

- **Oath** — physicians and dentists take the **Hippocratic Oath** upon receiving their diplomas; text determined by the **Higher Medical Council**
- **Educational credentials** — diploma in higher education in Medicine, Dental Medicine, Pharmacy, or Healthcare
- **Professional membership** — registration with the relevant professional union or association
- **Health status** — absence of diseases endangering patient safety (list approved by the Minister of Health)

# Professional Organizations (27)

Membership in professional organizations is mandatory and serves as a mechanism for peer oversight and standard-setting:

| Profession | Organization |
|---|---|
| Physicians | Bulgarian Medical Union (BMA) |
| Dentists | Bulgarian Dental Union (BDA) |
| Nurses, midwives, associated specialists | Bulgarian Association of Healthcare Professionals |
| Master pharmacists | Bulgarian Pharmaceutical Union (BPA) |

# General Practice Requirements (27)

Ongoing practice is governed by three general obligations:

- **Civil liability insurance** — mandatory financial safeguard for patients harmed by medical error or negligence
- **Freedom of professional action** — within the bounds of qualifications, medical standards, and medical ethics; not an absolute freedom
- **Prohibition of commercial advertising** — medical practice serves therapeutic rather than commercial ends; patients' health decisions must not be shaped by promotional influence

# Civil Liability

# Civil Liability — Overview (27)

Civil liability arises when a physician's act or omission causes harm to a patient, giving rise to an obligation of compensation. Two principal forms:

| Form | Conditions |
|---|---|
| Contractual liability | A medical service contract exists between physician and patient |
| Tort (delictual) liability | No contractual relationship — emergency or compulsory treatment |

Governed by Arts. 45–54 and Arts. 79–82 of the **Obligations and Contracts Act**

# Formation of the Medical Contract (27)

The medical service contract is typically concluded **orally**, arising when:

- A patient enters the doctor's office and is accepted for care
- Treatment actions commence during office hours following a patient visit
- The physician confirms a home visit
- Advice is provided by telephone

Key principle: Physicians **cannot refuse** to perform the service in emergency situations — unlike ordinary contractual parties, the duty to provide care may be legally non-deferrable.

# Contractual vs. Tort Liability (27)

| Aspect | Contractual | Tort |
|---|---|---|
| Legal basis | Arts. 79, 82 OCA | Arts. 45–49 OCA |
| Relationship | Contract exists | No prior contract |
| Damages covered | Material damages | Material **and** non-material |
| Typical context | Elective care | Emergency, compulsory treatment |

Non-material damages include pain and suffering, emotional distress, and loss of dignity resulting from the physician's unlawful conduct.

# Administrative Liability

# Administrative Liability — Mechanism (27)

Regulated by the **Health Act**, Art. 93 — patients (or their legal representatives) may lodge complaints with the **regional health inspection**:

- **Within 7 days**: official check is conducted
- If violation found: an **act establishing the administrative violation** is drawn up
- Director of regional health inspection issues an **administrative penalty decree**
- Patient informed of results **within 3 days** of completing the inspection

Cases under the Law on Professional Organizations or the Health Insurance Act are referred to district boards of the BMA/BDA and district health insurance fund.

# Administrative Penalties (27)

Sanctions are calibrated to the nature of the violator and severity of the offense:

- **Individuals** — fines
- **Legal entities** (clinics, hospitals) — property sanctions
- **Serious violations** — deprivation of the right to practice the medical profession:

$$D_{\text{disqualification}} \in [3, 12] \text{ months}$$

Enforcement authority is distributed among: Minister of Health, Director of Regional Health Inspection, Executive Director of the Medical Audit Executive Agency, Executive Director of the NHIF, and customs authorities.

# Disciplinary Liability

# Disciplinary Liability (27)

Disciplinary liability addresses violations of **work discipline** within the employment relationship. Its primary purpose is **preventive** — discouraging future violations.

Sanctions (Arts. 186–199 of the **Labor Code**), graduated in severity:

- **Written warning** — formal notice that improvement is required
- **Dismissal warning** — signals employment is in jeopardy
- **Dismissal** — termination of the employment relationship

Prerequisites: an act constituting failure to fulfill labor obligations, which is both unlawful and committed with fault.

A single action may simultaneously attract disciplinary, administrative, civil, **and** criminal liability — each following its own procedural pathway.

# Criminal Liability

# Criminal Liability — Purposes and Prerequisites (27)

Criminal liability serves three distinct social purposes:

- Reform and re-education of the convicted person
- Individual deterrence — preventing further criminal conduct
- General deterrence — educating society on the necessity of respecting legal and moral standards

Prerequisites (Arts. 9–16 of the **Criminal Code**):

- A **crime** — act fulfilling the elements of a criminal offense
- **Unlawfulness**
- **Culpability** (fault)

Proceedings initiated by the **prosecutor** (general cases) or the **injured party** (private cases).

# Circumstances Excluding Criminality (27)

The Criminal Code recognizes three legally significant exceptions relevant to clinical practice:

- **Extreme necessity** (Art. 13) — action taken to preserve life from immediate, unavoidable danger; harm inflicted must be less significant than the harm averted
- **Justified professional risk** (Art. 13a) — act performed to achieve a substantial benefit or avert significant harm; must conform to contemporary scientific standards and all reasonable prophylactic measures must have been taken
- **Accidental act** (Art. 15) — practitioner was not legally bound to foresee, or was objectively incapable of foreseeing, the harmful consequences

# Key Criminal Provisions — Patients' Rights (27)

| Article | Provision | Sanction |
|---|---|---|
| Art. 123 §1 CC | Death caused by professional negligence or ignorance in an activity of increased risk | ≤ 5 years imprisonment |
| Art. 126 §1 CC | Illegal termination of pregnancy — outside accredited facility or in violation of medical standards | ≤ 5 years imprisonment |
| Art. 141 §1 CC | Failure to provide medical assistance when called upon, without respectful reason | Probation or fine 500–1 500 EUR |
| Art. 141 §3 CC | Any person obliged to assist a sick individual who fails to do so | Probation ≤ 6 months or fine 500–1 500 EUR |

# Patient's Role in Criminal Proceedings (27)

In the **pre-trial phase**: patient participates with limited rights as a **victim**

In the **judicial phase**, the patient may constitute themselves as:

- Civil plaintiff — right to claim compensation within the criminal process **without paying court fees**; avoids separate civil action
- Private prosecutor — can independently support the prosecution regardless of the Prosecutor's Office position; ensures the victim's voice is heard

Proceedings under Art. 141 (failure to provide assistance) are initiated **only upon complaint by the injured party**.

# Clinical Cases — Physician's Liability

# Clinical Case 1 — Emergency Refusal (27)

**Scenario:** A general practitioner, reached by telephone at 22:00, refuses to visit a patient with chest pain, instructing them to “call an ambulance.” The patient suffers a myocardial infarction and dies before the ambulance arrives. No formal emergency call is made by the GP.

**Discussion questions:**

- Was a medical service contract formed by telephone contact?
- Which article of the Criminal Code is potentially applicable?
- Can the patient’s family constitute themselves as civil plaintiffs within the criminal proceedings?
- What “respectful reasons” might have excluded liability?

# Clinical Case 2 — Surgical Negligence (27)

**Scenario:** A surgeon performs an elective cholecystectomy. Postoperatively, a retained surgical sponge causes peritonitis requiring reoperation. The patient survives but sustains permanent digestive complications and is unable to return to physical employment.

**Discussion questions:**

- Identify all four forms of potential liability in this case.
- What damages fall within the scope of contractual civil liability?
- What additional damages may be claimed under tort liability?
- Could “justified professional risk” (Art. 13a CC) apply here? Why or why not?

# Clinical Case 3 — Repeated Disciplinary Violations (27)

**Scenario:** A hospital physician repeatedly arrives late for morning ward rounds, documents patient assessments incompletely, and is found to have signed discharge summaries without conducting the examination they purport to record. No patient has yet suffered documented harm.

**Discussion questions:**

- What graduated disciplinary sanctions are available to the employer?
- Can administrative liability arise in the absence of patient harm?
- At what point might criminal liability become relevant?
- What obligations does the hospital administration bear when a disqualifying health condition in a practitioner is subsequently discovered?

# Social History — Foundations

# The Biopsychosocial Model (34)

The **social history** enables treating physicians to move beyond purely biomedical frameworks toward understanding patients as individuals embedded within multiple social contexts.

**Three interconnected functions of social history taking:**

- Determine how social factors influence this patient's health and illness experience
- Identify the patient's social-medical needs
- Develop and organize a comprehensive medical-social plan

# Social Vulnerability and Screening (34)

The **Social Vulnerability Index** aggregates weighted risk factors across multiple domains:

$$\text{SVI} = \sum_{i=1}^{n} w_i \cdot \text{Risk\_Factor}_i$$

Standard domains assessed by validated screening instruments:

- Housing security and utility access
- Food sufficiency and nutrition
- Transportation access
- Employment status and financial stability
- Educational attainment and health literacy
- Personal safety

# Structure of the Social History

# Five Domains of Social History Assessment (34)

Comprehensive social history assessment follows a structured framework across five major domains:

1. Personal characteristics — identification, psycho-biological profile, health culture, health values and behaviors
2. Family and household environment — structure, material conditions, member characteristics, stressors and leisure
3. Professional and occupational environment — profession, workplace exposures, employment status
4. Social and domestic environment — community connections, ecological exposures, access to public services
5. Healthcare service utilization — access, continuity, rehabilitation needs, dispensary observation

# Domain 1: Personal Characteristics (34)

Standard identification data: name, gender, age, education, marital status, place of birth, current residence

Beyond identification, the social history must explore:

- **Psycho-biological qualities** — temperament, character, life goals, psycho-traumatic experiences; shape symptom interpretation and coping
- **Health culture** — beliefs, attitudes, and practices regarding prevention and treatment-seeking; varies substantially across populations
- **Health as a value** — patients differ in the priority assigned to health relative to other life values; informs counselling approach
- **Health-risk behaviors** — smoking, alcohol, substance use, disordered eating; serve complex social and psychological functions beyond simple “bad choices”

# Domain 2: Family and Household Environment (34)

Family structure encompasses nuclear, single-parent, blended, multi-generational, and chosen family arrangements — the clinical question is **who constitutes the patient's actual support network**.

Material conditions directly determine health through:

- Environmental exposures (lead, mold, heating adequacy, injury hazards)
- Food security and nutrition quality
- Medication and healthcare affordability
- Chronic stress from financial insecurity

Family stressors — divorce, bereavement, member illness, substance misuse — create cascading effects throughout family systems and manifest in individual patients as somatic symptoms or behavioral changes.

# Domain 3: Occupational Environment (34)

Work determines health through multiple pathways simultaneously:

| Pathway | Examples |
|---|---|
| Economic security | Insurance coverage, leave entitlements, retirement |
| Physical exposures | Dust, chemicals, noise, ergonomic loads |
| Psychosocial climate | Shift work, bullying, job insecurity, autonomy |
| Social identity | Occupational prestige, peer networks, purpose |
| Time structure | Access to medical appointments, adherence capacity |

Occupation, workplace, and compensation must all be documented; these elements jointly determine benefit access and social status beyond income alone.

# Domain 4: Social and Domestic Environment (34)

Community context and ecological conditions directly influence health:

- **Ecological exposures** near residence: physical, chemical, biological, and other environmental health hazards require assessment beyond the consulting room
- **Relationships with public authorities** — benefit denials, housing enforcement, immigration status, or criminal justice involvement may require social work or legal services integrated with healthcare
- **Transportation access** — one of the most commonly identified unmet social needs; consequences extend to medication access, nutrition, social connection, and continuity of care
- **Digital infrastructure** — internet access increasingly essential for telehealth, patient portals, and social connection; digital exclusion compounds health disadvantage

# Domain 5: Healthcare Service Needs (34)

Assessment of healthcare service needs encompasses:

- Access to appropriate **hospitalization** without financial barriers
- **Dispensary observation** and continuing specialist care
- **Rehabilitation** (physical, occupational, speech, psychological) for functional recovery
- **Home care services** — chronic underfunding creates gaps forcing institutional placement despite patient preference
- **Social care home placement** when home-based care proves infeasible or unsafe
- **Socio-legal assistance** — childbirth outside marriage, adoption, support for mothers of multiple children

The aim is community living with maximum independence wherever safety permits.

# Family Anamnesis

# Family Anamnesis — Scope and Purpose (34)

Family anamnesis extends the social history to document health patterns across generations, serving clinical and epidemiological purposes simultaneously:

- Identification of **hereditary predispositions** — monogenic conditions, polygenic risk traits, familial aggregation of chronic disease
- Detection of **shared environmental exposures** — household toxins, dietary patterns, behavioral norms transmitted across generations
- Mapping of **family dynamics** influencing individual illness — caregiving burden, communication patterns, conflict, bereavement

A three-generation pedigree (proband, parents, grandparents, siblings, offspring) constitutes the standard minimum; extended to cousins and collateral relatives when a hereditary condition is under investigation.

# Interprofessional Dimensions of Social Assessment (34)

Comprehensive social history rarely falls to the physician alone:

| Professional | Contribution |
|---|---|
| Physician | Ultimate responsibility; clinical integration of social findings into diagnosis and care planning |
| Nurse | Frontline social screening at intake and monitoring; identification of emerging needs |
| Social worker | Family dynamics, resource navigation, social service system access |
| Community health worker | Culturally concordant support; bridging health disparities related to language or marginalization |
| Case manager | Coordination across institutional sectors; longitudinal follow-through |

# The Medical-Social Plan (34)

The **medical-social plan** translates assessment findings into coordinated, individualized action. Effective plans are:

- **Realistic** — calibrated to actual resource availability, not idealized provision
- **Coordinated** — across healthcare, social services, community organizations, and informal networks
- **Strengths-based** — identifying and building upon existing patient capacities rather than cataloguing deficits
- **Iterative** — subject to periodic reassessment and adjustment as circumstances change

Motivational interviewing techniques support behavior change components of the plan by exploring ambivalence, eliciting personal reasons for change, and developing self-efficacy through achievable incremental goals.

Thank you for your attention!