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Structural analysis of the Polish Code of Medical Ethics

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Abstract

In this article is described the structural analysis of the Polish Code of Medical Ethics. It is presented in the context of the Constitution of the Republic of Poland; it is also analysed the scope of the Code of Medical Ethics.

Key words: structural analysis; physician law; medical Ethics

Introduction

The Code of Medical Ethics is composed of a general part and a detailed part. The contents are preceded by the medical oath. The position reached by the Constitutional Tribunal in its verdict[1], namely that the medical oath is not an integral part of the Code of Medical Ethics should be accepted. The medical oath does not establish separate deontological norms, but generalises (synthesises) the norms contained in it. The medical oath is the traditional solemn way of pledging to follow deontological norms resulting from separate provisions and regulations.

The Code of Medical Ethics has an introduction, like most codes of ethics, here called the general part. It presents the fundamental principles which should direct physicians in their activities. The detailed part consists of chapters dealing with specific issues. Chapter I deals with the treatment of patients by physicians, quality of medical care, respect of patients' rights, medical confidentiality, assistance to patients in terminal conditions, transplantation, procreation and medical certificates. Already here, we can notice the inconsistency of its authors. The issue of patients' rights is regulated in Art.12-22 of chapter I of the detailed part. However, we also find regulations concerning respect for patients' rights outside of these articles. Art. 6-8 and Art. 54 also deal with this issue. The issue of medical confidentiality, which undoubtedly touches upon that of patients' rights, is regulated by Art. 23-29. The inconsistencies noted above certainly justify the idea of systematising the Code, by placing the provisions regulating a given subject within a single chapter and reordering it thematically.

Chapter II deals with scientific research and biomedical experiments. Chapter IIa handles the relationship between physicians and the medical industry, while IIb refers to the human genome, or more precisely to the prohibition of discrimination based on genetic heritage, rules for the participation of physicians in research to identify carrier genes for diseases or genetic susceptibility to disease, interference with the human genome. Chapter III regulates the issue

1 Wyrok TK z dnia 23 kwietnia 2008 r. (sygn. akt SK 16/08).

of interrelationships between physicians. The Code also raises issues such as those of relationships between physicians and other medical or auxiliary personnel, that of improving professional qualifications, the work of physicians in state, local government and other institutions, collecting fees (Chapter IV). Chapter V deals with the relationship between physicians and society. While Chapter VI, "Final Principles", defines how physicians should act in cases not foreseen by the Code, as well as the duties of physicians teaching students.

The Code of Medical Ethics in the context of the Constitution of the Republic of Poland

Among other things, the legislator instructed members of the Polish Chamber of Physicians to respect the principles of medical ethics (Art. 2(1) Act on Medical Chambers), or more precisely, entrusted the General Medical Assembly with the duty of defining the principles of medical ethics. In line with the provisions of Art. 53 of the Act on Medical Chambers, members of the medical chamber are subject to professional liability for breaches of the rules of medical ethics and regulations relating to the practice of the medical profession. From a lexical point of view, a breach of the rules of medical ethics is when there is a discrepancy between a given behaviour and the standards derived from those rules. It should be noted that the legislator used the term "infringement of the rules of medical ethics". This is a significant difference to the Act of 17 May 1989 on Medical Chambers[2], which foresaw professional liability for "behaviour contrary to the rules of ethics and professional deontology" (Art. 41 of the Act). A provision constructed this way, was the basis for claiming that physicians and dentists bore professional liability solely for infringing rules which apply to practise of the profession. By the same token, the admission of the responsibility of a physician or dentist for the violation of a given provision of the Code of Medical Ethics, had to be preceded by a determination that this provision defines an ethical principle relating to the practice of the profession[3]. However, it should be said that even based on that act, there were opinions that the legislator had left open the possibility of also qualifying unethical behaviour by a physician in private life as professional misconduct[4].

Within this context, the solution adopted in the current Act on Medical Chambers seems more appropriate, since physicians answer for an infringement of the "rules of medical ethics" and not only for that of "principles of ethics and professional deontology". It should therefore be accepted that the physician or dentist can also bear professional liability for unethical

2 Ustawa z dnia 17 maja 1989 r. o izbach lekarskich (Dz.U. Nr 30, poz. 158 ze. zm.).
3 A. Augustynowicz, A. Budziszewska-Makulska, R. Tymiński, M. Waszkiewicz, *Ustawa o diagnostyce laboratoryjnej. Komentarz*, Warsaw 2010, p. 216-217.
4 E. Zielińska, *Odpowiedzialność zawodowa lekarza i jej stosunek do odpowiedzialności karnej*, Warsaw 2001, p. 135-141.

behaviour outside of the professional domain. A self-regulatory professional body should set high ethical requirements for its members, not only in relation to their profession. However, the question arises whether the basis for the professional liability of a physician or dentist should be every unethical behaviour outside of the professional domain? Or only those which are also crimes? If we consider that this concerns unethical non-professional behaviour which is a crime, then we can ask further questions. Does this concern crimes committed by a physician, independently of the nature and circumstances of the act, or only those crimes which impact the dignity of the profession?

Searching for answers to these questions, it is useful to refer to the already-mentioned Art. 17(1) of the Polish Constitution, which obliges the self-regulatory professional body to oversee the proper practise of the profession. This oversight must be performed within the limits of the public interest and in order to protect it. This supports the position that the basis for professional liability may be some unethical behaviour outside of the professional domain, but not all. Only those which can be qualified as impugning the dignity of the professions of physician or dentist. It is only by employing this limitation that the intervention of the self-regulatory professional body can be seen as supervising the proper exercise of the profession. Additionally, for reasons of purpose, it is appropriate to limit the possibility of holding physicians and dentists to their professional liability only if the unethical act, unconnected to practising the profession, is a prohibited act. Evidently, this concerns a prohibited act unrelated to the exercise of the profession, but simultaneously incompatible with the calling of the medical profession[5].

The indication in the Polish Constitution that self-regulatory professional bodies supervise the proper exercise of the profession determines the goal and scope of the determinations of the Code. The fundamental goal of creating deontological norms is to guarantee the best possible exercise of the medical profession. The determinations of a code of ethics, at least in its overall majority, should concern issues dealing with exercising the profession, i.e. in the case of physicians and dentists indicated in Art. 2 of the Act on the Professions of Physician and Dentist. Here, this means issues relating to the provision of health services, issuing medical opinions and certificates, conducting research, teaching the medical profession, managing a medical facility and employment in medical entities obligated to finance health services from public funds or institutions serving such facilities. The above raises the question of whether the Code of Medical Ethics contains norms unrelated to the practise of the medical

5 E. Zielińska, *Odpowiedzialność zawodowa lekarza i jej stosunek do odpowiedzialności karnej*, Warsaw 2001, p. 138.

profession? The answer to that question is affirmative. We find such norms in Art. 5, Art. 59, Art. 77 and Art. 78 of the Code.

One of the duties of the self-regulatory professional body of physicians and dentists, in light of the Act on Medical Chambers of 1989 under which the Code was voted upon, was to "define norms of ethics and professional deontology applicable to all physicians". What is therefore the meaning of Art. 5 of the Code, which places upon the Chamber of Physicians the duty to supervise that the principles of medical ethics and deontology and the dignity of the profession are observed by all members of the self-regulatory professional body, and see that the provisions of law do not infringe upon the principles of medical ethics? The Code should define the principles of medical ethics which obviously pertain to the exercise of the profession, and not the duties of the self-regulatory professional body. Additionally, in a sense Art. 5 of the Code duplicates the statutory norms defining the competence of the professional self-regulatory professional body of physicians and dentists. Which is why this provision should be seen as superfluous.

Art. 59 also does not apply to the practise of the medical profession. It imposes on physicians a duty of solidarily supporting the activities of their self-regulatory professional body, which is tasked with ensuring that physicians have the appropriate place in society. When criticising the activities of the medical self-regulatory body, they should do so above all within the medical milieu or in the pages of medical journals. The Act on Medical Chambers does not oblige members to support the activities of the self-regulatory body. What is more, members of the Chamber of Physicians have the right to elect and be elected to the bodies of the Chamber of Physicians (which is the most evident form of supporting the activities of the self-regulatory body) while also having the right of being informed of its activities (Art. 9(1) and (2) of the Act on Medical Chambers). This in no way implies an obligation to stand or actively participate in elections to the organs of the Chambers or to consult the information available on the activities of the Chamber. Furthermore, membership in the Chamber of Physicians, or supporting the activities of the self-regulatory body, do not constitute a form of practising the profession (Art. 2 of the Act on the Professions of Physician and Dentist). They should therefore not be subject to the provisions of the Code. Failure to fulfil the obligations specified in Art. 59 of the Code by a physician dealing with the provision of health services should not result in professional liability.

The assertion that the Code should apply to the practice of the profession of physician or dentist implies that it should not contain norms pertaining to persons without that professional title. Meanwhile, Art. 77, sentence 2 of the Code urges medical students to assimilate and

respect the principles contained in the Code. If therefore medical students do not respect these principles, should they then appear before the medical court? Of course not. In line with the provisions of Art. 53 of the Act of 2009 on Medical Chambers, members of the medical chamber are subject to professional liability for breaches of the rules of medical ethics and regulations related to the practice of the medical profession. But medical students are not. From a legal point of view, this provision is therefore an empty norm.

In line with Art. 78 of the Code, physicians teaching students or training other physicians should, through their conduct, provide an example worthy of emulation. If physicians, committed to their patients and excellent academic instructors, suffer from alcohol abuse, or are convicted of drunk driving, then under no circumstances, at least in this respect, are they an example to emulate. The sole question is whether the norm transcends the concept of supervision over the proper exercise of the profession? In light of Art. 32(3) of the Act on the Professions of Physician and Dentist, among others, teaching the medical profession is considered as practising the profession. And the provisions of the Code should apply *stricte* to this issue. Although we accept that a physician can bear professional liability for extra-professional prohibited acts which impugn the dignity of the profession (see 4.2), in the examples presented there is no basis for professional liability. This regulation should be made more precise, so that the private sphere does not form a basis for professional liability. Of course, with the caveat resulting from the preceding sentence.

These provisions, going beyond the constitutionally determined scope of the Code, should be removed or at least clarified.

Scope of the Code of Medical Ethics

Analysing the codes of ethics within the medical professions, one can see a great variation in terms of content, as well as in the specificity of their provisions. It would seem that the authors of the Code addressed the professions of physician and dentist in all their aspects. But the Code also displays differences in the level of detail of specific regulations. And so relationships between physicians and other professions (Art. 58), or employment in public or private institutions (Art. 61) are treated quite vaguely. The issues of information on health status (Art.13, Art. 16-17), patient consent (Art. 15) or professional secrecy (Art. 23-29) are regulated in detail, although not necessarily entirely without reservations.

The general rule which should guide the creators of codes of professional ethics is the consistency of the ethical norms they contain with the norms of the applicable law. This relates not only to the lack of mutually exclusive regulations, but also to not introducing

regulations which create the possibility of varying interpretations of norms within the statutes or the code. Precise wording of individual provisions in the Code is also extremely important. They should be drafted in such a way that, through interpretation, it is possible to determine the rule of prescribed or prohibited conduct, the infringement of which is subject to the sanctions specified in the act. Precise and consistent regulations serve to define appropriate standards of conduct for physicians. Discrepancies between rights and obligations under the law and the Code may result in the legal liability of the physician.

Discrepancies between the statutory rights and obligations and those formulated within the Code concern, among others, Art. 13 of the Code and Art. 31 of the Act on the Professions of Physician and Dentist and Art. 9 of the Act on Patients' Rights and the Commissioner for Patients' Rights. Among others, these discrepancies concern the scope of the rights of the patient to information and the right of third parties to obtain it. Doubts remain as to the relationship between statutory regulations and those in the Code with regard to the consent of the patient for health services – i.e. Art. 15 of the Code and Art. 32-34 of the Act on the Professions of Physician and Dentist and Art. 17 of the Act on Patients' Rights and the Commissioner for Patients' Rights. This relates to the physician's conduct vis-à-vis incapacitated persons under guardianship, minors, and the competence of the person effectively caring for the patient. The Code does not address the issues of admissibility of diagnostic and therapeutic procedures by a physician in the case of objections by the patient or other person authorised to provide consent. The Code does not provide for any participation of the guardianship court in the process of obtaining consent for health services. Therefore the regulations of the Code do not take into account the statutory provisions. Inconsistencies can also be observed between Art. 19 of the Code and Art. 34 of the Act on Patients' Rights and the Commissioner for Patients' Rights, i.e. issues relating to the patient's right to supplementary nursing care. To this doubtful group, we can also add Art. 24-27 of the Code in relation to Art. 40(2) of the Act on the Professions of Physician and Dentist, concerning exceptions to the duty of professional secrecy. Doubts should also be noted as to the conformity of Art. 51 of the Code with Art. 36 of the Act on the Professions of Physician and Dentist with regard to the presence of instructors during consultations.

Detailed analysis

The Code contains a series of articles which because they are imprecise or ambiguous, may be used to the disadvantage of the physician. Establishing that the principles of medical ethics have been infringed requires indicating a specific article of the Code of Medical Ethics,

which has been infringed. Professional liability is a quasi-criminal liability.[6] The more imprecise the wording and vague the rules of conduct, the easier it is to conclude that the principles of medical ethics have been infringed.

In the Code regulations we find a number of concepts that are vague. They create a lot of scope for interpretation. It should be remembered that the provisions of the Act on Medical Chambers provide for the physician's liability for infringement of the principles of medical ethics (Art. 53). This means that proceedings before the medical court can be initiated not only because of a medical error, but also because of a breach of professional ethics. With this in mind, it should be noted that a number of the provisions of the Code impose duties on physicians that are difficult to specify. Thus, the physician may refuse to treat the patient "in particularly justified cases". (Art. 7), should “treat patients kindly and courteously”. (Art. 12(1)), inform the patient with "tact and care" (Art. 17), take specific action in the event of a “serious mistake”. (Art. 21), provide healthcare without authorisation “in cases of particular risk (...)”. (Art.15(3)), perform the examination provided that it does not present an “excessive health risk (...)”(Art.15(4)), ensure “humane terminal care (Art. 30)”, refer to the procreation process “with a special sense of responsibility” (Art. 38(1)), the supervisor of a medical experiment should be “sufficiently qualified”. (Art. 47), show “mutual respect” to other physicians (Art. 52, first sentence) “show particular respect and consideration” to senior physicians (Art. 52, second sentence). There is no doubt that these formulations are linguistically pleasing and positive in their emotional scope, but from a legal point of view, the question arises about the actual content of the norms which they then produce. For instance, one can ask when is a mistake serious? When is is information tactful? When is respect particular? One can also turn the question around: if physicians do not display kindness, can they be charged with infringing the principles of professional ethics and convicted? From the point of view of the law and the Code, the answer is yes.

The determinations of the Code also lack terminological consistency. If the same things are being discussed, then the same terms should be used. Otherwise, the result is a terminological mess[7]. Meanwhile, the same things are referred to as: diagnostic, therapeutic and prophylactic procedures (Art. 8), diagnostic, prophylactic and therapeutic acts (Art. 10(1)), diagnostic and therapeutic procedures (Art. 13(3)). Farther along, in the section of the

6 E. Zielińska, *Odpowiedzialność zawodowa lekarza i jej stosunek do odpowiedzialności karnej*, Warsaw 2001, p. 9.
7 B. Lisowska, *Nowelizacja Kodeksu Etyki Lekarskiej budzi wątpliwości nie tylko prawników*, http://www.pulsmedycyny.pl, 25.02.2013.

Code dealing with the principles of conduct in medical practice, we can note diagnostic or therapeutic forms (Art. 57(2)) and diagnostic and therapeutic methods (Art. 57(3)).

A detailed analysis of individual regulations argues in favour of presenting the most important areas of concern.

In line with Art. 11 of the Code *"Physicians should strive to practise their profession in conditions which guarantee the proper quality of patient care."* As T. M. Zielonka notes, this is an indication in difficult disputes, moral dilemmas and also a justification of demands to take action to improve the quality of patient care.[8] The analysis of this article raises fundamental questions. Are physicians, knowing that in the medical facility where they provide health services only, the quality of patient care is not perfect, and who do not take any steps to improve it, subject to liability before a medical court? It would seem so. Since they should strive to provide the proper quality of patient care. Considering that many factors influence the quality of patient care, including lack of equipment, insufficient medical personnel, etc., the possibility of the physician influencing this situation can be limited.

In recent years, the problem of patient rights has been considered quite intensively. This relates not only to statutory activity. These questions are mirrored in the wealth of case law and jurisprudence. This issue is also not alien to the provisions of the Code of Medical Ethics. However, a detailed analysis of the regulations within the Code concerning the individual rights of patients raises some doubts.

One of the basic rights of patients is conscious participation in the decisions concerning their life and health. The guarantee of conscious participation in diagnostic and therapeutic activities is the obligation placed upon physicians to provide patients with understandable information allowing them to make conscious decisions. The right of the patient to conscious participation in the process of being provided healthcare is one of the fundamental standards of medical ethics[9]. At this point, attention should drawn to a specific logical sequence in terms of the thematic arrangement of individual articles. Art. 13 of the Code regulates the issue of the rights of the patient to information, Art. 15 that of the patient's consent to medical services. Further on, Art. 16-17 return to the issues raised in Art. 13. The regulations resulting from these articles will be discussed together since they address the same issues.

The duty of the physician, as formulated in Art. 13, is to respect the rights of patients to consciously participate in decisions concerning their health. Information provided to patients should be formulated in a manner which they are able to understand. At the same time, Art.

8 *Na marginesie Kodeksu Etyki Lekarskiej: Artykuł 11*, Gazeta Lekarska, No. 5, 1997, http://www.gazetalekarska.pl, 15 May 2013.
9 D. Karkowska, Ustawa o prawach pacjenta i rzeczniku Praw Pacjenta. Komentarz, Warsaw 2012, p. 147.

13(3) defines the scope of the subject matter for the patient's right to information. And so *"The physician should inform the patient about the degree of possible risk of diagnostic and therapeutic procedures and the expected benefits of such procedures, as well as about the possibility of using other medical procedures"*. The subject matter of the patient's right to information should be supplemented with information on the state of health, diagnosis and proposed diagnostic and therapeutic methods. Above all, conscious participation of the patient in diagnostic and therapeutic procedures requires information in this respect. The principle outlined in Art. 13(3) collides with Art. 6 of the Code, which states: *"Physicians are free to choose the method of action that they deem most effective"*. Information provided to patients serves to aid patients, not physicians. in making conscious decisions. Physicians merely select methods, which they then propose to patients, as those making the decision. Such an interpretation remains compliant with Art. 31(1) of the Act on the Professions of Physician and Dentist, which relates to information on possible or proposed therapeutic or diagnostic methods[10].

As noted above, Art. 16 and 17 of the Code relate to the issue of informing patients. They set out the conditions allowing a physician to refrain from providing information and indicate, quite imprecisely, who can be informed about the patient's health condition. Unfortunately, these provisions also fail to clearly state that the physician is obliged to inform patients on the state of their health[11]. Art. 16 foresees that informing the family or others should be agreed with the patient (Art. 16(1)). In the case of an unconscious patient, physicians may, for the benefit of the patient, provide the necessary information to a person whom they believe to be acting in the interest of the patient (Article 16(2)). If the patient is a minor, the physician will inform the statutory representative or the actual guardian (Art. 16(3)). These provisions take too broad an approach to the issue of informing third parties. They allow to inform the family, either directly related to some degree or in-laws, after consultation with the patient. Is the agreement mentioned in Art. 16(1) equivalent to obtaining the patient's consent to provide the information? It would seem so. Such an interpretation is justified in the context of Art. 25 of the Code, which exempts the physician from medical confidentiality if the patient agrees to it. Nevertheless, the wording of this article should be modified by indicating that the physician provides information to others after consent by the patient or their statutory representative. Furthermore, in the case of an unconscious patient, Art. 16 allows to provide information to

10 Supreme Court decision of 16 May 2012, Sygn. akt. III CSK 227/11

11 T.M. Zielonka, *Na marginesie Kodeksu Etyki Lekarskiej: Artykuł 16*, Gazeta Lekarska, No. 5, 1998, http://www.gazetalekarska.pl, 24 luty 2013.

an unclearly-defined group of people, according to criteria left to the sole and complex determination of the physician ("for the benefit of the patient", "to a person whom they believe to be acting in the interest of the patient"). What should be understood by the expression necessary information provided for the benefit of the patient? It is not entirely clear how, and on what basis, physicians should make these determinations. How can one determine the intentions of someone asking a question and contacting the physician personally once a year? Besides which, the Code does not define who the physician should provide information to, in the case of a patient who is conscious, but unable to understand the meaning of the provided information. According to the Code, patients who are minors have practically no right to information on the state of their health (since the physician has an obligation to provide information to the statutory representative or the actual guardian). These measures remain at odds with the provisions of the Act on Patients' Rights and the Commissioner for Patients' Rights and those of the Act on the Professions of Physician and Dentist. According to the measures implemented through these acts, a minor patient, over the age of 16, has the right to this information. Furthermore, in line with Art. 31(4) of the Act on the Professions of Physician and Dentist, in the case of a patient below the age of 16, unconscious or incapable of understanding the meaning of the information, the physician provides it to a close relative, in the sense of the provisions of the Act on Patients' Rights and the Commissioner for Patients' Rights. A close relative can be a spouse, relative or kin up to the second degree in a direct line, a statutory representative, a cohabitant or a person indicated by the patient (Article 3(1)(2)). The group of people defined in these acts is narrower than that resulting from Art. 16(2) of the Code. As a consequence, each case of informing a person who is not a close relative, but whom the physician is certain to be acting for the benefit of the patient, will be unlawful, although in accordance with medical ethics. The physician can therefore be liable before a court of law, but will not bear professional liability[12].

It is also proposed to change the content of Art. 14 of the Code and to change its location by including it in the provisions governing the physician's conduct towards the patient. Art. 14 of the Code prohibits physicians from exerting *"influence on the patient for a purpose other than medical treatment"*. Can physicians therefore not use their influence on patients to incite them to undergo diagnostic or therapeutic procedures? It is evident that the intention of the creators of the Code was not to limit physicians in carrying out activities, which are not strictly therapeutic, for the good of the patient. This unfortunate wording undoubtedly needs

12 A. Huk, *Tajemnica zawodowa lekarza w polskim procesie karnym*, Warsaw 2006, p. 236.

changing. Additionally, this provision is formulated in quite an unclear manner. In fact, it is not clear what use is meant. This undoubtedly needs more precision[13].

The basic condition for the admissibility of activities by a physician is the patient's consent to the proposed diagnostic and therapeutic procedure. The issue of the patient's consent to healthcare is regulated in Article 15 of the Code. According to the wording of this article, diagnostic, therapeutic and prophylactic procedures require the consent of the patient. This is a general norm in accordance with Art. 32 of the Act on the Professions of Physician and Dentist. The counterpart to the provision of healthcare by a physician with the patient's consent is the patient's right to consent or refuse to the provision of specific healthcare services after obtaining the relevant information, as stipulated in Art. 16 of the Act on Patients' Rights. Although the provisions of these acts create doubts as to their interpretation, they are much more precise in comparison to the wording of Art. 15 of the Code of Medical Ethics.

There are no doubts about the general norm expressed in Art. 15 of the Code, allowing the physician to make medical interventions with the consent of the patient. In relation to patient consent to healthcare, the Code distinguishes three categories of patients: the patient able to give informed consent, the patient unable to give informed consent and the minor patient. It is evident that only a patient who is of legal age and has not been incapacitated and who is also able to give informed consent is entitled to do so. In Art. 15(1) sentence 2 of the Codex, we can read: *"If patients are not able to give informed consent, it should be given by their statutory representative or by the person effectively looking after the patient"*. A patient unable to give informed consent is a person whose psychological or physical state does not allow for giving informed consent[14](e.g. an unconscious, or mentally ill person).The literal wording of this article allows the physician to intervene medically in the instance of a patient incapable of giving informed consent, after the consent of the statutory representative. A statutory representative is required by patients who are minors, are fully incapacitated and possibly partially incapacitated. The optionality in the case of a partially incapacitated person results from the fact that the curator appointed for such a person does not automatically obtain the status of statutory representative. The status of statutory representative must derive from a decision by a guardianship court to determine a curator[15]. In fact, it is difficult to determine the position of the authors of the Code on the issue of consent to healthcare services by an

13 T.M. Zielonka, *Na marginesie Kodeksu Etyki Lekarskiej: Artykuł 14*, Gazeta Lekarska, No. 3, 1998, http://www.gazetalekarska.pl, 24 February 2013.
14 D. Karkowska, *Ustawa o prawach pacjenta i Rzeczniku Praw Pacjenta. Komentarz*, Warsaw 2012, p. 243.
15 D. Karkowska, *Ustawa o prawach pacjenta i Rzeczniku Praw Pacjenta. Komentarz*, Warsaw 2012, p. 242.

incapacitated person, especially a partially incapacitated one. It would seem that the position of the Code of Medical Ethics is that a fully or partially incapacitated person (who has a statutory representative) is automatically unable to give informed cons ent for the provision of healthcare and foresees no participation of such persons in the decision to provide healthcare. It is somewhat as if there were no borderline cases. And this is different to the Act on the Professions of Physician and Dentist and the Act on Patients' Rights and the Commissioner for Patients' Rights. The provisions of the acts are also far from excellent. But they are not the subject of this analysis. In line with Art. 32(4) first sentence of the Act on the Professions of Physician and Dentist, if a fully incapacitated person is capable with discernment of expressing an opinion on the examination, it is also necessary to obtain the consent of that person. Pursuant to Article 17(3) of the Act on Patients' Rights if, among others, a person who is incapacitated, mentally ill or mentally handicapped, but has sufficient discernment, that person has the right to object to the provision of healthcare despite the consent of the statutory representative. If physicians take the position that in the case of fully incapacitated patients, only the consent of the statutory representative is required (and such a position in the light of the Code regulations may be justified) and fails to take into account, despite the existence of indications, the regulation under Art. 32(4) of the Act on the Professions of Physician and Dentist, they provide health services without the required consent. This may involve liability for infringement of the patient's rights, as referred to in Art. 4 of the Act on Patients' Rights and the Commissioner for Patients' Rights. They should not, however, incur any professional liability.

In the case of persons incapable of giving informed consent, who do not have a statutory representative, the consent to provide health care is given by the person effectively caring for the patient. This provision confers a worryingly broad power to the person effectively caring for the patient. That is because this person can agree to any healthcare service (examination, surgery, services creating a higher risk for the patient). At the same time, the Code does not explicitly define what should be understood by the phrase "person effectively caring for the patient". It would seem that this can refer to e.g. spouses, children taking care of parents, or vice versa, but also unrelated persons, if they effectively take care of the person. The Act on the Professions of Physician and Dentist and the Act on Patients' Rights and the Commissioner for Patients' Rights use the concept of actual guardian. The question is whether these concepts are identical. In our opinion, no. The Code "knows" the concept of actual guardian. This term is used in Art. 16(3) of the Code. Therefore, assuming the rationality of the authors of the Code, it should be concluded that the use of two different

terms in two different provisions cannot imply that their meaning is identical. Such an analysis of the definition of actual guardian leads to the conclusion that the answer to the question raised above must be negative. The actual guardian is the person who, without statutory obligation, provides permanent care for a patient who, due to age, state of health or psychological condition, requires such care (Art. 3(1)(1) of the Act on Patients' Rights and the Commissioner for Patients' Rights). In this definition, two elements are emphasised, namely the provision of care without statutory obligation (i.e. the carer is not a statutory representative and is therefore not a parent or other legal guardian) and the provision of permanent care for a person in need of such care[16]. Circumstances requiring permanent care are not acute ones, but a situation specified by law: age, state of health or psychological condition. We can speak of permanent care when it is provided during the entire duration of the justifying circumstance. The length of its provision does not decide its permanence. The requirement of permanent care can therefore be fulfilled although its provision is not long-term. Therefore the actual guardian can be someone who is not related to the patient, yet provides care in a permanent manner[17]. It should also be noted, that the actual guardian can only agree to examinations being carried out on a minor or person unable to give informed consent (Art. 32(3) of the Act on the Professions of Physician and Dentist and Art. 17(2) of the Act on Patients' Rights). The concept of examination is interpreted quite restrictively in law and covers basic medical activities consisting in inspecting the body and physical examination[18]. This means routine and risk-free medical procedures[19]. According to the regulations within the code, the person effectively caring for the patient is entitled to consent to any healthcare service, including those which pose a higher risk to the patient. These measures remain at odds with the provisions of the Act on the Professions of Physician and Dentist and the Act on Patients' Rights and the Commissioner for Patients' Rights. In consequence, this may involve liability for infringement of the patient's rights, as referred to in Art. 4 of the Act on Patients' Rights and the Commissioner for Patients' Rights.[20]

Conclusion

16 R. Kubiak. *Szczepienia dzieci bez obecności rodziców*, Medycyna Praktyczna. Szczepienia, No. 2, 2012, p. 80-81.
17 E. Zielińska, E. Barcikowska-Szydło, M. Kapko, K. Majcher. W. Preiss, K. Sakowski (in:) *Ustawa o zawodach lekarza i lekarza dentysty. Komentarz.* ed. E. Zielińska, Warszawa 2008, p. 452-453.
18 T. Dukiet-Nagórska, *Świadoma zgoda pacjenta w ustawodawstwie polskim*, Prawo i Medycyna 2000, No 6-7, p. 78-88.
19 M. Świderska, *Zgoda pacjenta na zabieg medyczny*, Toruń 2001, p. 56.
20 T. Dukiet-Nagórska, *Autonomia pacjenta a polskie prawo karne*, Warsaw 2008.

Firstly, the Act on the Professions of Physician and Dentist regulates exclusively the professional activity of a physician, as a person possessing skills and qualifications defined by law, and as a person possessing the right to practise the profession of physician. The Code of Medical Ethics – although it derives its legal legitimacy directly from the Act – also touches upon many aspects of the physician's behaviour (actions and omissions), stepping beyond the scope of professional activity (outside the scope of practising the profession). Therefore, the Code of Medical Ethics does not solely treat physicians as "bearers" of knowledge, skills and experience, equipped with exceptional rights, but also demands additional attributes (often difficult to grasp legally) which strictly determine (since under penalty of losing the right to practise the profession) the ability to practise as a physician or dentist.

Secondly, apart from the linguistic, legislative and technical difficulties of drafting moral norms, in the form typical for the law – hypothesis and disposition, or hypothesis, disposition and sanctions – when formulating the Code of Medical Ethics, the self-regulatory professional body did not avoid, in many places, significant deviations from the legal framework resulting from the Act on the Professions of Physician and Dentist, and sometimes also contradictions with it. While mutually contradictory norms should be reformulated urgently, there are a number of justifications for ethical regulation going beyond the statutory framework regulating the medical profession. Although it determines the purpose and scope of ethical regulation, the assertion in the Constitution that self-regulatory professional bodies supervise the proper exercise of professions, may in itself be treated as legitimising the extension of intra-professional ethical regulation, with the limits determined by public interest, when this supervision is considered in conjunction with that interest. This thesis clearly correlates with treating the medical profession as one of public trust. How many patients would entrust their life to physicians, purely as professionals within their domain, without trusting them as human being? [*As an aside to these considerations, in this last aspect, we shall likely face – or perhaps already do – an inevitable breakthrough, or perhaps mental progress, resulting from the increasing use of telemedicine and the progressive computerisation and automation of medicine. Artificial intelligence already makes more accurate diagnoses than even esteemed professorial medical councils – and even though on the one hand it is a reason for joy – dismay and frustration result from the fact that even the creators of these AIs have no idea what algorithms they use to do so!]*

Third, analysing the contents of the constitutional delegation to supervise the proper exercise of the profession (Art. 17) from a grammatical perspective, we should not forget that this supervision is closely linked to the limits of public interest and the preservation of it.

Supposing the rationality of the legislators, it can be assumed that they used the term "establishing" in the Act on Medical Chambers deliberately. And in fact, through this meant not only to select certain norms (out of all the existing ones) for the code, but also to establish them and give them binding validity. Such an approach also allows to legitimise systematic changes to the Code of Medical Ethics along with progressive changes in social norms, which are closely related to ethics, as well as the progress of knowledge, experience and medical technology – allowing to today make therapeutic decisions, once burdened with ethical doubts, without hesitation.

Fourthly, although the general principle of formulating codes of ethics should be the consistency of ethical and legal norms, its restrictive application must not lead to the creation of unambiguous rules. What would be the purpose of a code of ethics which repeats the norms of law literally, and in fact, would it still be a code of ethics? There is no doubt, however, that the definitions and concepts of both codes (legal and ethical) should be formulated in a way that is as coherent as possible, so that in a given situation, the content of the legal and moral norm is not contradictory. A characteristic of certain legal regulations, especially those concerning socially significant values, spheres of life and security (obviously outside the sphere of fundamental norms), should be to leave those it is addressed to with a margin to define them more precisely, resulting from the ethics, morality and deontology proper to a given area of life. It should not be any different in the case of legal regulations for at least some aspects of the medical profession and the functioning of the self-regulatory professional body.

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