Augustynowicz Anna, Sytnik-Czetwertyński Janusz, Waszkiewicz Michał, Małgorzata Grochala, Skowron Adam. Critical analysis of the Code of Medical Ethics. Journal of Education, Health and Sport. 2019;9(7):713-723. eISSN 2391-8306. DOI http://dx.doi.org/10.5281/zenodo.3354973
http://ojs.ukw.edu.pl/index.php/johs/article/view/7176

The journal has had 7 points in Ministry of Science and Higher Education parametric evaluation. Part B item 1223 (26/01/2017).
1223 Journal of Education, Health and Sport eISSN 2391-8306 7

The authors declare that there is no conflict of interests regarding the publication of this paper.

Received: 01.07.2019. Revised: 05.07.2019. Accepted: 30.07.2019.

Critical analysis of the Code of Medical Ethics

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Abstract

The wording of this article raises fundamental doubts. Since the physician should also strive of obtain the consent of a minor, the question arises as to who else they should obtain it from? Or in fact who, in the case of a minor, should agree to the provision of healthcare. The main part of this article is a critical analysis of articles of the Polish Code of Medical Ethics.

Key words: analysis; Code of Medical Ethics; ethic

Introduction

On the basis of Art. 15(2) of the Code of Medical Ethics *"In the case of minors, the physician should also try to obtain their consent, as long as they are able to provide informed consent"*. The wording of this article raises fundamental doubts. Since the physician should also strive of obtain the consent of a minor, the question arises as to who else they should obtain it from? Or in fact who, in the case of a minor, should agree to the provision of healthcare. An analysis of Art. 15(1) second sentence leads to conclude it is the statutory

representative or the person effectively caring for the minor patient. Since they are the ones providing consent in the case of patients unable to provide informed consent.

Thus, the minor patient was indirectly "qualified" to a group of patients incapable of giving informed consent. On the other hand, the physician should try to obtain the consent of minors "*as long as they are able to provide informed consent"*. It is difficult not to notice this strange construction, from a legislative point of view. The Code also does not answer the question of whether a physician can provide a healthcare service if the minor patient, able to give informed consent, does not give it? Contrary to statutory norms, the Code does not define the age limit to reach to require obtaining consent, including in the case of minors. Based on the Act on Patients' Rights and the Commissioner for Patients' Rights (Art. 17(1)) and the Act on the Professions of Physician and Dentist (Art. 32(5)), a patient who is a minor and over the age of 16 also has the right to provide consent. In the case of the Code, it is not age but the ability to give informed consent which is the determining criterion for the necessity of obtaining the consent of a minor patient. It would appear that the requirement for the physician to determine, each time, if the minor is capable of providing consent is extremely difficult, if not impossible. We should remember that the physician not only may not know how to test the emotional and intellectual maturity of the minor, but also may not have the time to do so. Although it should be underlined that the formal age limit in the acts referred to above is sometimes criticised in the relevant literature. According to M. Safian, it should be treated in a subsidiary manner (as creating a presumption in favour of the ability to give consent). The fundamental criterion should be the actual ability to give informed consent[1]. So according to the principle used in the Code of Medical Ethics. This issue was already the subject of a decision by the Constitutional Tribunal[2], which reached a different conclusion. According to the decision of the Constitutional Tribunal, a general requirement for the personal consent of a minor patient depending on the level of their development would require the creation of an institutional review of this level in each individual case. This would mean that professional staff would have to be provided in almost every healthcare facility. This would also delay the provision of medical assistance. Another possibility, i.e. leaving the decision on the patient's discernment to the discretion of the medical personnel called upon to perform essential medical activities. In the view of the Tribunal, this could lead to serious infringements of patients' rights. Making the proper determination of what is good for the minor requires knowing the needs, situation and sensibilities of the specific child. Those close to them are naturally the best qualified to do so. The solution adopted, which also requires the consent of a minor over 16 years of age, is in line with the Polish Constitution[3], and the Convention on the Rights of the Child[4], although it may be considered unsatisfactory for various reasons.

Article 15(3) and (4) of the Code provides for the possibility of a physician providing healthcare without the patient's consent in two sets of cases. The physician may initiate diagnostic, therapeutic and prophylactic procedures without the patient's consent only in exceptional cases of a threat to the life or health of the patient or other persons. In addition, an examination without the required authorisation may also be carried out by a physician at the request of the body or institution empowered to do so by law. Provided, however, that the examination does not present an excessive health risk for the patient. Essential doubts relate to the clarification of what is meant by "without the patient's consent". Does this refer to the

1M. Safian, *Prawo i medycyna. Ochrona praw jednostki a dylematy współczesnej medycyny*, Warsaw 1998, p. 56-57.

2Wyrok TK z 11 października 2011 r. sygn. Akt. K 16/10 (Dz.U. Nr 240, poz. 1436)

3Konstytucja Rzeczypospolitej Polskiej z dnia 2 kwietnia 1997 r. (Dz.U. Nr 78, poz. 483 z późn. zm.).

4Konwencja o prawach dziecka, przyjęta przez Zgromadzenie Ogólne Narodów Zjednoczonych dnia 20 listopada 1989 r. (Dz. U. z 1991 r. Nr 120, poz. 526 oraz z 2000 r. Nr 2, poz. 11).

provision of healthcare when the patient cannot give consent and does not have a statutory representative at the time or a person effectively caring for the patient (Art. 15(1) second sentence)? Or is this about providing healthcare even if the patient objects? It would seem that initiating a diagnostic, therapeutic or prophylactic procedure without consent concerns the first of the situations noted. If so, this provision should be clarified by specifying that this is a situation where the patient cannot give consent and cannot communicate with their statutory representative or the actual guardian. It is also surprising that medical intervention is allowed in "exceptional" life-threatening cases. Can a physician just "skip" the ordinary, life-threatening cases? What are the criteria for differentiating these cases? And subsequently, should a physician have the right to initiate medical interventions without consent in exceptional life-threatening cases? It is also worth noting that these regulations are not consistent with the provisions of the Act on the Professions of Physician and Dentist. The Act allows for the provision of health services to patients without their consent, if they require immediate medical assistance, and due to their state of health or age, cannot consent, and additionally it is not possible to communicate with a person authorised to give consent (Art. 33(1)). In addition, the physician should consult with another physician if possible to decide whether to take medical action. In the case of surgical procedures or methods of treatment or diagnostics posing an increased risk to the patient, the circumstances allowing to undertake them without the patient's consent, or the consent of the competent guardianship court, is the risk of loss of life, serious bodily injury or serious health disorder caused by the procedure for obtaining consent (Art. 34(7) of the Act). The terms used by the legislator in Art. 33(1) and 34(7) are much easier to interpret than the phrasing of "exceptional life-threatening cases".

The patient has the right to receive care from family or friends, as well as to have contact with a clergyman (Art. 19 of the Code). Is this about the right to additional nursing care under Art. 34 of the Act on Patients' Rights? Or is it possible that the right to receive care, as set out in Art. 19, should be understood to mean both the right to communicate with external persons (which is also a specific form of care) as well as to additional nursing care? And why does the patient only have the right to be cared for by family and friends? Excluding friends or other people indicated by the patient, in other words people close to them? It would seem that the intention of the authors of the Code was to grant the patient the right to be cared for by their close ones. This is also indicated by the wording of the second sentence of Art. 19 of the Code, according to which a physician is obligated to treat with understanding the persons close to the patient who express to the physician their concern for the life and health of the patient. It is to be hoped that the wording of this provision will not constitute a basis for assuming that the physician can give information about the patient's health to anyone expressing concern for the patient's life and health. It is also worth noting that the Code of Medical Ethics addresses the issue of patient rights, and rightly so, from the side of the physician's obligations relating to the exercise of rights. In this context, the wording of Art. 19 of the Code concerning the patient's right to receive care from family or friends seems incorrect. It would be definitely better to indicate what obligations the physician has with regard to the exercise of this right.

Important reservations also exist as the precision of the wording of Art. 21 of the Code. It requires the physician, in the event of a serious mistake or unforeseen complications during the treatment, to inform the patient about them and take action to remedy their consequences. Is the physician obliged to inform the patient and take appropriate action in case of a "serious" mistake or "any" which one?[5] Making a literal interpretation, only in the event of a serious mistake. There remains the separate issue of when to determine that a mistake is "serious". This term is vague and could be misused by health professionals and should

5T. M. Zielonka, *Na marginesie Kodeksu Etyki Lekarskiej: Artykuł 21*, Gazeta Lekarska, No. 12, 1998, http://www.gazetalekarska.pl, 15 August 2013.

therefore be deleted from this provision. A similar problem concerns informing and taking action to remedy any "unforeseen complications" in the diagnostic and therapeutic process. Can we therefore consider that if a physician predicted that a complication would occur, he or she would not have to inform the patient about it and remedy the consequences of the "foreseen complications"? In the current wording, this gives grounds for rejecting allegations of non-compliance with the principles of medical ethics. The provision in question requires self-criticism on the part of the physician. It is relatively easy to admit to the existence of unforeseen complications, but much harder to admit having made a mistake to the patient. This self-criticism can have an impact on a career. It can also lead to legal liability.[6].

Article 22 of the Code formulates the rules concerning the management of waiting lists quite enigmatically. According to its wording *"In cases requiring special types of diagnostics, therapy or prophylactic measures, which cannot be administered simultaneously to all those in need, the physician determining the order of patients should rely on medical criteria".*Unfortunately, the authors of the Code, for unfounded reasons, limited the scope of medical activities only to "cases requiring special types of diagnostics, therapy or prophylactic measures". In Poland, access to healthcare services is limited not only in the case of healthcare services, but also routinely used ones[7]. The legislator explicitly indicated in Article 6(2) of the Act on Patients' Rights that in the situation of a limited possibility of providing appropriate (namely all) health services, the patient has the right to procedure determining the order of access to such services which is transparent, objective, and based on medical criteria. Additionally, Art. 20(1) of the Act on the Public Funding of Health Care[8] stipulates that healthcare services in hospitals and specialist services in ambulatory healthcare are provided in the order in which they are requested in the days and hours of their provision by the service provider who signed an agreement for the provision of healthcare services. Therefore, medical considerations should determine the order of providing healthcare services not only in cases requiring special types of medical intervention. The question remains open as to when we are talking about cases requiring special diagnostic and therapeutic methods. And what are "special" diagnostic and therapeutic methods?

An example of the discrepancies between statutory and code regulations may also be those concerning professional secrecy. Professional secrecy is an important prerequisite for the physician to gain the patient's trust. This is a very important element of the physician's ethos, resulting from kindness and respect for the patient. Discretion is also a direct manifestation of tact and sensitivity, which are among the main principles and virtues of the medical profession.[9] Already in the Hippocratic Oath, we read *"What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about."*[10]. Its importance is also emphasised in the Pledge made by physicians, in which we find the obligation to keep the "*medical secret even after the death of the patient"*.

With regard to the issue of medical secrecy, the Code of Medical Ethics is drafted quite chaotically and lacks clarity[11].

6T. M. Zielonka, *Na marginesie Kodeksu Etyki Lekarskiej: Artykuł 21*, Gazeta Lekarska, No. 12, 1998, http://www.gazetalekarska.pl, 15 August 2013.

7T. M. Zielonka, *Na marginesie Kodeksu Etyki Lekarskiej: Artykuł 22*, Gazeta Lekarska, No. 1, 1999, http://www.gazetalekarska.pl, 15 August 2013.

8Ustawa z 27 sierpnia 2004 r. o świadczeniach opieki zdrowotnej finansowanych ze środków publicznych (Dz.U. z 2008 r., Nr 164, poz. 1027).

9J. Hartman, *Bioetyka dla lekarzy*, Warsaw 2012, p. 93.

10T. Brzeziński, *Etyka lekarska*, Warsaw 2002, p. 65.

11T. M. Zielonka, *Na marginesie Kodeksu Etyki Lekarskiej: Artykuł 24*, Gazeta Lekarska, No. 6, 1999, http://www.gazetalekarska.pl, 24 February 2013.

Article 23 of the Code defines the obligation by physicians to maintain professional secrecy and describes its scope. Articles 24, 25 and 26 concern cases in which the physician is exempted from the obligation of secrecy. The Code of Medical Ethics, which lists in Art. 25 the grounds for waiving the obligation to maintain medical secrecy, uses the phrase "exemption (...) may occur" and enumerates exceptions to the obligation to maintain secrecy. These are situations when the patient consents to it, if preserving secrecy significantly threatens the health or life of the patient or other persons, or if it is required by law. The physician is not obliged to disclose information covered by professional secrecy even in the event of a threat to life or health. This is because the use of the term "may occur" makes the disclosure of information optional. It is true that the wording of Art. 40 of the Act on the Professions of Physician and Dentist on this matter is also far from excellent. However, the first sentence of Art. 40(2) – "The provision in 1 does not apply when:[…]" – allows to ssume that there are situations in which a physician is obliged to disclose information covered by professional secrecy. The provisions of the Act do not presuppose that disclosure of confidential information is optional, which is essential, especially in the case of a threat to the life or health of the patient or other persons, or in a situation where the disclosure of confidential information is required by legal acts. The jurisprudence emphasises that pursuant to Article 40(2) of the Act on the Professions of Physician and Dentist, circumstances precluding the obligation to maintain medical secrecy may be divided into two groups. In some circumstances, the Act only grants the physician the right to disclose information covered by professional secrecy, in others, it imposes an obligation on the physician to disclose it.[12] The obligation to disclose will relate, among others, to a situation in which the legal provisions oblige to disclose the confidential information and also when preserving confidentiality may constitute a threat to the life or health of the patient or other persons. A situation can therefore arise in which the physician, while accepting the optional nature of disclosing information, refrains from providing it. The physician will therefore not bear professional liability, but may be liable before a court of law.

The unfortunate wording concerns not only the first sentence of Art. 25 of the Code of Medical Ethics. It is also worth noting its juxtaposition with individual exceptions. *"Exemption from medical secrecy may occur when the patient consents to it"*. This wording indicates that the patient's consent does not constitute an inherent basis for exemption from the obligation to maintain professional secrecy. For when the patient consents, the exemption from the obligation of professional secrecy may occur. The question therefore arises as to what the intention was of those who created this ethical norm and what position should be taken in this respect? It was probably a case of indicating that the patient is not the only one to authorise release of information covered by professional secrecy. Even with the patient's consent, confidential information can only be disclosed insofar as the information in question directly concerns the patient[13]. In recognition of this position, the physician may not disclose information covered by professional secrecy relating to third parties. Even if it was obtained from the patient and the patient agreed to its disclosure. Such an authorisation would be void of legal meaning[14]. Although it should be said that the very wording of the Code in this respect leaves much to be desired.

"Exemption from medical secrecy may occur […] if the provisions of law so require." Reading this literally – if provisions of law require confidential information to be disclosed, the exemption may occur. Meanwhile, in the cases specified in the provisions of the law, exemption occurs. If a legal provision obliges to disclose information covered by professional

12M. Filar, *Lekarskie prawo karne*, Kraków 2000, p. 147. See also M. Sośniak, *Cywilna odpowiedzialność lekarz*a, Warsaw 1989, p. 169.

13M. Filar, *Lekarskie prawo karne*, Kraków 2000, p. 354.

14M. Safian, Prawo i medycyna. *Ochrona praw jednostki a dylematy współczesnej medycyny*, Warsaw 1998, p. 135-137.

secrecy, the physician must fulfil the obligation. As an example, the provisions of the Act on the Prevention and Control of Infections and Infectious Diseases in Humans[15]obliges physicians to file a report if they suspect or recognise an infection, an infectious disease or death, due to an infection or infectious disease, at the same time indicating the scope of information disclosed in the report.

Doubts are raised not only by the introductory sentence of Art. 25 in relation to the individual exceptions to the obligation of professional secrecy, but also by the drafting of the exceptions themselves. Exemption from medical secrecy may occur when the patient consents to it. In light of the provisions of the Act on Patients' Rights and the Commissioner for Patients' Rights, as well as the Act on the Professions of Physician and Dentist, not every patient is empowered to exempt a physician from the obligation of professional secrecy. This concerns patients who are minors or fully incapacitated, and potentially partially incapacitated. In Art. 14(2)(3) of the Act on Patients' Rights, the basis for medical personnel being released from the obligation of professional secrecy is the consent of the patient or their statutory representative. A similar basis for exemption from the obligation in question is set out in Art. 40(2)(4) of the Act on the Professions of Physician and Dentist. The physician cannot, despite the improper drafting of this provision, interpret it as providing consent for the disclosure of information in the event of the consent of every patient. An appropriate amendment to the Code should therefore be postulated, indicating that the physician is released from the obligation to preserve professional secrecy, in the case of consent by the patient or their statutory representative to its disclosure.

A physician can also be released from professional secrecy if "*the provisions of law so require.*" The literal wording of this article leads us to assume that if the exemption from the obligation to maintain professional secrecy follows from the provisions of the decree, it obliges the physician to disclose the information. Nevertheless, in light of Art. 31 of the Polish Constitution, such a position cannot be accepted. The Polish Constitution obliges everyone to respect the freedoms and rights of others. Patients' rights, including the right to the confidentiality of information pertaining to them, belong to the broader category of human rights. Restrictions on the exercise of constitutional rights may be imposed only through an act and only when they are necessary, among others, for the protection of public safety and order, health or the freedom and rights of other persons (Art. 31(3), first sentence of the Polish Constitution). Therefore, a physician shall reveal confidential information only if required to do so by the provisions of acts. These exemptions should not result from the provisions of decrees. Such a position is consistent with the provisions of the Act on Patients' Rights and the Commissioner for Patients' Rights (Art. 14(2)(1)) as well as the Act on the Professions of Physician and Dentist (Art. 40(2)(1)) and should be taken into account in the drafting the regulations of the Code.

It should also be noted that in some places the Code of Medical Ethics is written in a rather verbose manner, the wording of some articles seems more like a commentary on the Code than a concise definition of a deontological norm. A good example of this is Art. 26 of the Code[16]. It is not a breach of medical confidentiality if, after a medical examination is ordered by an authorised body, the result of the examination is passed on to the orderer. However, it is a precondition that the physician informs the person to be examined before the examination begins. Any information which is not necessary to substantiate the conclusions of the examination shall continue to be covered by medical confidentiality. In principle, this article does not add any new content. It should be noted that Art. 25 of the Code states that exemption from medical confidentiality shall be granted if required by the provisions of the

15Ustawa z 5 grudnia 2008 r. ustawy o zapobieganiu oraz zwalczaniu zakażeń i chorób zakaźnych (Dz. U. Nr 234, poz. 1570 z późn. zm.).

16T. M. Zielonka, Gazeta Lekarska, No. 11, 1999, http://www.gazetalekarska.pl, [accessed: 24.02.2013].

law, and the commented Art. 26 also refers to the transfer of information to bodies authorised by law. At the same time, the provision on maintaining the confidentiality of information which is not necessary to justify conclusions resulting from the examination, is a repetition of the norms from Art. 24 and 28 of the Code[17]. Explaining Art. 24, it allows the physician to provide information on the state of health to another physician, if it is necessary for further treatment or for issuing a decision on the state of health, while Art. 28 provides for the access of persons assisting or helping physicians with their work, to the extent necessary for the proper performance of their professional duties. It should be noted here that the wording of Art. 28 also raises doubts. This provision obligates physicians to ensure that the persons assisting or helping them in their work observe professional secrecy. Moreover, the physician must supervise the proper keeping and securing of medical records so as to prevent their disclosure. Medical records should only contain information necessary for medical care. This article needlessly conjoins two separate issues. The first issue concerns the observance of professional secrecy by the persons assisting or helping physicians and the second concerns the rules for maintaining medical records. They should be placed in separate articles[18].

In Art. 24, the Code of Medical Ethics provides for a rule which has no equivalent both in the Act on the Professions of Physician and Dentist and the Act on Patients' Rights and the Commissioner for Patients' Rights. According to the wording of this article: *"The physician has the right to disclose any noticed facts that threaten health or life as a result of human rights violations."* It would be advisable to consider removing this provision from the Code. This provision has no relevance as an additional exception to the principle of maintaining professional secrecy, being superfluous to the confidentiality exemption due to a threat to the life or health of the patient or other persons, as referred to in Art. 25. If its introduction was dictated by a desire to emphasise this issue for physicians, it is proposed to delete it[19].

Article 29 of the Code is of a similar nature, dealing with the obligation for the physician to safeguard the confidentiality of information contained in the genetic material of patients and their families. Guaranteeing the confidentiality of information contained in genetic material is obviously necessary. The uniqueness of the genetic code of each person gives test results special significance. The information contained in the genetic material of patients and their families constitutes information covered by the scope of medical confidentiality (Article 23 of the Code). This issue should not be included as a separate ethical norm. It would seem that it currently does not present such an unique specificity that it would justify the creation of a new article. Further articles could be created, stating that the confidentiality of information obtained during an interview, found during the examination of a patient or the results of additional tests, should be secured[20].

Under Art. 35 of the Code, a physician may not receive any financial or personal benefits for the removal or transplantation of cells, tissues or organs. Is the remuneration that a physician receives for working in a medical facility dealing with these issues a financial benefit? Assuredly so. It follows that a physician cannot be employed in a transplantation unit, but must always work there for free.

The Code of Medical Ethics imposes on physicians (without defining any specialisation) the obligation to provide information, consistent with medical knowledge, concerning the processes of fertilisation and methods for regulating conception, an introduction to the possibilities of modern genetics, diagnostics and birth therapy (Art. 38). Should it really be the duty of all physicians, regardless of their specialisation? Therefore, if an internist, a

17 T. M. Zielonka, Gazeta Lekarska, No. 11, 1999, http://www.gazetalekarska.pl, [accessed: 24.02.2013].

18 T. M. Zielonka, Gazeta Lekarska, No. 11, 1999, http://www.gazetalekarska.pl, [accessed: 24.02.2013].

19 A. Huk, *Tajemnica zawodowa lekarza w polskim procesie karnym*, Warsaw 2006, p. 238.

20 T. M. Zielonka, *Na marginesie Kodeksu Etyki Lekarskiej: Artykuł 29*, Gazeta Lekarska, No. 12, 1999, http://www.gazetalekarska.pl, 15 August 2013.

cardiologist, or a nephrologist do not pass on such knowledge or indicate it in a very general way, this violates Art. 38? Literally speaking, yes.

Medical experiments with human subjects may be carried out if they serve to improve the health of the patient participating in the experiment or if they result in significant data to broaden the scope of medical knowledge and skills (Art. 42). What about experiments with a placebo? They will certainly not improve the health of the patient. And do they significantly broaden the scope of medical knowledge and skills? Debatable and doubtful. But they can certainly lead to a discussion about the ethics of such experiments and an assessment of the ethics of the physicians participating in them. Reservations can also be made, within a similar context, as to Art. 57(1) of the Code. A physician is not allowed to use methods considered by science to be harmful, worthless or scientifically unverified. The chapter devoted to scientific research and medical experiments imposes on the physician the obligation to pass on to the medical community and publish all discoveries and findings related to the exercise of the profession (Art. 48). A simple conclusion can be drawn from the analysis of this article: physicians with such findings, who do not communicate them to the medical community and do not publish them, infringe the rules of medical ethics. It is irrelevant that the physician is involved in providing health services and does not participate in scientific and didactic activities. In view of the above, does this provision create an obligation to undertake efforts to present one's findings at conferences, conventions and in the scientific press?

In Art. 51, the Code requires the consent of the patient or his statutory representative to participate in scientific or didactic demonstrations. Meanwhile, Art. 36 of the Act on the Professions of Physician and Dentist stipulates that Article 22(2) of the Act on Patients' Rights does not apply, to the extent necessary for teaching purposes, to academic clinics and hospitals, medical research and development facilities and other units authorised to educate medical students, physicians and other medical personnel. The exemption from Article 22(2) has the effect that persons other than those whose presence is necessary, because of the nature of the provided healthcare, may be present during the examination. However, this is contrary to the principles of medical ethics.

The provisions of Chapter IIa, “Relationship of the physician with industry”, also raise important concerns. To start with, a change of title should be proposed, adding that this concerns the medical industry. According to Article 51a(2), *“a physician may accept payment from a manufacturer of medicines or medical products (...) if this payment is proportionate to the contribution of the physician”*.What are the criteria for assessing this proportionality? In addition, the question arises as to whether this norm is compatible with the constitutional principle of freedom of contract and commercial activity. Why can't two free entities agree on arbitrary remuneration?

Article 51b of the Code should be seen as redundant, according to which *"A physician having financial connections with the medical industry must not in any way depart from making fully objective clinical decisions or acting in the best interests of the patient and the persons taking part in the studies."*A physician must always make fully objective clinical decisions and act in the interests of the patient. This requirement applies to all physicians, regardless of whether they have a financial relationship with the medical industry or not. This results, for instance, from Art. 2(**?**) of the Code. The lack of precision of the wording in “in the […] interests […] of the persons taking part in the studies”. Does this concern the researchers, or those taking part in the studies? It is also not indicated what type of studies – pharmaceutical, scientific, clinical?[21] Moreover, the physician must remember about the obligation to disclose, e.g. to those taking part in lectures, any links to any companies, any subsidies or other benefits received from such, which may constitute a conflict of interest (Art. 51c). Participants in these lectures are not only those attending sponsored medical

21T. M. Zielonka, *Na marginesie Kodeksu Etyki Lekarskiej. Art. 51B*, Puls, No. 5, p. 26-27.

conferences, but also students. Therefore, a physician who is an academic lecturer, under penalty of professional liability, should disclose such links. Links with a pharmaceutical or medical product manufacturer should be disclosed by the physician to patients who are to be subjects in research sponsored by that manufacturer (Art. 51e). The question arises here as to what significance this information has if participation in this study is the only chance for patients to extend their lives. It would seem that professional liability gives rise to the absence of this information here. This should apply to situations in which the patient is pressured to participate in studies. Moreover, a physician cannot accept remuneration simply for referring a patient to studies conducted or sponsored by a manufacturer of pharmaceutical or medical products (Art. 51f). If a physician informs patients about the possibility of participating in studies during a "private" visit and indicates that, if they agree, the physician will refer them for these studies, and during a publicly-funded visit, refers them for the study, is the principle set out in Art. 51f infringed? We could consider it to be the case.

Physicians should show themselves mutual respect. Particular respect and consideration should be given to senior physicians, especially former professors (Art. 52(1)). What differentiates the "respect" shown to another physician from the "particular respect" which should be shown to senior physicians? The content of Art. 52(2) also raises doubts. Ultimately, the Constitutional Tribunal ruled that Art. 52(2) of the Code, to the extent that it prohibits truthful and justified protection of the public interest in public statements concerning the professional activity of another physician, is inconsistent with the Polish Constitution[22].

A physician should not select and recommend a treatment centre or a method of diagnostics based on their own benefit (Art. 57(3)). But what if this is one of the few, or the only centre focused on the treatment of a given disease? While the leading specialist in this domain is the physician in question. And if, as a result of providing medical assistance to patients, the physician would benefit financially (because it is difficult to require charity work), this would violate ethical principles?

Article 58 indicates the general norm for conduct between a physician and other personnel. Physicians should treat medical and auxiliary personnel with due respect and in a courteous manner. However, they should bear in mind that they have the exclusive right to make decisions relating to treatment they direct. In the context of Art. 6, which grants the physician the freedom to choose the most effective methods, the second sentence of Art. 58 is superfluous. The second sentence of Art. 58(2) reproduces the standard resulting from Art. 6.

The Code prohibits physicians from advertising themselves (Art. 63(2)). The question is what is meant by advertising. Is information placed in a newspaper about services offered, opening hours, etc. an advertisement or merely information? What about placing information on promotions and loyalty packages in a dermatological practice? Furthermore, a physician must not procure patients in a manner that is inconsistent with the principles of ethics and medical deontology and loyalty to colleagues (Art. 65)? The question arises as to when precisely these principles are infringed. It would seem that it would be more appropriate to indicate what a physician is not allowed to do.

It is good practice to treat other physicians and immediate family members, including widows, widowers and orphans of physicians free of charge (Art. 67). Can immediate family members therefore successfully request free treatment in a private practice? And if they are refused, can they expect a physician to be punished by a medical court for breach of good practice?

Conclusion

The deliberations made so far allow to formulate several conclusions regarding the content of the Code of Medical Ethics.

22Wyrok TK z 23 kwietnia 2008 r. Sygn. Akt. 16/07 (M.P. Nr 38, poz. 342).

1. Its regulations should concern the various aspects of the proper exercise of the profession by physicians and dentists. Hence, the proposal to remove from the Code regulations which address persons who do not practise the profession of physician or dentist. Or those which impose obligations in an area in which existing legal regulations only provide for a right.
2. All provisions of the Code should maintain uniform terminology.
3. The provisions of the Code should be precise enough to limit the possibility of using them to the disadvantage of a physician or dentist.
4. The Code should not contain provisions whose interpretation leads to discrepancies between statutory rights and obligations and those of the Code. Apart from sets of ethical principles, physicians are bound by the norms of conduct resulting from the binding provisions of the law. There is therefore no need to duplicate them in the Code. This applies to, for instance, the issue of providing information about the state of health of the patient, consent for healthcare services or professional secrecy. However, if the authors of the Code decide to regulate, within a set of ethical principles, the issues raised in legal acts, these should be formulated in a similar way. This is because the provisions of the Code which diverge from the provisions of universally binding legal acts are not binding.

The above remarks should not be regarded as malicious on the part of the authors. The Code of Medical Ethics must be written precisely, without ambiguity, to exclude a multiplicity of interpretations. It is a set of ethical norms, on the basis of which medical courts may impose penalties on members of the self-regulatory professional body. Penalties which can have serious consequences, including being disqualified from practising the profession.

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