The essence of medical secrecy according to the Polish law

Michalak K.*

Faculty of Law and Administration, Jagiellonian University, Krakow, Poland

ABSTRACT

Purpose: The purpose of this paper is to present the essence of medical secrecy. Notes included in the article refer to Polish law. It is desirable to, firstly, attempt at a definition of "medical secret", and secondly, at the basis of the proposed definition determine the content and substance of a physician's duty to maintain confidentiality of certain information.
Materials and methods: Indications and other selected postulates presented in this paper will be based on a review of existing legislation and scientific reflection.
Conclusions: Obligation of medical secrecy is in fact a number of duties of different importance, which generally ensures confidentiality of personal data.
Key words: Medical secrecy, physician's duty, confidentiality of certain information, liability

***Corresponding author:**
Faculty of Law and Administration,
Jagiellonian University, Krakow, Poland
ul. Gołębia 24
31-007 Kraków

Received: 30.04.2014
Accepted: 30.05.2014
Progress in Health Sciences
Vol. 4(1) 2014 pp 239-244

"[...] : 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 " [1].

INTRODUCTION

Reflecting on the essence of professional physician secrecy or, more broadly, professional secrecy, first, we shall consider the methodological difficulty. On the one hand, we are dealing with an important legal phenomenon, but on the other hand, we are referring to confidentiality, a secret that is not actually related to the legal sciences and their specific conceptual framework [2]. After all, even the term "secret" is not easy to define precisely. This difficulty has been pointed out in the literature on the subject [3]. Meanwhile, the notion and the term are used in bills and other legal acts of different origins and levels of importance. The legal system requires a well-defined, professional group to fulfil an important duty, the nature and scope of which is not precisely specified. This conclusion emerges from the fact that, *de lege lata*, it is indicated that the term "medical confidentiality" is not clearly defined legally [4]. Therefore, the act refers to the current, commonly recognised understanding of the term [5]. The legal state should be regarded as methodologically flawed, as it is inevitably difficult to determine the scope and nature but, above all, the content of the relevant secret on such a fluid and flexible basis. As noted in the literature on the subject, the concept of medical secrecy can, *inter alia*, be established on the basis of an analysis of ethical, professional, and legal layers [6].

In this case, it is desirable to attempt to define "medical secret", and secondly, on the basis of the proposed definition, to determine the content and substance of a physician's duty to maintain confidentiality regarding certain information. The results and conclusions presented in this paper will be based on a review of existing legislation and scientific reflection. Contrary to appearances, the scope of this study is extensive and very complex. Therefore, I will confine myself to a possibly wide and comprehensive indication of the essence of "medical confidentiality". Readers interested in a comprehensive diagnosis of the subject should refer to the literature on the subject. Limited in scope by the subject of this study, some aspects of criminal, civil, and administrative protection related to medical secrecy will be indicated [7].

Medical secrecy in general

The major importance of medical secrecy was already noticed and broadly described in the Polish legal literature of the interwar period. An apt metaphor for the essence of secret was presented by Waclaw Makowski. He wrote: "[...] walls protect a citizen from obsessions of others, and a person who enters involuntary to housing commits an offense against freedom, contrary to inviolability of the home, thus a similar offense is committed by a person who enters the realm of personal life, revealing the secret " [8].

Analysing the issue of secret, t we should start with a characteristic feature of information and facts, which is confidentiality. The concept is closely related to the mystery of the condition that refers to the information.

However, confidentiality can also be considered a component of the mystery and its characteristic, without which a secret cannot exist. Therefore, confidentiality refers to the actual situation relating to news, information and events, in which a limited number of persons ,who have some feature in common (such as a profession), are aware of relevant information and events that are covered by secrecy, and due to that they- are not known to more or less defined general public. Restricting access to information is a mean of maintaining secrecy, which is a significant element of medical secrecy *in genere* [9].

Medical secrecy, although directly expressed, *inter alia*, in the Act on medical professions and in the corporate medical code relating to the rules of professional conduct, shows the undoubted constitutional genesis. Namely, art. 47 of the Constitution of the Republic of Poland establishes the right of every person to privacy protection. In art. 51 the Constitution enriches the above adjustment by reference to the protection against disclosure [10]. Sometimes the obligation to maintain medical secrecy results from acts of international genesis and significance [11]. These are e.g.: art. 17 par. 1 and art. 18 par. 1 of the International Covenant on Civil and Political Rights [12]. These provisions establish respectively: the right to privacy and the right to freedom of every human being. Art. 8 paragraph 1 of the Convention for the Protection of Human Rights and Fundamental Freedoms guarantees the right to privacy [13]. Whereas, art. 10 paragraph 1 establishes the right to freely receive and disclose information. Some other precise and direct provisions relating to professional secrecy of physicians can be found in the International Code of Medical Ethics of 1949, the Declaration of Helsinki of 1964, the Lisbon Declaration of 1981 [14]. Other provisions relating to medical confidentiality were accepted in 1994, e.g. the Amsterdam Declaration of the World Health Organization on the promotion of patients' rights in Europe. The declaration is included in Chapter 4 entitled "Confidentiality and Privacy" and it states: "All information about a patient's health status, medical condition, diagnosis, prognosis and treatment and all other information of a personal

kind must be kept confidential, even after death" [15].

The issue of medical confidentiality is closely related to the provisions of the Act on the Profession of Physician and Dentist [16], as well as the provisions of the Code of Medical Ethics [17].
As far as the discussed issues are concerned, a careful analysis of the provisions is required.

In accordance with art. 23 CME a physician has a duty to maintain secrets concerning a patient. This provision demonstrates two important aspects of the issue. These are, respectively, the subjective and objective scope of the duty. The personal scope is limited to the entities who can practice the medical profession. Therefore, these are persons described in art. 5 and the following PDA. The obligation to respect medical confidentiality, the law and institutional basis of professional activity of physician, as well as the fact whether the institution, in which the physician practices his profession, is public or private, will be irrelevant [18]. The objective range will correspond to medical secret with all its components. The further content of the provision of the CME clearly shows that all information about patient and his surroundings obtained by a physician in relation to the performance of professional activities are covered by professional secrecy. The physician's confidentiality will therefore refer to the information relating to the facts concerning not only the patient and his health, understood as a person using medical assistance, but also to the patient's life environment, as well as general personal and material conditions about which the physician learned in contact with the patient. To put it succinctly, the duty of medical confidentiality should refer to the patient and his environment. The commented regulation creates a functional relation between medical confidentiality and circumstances in which the physician got the information about the patient and his environment. The duty of confidentiality covers only the information that physician got in the course of professional activities. Importantly, the patient's death does not absolve the physician from the obligation of secrecy. Here, the temporary scope of the duty of medical confidentiality is indicated. Literally expounding, the commented regulation determines that duration of this obligation is absolutely unlimited– perpetual. The professional secrecy of a physician is primarily defined in art. 40 PDA provision, which obliges a physician to "maintain the confidentiality of information related to the patient, and obtained in connection with the exercise of the profession". There is a very thorough analysis of the literal indications that PDA creates a narrower scope of subjective protection of medical confidentiality than CME. This is due to the fact that the provision applies only to the information related to the patient. *Lege non distinguente,* it is the information that is logically connected with the patient. However, by the conjunction expressed through the connection that contains "a", PDA defines formal criterion - a causal relationship between the profession and obtaining the relevant information. M. Rusinek, on the basis of an analysis of the basics of professional secrecy, rightly pointed out that the causal link should be understood as widely as possible and, therefore, not only as a direct causal relationship [19]. A duty understood in such way refers to any information that the physician got in relation to medical contact with the patient - including those found out by accident - not closely connected with treatment. The existence of the link between obtaining information by the physician and a health service can be relatively easily verified. This can be done by putting a simple question. Namely, would the physician get the information about the patient without carrying out medical treatment of the patient. A negative answer resolves the issue of medical confidentiality as it forces to maintain it [20]. On the basis of art. 40 PDA it shall be noted that medical secrecy has no absolute character. The rule expressed in paragraph 1 art. 40 is not an exception. The exceptions are set out in paragraph 2 of the commented provision [21]. Art. 40 paragraph 2 point 1 states that medical secrecy may be harmed by the provisions of the bills. For example, on the grounds of procedural laws it would be the situations to which art. 180 § 2 of the Code of Criminal Procedure [22], 261 § 2 of the Code of Civil Procedure [23] and 83 § 2 of the Code of Administrative Procedure refer. There are also other factual states to which the act refers [24].

Both of the above-mentioned provisions include the term "patient" as an entity - the source of information - in relation to which one is obliged to preserve medical secrecy. The term patient is not legally defined in the acts commented in this article. There are reasons for which it is justified to understand the concept of patient as widely as possible. The patient is any person that participate in any sort of treatment, in which the physician performs his professional activities. In particular, there is no reason to limit the scope of this concept only to those patients, who require urgent medical attention or hospitalization [25]. The patient is also a person who voluntarily chooses to undergo medical treatment or therapy, even if they do not have clear medical indications for such treatment. Continuing, a person who is subject to treatment or diagnostic tests, ordered by the authorized institutions such as the police, prosecution, court, Department of Social Security and Agricultural Social Insurance Fund, is not devoid of the status of a patient - and consequently the benefits of medical confidentiality. In such cases, medical secrecy is limited, which is the consequence of the essence of informative nature of such research, but in other

cases medical confidentiality is not undermined or abolished [26].

The obligation of medical confidentiality should refer to the specific messages which is the information about the patient and his environment. Such determination is supported by a variety of reasons. Can be identified first - coherence and consistency of terminology which is always desirable in legal sciences, and secondly, the fact that the concept of the "information" is broader in its scope than other proposed options such as the "fact" or "message". This is because the information is the communicated message. While message is a semantic arrangement of the facts and opinions. Thus, using terms "message" and "fact" as equivalents and alternating to the term "information", the logic error *pars pro toto* becomes inevitable.

The information about the patient that physician learned in connection with the examination is therefore covered by medical secrecy. In the first place, it is general information, which is functionally associated with treatment. In particular, it is the information collected during the conversation, interview and diagnostic tests results. It is also a predicted diagnosis, medical history and previous therapeutic ventures. It is also the information on the previously applied treatment methods, previous diseases, stays in hospitals and health care facilities, and used pharmaceuticals. Medical confidentiality encompasses medical documentation concerning the subject. In particular, such documents as certificates, notes and medical files [27]. Such catalogue of "medical nature" does not raise doubts . Simultaneously, we cannot be deny that other types of information about the patient are also protected. 'Other' means such information that is collected in connection with the treatment, which is not significant for the therapy. What I mean is non-medical information relating to the patient. For instance: financial and family status of the patient, as well as political views, religion, occupation and widely understood lifestyle of the patient [28]. Therefore, medical secrecy has undoubtedly wide range. However, it is the *ratio legis* of the commented regulation to protect information, broadly. The protection should be provided in relation to the general information about the patient - both medical and deprived of medical importance. From the point of view of the protection of personal and civil liability of the offender, publication of the information about the patient, even of non-medical nature, may result in damage and other negative consequences that are more distressing than in the case of disclosure of information of the strictly medical dimension. Publication of secrets concerning private life of patients may indeed have a strong influence on the views of personal success, career development and even assets. As rightly noted in the literature, the borders of what is covered by medical confidentiality is smooth and there is no simple method to describe it clearly. It must be observed that it should be determined on the basis of precepts of common sense [29].

Although an obligation of confidentiality to the patient's environment is not mentioned in art. 40 PDA, it is a duty explicitly expressed in art. 23 CME. As the insightful establishment of the hierarchy of law sources is not the matter of this study, it should be sufficient to say that the Code of Medical Ethics is not an act of universally binding law. *Prima facie*, it shall be stated that the power of imposed injunctions is not absolute, while there is a statutory regulation of a similar scope of standardization. However, in practice a wider variant is implemented to protect information concerning the patient by medical confidentiality. This is an outcome of the existing specific sanction. Namely, members of the medical chambers are subject to professional liability for a breach of the principles of medical ethics and regulations connected with practicing the medical profession, hereinafter called "professional misconduct"[30]. According to art. 53 of the Acton Chambers of Physicians [31], members of medical chambers are subjected to professional liability "for infringement of the principles of medical ethics and the provisions relating to the exercise of the medical profession (emphasis aut.) […]". Thus, the rules of the Code of Medical Ethics are accompanied by *sui generis* sanction in a form of disciplinary proceedings of statutory genesis. A detailed analysis of the determinants of professional and medical liability is not the subject of this study [32]. The pattern of standards for the evaluation of a physician's conduct will therefore guarantee ethical, deontological and legal provisions governing the practice of the medical profession. The range is commented in art. 25-29 of CME and art. 40 of PDA. It shall be underlined that in the light of the foregoing thesis, a conclusion that a breach of broadly understood duties and responsibilities in the field of medical secrecy shall be punished - whatever the source of the information - becomes legitimate. Moreover it shall be noted that the proper ethical and moral standard for physicians should be established and maintained through the strict enforcement of the provisions of the Code of Medical Ethics. The code itself is an act of great prestige in the medical community. As a result, compliance with its provisions is the interest of every physician.

In conclusion it shall be noted that the violation of medical confidentiality by disclosure of the information related to the patient consists in each act or omission of physician, resulting in sharing the information about the patient and his environment with the unauthorized persons. On that basis a catalogue of exemplary situations, in which

violation of medical confidentiality occurs, can be indicated [33]. These are such situations as: oral or written disclosure of direct information; failure of secrecy of correspondence and communication; disclosing the information to one or more persons; disclosing the information directly or with the use of technical means; involving inadequate protection of medical documentation; leaving the database and documents without supervision, allowing unauthorized persons to get acquainted with their contents. Infringements of professional secrecy can be committed by the disclosure of fragmentary information concerning the patient and his environment, which may be used to determine the identity of the person or persons to whom they relate.

CONCLUSIONS

The findings relating to the nature and scope of medical secrecy have been presented on the basis of acts of different importance in the hierarchy of law sources. The relationship between art. 40 PDA and regulations derived from the Code of Medical Ethics is particularly interesting. The claim that deontological ethical standards and the result of CME cannot modify the content and application of PDA does not require further justification. It shall be noted that the conflict between the directives of legal and ethical norms should be resolved in favour of the legal norms. In the case of non-compliance to ethical and legal standards the law will determine the appropriate method of conduct. As it is rightly observed, it would be unacceptable if the ethical standards were above the written law [34]. The above mentioned conclusion do not change the fact that provisions of PDA and CME should be used simultaneously, if possible.. That application should be based on the analogous and non distinctive interpretation. In this way a wide range of guarantee, arising from medical confidentiality, will be ensured. Therefore, the provisions of PDA and CME should be used complementarily. Summing up, on the basis of such sources of medical confidentiality, we can state that the obligation of medical secrecy is in fact a number of duties of different importance, which generally ensures confidentiality of personal data.
Within this framework we can distinguish the following obligations and duties:

- Obligation: of maintaining unlimited duration [35] - not limited by term, and therefore , perpetual - confidentiality of information about the patient and his environment;
- Duties: consisting in proper fulfilment of other obligations. Their aim is to ensure the effective protection of information, as well as strengthening the protection of information about the patient. These are:

1. duty to ensure compliance with professional secrecy - medical and other - by the person assisting in the medical procedure;
2. duty to disclose selected information to the person assisting in medical practice. It requires an appropriate degree, which enables such person to perform his duties within the framework of treatment properly;
3. duty to ensure the proper conduct - only to the extent relevant to medical practice - medical records and data and their proper protection.

Conflicts of interest
None.

REFERENCES

1. Excerpt from the troop of medical oath, commonly called the Hippocratic oath. Modified in 1948 (the Geneva oath) the relevant passage reads: "secrets entrusted to me by them (patients ed. K.M.) I will respect".
2. Cf. Sobol E. [ed], Mały słownik języka polskiego, Warsaw 1993, p. 929, “a secret - something mysterious, news / information that should not be broadcasted, which should not come to light - the secret”, (author's own translation). (Polish)
3. Cf. Rusinek M. Tajemnica zawodowa i jej ochrona w polskim procesie karnym, Lex/el. 2007, p. 2. Szewczyk M. Prawnokarna ochrona tajemnicy zawodowej lekarza [in:] Czasopismo prawa karnego i nauk penalnych, year IV: 2000, No 1, p. 161. (Polish)
4. Rusinek M. Op. cit, p. 3. But compare a broader understanding of the term "legal definition" and its goals. Described by Błachut M., Gromski W., J. Kaczor [in:] Technika Prawodawcza, Warsaw 2008, p. 34 -35. Compare also the conditions under § 146 et seq. of the Prime Minister regulation of 20 June 2002 concerning principles of legislative techniques. (Polish)
5. Valuable definition is given in: Markowski A. [ed], Słownik poprawnej polszczyzny, Warsaw 2004, p. 784, “[...] mystery - a message that should not be broadcasted, secret, non-disclosure, hiding something; Medical mystery - the message, which disclosure is prohibited by law” (author's own translation). (Polish)
6. Rejman G. Tajemnica lekarska, Studia Iuridica UW XXXI/1996, p. 150. (Polish)
7. Cf. at this Rejman G. Op. cit, p. 154 et seq.
8. Makowski W. Komentarz do kodeksu karnego z 1932 r., Warsaw 1932, cf. comments on art. 253, per Rejman G. Op. cit, p. 150. (Polish)
9. Contrary: Rusinek M. Op. cit, p. 2 et seq. Author identifies two components of professional secret: confidentiality and limitations of its scope. (Polish)
10. Zielińska E. [ed], Barcikowska- Szydło E.,

Kapko M., Majcher K., Preiss W., Sakowski K. Ustawa o zawodach lekarza i lekarza dentysty. Komentarz, Lex/el. 2008, notes on art. 40 point 1. (Polish)
11. Cf. at this Szewczyk M. Op. cit, p. 162. (Polish)
12. Published in the Journal of Laws of 1977. No. 38, item 167. (Polish)
13. Published in the Journal of Laws of 1993. No. 61, item 284. (Polish)
14. Per Zielińska E. [ed], op. cit, notes on art. 40 point 29. (Polish)
15. Declaration: http://www.who.int/genomics/ public/ eu_declaration1994.pdf
16. Act of 5 December 1996 (Journal of Laws of 1997 No. 28, item 152) on physician and dentist. Next: PDA. (Polish)
17. The Code is a set of ethical and deontological rules. Adopted in 1991, during the II Extraordinary National Congress of Chambers of Physicians. Reviewed in 1993 and in 2003. Next: CME.
18. Zielińska E. [ed], op. cit, notes on art. 40 point 6. (Polish)
19. Rusinek M. Op. cit, p. 19. (Polish)
20. Paraphrase of Rusinek M. Op. cit, p. 19. (Polish)
21. For the proposed scheme of exceptions cf. Safjan M. Prawo i Medycyna, Warsaw 1998, p. 130 et seq., referece per Zielińska E. [ed], op. cit, notes on art. 40 point 7. (Polish)
22. Cf. Rusinek M. Op. cit, p. 56 et seq. (Polish)
23. Cf. to this Zielińska E. [ed], op. cit, notes on art. 40 point 16. (Polish)
24. Cf. catalogue described in: Zielińska E. [ed], op. cit, notes on art. 40 point 8. (Polish)
25. World Health Organization adopted, in official documents, that: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", available at: http://www.who.int/governance/ eb/who_constitution_en.pdf
26. Cf. art. 40 par. 2 point. 2 PDA and differently constructed art. 26 CME. (Polish)
27. Cf. Zielińska E. [ed], op. cit, notes on art. 40 point 3, and invoked there literature. (Polish)
28. Cf. Zielińska E. [ed], op. cit, notes on art. 40 point 3, and invoked there literature. (Polish)
29. Safjan M. Problemy prawne tajemnicy lekarskiej, Kwartalnik Prawa Prywatnego, 1995, No. 1, p. 16. (Polish)
30. Cf. at this Safjan M. Op. cit, p. 17-18, and Kunicka-Michalska B. Ochrona tajemnicy zawodowej w polskim prawie karnym, Warsaw 1972, p. 2, reference per: Zielińska E. [ed], op. cit, notes on art. 40 point 4. (Polish)
31. Act of 2 December 2009 (Journal of Laws of 2009 No. 219, item. 1708) on Chambers of Physicians. (Polish)
32. Literature: Iżycka-Rączka M. Odpowiedzialność lekarza, Medycyna po Dyplomie, 2000, No. 8, p. 24, and: Jończyk J. Odpowiedzialność personelu medycznego według Kodeksu Pracy, Prawo i Medycyna, 2000, No. 5, p. 118, reference per Zielinska E. [ed.], op. cit, notes on art. 40 point 26. (Polish)
33. Cf. at this Rejman G. Op. cit, p. 157. (Polish)
34. Gubiński A. Commentary on the Constitutional Tribunal resolution of 03.17.1993, [in:] Państwo i Prawo 1993, No. 9, p. 104 – 111. (Polish)
35. Cf. at this Rejman G. Op. cit, p. 156. (Polish)