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Medical confidentiality in the Polish legal system: a real or illusory instrument of patient privacy protection?

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Summary

Health information provided by patients in the doctor's office belongs to the sphere of their private life. Medical confidentiality is intended to prevent unwarranted interference with the content of this information, both by state authorities and private entities. Thus, it is an instrument to protect the individual's constitutional right to privacy and, at the same time, guarantee an effective diagnostic and therapeutic process. For these reasons, access to the information covered by medical secrecy should be exceptional, especially since this data is highly sensitive in nature. This is especially true of psychiatric confidentiality. Contrary to these seemingly obvious assumptions, the Polish legislator introduces into the legal system further legal solutions that seriously interfere in the sphere of information about an individual's health. This makes medical (psychiatric) secrecy an institution of illusory nature and violates the patient's constitutional right to privacy. It also negatively affects the effectiveness of the diagnostic and therapeutic process. The latter requires complete trust in the doctor-patient relationship and, thus, full confidentiality. The article discusses the ratio legis of medical secrecy, the interrelation of psychiatric and medical secrecy, and the prerequisites for abrogating these secrets. It then discusses the relationship between medical confidentiality and other legal duties incumbent on physicians. Against the backdrop of these considerations, legal solutions that reflect the tendency to weaken the legal protection of medical confidentiality and thus pose a real threat to the information covered by it, were analyzed.

Key words: medical confidentiality, psychiatric confidentiality, patient's right to privacy

Introduction

Medical confidentiality has its origins in antiquity and refers to the Hippocratic Oath. In modern legal systems, professional secrecy (not only medical confidentiality, but, for example, attorney-client privilege, bank secrecy, or seal of confession) limits the state's power in favor of individual rights. The existence of professional secrets can be seen as a manifestation of the assumption that an individual's privacy is an autonomous value protected from its unjustified violation by state authorities or other entities. This conviction has been articulated in many international legal acts, including Art. 17 of the International Covenant on Civil and Political Rights ratified by Poland in 1977 [1] and Art. 7 of the Charter of Fundamental Rights of the European Union [2]. This issue is most precisely regulated by Art. 8 of the European Convention on Human Rights (formally the Convention for the Protection of Human Rights and Fundamental Freedoms) [3]. This Article states that everyone has the right to respect for his private and family life, his home and his correspondence. Thus, there shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others. The content of this provision indicates that while the protection of privacy is an undisputed issue, the scope of this protection may be limited due to the need to protect other legal assets that *ad casum* are in conflict with individual privacy.

Professional secrets guard specified interests of both an individual and social nature. For example, the attorney-client privilege protects the broad interests of the client. Defender-client privilege exemplifies the constitutional right to defense of the accused, which is one of the integral elements of the right to a fair trial. In a broad sense, it also serves the interest of justice. Medical confidentiality, creating a guarantee of discretion for the patient in his dealings with the doctor, is a *conditio sine qua non* of an effective diagnostic and therapeutic process. The complete confidentiality of the doctor-patient relationship increases the likelihood that the patient will disclose all relevant information about his condition, which is a prerequisite for making an accurate diagnosis and implementing adequate treatment. Thus, in a broader sense, medical confidentiality has a beneficial effect on public health. In practice, the scope of professional secrecy is a compromise established at the statutory level between (justified by the public interest) state authority and (justified by the right to privacy) individual autonomy.

Sources of medical confidentiality in Polish law

The normative sources of medical secrecy can be traced directly to the provisions of the Polish Constitution of 2 April 1997 [4], which guarantee the protection of pri-

vate life (Article 47), the protection of the secrecy of communications (Article 49) and the protection of personal data (Article 51, paragraph 1). It is worth noting that the provisions of the previous Constitution of the Polish People's Republic of 22 July 1952 [5], known as the Stalinist Constitution, provided only for the right to inviolability of the dwelling and secrecy of correspondence. Nevertheless, at the time of the aforementioned Constitution, as in 1984, the Polish Supreme Court took the position that the sphere of private life, family life, and the sphere of intimacy of an individual belong to his personal property, and thus are subject to protection under Articles 23 and 24 of the Civil Code [6, 7].

Chronologically, the first of the current legal acts regulating medical secrecy is the Act of 5 December 1996 on the Professions of Physician and Dentist (hereinafter as PPD) [8]. Article 40(1) of this Act states that "A doctor is obliged to keep confidential all information related to the patient and obtained in connection with the practice of his profession". The Code of Medical Ethics (CME) [9], adopted at the Extraordinary Second National Congress of Chambers of Physicians in 1991 and amended in 1993 and 2003, contains similar regulations, with an additional provision: "The death of a patient does not exempt a physician from the obligation to maintain medical confidentiality" (Article 23 of CME). In turn, the Act of 6 November 2008 on Patients' Rights and Patients' Ombudsman (hereinafter as PRPO) [10] subjectively extends the obligation of secrecy, referring it to all medical practitioners and thus constituting the normative source of general medical secrecy (Articles 13 and 14).

A special type of medical secrecy is psychiatric secrecy, regulated by Articles 50, 51 and 52 of the Act of 19 August 1994 on the Protection of Mental Health (hereinafter as PMH) [11] which obligate persons performing activities under this Act to keep secret everything of which they become aware in connection with these activities (Article 50(1) of PMH). Noteworthy here is the further expansion of the persons obligated to maintain secrecy, from medical professionals to all people who perform the activities described by PMH. The PMH also prohibits the recording in medical records of statements that include an admission of having committed a criminal act by a patient (Article 51 of PMH). It is also forbidden to interrogate persons bound to psychiatric secrecy as witnesses on the circumstances of this kind of statements (Article 52(1) of PMH). This prohibition shall apply *mutatis mutandis* to doctors performing expert witness activities (Article 52(2) of PMH).

Exceptions to medical confidentiality

For obvious reasons, the Acts establishing secrecy also regulate exceptional situations in which disclosure of information covered by medical secrecy is permissible. This applies to situations in which maintaining secrecy conflicts with another, in the opinion of the legislator, more important social or individual interest. However, even in these cases, the secret can only be disclosed to authorized persons or institutions.

De lege lata, these situations are set forth in Article 40(2) of the PPD. Abrogation of secrecy is possible when: this is provided for by other laws, the medical examination was conducted at the request of authorized bodies, the observance of secrecy may constitute a danger to the life or health of the patient or other persons, the patient or the patient's legal representative consents to it (to the extent determined by the patient, previously informed of the adverse consequences of its disclosure), or there is a need to provide information to a court physician or another physician providing health services to the patient. Analogous provisions can be found in Articles 24, 25 and 26 of the CME and Article 14 of the PRPO. The latter Act also abolishes the obligation of medical secrecy for the purposes of proceedings before the provincial commission for adjudication of medical events (Article 14(2a) of the PRPO). The original version of Article 14(3) stated, also, that "medical professionals are bound by secrecy even after the death of the patient." The current content of this paragraph will be discussed later.

The catalog of exceptions to the obligation of psychiatric secrecy is formulated differently. In accordance with Article 50(2) of the PMH the obligation is waived if it is necessary to provide information covered by the secrecy to a doctor providing care to a person with a mental disorder, to government or local government authorities and social welfare workers (to the extent necessary to perform social welfare tasks), to special services officers (to the extent necessary to carry out screening proceedings under the provisions on the protection of classified information) and to a police officer authorized in writing by the head of a police organizational unit for the purpose of search and identification of persons.

The legislator did not specify what relationship exists between the catalogs of exceptions cited above, contained in the PMH and the other Acts. Indeed, if the PMH is treated as *lex specialis*, to the other norms creating exceptions to the obligation of medical confidentiality, then disclosure of the psychiatric information would be impossible in situations of danger to life or health, as well as at the request of the court. If, on the other hand, all catalogs should to be treated as complementary, then psychiatric confidentiality would be protected to a lesser degree than other information about the state of health. A systemic interpretation, taking into account the other provisions of the PMH and their *ratio legis*, indicates that weaker protection of psychiatric secrecy was not the legislator's intention. However, there is no consensus position of the doctrine on this issue [12-17].

An issue that is factually, if not formally, closely related to the disclosure of medical secrets is the release of medical records to authorized entities. A list of these is included in Article 26 of the PRPO. It is worth noting that when this Act was originally established in 2008 (Journal of Laws of 2009 No. 52, item 417) the list included – apart from the patient, his legal representative or a person authorized by the patient – 20 items, among which were entities providing other health services to

the patient, public authorities (unfortunately, not defined in more detail), the National Health Fund, national and provincial consultants, self-governing bodies of medical professions, the Minister of Health, courts, prosecutor's offices, authorized bodies (if the examination was conducted at their request), disability pension authorities and disability evaluation boards, entities that keep records of medical services, insurance companies with the patient's consent (a redundant provision, since the patient can disclose his or her records to any entity), and medical professionals under the accreditation procedure. This list raised some doubts from the beginning, e.g., regarding the inclusion of disability pension authorities, which were granted greater powers than insurance companies. In the next few years, the list was only expanded and now includes 30 items. New entities included on the list are mainly control institutions (i.e., Patients' Ombudsman, the Ombudsman for Psychiatric Hospital Patients, institutions appointed by the Minister of Health to conduct inspections, including inspections in the scope of the provisions of the Act on the Health Information System, or inspection bodies appointed by the founding entity of the medical establishment, the Agency for Health Technology Assessment and Tariff System, the Medical Research Agency), as well as the medical commissions of the Ministry of Internal Affairs or the provincial Commissions for Adjudication of Medical Events, and the patient's heirs in connection with proceedings before above commissions. It should be emphasized that these access rights have not been subjected in any way to the consent of the patient to whom the records pertain.

The special nature of psychiatric confidentiality, emphasized in the doctrine [12, 16, 18, 19] raises questions in the context of the provisions discussed above that allow releasing medical records. The only provision of the PMH relating to these records is the prohibition, already cited above, on recording in the medical records statements that include admissions of having committed a criminal act (Article 51). Apart from this one exception, the handling of psychiatric records is analogous to that of any other medical record. Considering the regulations of Art. 26 of the PRPO and the extremely wide range of subjects who also have access to psychiatric records, the special protection of psychiatric secrecy is illusory in this regard.

Another issue that raises debate in the medical and legal community is the collision between the duty to maintain medical secrecy and the obligation to denounce criminal acts. If a doctor, in the course of his professional activities, becomes aware of a patient's intention to commit a criminal act that may pose a threat to the life or health of the patient or another person, then this fact, based on Art. 40(2)(3) of the PPD results in the abrogation of medical confidentiality and imposes an obligation on the doctor to report such information to authorities. This situation is not in doubt in the doctrine.

The situation is different in the case of criminal acts already committed. The obligation to denounce arises from Art. 240 of the Act of 6 June 1997 – Criminal Code (hereinafter as CC) [20] to the extent of the crimes of significant gravity enumerated

in this provision (including such crimes as murder, torture, qualified forms of rape, terrorism). For the sake of completeness of consideration, it should be pointed out that the obligation to denounce is already actualized at the stage of preparation (if it is punishable – Art. 16(2) of the CC), and in other cases, at the stage of attempt (Art. 13 of the CC). The second provision, from which the obligation to notify about a committed crime arises, is Art. 304 of the Act of 6 June 1997 – Code of Criminal Procedure (hereinafter as CCP) [21], which is also applicable in minor cases. In the first situation, it is a legal obligation, the non-fulfillment of which is punishable by imprisonment of up to three years; in the second situation, it is a social obligation. The doctrine, as a rule, agrees that in the second case, the social duty yields to the legal duty of medical confidentiality [e.g., 12, 22]. There is a lack of a consensual doctrinal position regarding the criminal acts listed in Art. 240 of the CC. For example, according to Kubiak [23], the duty to denounce is superior to the regulation of medical confidentiality. This point of view is shared by other authors, and is based on the literal construction of Art. 40(2) of the PPD, abrogating the duty of secrecy "when laws so provide" [22, 24-30]. In turn, E. Plebanek, as well as other authors she cites, take the position that the duty of denunciation described in Art. 240 of the Criminal Code is not a per se premise for abrogating the statutory obligation to maintain medical secrecy. Thus the doctor is liable under Art. 266(1) of the CC for the disclosure of information covered by this secrecy [31-36].

Referring to the above-mentioned problem, it is worth noting the point of view once expressed by Filar [37]. This author rightly noted that in the situation discussed above, there is a de facto collision of two legal obligations, only one of which can be fulfilled. Thus, the doctor, taking into account all the facts known to him, should make an autonomous decision as to which duty (denunciation or secrecy) he will fulfill. Regardless of his decision, he should not bear the legal consequences of violating the second duty, since in such a situation the norm of Art. 26(5) of the CC applies [12].

There is a greater consensus of doctrinal opinion in the case of psychiatric secrecy. It is widely believed that due to the absolute nature of this secrecy, the provisions of the PMH, unlike the general regulation of medical secrecy, result in the abolition of the obligation of denunciation which arises from Art. 240 of the CC [15, 38, 39]. The authors found a contrary standpoint only in the legal opinion of the Radwan-Rohrenschef law firm, posted on the website of the Psychotherapy Section of the Polish Psychological Association [40].

It is impossible here to avoid doubts about the scope of "psychiatric confidentiality." According to the statutory definition, it applies to all activities arising from PMH, regardless of the profession of the person who performs the activity. Thus, the subjective scope is not limited to the doctor. More questionable is the objective scope, especially in the context of sexology. There is no doubt that the information obtained by a doctor during a sexological examination is highly intimate and should be covered by the right

to privacy. However, the question arises whether such an examination is an activity under the PMH. This standpoint is expressed, for example, by Obara [13], who justifies it by classifying sexual disorders in the "Mental and Behavioral Disorders" chapter of the ICD-10 classification. It should be noted, however, that in the ICD-11 classification, sexual disorders are placed in a separate chapter on sexual health ("Conditions related to sexual health"). The reasoning adopted by Obara is, therefore, theoretically outdated. The question arises as to whether this classification change allows for a narrow interpretation of the term "activities under the PMH" in a way that excludes sexual disorders from this scope. Perhaps other elements of the medical examination, such as a medical interview of possible mental disorders, are then conclusive? The authors of this paper take the position that sexual health is part of broadly-defined mental health. Thus, actions under the Act on the Protection of Mental Health should also be understood as actions taken toward persons with sexual disorders.

Undoubtedly, this issue requires further discussion. It is particularly important in the context of the 2017 amendment to Art. 240 of the CC, as a result of which Art. 200 of the CC, concerning the crime of pedophilia, was covered by the legal obligation of denunciation.

Potential threats to information covered by medical confidentiality

Some provisions that abrogate the obligation of medical secrecy raise serious doubts due to their construction or position in the legal system. The criteria used by the authors in identifying such norms are:

- low rank of the legal act by which the statutory obligation of secrecy was repealed,
- the (in) consistency of the norm with the legal system as a whole,
- the *ratio legis* of a provision, i.e., the importance of the social (individual) interest for which it was introduced, compared to the constitutionally guaranteed right of the patient to privacy,
- the legibility of the provision for the average person who is to apply such regulations.

Chronologically, the first provision that can be classified in this group is Art. 226 of the CCP. In its original version, only the court, at the prosecutor's request, was authorized to release medical confidentiality and consent to release medical records in preparatory proceedings. This solution was changed by the Act of 10 January 2003, amending the Act – the Code of Criminal Procedure, the Act – Introductory Provisions of the Code of Criminal Procedure, the Act on Crown Witnesses, and the Act on Protection of Classified Information [41]. In Art. 226 of CCP, the following second sentence was added: "However, in pre-trial proceedings, the use, as evidence, of documents containing medical confidentiality shall be decided by the prosecutor." The effect of

this change, intended by the legislator to speed up the conduct of proceedings, was to create a situation in which the prosecutor is not authorized to question a doctor about circumstances covered by medical secrecy without court approval, but has an unfettered right to access medical records, which contain essentially very similar (and often identical) information about the patient's condition. Especially since the doctor is obliged to complete the medical records immediately after providing health services – in accordance with §4 (1) of the Regulation of the Minister of Health of 6.04.2020 on types, scope and models of medical records and the manner of their processing [42].

Another such change in regulations was the solutions introduced by the Act of 10 June 2016, amending the Act – the Code of Criminal Procedure, the Act on the Profession of Physician and Dentist, and the Act on Patient's Rights and the Patient's Ombudsman [43], which modified previous regulations about the absolute protection of medical secrecy after the death of the patient by adding the phrase "unless a close relative consents to the disclosure of the secret" (Art. 40(3) of the PPD, Art. 14(3) of the PRPO). The indicated legislative procedure has redrawn the absolute nature of secrecy in its temporal aspect [12].

Protests and ambiguities over these provisions forced further amendments two years later. The Act of 6 December 2018, amending the Act on the Profession of Physician and Dentist and some other acts [44], modified Art. 40 of the PPD and Art. 14 of the PRPO, which in their present version state that the exemption from secrecy does not apply if its disclosure is opposed by a person close to the patient, or opposed by the patient himself in his lifetime (as a rule) – Art. 40(3a) of the PPD and Art. 14(4) of the PRPO. The principle of court resolution of possible disputes between persons close to the patient has also been introduced (Art. 14(6) PRPO, Art. 40(3b) PPD). The same Act also introduced the possibility of overcoming the objection of a deceased patient, based on the evaluative criteria of the interests of the participants in the proceedings, their actual ties to the deceased patient or the circumstances of the objection (Art. 14(7-8) PRPO, Art. 40(3c-3d) PPD). Thus, the will of the deceased and his right to privacy and the interests (often financial) of the patient's relatives were placed on the line, leaving these issues to the court's assessment [45-47]. A side effect of these changes was a marked deterioration in the clarity of these provisions for medical professionals, who, as a rule, do not have legal training.

Another normative solution, interfering with the patient's right to privacy, was the obligation introduced on 1 January 2019 (in connection with §10(2) of the Regulation of the Minister of Health of 13 April 2018 on prescriptions [48]) to electronically record paper prescriptions, requiring the patient's PESEL number to be provided with each prescription. This lower-order legal act, giving the impression of being purely administrative, has made the information required to assign a diagnosis to a patient known to a wide range of people (pharmacy staff, IT support). It is not difficult to guess that a man taking sildenafil suffers from erectile dysfunction, while a person receiving reimbursed risperidone suffers from schizophrenia.

An even more serious and growing threat to information covered by medical confidentiality is the solutions provided for in the Act of 28 April 2011 on the information system in health care [49], and the executive Acts issued on its basis – i.e., the Regulation of the Minister of Health of 8 May 2018 on types of electronic medical records [50] and the Regulation of the Minister of Health of 26 June 2020 on the detailed scope of data of a medical event processed in the information system, as well as the manner and timing of transferring such data to the Medical Information System (hereinafter as MIS) [51]. Based on these provisions, access to a broad dataset of patient health information has been granted to numerous entities, including those not directly related to the provision of health services. Listing the entire catalog of these data and institutions, given the limited framework of the study, does not seem advisable and, given the need for clarity of argument, is also impractical. Only by way of example, it can be pointed out that medical data includes, among other things, principal and comorbid diagnoses, epicrisis contained in discharge reports and refusal cards from emergency rooms, medical procedures performed, time spent on leave from the hospital, information on the patient's weight and height, use of tobacco products, telephone number, and e-mail address.

The list of institutions entitled to full access to the data in the MIS, regardless of the patient's consent, includes, among others, the doctor, nurse or midwife of primary health care, any medical worker in a life-threatening situation of the patient, and institutions that finance treatment. Limited access to the data have doctors and other medical staff of medical boards or local government units. It should also not be overlooked that – since the data is processed in electronic form – for obvious reasons, such access is also available to the IT support staff of all the aforementioned institutions. It should be emphasized that the patient's objection has no meaning and does not abolish the obligation to send electronic medical records to the Medical Information System.

It is also worth noting that the analysis of the aforementioned provisions is very difficult for a non-medical law professional. Extremely extensive lists of data required to be made available in electronic form and the equally extensive lists of institutions authorized to obtain them, as well as the very large number of references (to other editorial units in the various legal acts), results in limited clarity of these provisions.

Equally, if not more, alarming are the provisions that appear in the legislation governing the special services. For example, according to Art. 22a of the Act of 9 June 2006 on the Central Anticorruption Bureau (CBA) [52], the CBA may process personal data, including, among others, genetic, biometric, health, sexuality, and sexual orientation data of an individual, without the knowledge and consent of that person. In order to exercise this authority, the CBA may use databases maintained by public authorities and state or local government organizational units, i.e., for example, data from the National Health Fund (Art. 22a(2) of the aforementioned Act). Moreover, according to paragraph 5 of the provision, the data may be obtained electronically, without the need to submit written requests for access each time, i.e., without restriction.

Potential threats to information covered by medical secrecy, in the cases analyzed here, arise primarily from the very broad (and successively expanding) catalog of entities having access to data on the patient's health status, without the patient's consent, as well as from the parallel expansion of the catalog of premises (situations) justifying access to such information. In practice, interference with a patient's constitutional right to privacy is sometimes justified by requirements that arise from sub-statutory acts, which is contrary to Art. 31(3) of the Polish Constitution. Another issue that should be taken into account is the inconsistency of the regulations introduced and the potential incomprehensibility of these provisions, by those obliged to maintain medical confidentiality. Misinterpretation of the provision may result in the disclosure of medical data, to a wider (than required) extent, or disclosure to an unauthorized person.

The overview of regulations making a breakthrough in medical secrecy presented above is not intended to be complete. Due to the multiplicity of such solutions, their holistic presentation would significantly exceed the framework of this study. However, the authors hope that the conclusions made here will provide a stimulus for further discussion of the issue presented.

Conclusion

Medical confidentiality is widely regarded as an integral instrument for protecting patient privacy. This function of medical secrecy derives from the Act on the Profession of Physician and Dentist, the Act on Patient's Rights and Patient's Ombudsman, the Act on the Protection of Mental Health, as well as the Code of Medical Ethics. In the same Acts, exceptions to the obligation of secrecy are relatively precisely defined. Despite this, numerous legal acts of various ranks contain provisions that allow many individuals and institutions access to data covered by medical secrecy. The way these provisions are arranged in the legal system, their vagueness and low level of precision make it much more difficult to gain knowledge about the circulation of sensitive data. As a result, sensitive data can be processed by various individuals and institutions without control, and even without the knowledge, of the person concerned and beyond judicial control. In turn, data from medical records can be disclosed after a patient's death even against the patient's explicit objection during his lifetime.

The authors take the position that an open and substantive discussion is needed on the balance between the public interest or the interests of justice and patient privacy. Equally important is a discussion of the balance between the need for health security and said privacy. Deciding how much privacy is worth "giving up" for the promise of safety is not a simple administrative exercise, but one of the most fundamental axionormative dilemmas of the modern state.

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