

Contemporary challenges in the medical profession in Poland

Polscy lekarze wobec wyzwań współczesności

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- legal regulations
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ABSTRACT

The article describes four important non-medical areas in the profession of a physician: legal, administrative, economic and logological. These areas are complementary to the core knowledge in all medical professions, particularly of a physician. The aim of the article is to indicate some specific problems faced by a contemporary physician which, despite not being part of medical knowledge, are impossible to avoid.

SŁOWA KLUCZOWE

- regulacje prawne
- działalność lecznicza
- ochrona danych
- Kodeks Etyki Lekarskiej
- niedostatek zasobów finansowych

STRESZCZENIE

Praca opisuje cztery istotne, niemedyczne dziedziny w zawodzie lekarza: prawną, administracyjną, ekonomiczną i naukoznawczą. Dziedziny te dopełniają wiedzę, stanowiącą rdzeń wszystkich zawodów medycznych, szczególnie lekarza. Zadaniem pracy jest wskazanie niektórych szczególnych problemów, z jakimi musi mierzyć się współczesny lekarz, które choć nie są częścią wiedzy medycznej stały się dziś niemożliwe do ominięcia.

Introduction

The profession of physician has practically become multi-disciplinary. In addition to the obvious medical knowledge, a physician needs to have a thorough knowledge of law, economics, management, public health, administrative procedures and medical ethics. Apparently, the breadth of these additional areas of knowledge has been increasing significantly.

This article does not question the sense of this state of affairs, but it is rather an attempt to note some specific issues in each of non-medical areas whose knowledge is indispensable in the medical profession nowadays.

These issues have been divided into: legal, administrative, economic and logological.

Legal issues

Changes in the legal environment – the legal regulations in force and their practical implementation – are an important factor that affects the undertaking and the conditions of exercising all medical professions. A special characteristic

of a physician as a regulated profession, as well as one of public confidence includes precisely legally defined rules of access to and exercise of the profession, much more so than in the case of other professions. However, medical studies do not provide their graduates with sufficient skills in the identification and interpretation of legislation regarding them. Therefore, legal issues may pose significant problems in the daily practice of a contemporary physician.

The onset of these problems is related to the choice of form of practising the profession. The Medical Activity Act of 15 April 2011 (Journal of Laws of 2018, item 2190 as amended) (1) defines many forms of exercising activity by physicians and dentists within professional practice. This includes primarily individual and group medical practices that may be of specialized profile³. The organizational and economic considerations of health care system led in 2011 to distinguishing further types of individual practices, i.e. call-out practices and practices in an establishment of a medical organization. Each of these types has different requirements and restrictions, but also different options available for conducting medical activity (e.g. in relation to the possibility of employing auxiliary staff and other physicians). Moreover, it is important to register in the local medical chamber

³ In this respect, there is inconsistency between the aforementioned act, which defines specialized practices only for individual practices, and the Medical and Dental Professions Act of 5 December 1996 (Journal of Laws of 2019, item 537 as amended), which in article 53, paragraph 2, defines "specialized group medical practices".

the appropriate number of single practices if the medical profession is exercised in more than one form (e.g., permanent – office-based, and based on a contract with another medical organization). However, it should be emphasized that the above requirement does not mean the necessity to register separate businesses by the physician. Following the regulations of economic activities [primarily the Business Act of 6 March 2018 (Journal of Laws item 646 as amended) and tax laws] (2), all practices run by a physician may constitute one economic activity and be charged accordingly with tax, as well as health and social insurance payments.

The above issue is associated with the acceptability of running a medical practice and an economic activity of other nature by a physician. Such a combination may be dictated by the nature of the activity (e.g., providing accommodation for patients) or result only from the desire to optimize the activity (e.g., by balancing profit and loss of the individual types of activity). Legal regulations pertaining to this issue are not comprehensive. The Medical and Dental Professions Act in article 46, paragraph 1 (3), defines only the prohibition of selling medicinal products and medical devices by a physician⁴. The Business Act does not contain any guidance in this regard – hence, in accordance with the constitutional principle of freedom of economic activity, this lack of restrictive regulations must imply legal consent to such activities. In spite of the above, it is commonly assessed that the nature of the profession of physician excludes the possibility of combining medical practice with another economic activity (4). This view is not supported by the regulations in force, as well as by the deontological standards adopted by medical self-governance institutions. The current Code of Medical Ethics (KEL) (5) does not contain prohibition of conducting other economic activities by physicians. One must be aware, however, that any physician's activity, including those conducted for profit, is assessed in the light of the obligation to care for the dignity of the medical profession (article 1, paragraph 2 of the KEL). Thus, in the absence of a general legal prohibition of combining medical practice with another economic activity, the acceptability of such a combination will depend on the impact of this activity on the physician's adherence to ethical standards related with the profession. Any violation of these standards may result in facing professional consequences imposed by medical self-governance institutions.

One of the issues most often raised by physicians, in the context of the possible professional, civil and criminal liability, is the acceptability of revoking the duty of professional confidentiality. Confidentiality is not only physician's duty, but also one of the fundamental patient rights (6).

Regulations governing medical confidentiality, and in particular the circumstances and conditions for the exemption from this duty, have changed dynamically in recent years. The direction of these changes has indicated a relaxation of physicians' duty of confidentiality. At the same time, the European Union regulations for the protection of personal data (7) and, first of all, the resulting possibilities of imposing

high financial penalties, have raised significant concerns regarding the sharing of patient information.

In this context, it should be noted that all cases of exemption from the duty of medical confidentiality must be based on enacted laws⁵, and in cases of requests for the disclosure of confidential information, the requesting entity is responsible for indicating the legal basis for such a disclosure.

Situations involving disclosure of confidential medical information on the request of an eligible entity must be differentiated from cases in which a physician is required to provide specific information. The most widespread example is article 240 of the Criminal Code (8). In contrast to article 304 of the Code of Criminal Procedure, it contains the legal, and not only social, obligation to inform about the offenses listed therein⁶. Failure to fulfill the information obligation resulting from this provision is punishable by up to 3 year imprisonment. Similarly, though without determining penalties, the obligation to inform about suspicion of a criminal offense is defined in article 12, paragraph 1, of the Prevention of Family Violence Act (9)⁷.

The above issues are only selected examples, although occurring frequently, of problems faced by physicians. They are varied in nature and relate to different stages of medical activity. However, they indicate the need for a broader knowledge of legal considerations regarding the profession of physician and for continuous updates of this knowledge, as well as the need to use the services of representatives of other free professions of public confidence if the physician's knowledge is insufficient.

Administrative problems

The challenges posed to the present-day physicians by the legislation in force include the General Data Protection Regulation (also called GDPR) (7).

This regulation has been in force for over 1.5 years now and has been a basis for imposing several administrative penalties. The penalty imposed by the Greek Regulatory Authority may be of particular relevance to the everyday functioning of medical practices. This decision regarded consent as a basis for data processing in the context of relations between the employer and the employee. It seems that the decision could bring an end to collecting consents for personal data processing from employees or patients in an "en bloc" manner or "for later use" (when the physician's aim is only provision of healthcare services).

The Greek Regulatory Authority considered that consent cannot be a basis for personal data processing in situations in which other legal bases exist. Moreover, this legal basis cannot be changed during data processing, and an inherent consequence of granting consent is the possibility of withdrawing it at any stage of processing by the entity to which the data relate. In addition, the Authority noted that the penalized employer had misled the entity to which the data related by implementing the so-called information obligation

⁴ In accordance with the aforementioned provision, it is also forbidden for a physician to sell medical device accessories, in vitro diagnostic medical devices, accessories for in vitro diagnostic medical devices, active implantable medical devices.

⁵ From the perspective of a physician, such a basis would be the occurrence of one of the indications listed in article 40 of the Medical and Dental Professions Act, with a reservation that section 2, item 1 of this article indicates the possibility of including regulations regarding the disclosure of confidential medical information in other acts, but not regulations of lower legal force.

⁶ These offenses are: genocide; participation in a mass attack; coup; attack on a constitutional AUTHORITY of the republic of Poland; espionage; attempt of assassination of the President of the Republic of Poland; attack on a unit of the Polish armed forces, a defense facility or device; homicide; causing a grave injury; causing a disaster; piracy; unlawful detention; rape or forced sexual act; sexual exploitation of a person with incapacity or mental disorder; sexual intercourse or forced sexual act with a minor; taking or holding a person hostage; offenses of terrorist nature.

⁷ The information obligation covers offenses involving family violence prosecuted ex officio.

pursuant to article 13 of GDPR, as by wrongfully attributing the basis of data processing to the consent, the employer indicated to the employee an inappropriate legal basis and wrongfully reassured the employee that he/she could affect the processing of his/her personal data by withdrawing the consent.

In this employment-related context, a judgment of the District Court in Toruń which predated the decision of the Greek Regulatory Authority should be mentioned (11). The court ordered paying a compensation to an employee who had refused to sign documents expressing his/her consent to personal data processing by the employer, which resulted in an immediate termination of the contract of employment without notice due to employee's misconduct (article 52, section 1 of the Labor Code) (12). While referring only to issues related to personal data processing, the District Court recognized no reasonable justification for collecting from employees their consents for the processing of personal data which the employees are obliged to disclose pursuant to the Labor Code. Concurrently, the District Court noted that processing of other personal data than those indicated in the Labor Code based on consent is consequently associated with admitting that non-disclosure of these data cannot have any negative consequences for the employee. Therefore, the Court argued that "(...) termination of the contract for disciplinary reasons due to the lack of consent to personal data processing in clearly unlawful. As the consent is voluntary, refusal to grant this consent cannot be considered as a breach of employment obligations".

This decision directly concerns labor relations, but it appears that its idea emphasizing certain characteristics of consent as the basis for personal data processing may also be referred to the still frequent practice of collecting consents to the processing of patient data by physicians. It should be stressed that consent, by virtue of its "revokability" at any time, cannot constitute a basis for the processing of data of both the usual and special categories. Despite that, many medical practices consistently choose consent as the basis, and in their information clauses offered to patients they indicate the possibility of withdrawing consent at any stage of data processing, apparently not fully realizing the consequences of a possible execution of this right by the data subject. This may be due to the wrong presumption that consent to treatment is equal to consent to personal data processing⁸ (13).

It appears that in order to provide healthcare services, processing of personal data can only be based on article 9, section 2(h) of GDPR⁹ (14-16). According to the definition in article 4 of the Regulation, health data are personal data concerning the physical or mental health of a natural person, including the use of healthcare services, revealing information about the person's health status. However, the Regulation also includes a broad range of recitals, therefore in this context it is difficult to skip recital 35 of GDPR which indicates that health data include "information about

the natural person collected in the course of the registration for, or the provision of, health care services; (...) a number, symbol or particular assigned to a natural person to uniquely identify the natural person for health purposes"¹⁰. (17)

Of course, the objective of provision of healthcare services does not exhaust the catalog of objectives for which medical establishments may process personal data of patients, but there seem to be few aspects of the activity of medical establishments that will require consent of the data subject. This includes, e.g., marketing, participation in clinical trials (but not provision of healthcare alone), transfer of medical data to a third country (18). Whereas the above mentioned decision shows that the practice of collecting consents "just in case" not only fails to ensure the legal basis for data processing in case that selected by the Administrator proves to be inappropriate, but also, in itself, it is an action which may result in the imposition of sanctions.

Economic problems

Economic phenomena accompany people in each aspect of life, including the healthcare system. The main problem of economics is the rarity and limitation of resources that all societies must cope with in the light of unlimited needs (19). This fact also concerns the health sector in which the most important economic problem faced by physicians is working with limited resources: financial, physical and human.

In recent years, the Polish healthcare system has faced a particularly severe shortage of financial resources – in the years 2010-2018, the public expenditure in Poland did not exceed 4.6% of GDP, with the average for the European countries belonging to the Organization for Economic Cooperation and Development (OECD) of approx. 6.5% of GDP. In accordance with the OECD data, in 2018 the public expenditure in Poland amounted to only 4.5% of GDP (20), i.e. 95.5 billion PLN (21). It should be noted that approx. 90% of this amount were the expenditures of the National Health Fund (22).

The problem of insufficient financing of the healthcare system and problems generated thereby have led to a protest by resident physicians which started in autumn 2017. The main demand of the Union of Residents of OZZL was "an increase in the healthcare expenditure to a level observed in other European countries, no less than 6.8% of GDP within three years." Other demands were generally implications of a too low level of funding and concerned:

- Solving the issue of queues of patients awaiting provision of medical services.
- Solving the issue of decreasing number of medical staff.
- Solving the issue of bureaucracy in healthcare.
- Improving the working conditions and pay in healthcare.

⁸ For example, following M. Saj in an interview by A. Pochrzęst-Motyczyńska.

⁹ This legal basis is also indicated by the Polish Chamber of Physicians and Dentists in a patient information. (17)

¹⁰ Personal data concerning health should include all data on the state of health of the person to whom the data relate, revealing information about the past, present or future state of physical and mental health of that person. This includes information about the natural person collected in the course of the registration for, or the provision of, health care services as referred to in Directive 2011/24/EU of the European Parliament and of the Council to that natural person; a number, symbol or particular assigned to a natural person to uniquely identify the natural person for health purposes; information derived from the testing or examination of a body part or bodily substance, including genetic data and biological samples; and any information on, for example, a disease, disability, disease risk, medical history, clinical treatment or the physiological or biomedical state of the data subject independent of its source, for example from a physician or other health professional, a hospital, a medical device or an in vitro diagnostic test. In the commentary edited by E. Bielak-Jomaa and D. Lubasz, by interpreting the concept of medical data and the concept of "information about the use of healthcare services", M. Kuba indicates that these are data collected during registration of patients, "including a number, symbol or particular", recognizing an open set of these data.

An important issue is also the insufficient number of doctors – as indicated in the position of the Union of Residents of OZZL: "in Poland, there are only 24.6 persons employed in the medical sector per 1000 inhabitants, including 2.2 doctors and 5.1 nurses. In comparison, the former value is 61.4 in Germany and 63.5 in France." (23). The reason for this situation can be explained by the insufficient salaries in relation to the scope and amount of professional duties. Due to staff shortages, it is a common practice to use the opt-out clause, expressed by an employee on duty in a written statement in which he/she agrees to work overtime, i.e. over 48 hours per week (on average) in the given billing period (1).

The insufficient level of funding and staff shortages contribute to the increase in the queues of patients awaiting treatment which, as indicated by the Union of Residents of OZZL, are humiliating for both the patients and the medical staff (23). In accordance with the Watch Health Care foundation (study conducted between December 2018 and January 2019), the average wait time for a visit to a specialist is 4 months, with the longest wait times observed for visits to endocrinologists (24.2 months) and pediatric cardiologists (11.8 months) (24).

As a result of an agreement of 8 February 2018 between the representatives of the protesters and the Minister of Health, a law was enacted on 5 July 2018 to amend the act on the healthcare services financed by public funds and certain other acts – the so-called "6% of GDP on Healthcare Act". In accordance with this amendment, public expenditure on healthcare may not be lower than 6% of GDP since 2024. Until that time, a systematic increase in expenditure is scheduled which may not be less than 4.86% of GDP in 2019; 5.03% of GDP in 2020, 5.30% of GDP in 2021, 5.55% of GDP in 2022 and 5.80% of GDP in 2023 – apparently the protesters failed to achieve their main goal (25).

In terms of improving the working conditions and pay, the above act established the so-called "loyalty voucher" in the form of a bonus of 600 PLN gross monthly (700 PLN for priority specialties) for resident physicians who will declare that they will work full-time at institutions providing publicly funded healthcare for two of the five years following their residency period. Further to this bonus for resident physicians, the base salary was introduced for medical specialists employed by providers of 24-hour or all-day services contracted by the National Health Fund (NFZ) who will declare that they will not be additionally employed by another provider of the same range of healthcare services financed from public funds. This base salary was set at 6750 PLN (25).

In the opinion of physicians, the Ministry of Health did not fulfill the provisions of the agreement reached in February 2018, thus in August 2019, the Union of Residents of OZZL and OZZL itself, with the support of NIL, launched the protest titled Healthy Work Action (26). The organizers encourage revoking the signed opt-out clauses and limiting work to 48 hours a week. This protest is "a form of opposition to the current state of healthcare in Poland and the absence of full implementation of the Agreement between the Government and the physicians reached in February 2018." The protesters' demands have remained unchanged in relation to the 2017 protests. In addition, the "Poland is a Sick Country" campaign was launched in September, in which a Manifesto was directed to the Members of Parliament of the 8th term of the Sejm and the 9th term of the Senate, as well as candidates to the 2019 parliamentary election (27). Again, the primary demand concerned healthcare financing

– the physicians expect reaching a minimum public expenditure on healthcare of 6.8% of GDP by the end of 2021 and 9% of GDP by the end of 2030. The explanatory memorandum states that: "every day of delay in the financing of the healthcare system below the EU average (6.8%) causes an increase in the system debt and contributes to the deaths of Poles which could be avoided by reaching the above value. This is the absolute minimum needed immediately. The expenditure of 9% of GDP means stable prospects for old age and a sense of security. It is an investment that simultaneously supports the economic growth of our country."

The manifesto has been signed by almost 34 thousand people to date¹¹. An insufficient level of resources available in the system also affects the way in which the profession of physician is conducted – the available therapeutic options and treatment methods funded by the National Health Fund are limited, which in certain clinical situations makes it impossible to use the most effective or preferred therapy. For example, reimbursement of modern medicinal products by the Polish system is delayed compared to other European countries or available for a selected small group of patients in medication programs (27).

Apparently, the main economic problem of healthcare systems is limitation of financial resources which implies a whole range of associated problems in the profession of physician, in the form of insufficient salaries, staff shortages, working overtime, increasing queues for services or restrictions in the availability of therapeutic options. In addition, all these problems may lead to occupational burnout, frustration and reduced job satisfaction. It is to be hoped that the increase in the level of funding guaranteed by law will solve at least part of the problems faced daily by practicing physician.

Logological problems

One of the important challenges currently faced by physicians is conducting the profession in accordance with the current medical knowledge in a not always controllable environment. The obligation imposed by the legislator in article 4 of the Medical and Dental Professions Act of 5 December 1996 (3) (hereinafter: the Medical Act) assumes that a physician constantly updates his/her knowledge and possesses skills allowing him/her to use the current medical and research methods. However, the above does not clearly state that it is responsibility of a physician to use new and unstudied therapeutic methods. This might raise a question whether a physician is also required to hold the knowledge of the most recent, also unstudied, therapeutic methods in light of the fact that knowledge is not limited to the country in which the profession is practiced. If a positive reply is presumed, another question can be raised – whether it is also responsibility of a physician to use, where necessary, these new and unstudied methods. The legislator does not provide an unequivocal answer to this question. Therefore, it can be considered that innovative therapeutic methods which should be known to a physician can but do not have to be used.

These considerations should start with regulation of medical experiment. In principle, the mentioned Medical Act is essential for the considered topic, as the legislator refers to it in other legal acts in unregulated cases. In consequence,

¹¹ As of 30 Sep 2019.

the perspective on the nature and rules of the conduct of experiment is narrowed only to that of a physician. A negative effect of this is primarily lack of the legal definition of medical experiment (28). Moreover, as rightly recognized by the Act, a precise distinction between a therapeutic and scientific experiment is difficult in practice (29).

Furthermore, it is worth considering whether the legislator, who requires that the physician possess the current medical knowledge and use it in practice, at the same time allows the physician to use innovative therapeutic methods or complicates using them. To this end, regulations concerning therapeutic medical experiment are analyzed. As scientific experiment aims to broaden medical knowledge [article 21(3) of the Medical Act], and improvement of the patient's health status is not its principal objective, it is not analyzed in detail (3).

The initial question in these considerations should be about the entity eligible to decide whether to conduct a medical experiment. In accordance with the competences defined in article 29 (1), of the Medical Act, a medical experiment can be carried out only after a favorable opinion by an independent bioethical committee (3). The idea of control over medical experiment is long and assessing groups have existed under different names in various countries for more than twenty years (30). While the mere fact that consent to proceed with a medical experiment is expressed by an independent group does not raise concerns, the composition and rules for appointing the members of the decisive body can raise them. In accordance with section 3, item 2 of the regulation of the Minister of Health and Social Care on detailed rules of appointment and funding and mode of operation of bioethical committees (31), members of these committees are specialist physicians and one representative of each of other professions, in particular: clergyman, philosopher, lawyer, pharmacist, nurse, who have at least 10-year experience in their respective professions. It should be noted that a precise distribution of impact between medical and other professionals is lacking. The phrase "in particular" means an open choice in this case. The legislator allowed that the members of bioethical committees can include other professionals and that there can be bioethical committees not including specialists in legal sciences or bioethicians. What is more, the above phrase requires that physicians becoming members of bioethical committees hold specialist titles, but it does not require that they represent different professions. It is therefore possible that the decision to endorse or reject a medical experiment will be issued by a group not including a physician specialized in the field of that experiment.

Another area worth analyzing is the question whether a medical experiment can be directed by any physician or whether the legislator has considered some limitations in this regard. In accordance with the competences defined in article 23 of the Medical Act (3), a medical experiment should only be led by an "appropriately qualified" physician, but the Act does not specify how to understand "appropriate qualifications" and does not indicate the entity authorized to assess these qualifications. The Act presents a fair view that these qualifications should be adequate for the individually designed experiment (30). The lack of the entity authorized to assess the "suitability" of the qualifications in practice causes that this area is assessed by the bioethical committee. Is another dubious aspect of the considered regulation as – with the committee composition potentially differing in every case – the assessment is made both by medical specialists and persons specializing in other disciplines.

The last of the analyzed areas is the time in which a bioethical committee needs to make a decision regarding a medical experiment. It is a crucial aspect as medical experiment is conducted only in situations in which standard methods are ineffective or insufficiently effective. Therefore, such situations involve patients with conditions considered as incurable according to the current standards. The regulation allows a bioethical committee to issue its opinion within no more than 3 months after receiving the complete documentation of the experiment (section 6, item 8). The three-month period seems unfavorable for the health status of the potential participants of the experiment as it can change dramatically. This, *de facto*, can cause modification of the designed course of the experiment and, as a result, obligation to change the application documentation. Thus, it is a circumstance strongly complicating the application decision by the physician because of concerns that the participant may not live by the time the committee issues a decision or the experiment starts. What is more, there are no regulations regarding delays in issuing the decision. For example, the committee may defer its decision due to high workload or changes in the committee composition. Although the legislator allows appealing against the decisions of the bioethical committee, the Appeal Bioethical Committee has a maximum of 2 months for appeal consideration and is not entitled to act in cases of tardiness in issuing an endorsement or rejection decision for conducting a medical experiment.

To conclude this section, it should be noted that the use of innovative therapeutic methods constitutes a major challenge for a physician. First of all, the procedure standardized by the Medical Act is long and complicated. The physician often chooses not to use innovative solutions as the wait time for approval may greatly exceed the time available to the patient for commencing treatment. What is more, the bioethical committee, which is the sole body entitled to authorize a medical experiment may not include a physician specialized in the field of the planned experiment. Overall, it is necessary that the legislator consider amendments to the regulations concerning medical experiment.

Substantive problems

The greatest substantive problems faced by physicians are caused by those diseases which are manifested in a non-typical way and whose differentiation is complicated (and not necessarily, but often, expensive). However, by implementing a holistic approach, the physician must build his/her relation with the patient also by considering the various biological, psychological, sometimes spiritual, usually environmental and social, and even economic factors.

The substantive issues faced by physicians are generally derived from their specific specialty. Different substantive issues are experienced by a psychiatrist and a family doctor, primarily because their patients report different problems, and some of these problems affect the patients' behavior in relations with physicians. Of course, practitioners deal with issues typical for the profession of physician as such on everyday basis, regardless of their specialty. These issues are sometimes associated with patient's nature (hypochondria, malingering, concealing disease, etc.). Whether patients report to an internal medicine specialist or a surgeon, difficulties experienced by physicians in their professional conduct are often similar.

Moreover, the profession of physician is linked with certain social phenomena typical of the modern world, such as relying more on the diagnosis and advice provided by Google than on advice received from a qualified healthcare professional. Therefore, contemporary relationships between patients and physicians are mainly characterized by a reciprocal lack of trust. This effectively prevents from providing effective help, particularly that needed within a short period of time.

It seems that the majority of substantive problems are faced by family doctors, increasingly providing healthcare services to elderly patients affected by poly pathology, including co-occurrence of physical and mental conditions (in particular, mobility restrictions combined with dementia or depression). The phenomenon of society ageing and the systemic lack of geriatricians pose several substantive problems to various specialists. Similarly, other negative trends in the society, such as obesity, addictions, various pain conditions, etc.) affect specialists in different fields.

However, substantive problems may stem from the personal characteristics (often restrictions) of the physician. There are still doctors who fail to accept that they need to discuss with the patient matters beyond the narrow area of their specialty, including specific sensitive health problems, as well as physical examination of intimate body parts (not only routinely, but especially in the light of absolute indications), particularly if the physician is not a specialist in the given field of medicine. This problem is largely a result of insufficient academic preparation for the profession.

Further to the above, substantive problems in contemporary everyday practice are caused not only by the characteristics of clinicians or their patients, but also by concerns regarding the use of certain medicinal products, for example, burdened by the risk of inducing unacceptable (conscience-wise) side effects or by the uncertainty of effectiveness (or quality) of generic medicines, that are usually less expensive.

The fact that the contemporary medicine provides both sides – the patient and the healthcare professional (not necessarily a physician) – with modern, usually minimally invasive, accurate and perfectly effective diagnostic and therapeutic techniques, as well as medical devices to use these techniques, does not make the physician's daily practice easier or problem-free. Problems faced currently are simply different from those experienced a few years, and especially a few decades, ago. It is quite the opposite – the very rapid technological progress in medicine forces physicians not only to constantly update their knowledge, but also to do it sufficiently quickly. Intense training is conducted in short periods of time and usually on multiple topics. As a consequence, a usually outstanding knowledge is accompanied by experience in the diagnosis or treatment of specific diseases, but in an increasingly narrow range constituting a small fraction of a much wider specialty, as well as only basic ability to deal with other diseases, including those falling within the same field of medicine.

Finally, providing healthcare in the state of chronic fatigue may be a frequent substantive problem. An insufficient number of specialists usually results in excessive load (for those specialists who are available) highlighting the awareness of responsibility for the health and lives of a very large group of patients. The negative effects of such a situation affect primarily the quality of work. Another consequence may also be the decision to give up working in such conditions, which of course further weakens the organization for which the physician worked, and therefore further decreases the availability of healthcare services to patients.

Conclusion

The most important non-medical issues faced by physicians are legal, economic and administrative problems. They require constant attention, regardless of the daily work and substantive knowledge of medicine. Therefore, it is necessary to indicate the specific problems and their solutions so that physicians could – under the heavy load of responsibilities – implement ready-to-use processes in dealing with issues not strictly associated with their profession.

REFERENCES

- (1) Medical Activity Act of 15 April 2011 (Journal of Laws of 2018, item 2190).
- (2) Business Act of 6 March 2018 (Journal of Laws item 646 as amended) and tax laws.
- (3) Medical and Dental Professions Act of 5 December 1996 (consolidated text Journal of Laws 2019, item 537, as amended).
- (4) Answer of the Minister of Economy to the written question no. 23318 asked during the 6th term of the Sejm <http://orka2.sejm.gov.pl/IZ6.nsf/main/00FD7CF8> [access date: 30 Sep 2019].
- (5) Kodeks Etyki Lekarskiej (Code of Medical Ethics): https://www.nil.org.pl/data/assets/pdf_file/0003/4764/Kodeks-Etyki-Lekarskiej.pdf [access date: 30 Sep 2019].
- (6) Patient Rights and Patient Ombudsman Act of 6 November 2008 (Journal of Laws of 2019, item 1127 as amended).
- (7) Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation); OJ L 119 of 4 May 2016.
- (8) Criminal Code of 6 June 1997 (Journal of Laws 1997, No. 88, item 553).
- (9) Prevention of Family Violence Act of 29 July 2005 (Journal of Laws of 2019, item 730).
- (10) [https://www.dpa.gr/pls/portal/docs/PAGE/APDPX/ENGLISH_INDEX/DECISIONS/SUMMARY%20OF%20DECISION%2026_2019%20\(EN\).PDF](https://www.dpa.gr/pls/portal/docs/PAGE/APDPX/ENGLISH_INDEX/DECISIONS/SUMMARY%20OF%20DECISION%2026_2019%20(EN).PDF) [21.09.2019 r.].
- (11) Sentence of the District Court in Toruń of 28 December 2018, document code. IV P 364/18, <https://orzeczenia.ms.gov.pl> [access date: 23 September 2019].
- (12) Labor Code Act of 26 June 1974 (Journal of Laws 1974, No. 24, item 141).
- (13) Pochrzęst-Motyczyńska A. RODO: Lekarze wciąż nie mają pewności jak prawidłowo administrować danymi pacjentów. <https://www.prawo.pl/zdrowie/rodo-jak-prawidlowo-administrowac-danymi-pacjentow,402426.html> [access date: 29 Sep 2019].
- (14) Łokaj M. RODO w ochronie zdrowia – przewodnik po zmianach w zakresie ochrony danych osobowych w placówkach medycznych. LEX 2018.
- (15) Korulczyk K., Umowy powierzenia danych medycznych. LEX 2018.
- (16) Polish Chamber of Physicians and Dentists (in a patient information clause) <https://www.nil.org.pl/aktualnosci/lekarzu,-lekarzu-dentysto!-udostepniamy-klauzule-informacyjna-dla-pacjentow> [access date: 28 Sep 2019].
- (17) Cuba M. In: Bielak-Jomaa E, and Lubasz D. RODO. Ogólne Rozporządzenie O Ochronie Danych Osobowych. Komentarz. Warszawa 2018; 280.
- (18) Przysławska M. In: Jackowski M. Ochrona danych medycznych. RODO w ochronie zdrowia. Warszawa 2018; 135.
- (19) Milewski R. et al. Podstawy ekonomii (Basics of economics). Wydawnictwo Naukowe PWN. 2018.

- (20) OECD database <https://stats.oecd.org/Index.aspx?ThemeTreeId=9> [access date: 30 Sep 2019].
- (21) Polska – wskaźniki makroekonomiczne (Poland – macroeconomic indicators). Central Statistical Office <https://stat.gov.pl/wskazniki-makroekonomiczne/> [access date: 30 Sep 2019].
- (22) Financial plan of the National Health Fund for 2018. <https://www.nfz.gov.pl/bip/finanse-nfz/> [access date: 30 Sep 2019].
- (23) Position and demands of the Union of Residents of OZZL. <http://www.rezydenci.org.pl/2017/10/02/protest-2-pazdziernika-stanowisko-postulaty-pr-ozzl/> [access date: 30 Sep 2019].
- (24) Report on the availability of guaranteed healthcare services in Poland, No. 19/15/02/2019, as of Dec/Jan 2019 <http://www.korektorzdrowia.pl/barometr/> [access date: 30 Sep 2019].
- (25) Act of 5 July 2018 on the amendment of the Publicly Funded Healthcare Services Act and some other acts (Journal of Laws of 2018, item 1532). <http://prawo.sejm.gov.pl/isap.nsf/DocDetails.xsp?id=WDU20180001532> [access date: 30 Sep 2019].
- (26) Union of Residents of OZZL, Health Work Action. <http://www.rezydenci.org.pl/akcja-zdrowa-praca/> [access date: 30 Sep 2019].
- (27) Manifesto directed to the Members of Parliament of the 8th term of the Sejm and the 9th term of the Senate, as well as candidates to the 2019 parliamentary election. <https://polskatochorykraj.pl/> [access date: 30 Sep 2019].
- (28) Karski L. Eksperyment medyczny przeprowadzony na organizmie ludzkim – aspekty prawa międzynarodowego, europejskiego i krajowego (Medical experiment conducted in humans – aspects of international, European and national laws), *Studia Ecologiae et Bioethicae UKSW*. 11(2013)1.
- (29) Puk M. Eksperyment medyczny w świetle Kodeksu etyki lekarskiej. Zagadnienia problemowe. (Medical experiment in light of the Code of Medical Ethics. Selected problems). MW 7/2015.
- (30) Medical and Dental Professions Act. Commentary edited by prof. Ogiełto L. 2nd ed., Warszawa 2015, access: Legalis.
- (31) Rozporządzenie Ministra Zdrowia i Opieki Społecznej z dn. 11 maja 1999 r. 1999 (Journal of Laws of 1999, no. 47, item 480).