Biuletyn Stowarzyszenia Absolwentów i Przyjaciół Wydziału Prawa Katolickiego
Uniwersytetu Lubelskiego t. XV, 17 (1) 2020, s. 195-212
https://doi.org/10.32084/sawp.2020.15.1-11

Iwona Warchoł

THE ROLE OF THE RULES FOR PURSUING THE PROFESSION OF NURSE IN THE PROTECTION OF PATIENTS' RIGHTS

Opening remarks

According to the World Health Organization, in the treatment of patients' rights, a distinction is made between social and individual rights. Social rights are those of the individual's rights that stem from belonging to a particular society. These include, for example, the right to equal access to health care, the elimination of unjustified discriminatory barriers (on grounds of age, gender, nationality, religious persuasion, and social or economic situation). From the viewpoint of the quality of health care services, individual rights are fundamental. These are: the right to respect of his or her person as a human being, the right to self-determination, the right to respect of his or her physical and mental integrity and to the security of his or her person, the right to respect of his or her privacy and his or her moral and cultural values and religious and philosophical convictions.

The Council of Europe has for long addressed issues related to the progress of biological and medical sciences. This is seen, *inter alia*, in many recommendations of the Parliamentary Assembly and resolutions of the Committee of Ministers issued before the 4 April 1997 Oviedo Convention for the Protection of Human Rights and the Dignity of the Human Being with regard to the Application of Biology and Medicine, also known as the Convention on Human Rights and Biomedicine or the European Bioethics Convention (EBC) in the literature [Biesaga 2006, 24].

In health care, it is of crucial importance that these rights be duly safeguarded and respected because, as a result of the development of new and in-

IWONA WARCHOŁ, Ph.D., associate professor in the Department of Administrative Law and Administration Sciences, Faculty of Law and Administration, Kazimierz Pułaski University of Technology and Humanities in Radom; ul. J. Malczewskiego 29, 26-600 Radom, Poland; e-mail: rachela109@wp.pl; https://orcid.org/0000-0002-8159-7624

creasingly complicated methods that require specialist knowledge and often involve the collaboration of whole teams of professionals, there is a risk of depersonification and dehumanization of the patient [Maciąg and Sakowska 2006, 57].

The Polish Constitution[1] grants everyone the right to health. Public authorities ensure citizens equal access to health care services financed from public funds, irrespective of their material situation. The need to have separate legal regulations on this matter in place stems from the universal human rights standards set out in international treaties ratified by Poland, i.e. from the supranational legal order, and from the domestic legislation. The inherent, universal, and inalienable nature of human rights requires a democratic state ruled by law to afford them a proper level of protection, which is the task of the legislator [Ostrzyżek 2005, 25].

Currently, this is laid down in Art. 68 of the Polish Constitution. It is also adderssed by numerous international instruments. The Constitution of the World Health Organisation says that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.[2] These issues are further covered by the International Covenant on Economic, Social and Cultural Rights.[3] Under its Art. 12, the state parties recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The same article also imposes on the state parties certain obligations to enable them to achieve the full realization of this right. The European Social Charter offers similar solutions.[4] Its Part

[1] The Constitution of the Republic of Poland of 2 April 1997, Journal of Laws of 2009, No. 114, item 946.

[2] The Constitution of the World Health Organization adopted by the governments represented at the International Health Conference and the Protocol concerning the International Office of Public Hygiene, done at New York on 22 July 1946, Journal of Laws of 1999, No. 8, item 67 as amended.

[3] International Covenant on Economic, Social and Cultural Rights, open for signature in New York on 19 December 1966, Journal of Laws of 1977, No. 38, item 169.

[4] European Social Charter, done at Turin on 18 October 1961, Journal of Laws of 1999, No. 8, item 67 as amended.

I, point 11 says that everyone has the right to benefit from any measures enabling them to enjoy the highest possible standard of health attainable.

The literature on the subject and the case-law[5] of the Constitutional Tribunal shows that Art. 68, sect. 1 confers on everyone a subjective right to health. Yet, the other paragraphs of the same article pose some interpretation challenges. At first sight, they address public authorities which are obliged to perform certain duties listed therein. However, the scope of these duties is limited by the state's financial capabilities. However, in the relevant case-law, it is consistently argued that these regulations do not provide grounds for pursuing specific claims against health care providers.[6] The scope and conditions of access to health care services financed from public funds are regulated by laws. Only violation of their provisions authorizes the suffering entity to resort to protective legal instruments. However, as follows from the constitutional approach to the rights in question, by refining the provisions of the Constitution in lower ranking legal acts, the legislator must design such a system that will enable such rights to be actually respected [Kubiak 2017, 5].

Apart from the Constitution, there is a number of laws regulating the operation of the health care service and containing provisions that guarantee the protection of patients' rights. The most noteworthy are: the Act of 5 December 1996 on the Professions of Doctor and Dentist,[7] the Act of 15 July 2011 on the Professions of Nurse and Midwife,[8] the Act of 27 August 2004 on Health Care Services Financed from Public Funds,[9] and the Act of 6 November 2008 on the Protection of Patients' Rights and the Ombudsman for Patients' Rights.[10]

---

[5] Judgement of the Constitutional Tribunal of 23 March 1999, K/98, OTK 1999, no. 3, item. 38.

[6] Judgement of the Supreme Court of 21 December 2004, I CK 320/04, unpublished; judgement of the Court of Appeals in Poznań of 23 May 2006, I ACa 1266/05, unpublished.

[7] Journal of Laws of 2020, item 514 as amended [henceforth cited as: APDD].

[8] Journal of Laws of 2020, item 562 as amended [henceforth cited as: APNM].

[9] Journal of Laws of 2020, item 695 as amended.

[10] Journal of Laws of 2020, item 849 [henceforth cited as: APPRS].

1. The right to adequate health services

The patient has the right to health services suited to the requirements of current medical knowledge. This entail the obligation to provide the patient with health services at a sufficiently high level and to offer a sense of therapeutic security, yet without a guarantee of the positive effect of medical act, in other words, a guarantee to cure the patient. The notion of "current medical knowledge" refers to the medical intellectual process, i.e. the use of medical knowledge. Given that, the legislator demands nurses to exhibit high diligence and reliability in the pursuit of their profession. For a nurse to carry out medical acts using current medical knowledge is an unquestionable condition for pursuing the profession in accordance with the law (Art. 11, sect. 1 APNM). Satisfying this condition is an objective category and does not depend on the nurse's personal beliefs.

In line with global trends, in the professional practice of nurses, more and more emphasis is laid on the use of research data, which is expected to improve not only the safety of patients and medical staff or the effectiveness of performed medical procedures but also the financial efficiency thereof. The education of nursing students at the BA and MA level at medical universities boasting a long tradition of conducting scientific research and implementing their results into clinical practice should place a greater emphasis on training in research methodology, critical analysis of research data or skills of critical reading of research papers, in other words, all the components of evidence-based nursing practice [Gotlib, Belowska, et al. 2014, 282].

The borderline between cognitive and practical learning goals is blurred; still, they remain intertwined, just like medical science and professional practice [Lenartowicz and Kózka 2010, 11-13]. The contemporary progress of science and technology often renders the knowledge obtained at university less relevant over time. It is argued that in medical sciences the so-called knowledge half-life, that is, the amount of time before half of the knowledge is made obsolete, is three to eight years depending on the discipline [Boratyńska and Konieczniak 2001, 173]. Therefore, a person practising the nursing profession is urged to update, broaden, and deepen their knowledge throughout the entire period of professional activity. In the event of limitations in providing adequate health care services, the patient has the right to

an objective and medical criteria-based procedure of determining the order of access to such services. The medical criteria that healthcare providers should follow when drawing up waiting lists are set out in the law.

2. The right to immediate medical aid

The patient has the right to be immediately rendered health services due to a threat to health or life. Given that, a health care facility may not refuse the person in need proper assistance. The patient has the right to nurse's assistance in any case if any delay in such assistance could result in a risk of loss of life, serious injury or serious health disorder and in other emergency cases. When a delay in providing medical assistance by a nurse is likely to cause a state of health emergency, the so-called mandatory immediate provision of health services should occur, irrespective of the patient's citizenship, health care system affiliation, financial standing, etc. [Lach 2011, 84]. It is also irrelevant whether a given health care establishment is funded by the National Health Fund and whether the so-called service volume limit has been exhausted. In such a situation, the patient is entitled to health services outside the queue and without an obligatory referral. At this point, it is worth recalling the Judgement of the Supreme Court of 10 January 2014.[11] First, it shows that a doctor and a health care establishment may request reimbursement of the cost of saving the life of a patient insured in the National Health Fund; second, the service volume limits provided for in contracts with the National Health Fund do not apply to health services rendered in life-threatening conditions.

In accordance with their qualification, the nurse has an obligation to assist in any case whenever a delay in assistance could cause a state of health emergency (Art. 12, sect. 1 APNM). The legislator requires each nurse to "assist," yet without specifying what this assistance should involve.

In the grounds for its judgement of 13 October 2006, the Supreme Court pointed out that, "Although each health services is provided in the situation of a threat to human health, the legislator clearly distinguishes between health services provided under normal conditions, i.e. where the provision of

[11] I CSK 161/13, unpublished.

assistance does not require immediate action and can be postponed, and in a situation where it must be provided immediately since, if delayed, it may result in a loss of health or life."[12]

3. The right to request consultation

The patient has the right to require that a nurse or midwife providing them with health services seek the opinion of another doctor, nurse, or midwife, respectively (Art. 6, sect. 3, point 2 APPRS). When making such a request, the patient may, but they do not have to, designate a specific individual whose consultation should be sought. The professional independence of nurses manifests itself in the option for the nurse of seeking advice and support within their own professional group by consulting another nurse or doctor.

However, both a doctor, nurse, or midwife may refuse to provide consultation if they consider the patient's request to be unfounded. However, this needs to be logged in medical records.

If the patient is treated in a stationary health care establishment, the right to consultation should be exercised with no limits because such an establishment employs some other medical professionals, unless, at the moment, there is no nurse available with appropriate qualification to express an opinion or the patient requests consultation with a person pursuing the nursing profession outside this establishment.

All in all, irrespective of whether the opinion of another nurse is obtained by the one seeking advice of a medical nature or on the initiative of the patient themselves, the opinion of the consulting nurse is, in principle, regarded as being of advisory character only, and the nurse seeking advice remains responsible for the performance of the actual medical procedure. However, obtaining the opinion of another professional is undoubtedly evidence of due diligence in the provision of health services by the nurse [Karkowska 2013, 131].

[12] III CKS 123/06, Lex no. 258671.

4. Due diligence

The patient has the right to health services provided with due diligence. This means, but not only, that a nurse or midwife must not perform an activity that goes beyond their professional skills. In the event of medical doubts, the doctor administering treatment has an obligation of consulting an expert or convene a case conference. Nurses and midwives fall under a similar obligation. A person practising the profession of a nurse based on current medical knowledge and in accordance with professional qualification is not free from negligence or carelessness. The nurse is required to act with due diligence (Art. 11, sect. 1 APNM). This condition is also reiterated in the Code of Ethics for Nurses and Midwives, and any conduct violating such standards is considered unethical.

Failure to exercise due diligence can take the form of a subjective and objective malpractice. The subjective malpractice means that the nurse does not carry out a specific activity diligently and is not fully concentrated on it, which means that they "do not strive" to act effectively. The subjective malpractice may relate to both medical (inattention, disregard, undue haste, ignorance, carelessness) as well as non-medical techniques (e.g. patient abandonment, lack of necessary supervision, refusal to assist, failure to provide proper nursing care, failure to inform the doctor when necessary, failure to applying proper supervision over a patient who is subject to a direct coercive measure).

On the other hand, the objective malpractice means that the nurse does not carry out a specific activity diligently because they do not follow the rules that reasonably govern its effective and safe performance. These rules determine practical activities. The rules of proper conduct for nurses are based on recently developed guidelines, standards, and procedures for specific types of nursing services (the so-called standardization of nurses' work) [Karkowska 2013, 123-24].

Any nurse who carries out an activity in accordance with both the current state of the art and due diligence is not liable for the undesirable result of that activity. Consequently, the nurse is not exposed either to civil liability (tort liability) or to criminal liability for the so-called offence against life and health leading to consequences under criminal law.

There is extensive case-law regarding due diligence in medical procedures, but the vast majority of cases involve doctors. In my opinion, however, similar legal interpretation would also apply in the case of nurses, which is why I will take the liberty of quoting some excerpts from the grounds for two decisions of the Supreme Court showing how the concept of due diligence should be understood.

"Since the therapeutic procedures conducted by the defendant [...] were *lege artis*, the doctor cannot be held liable for the medical failure under criminal law."[13]

"The high demands imposed on the doctor do not naturally entail their responsibility for the result of treatment or no-fault liability. The doctor can be held liable based on guilt which can only be attributed to them in the event of simultaneous occurrence of an element of objective and subjective malpractice. The objective element is associated with the violation of the principles of medical knowledge, experience, and deontology, which embrace the so-called medical error, i.e. a violation of the rules of doctor's conduct against the background of medical science and practice. Therefore, a medical error essentially accounts only for the objective element of guilt (keeping in mind that there are categories of medical errors that will be sufficient to prove guilt also in the subjective perspective). The subjective element refers to the doctor's professional diligence assessed against a specific model and standard of conduct and by adopting the criterion of a high level of average diligence of each doctor. [...] The doctor's liability will arise in the event of a 'mistake in art,' i.e. carrying out a procedure contrary to the principles of medical knowledge, if it was a culpable mistake, i.e. involving conduct departing from the established model. When assessing the doctor's conduct, their valid expectation should also be taken into account of not exposing the patient to deterioration of health. There is also a useful practical test based on the question of whether the adverse effect could have been avoided and whether the doctor should have and could have done more (better) in the treated case […].

[13] Decision of the Supreme Court of 14 March 2013, IV KK 420/12, unpublished.

However, the doctor will not be liable for the result of a surgical procedure which led to complications attributable to specific circumstances beyond their control."[14]

5. The right to information on health status

The obligation of providing information on health is subject to the provisions of Art. 9-10 of the Act on Patients' Rights and the Patients' Rights Ombudsman. The content of its Art. 9, sect. 1 is intricately connected with the provisions of other specific acts that impose the obligation of information as a prerequisite for any medical intervention to which the patient consents to be lawful. The obligation of information, which corresponds to the patient's right to information on their health status, is also laid down in Art. 31 APDD. Like Art. 9 APPRS, this provision is also relatively general. None of them constitutes *lex specialis* in relation to the other [Świderska 2009, 273].

Full satisfaction of the obligation of information is a necessary condition for the patient to express their lawful consent to agreed treatment [...], and the ineffectiveness of consent due to the absence of proper information renders any doctor's action unlawful. The goal of the doctor's obligation to explain the effects of a surgical procedure to their patient is to enable the patient to make a "go" or "no-go" decision while being fully aware of what they con-sent to and what complications may occur.[15]

The nurse's obligation to provide patient-related information to the extent relevant to intended medical procedures is closely related to respect for the person's right to privacy. The nurse is obliged to inform the patient about their rights in accordance with the Act on Patients' Rights. Hence, this obligation does not cover specific aspects of patients' rights originating under other laws.

The nursing profession is an independent medical profession, and only in relation to this profession the legislator imposes the obligation to provide information on the patient's health status – to the extent necessary to provide

[14] Judgement of the Supreme Court of 24 October 2013, IV CSK 64/13, unpublished.

[15] Judgement of the Supreme Court of 20 November 1979, IV CR 389/79, OSNC 1980, no. 4, item 81.

nursing care – and nursing care and procedures (Art. 9, sect. 8 APPRS and Art. 16, point 2 APNM). These two standards form a single whole and should be so interpreted. To satisfy this obligation, the nurse needs to recognize the patient's health needs and to establish a nursing diagnosis. The nurse's obligation of information applies to both nursing activities performed independently, i.e. without a doctor's request, and ones based on such a request [Karkowska 2013, 153].

In some regulations, in addition to the Act on Patients' Rights, the legislator explicitly reserves what information is to be provided by a doctor, surgeon, nurse, or midwife. Pursuant to the Act of 19 August 1994 on the Protection of Mental Health,[16] the nurse is required to provide information on why direct coercion has been used (Art. 18, sect. 2, 3 and 8 APMH).

In light of the provisions of the Act of 5 December 2008 on Preventing and Combating Human Infections and Infectious Diseases,[17] the nurse is obliged to instruct an infected person, person suffering from an infectious disease or a person who has legal or actual custody of a minor or helpless person about measures to prevent transmission of the infection to other persons. The nurse is also obliged to provide information on the potential obligation imposed on persons suspected of infection or an infectious disease to submit to sanitary and epidemiological tests. The same applies to newborns, infants and pregnant women suspected of infection or an infectious disease that can spread from the mother to the foetus or child, pupils, students or PhD students getting ready for work which goes with the risk of transmission of infection or an infectious disease to other persons (Art. 26, sect. 1 in conjunction with Art. 6, sect. 1, point 1, 2, 3, 4 and 5 and Art. 10, sect. 2 AID).

Next to the right to information, the Act on Patients' Rights establishes the right not to be informed by the doctor (Art. 9, sect. 4 APPRS in conjunction with Art. 31, sect. 3 APDD). However, there is no corresponding patient's right in relation to nurses. It can therefore be assumed that the nurse is always obliged to inform the patient, and the patient cannot refuse to become acquainted with this information.

[16] Journal of Laws of 2020, item 685 [henceforth cited as: APMH].

[17] Journal of Laws of 2020, item 284 as amended [henceforth cited as: AID].

6. Confidential information

The patient has the right to require that the medical professionals, including those providing them with health services, keep all information related to the patient and obtained in connection with their practice of medical profession confidential. This right is valid for an indefinite period of time. It applies to both current and former patients and continues after the patient's death, rehabilitation, or hospitalization. The information in question also cover information about the patient's family and financial status.

The nurse's obligation to maintain secrecy is at the very heart of their profession. They swear it solemnly when making their professional pledge. The principle of respect for confidentiality is explicitly set out in applicable legal regulations. The requirement to keep patient's information obtained in connection with the pursuit of the profession of nurse confidential is one of the fundamental principles of the profession (Art. 17, sect. 1 APNM). It also explicitly stated in the Code of Ethics for Nurses and Midwives. From a slightly different point of view, the obligation to maintain secrecy arises from the patient's right to keep information related to them and obtained in connection with the pursuit of the nursing profession confidential (Art. 13 APPRS); moreover, it stems from the requirement to respect medical data contained in medical records kept in health care facilities and in professional practice establishments (Art. 23 in conjunction with Art. 24 APPRS).

This patient's right, however, is subject to restrictions under the law. It will not be respected either if keeping certain information secret is likely to endanger the life or health of the patient or other persons, or if the patient (their legal representative) agrees to disclose it.

The obligation to keep information related to the patient and obtained in connection with the pursuit of the profession of nurse confidential is not absolute and there are cases where persons practising the nursing profession are released from it. They may even be obliged to disclose information at their disposal. The circumstances waiving the patient's right to confidentiality are provided for in the APNM and in other laws. They are listed

there[18] and can generally be divided into two sets. The first set lists circumstances in which the patient has no more interest in keeping certain information confidential and situations in which maintaining confidentiality may pose a threat to the health and life of the treated person [Safjan 1998, 130-31]. The other set lists circumstances involving the so-called vital public interest or the interest of third parties in waiving confidentiality.

7. Consent to services

Everyone has the right to have their physical, mental, and moral integrity respected. As regards the European medical law, there is a well-established principle that health services (intervention) cannot be rendered to anyone without their consent.[19] In Polish medical law, the legislator expressly regulated the issue of patient's, or their statutory representative's, consent to health services provided by a medical doctor (Art. 32 and Art. 34 APDD in conjunction with Art. 18 APPRS). Yet, the legislator failed to lay down the rules of patient's, or their statutory representative's, consent to health services provided by a nurse. This problem is crucial because the nurse can perform their professional procedures on the basis of a doctor's referral but also without it, to the extent provided for by the legislator.

Nurses assume personal and independent liability for performed medical procedures, which is why the legislator should not overlook such a significant area of Polish medical law as the patient's consent to such procedures performed by a nurse. Consequently, the Polish legislator should consider the development and incorporation in the APDD of the principles of confirmation of patient's consent to health services provided by a nurse on the basis of a doctor's referral and without it as well as the principles of the nu-

[18] Restrictions on the obligation to maintain professional secrecy by nurses need to be re-considered in the following situations: 1) statutory or non-statutory obligation to report to the relevant public authorities (e.g. sanitary authorities) about the circumstances covered by professional secrecy; 2) obligation to report an offence; 3) a nurse giving testimony as a witness in criminal proceedings; 4) a nurse giving testimony in proceedings before a regional commission adjudicating on medical events; 5) a nurse acting in the role of an expert; 6) scientific research; 7) practical training in medical professions.

[19] The obligation to obtain patient's consent is clearly worded in Art. 5 of the European Bioethics Convention.

rse's conduct in the event of refusal of patient's consent or patient's objection to be rendered health services by a nurse [Karkowska 2013, 169].

8. Privacy and personal dignity

The provision of Art. 20, sect. 1 APPRS points directly to the patients' right to respect their privacy and dignity when being rendered health services. On the other hand, the Code of Ethics for Nurses and Midwives obliges the nurse to respect the patients' right to privacy and dignity when being rendered medical services. The APNM does not contain any separate regulations regarding the patients' right in question, still it requires nurses to practise their profession while respecting patients' rights (Art. 11, sect. 1 APNM).

The patient has the right to have their privacy and dignity respected, in particular when being provided health services. Therefore, they are in a position to expect medical personnel to show respect, be tactful and kind, show understanding and patience. The patient should also be treated on equal terms in any interpersonal relations; they cannot be forced to submit to certain rules that violate their sense of dignity. Every patient, regardless of their age, has the right to request that a relative be present during the provision of health services. This right may, however, be waived by medical professionals providing health services in the event of a probability of an epidemic emergency or because of the patient's health safety. Such waiver should be recorded in the medical records. In addition, persons pursuing the medical profession other than those providing health services participate in the provision thereof only when it is necessary and justified by the type of service or the need for control activities and when the patient (or their statutory representative) so agrees.

The patient's right to dignity also covers the right to pass away in peace and dignity. A terminally ill patient has the right to be rendered health services offering relief of pain and other suffering. A dying patient has the right to professional nursing care, psychological support, additional care of their relatives or pastoral care. In critical situations, they have the right to receive pharmacological agents that will enable them to overcome emotional stress.

9. Medical records

Currently, the fundamental regulations regarding medical records are contained in the Act on Patients' Rights and the Patients' Rights Ombudsman. These regulations have been significantly amended by the Act of 23 March 2017 amending the Act on Patients' Rights and the Patients' Rights Ombudsman and some other acts.[20] The statutory regulations also go with prescriptive acts, in particular the Regulation of the Minister of Health of 9 November 2015 on the types, scope and specimens of medical records and methods of their processing.[21] It has been ranked as the so-called sensitive data that is subject to special protection [Kubiak 2017, 176-77].

The patient has been granted many entitlements related to access to medical records and requesting adequate safeguards to be put in place in relation to their medical data. Medical records can be made available: 1) for review, including health care databases, in the seat of the establishment providing health services; 2) as excerpts or copies, in which case the disclosing establishment may charge a fee; 3) as an original copy issued upon acknowledgement of receipt and subject to return after use if an authorized body or authority requests access to the original records (Art. 27 APPRS).

Medical records has the most extensive in medical establishments that keep both collective and individual records. Nurses who provide health services as part of their professional practice only keep individual medical records. The nurse's obligation to keep patient's individual medical records is strictly related to the pursuit of the nursing profession. The owner of medical records is the establishment providing health services, i.e. a health care provider which employs the nurse or in which the nurse pursuits their medical profession.

The nurse is obliged to ensure that the nursing records are properly kept and are not disclosed. The nursing records should only contain information required for nursing and should be kept lawfully. Medical records contain information about the patient's health. Essentially, this is information about

[20] Journal of Laws, item 836.

[21] Journal of Laws, item 2069.

medical activities undertaken by a doctor, nurse or other persons authorized to do so [Karkowska 2013, 222-23].

10. Additional care

Every patient, regardless of their age or disease, has the right to additional nursing care in a medical establishment rendering health services, i.e. both in stationary and 24/7 facilities as well as in outpatient clinics. Additional care is care offered parallel to (but not instead of!) assistance provided by qualified medical personnel in a hospital or other stationary health care establishment. This type of care does not involve the provision of health services, nor assistance to women in pregnancy, at labour and in the postpartum period, and can be performed by any person indicated by the patient (i.e. one who does not necessarily have adequate qualification or vocational training).

It should also be noted that a nurse and midwife may provide additional nursing care in a health care establishment under a civil law contract concluded with a patient, their relative, or a legal guardian. Importantly, such a contract cannot cover activities that are already funded by the National Health Fund at the same stationary health care facility. What is more, the nursing staff taking care of patients in a stationary health care establishment is not exempted from their service obligations towards patients who exercise their right to additional care. The decision to exercise this right is made by the patient themselves, and if due to age or illness they are not able make an independent decision, it is made by their parents, legal guardian and sometimes the actual caregiver. Additional care cannot be imposed by other persons, including by medical staff or family. This right is particularly important with children since they are constitutionally guaranteed the right to special health care. Yet, also in this case, the cost of exercising the right to additional care is incurred by the patient themselves.

Conclusion

The legal status of the nursing profession is undergoing a constant change. Out of an auxiliary function, it has evolved towards an independent medical profession. As from 1 January 2016, specific nurse groups are entitled to refer patients to basic diagnostic tests, as well as being able to prescribe and

administer medicaments, medical devices, and special-purpose foodstuffs and to issue prescriptions as part of treatment pre-ordered by a doctor. These changes enhance the professional prestige but also broaden the scope of legal and professional liability of nurses, which makes the subject of law in nursing even more relevant [Zarzeka, Panczyk, et al. 2016, 247-48].

The rules of pursuing the nursing profession are obligatory, and nurses have the legal obligation to observe them. This is a standard required by the law and, in principle, certain legal rules governing the profession cannot be denied or refused by relying on different non-legal traditions of the profession, customs observed in the place of practising the profession, or differrences in professional ethics. In other words, these rules are universal. To the extent adopted by the legislator, they apply to all persons practising the nursing profession, irrespective of the legal form thereof (employee or non-employee status, entrepreneur status, etc.).These rules take precedence over internal regulations in place at health care establishments where nurses practise their profession.

Internal organizational and normative rules may not contain provisions contrary to the rules of pursuing the profession. The same requirement applies to contracts concluded under public health insurance financed from public funds or contracts concluded with and financed by private personal insurance providers. The provisions of such contracts may not contradict the rules of pursuing the nursing profession. Moreover, the legislator requires the provisions of internal organizational and normative documents and the provisions of contracts concluded with health care providers under health insurance to be framed in such a way that their implementation allowed the actual and not formal observance and respect of the said rules in the nursing practice.

The obligation to respect the rules of pursuing the nursing profession, irrespective of the organizational and legal conditions of its pursuit, is an unquestionable manifestation of the independence of the profession. These rules are directly applicable to the pursuit of the profession; they are not subject to modifications based on a contract of employment or another civil law contract concluded with the employer, nor are they subject to revision in the case of self-employed individuals. They are also immune to unfavourable mo-

dification in a contract concluded directly with a patient [Karkowska 2013, 115-16].

REFERENCES

Biesaga, Tadeusz. 2006. "Europejska Konwencja Bioetyczna." *Medycyna Praktyczna* 11-12:24-28.

Boratyńska, Maria, and Przemysław Konieczniak. 2001. *Prawa pacjenta*. Warszawa: Wydawnictwo Difin.

Gotlib, Joanna, Jarosława Belowska, et al. 2014. "Wiedza i postawy pielęgniarek wobec wykorzystywania wyników badań naukowych w codziennej praktyce klinicznej – doniesienia wstępne." *Problemy Pielęgniarstwa* 3 (22):281-87.

Karkowska, Dorota. 2013. *Prawo medyczne dla pielęgniarek*. Warszawa: LEX Wolters Kluwer business.

Kubiak, Rafał. 2017. *Prawo medyczne*. Warszawa: Wydawnictwo C.H. Beck.

Lach, Daniel E. 2011. *Zasada równego dostępu do świadczeń opieki zdrowotnej*. Warszawa: Wolters Kluwer Polska.

Lenartowicz, Helena, and Maria Kózka. 2010. *Metodologia badań w pielęgniarstwie*. Warszawa: Wydawnictwo Lekarskie PZWL.

Maciąg, Agnieszka, and Izabela Sakowska. 2006. "Rola i prawa pacjenta w obszarze usług zdrowotnych." *Studia i Materiały – Wydział Zarządzania UW* 1:50-62.

Ostrzyżek, Artur. 2005. "Prawo do ochrony zdrowia w świetle artykułu 68 Konstytucji Rzeczypospolitej Polskiej z dnia 2 kwietnia 1997 r." *Prawo i Medycyna* 4:21-18.

Safjan, Marek. 1998. *Prawo i medycyna. Ochrona praw jednostki a dylematy współczesnej medycyny*. Warszawa: Oficyna Naukowa.

Świderska, Mariola. 2009. "Prawo pacjenta do informacji, wyrażenia lub odmowy zgody na interwencję medyczną w świetle nowej ustawy o prawach pacjenta i Rzeczniku Praw Pacjenta i znowelizowanej ustawy o zawodach lekarza i lekarza dentysty. Materiały z Konferencji Naukowo Szkoleniowej «Prawo do wyrażania zgody na zabieg medyczny i inne prawa pacjenta». Warszawa 17-18 września 2009 r." http://www.prawoimedycyna.pl/?str=artykul&id=546 [accessed: 27.03.2018].

Zarzeka, Aleksander, Mariusz Panczyk, et al. 2016. "Prawo w pielęgniarstwie – przegląd aktualnego, dostępnego, polskiego piśmiennictwa naukowego z zakresu pielęgniarstwa." *Pielęgniarstwo Polskie* 2 (60):247-55.

The Role of the Rules for Pursuing the Profession of Nurse in the Protection of Patients' Rights

Summary

The article discusses protection of patients' rights in the context of practising the nursing profession. After an introduction in the general context of medical law, the author addresses individual patient's rights and discusses how they should be respected by persons pursuing the nursing profession. These rights are the following: the right to proper health service, the right to immediate medical aid, the right to request consultation, pursuit of the nursing profession with due diligence, the right to information on health status, confidential information, consent to services, protection of privacy and personal dignity, protection of medical records, and the right to additional care.

Key words: medical law, patients' rights, profession of nurse, rules for pursuing the profession

Rola zasad wykonywania zawodu pielęgniarki w ochronie praw pacjenta

Streszczenie

Artykuł dotyczy ochrony praw pacjenta w szczególnym kontekście związanym z zasadami wykonywania zawodu pielęgniarki. Autorka po wprowadzeniu w ogólny kontekst prawa medycznego przedstawia poszczególne prawa podmiotowe w aspekcie tego, jak mają je respektować osoby wykonujące zawód pielęgniarki. Są to następujące prawa: prawo do odpowiednich świadczeń zdrowotnych, prawo do natychmiastowej pomocy medycznej, prawo do żądania konsultacji, wykonywanie zawodu z należytą starannością, prawo do informacji o stania zdrowia, tajemnica informacji, zgoda na udzielenie świadczeń, ochrona intymności i godności osobistej, ochrona dokumentacji medycznej oraz prawo do dodatkowej opieki pielęgnacyjnej.

Słowa kluczowe: prawo medyczne, prawo pacjenta, zawód pielęgniarki, zasady wykonywania zawodu

Informacje o Autorze: Dr IWONA WARCHOŁ, adiunkt w Katedrze Prawa Administracyjnego i Nauki o Administracji, Wydział Prawa i Administracji, Uniwersytet Technologiczno-Humanistyczny im. Kazimierza Pułaskiego w Radomiu; ul. J. Malczewskiego 29, 26-600 Radom, Polska; e-mail: rachela109@wp.pl; https://orcid.org/0000-0002-8159-7624