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Legal and ethical aspects of medical standards.

The practice of medical disciplinary boards

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Abstract

This article takes on the issue of medical standards from the perspective of the exercise of the medical profession. In the context of evaluation of diagnosis and treatment certain problems surface in relation to the definitions of health and disease. The ambiguity of these terms is not conducive to standardization. On the other hand, there is the question whether a standard in the form of universally binding law should contain medical knowledge or merely content itself with regulating the organization of health-care. Decisions of medical disciplinary boards („medical courts" in Polish law) can be helpful in the shaping of correct practice.

Key words: public health

Introductory notes

Debates surrounding the term „health" have led to numerous proposals for a definition. However, in practice, only three concepts have been reflected in legislation: bio-medical, functional and one grounded in holistic medicine, used in World Health Organization documents. It is worth noting that the scope of those definitions is important from the perspective of the exercise of the medical profession. The Act on the Professions of Physician and Dentist[1]] stipulates that the exercise of the profession of physician consists in the diagnosis, treatment and prevention of diseases, and issuing medical certificates, but does not define the terms. The ambiguity of these terms is not conducive to standardization in medical practice. It is worth noting, however, that the term „disease" is classified as one of the positions entered the International Statistical Classification of Diseases and Related Health Problems[2]. Consequently, „health" should be regarded as that condition which is not listed in the document.

„Health" and „disease" are terms closely linked to the person of a physician. Hence, treatment is referred to as medical procedure with the goal of restoring the patient" sheathe improving the patient's quality of life. There is currently no doubt that correct medical practice must be grounded in up-to-date medical knowledge. The above requirements have led to increasingly frequent introduction of medical standards[3]. Standards are created based on current

[1] Ustawa z 5 grudnia 1996 r. o zawodach lekarza i lekarza dentysty (Dz. U. z 2008 r. Nr 136, poz. 857 z późn) [Act of December 5, 1996 on the professions of a doctor and a dentist(Journal of laws from 2008, No. 136, item 857 as amended]

[2] Klasyfkacja ICD-10Międzynarodowa Statystyczna Klasyfikacja Chorób i Problemów Zdrowotnych[International Classification of Diseases]

[3] Standardy medyczne [Medical Standards]: http://www.mz.gov.pl/system-ochrony-zdrowia/organizacja-ochrony-zdrowia/standardy-medyczne, [dostęp 30 listopada 2018 r.]

medical knowledge by expert panels across a variety of medical fields, by medical associations and by physicians' associations. The standards provide precious guidelines in a doctor's daily practice. We distinguish legal and other standards. In the latter case we are dealing with recommendations, advice and procedural algorithms. Nonetheless, some standards follow from universally binding legislation, for example ministerial regulations. The medical community, however, calls attention to how medical standards facilitate medical practice but are not always applicable, as they refer to the average situation. This means that they do not and in practice cannot consider all the circumstances applicable to a doctor providing health-care. Here, the question arises whether and to what extent medical knowledge should be contained in those standards. And to what extent those standards should instead be merely technical and organizational norms relating to the provision of health-care. It ought not to be forgotten that a physician's conduct consistent with current medical knowledge should also reflect ethical norms that frequently supplement the provisions of the law and hence also affect the standard of exercise of the medical profession.

Health and disease as legal terms

For many years' health had been defined based on the bio-medical concept. Practitioners attention focused on the somatic sphere, accessible to objective clinical examination. Health was understood in negative categories: lack of disease, or the opposite condition. In keeping with the bio-medical concept of health, the human body was regarded as a machine, and disease was a variable deviation from the norm[4]. With that way of defining health, disease was taken to mean any pathological condition, dysfunction (disability, failure) of a human person's organ or system[5]. In practice, it is known that certain small clinical pathologies, e.g. visual impairments requiring only the use of glasses for vision correction, are difficult to classify as diseases. In the bio-medical model, the line between health and disease as conditions can prove very difficult to

[4] Ostrzyżek A., Marcinkowski JT., Biomedyczny versus holistyczny model zdrowia a teoria i praktyka kliniczna, Higiena i Epidemiologia, 2012, 93(4):683-685

[5] Czupryna A., Poździoch St., Ryś A., Włodarczyk C., Zdrowie publiczne tom 1, Vesalius, Kraków, 2000.

draw. The rapid development in medical and bio-technological sciences at the present creates new opportunities for successful diagnosis and therapy for patients. Biological disturbance in the organism can be compensated by doctors by suitable administration of medicines or medical products (e.g. hearing aid, nasal spray).

A new concept of health surfaced — the holistic concept, approaching the human being. The holistic model gives a wider perspective of health, grounding it in four planes:

- physical (biological functioning),
- psychic (cognitive and emotional functioning),
- social (maintaining proper relations with other humans), and spiritual (linked with personal convictions, beliefs or religious practice)[6].

This holistic outlook influenced the definition of health in the Preamble to the WHO Constitution. There, „health a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity[7]. The definition in the Preamble has no normative value; rather, it is of interpretative significance[8]. Literature sometimes expands it to include cultural factors. In accordance with those interpretations, health is the fullness of an individual's physical, mental, social and cultural well-being[9]. Later, the Preamble provides: „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”[10]. The document does not yet, however, mention the right to health directly or define its scope. Interpretations of the passage, however, include opinions that the right to health should be regarded as a fundamental human right[11].

Physicians have noted that a human being's health needs to be considered in three dimensions: biological, psychological and sociological. The former two concern the individual,

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6 Ostrzyżek A., Marcinkowski JT., Biomedyczny versus holistyczny model zdrowia a teoria i praktyka kliniczna, Higiena i Epidemiologia, 2012, 93(4):683-685.

7 Preambuła Konstytucji Światowej Organizacji Zdrowia (Dz. U. z 1948 r., Nr 61, poz. 477)**[**Preamble of the Constitution of the World Health Organization (Journal of laws from 1948, No. 61, item 477 as amended].

8 Barcik J., Międzynarodowe prawo zdrowia publicznego, Wydawnictwo C.H. BECK, Warszawa 2013.

9 Korporowicz V., Ekologiczne uwarunkowania zdrowia społecznego W: Holly R. (ed.), Ubezpieczenia zdrowotne, Szkoła Główna Handlowa, Warszawa 1999

10 Preambuła Konstytucji Światowej Organizacji Zdrowia (Dz. U. z 1948 r., Nr 61, poz. 477)**[**Preamble of the Constitution of the World Health Organization (Journal of laws from 1948, No. 61, item 477 as amended]

11 Barcik J., Międzynarodowe prawo zdrowia publicznego, Wydawnictwo C.H. BECK, Warszawa 2013

and the third the individual's co-existence with the environment[12]. In the mid-20th century attention was brought to the social aspects of health and disease. The point of departure was Talcott Parsons's concept, emphasizing scientific need for medicine to open itself to sociological knowledge. In Parsons's opinion, illness is a request for assistance (to be „taken care of") and a „withdrawal into a dependent relationship"[13]. In his concept, illness is a condition preventing or restricting the individual's fulfilment of daily social roles associated with belonging to various groups such as professional, social or family groups. When addressing health and disease (illness) in Parsons's concept, it is also necessary to draw the distinction between a somatic and a mental illness. The former permits temporary „suspension" of the individual's responsibilities, and the latter enables the exclusion of those individuals who do not submit to ordinary ways of control[14].

The diversity of concepts available confirms the fact that no single ideal concept has been found yet. Nonetheless, the bio-medical concept, while not perfect, is nowadays one of the two basic models for health, and its assumptions extended to include the elements described in the holistic concept provide the basis for the shaping of health-care systems especially in the aspect of economics[15]. Furthermore, the bio-medical concept, describing health as the condition opposite to illness or disease (as a deviation from the biological norm) lays the groundwork for defining the above terms for legal purposes. An example can be found in the International Statistical Classification of Diseases and Related Health Problems[16], which classifies disease as one of the items discussed in the document.

The ICD–10 provides the basis for the identification of health tendencies and keeping of statistics worldwide. Moreover, it equips medical staff and especially physicians with common

[12] Zaborowski P., Filozofia postępowania lekarskiego, Państwowy Zakład Wydawnictw Lekarskich Warszawa 1990

[13] Kołodziej A., Choroba jako dewiacja i „profesjonalna" rola lekarza; relacja pacjent – lekarz w funkcjonalnej teorii Talcotta Parsonsa, Hygeia public health 2012, 47(4): 398-402

[14] Kołodziej A., Choroba jako dewiacja i „profesjonalna" rola lekarza; relacja pacjent – lekarz w funkcjonalnej teorii Talcotta Parsonsa, Hygeia public health 2012, 47(4): 398-402

[15] Piontek B., Mucha K., Kategoria „zdrowie" i „choroba" i ich implikacje dla zarządzania systemem ochrony zdrowia, Nierówności Społeczne a Wzrost Gospodarczy 2016, 4 (48): 232

[16] Komunikat Ministra Zdrowia i Opieki Społecznej z 28 października 1996 r. w sprawie wprowadzenia Dziesiątej Rewizji Międzynarodowej Statystycznej Klasyfikacji Chorób i Problemów Zdrowotnych.(Dz. Urz. Ministra Zdrowia i Opieki Społecznej Nr 13 z dnia 30 listopada 1996 r., poz. 35) [Announcement of the Minister of Health and Social Welfare of October 28, 1996 on the introduction of the Tenth Revue of the International Statistical Classification of Diseases and Health Problems (Journal of the Office of the Minister of Health and Social Welfare No. 13 of 30 November 1996, item 35)]

language and options to pass on health information. This classification makes exchange and sharing of health information possible. Member states apply the latest ICD version in mortality and morbidity statistics. The ICD continues to be revised and published in a series of editions reflecting progress in health-care and medical science. Currently underway is version ICD-11, published on 18 June 2018. To leave member states the time to prepare for the implementation, including translation into national languages, this version will take effect from 1 January 2022[17].

Medical standards — legal aspects

Common language in matters of health and illness is a necessity in the doctor-patient relationship. All the more so considering that the basic criteria of correct medical practice are defined in Article 4 of the Act on the Professions of Physician and Dentist, requiring both to practice in line with current medical knowledge, means and methods available, due diligence and professional ethics. The requirement of current knowledge means that the doctor's information must be current when providing health-care. Consequently, certain medical fields have witnessed the formation of action schemes consistent with current medical knowledge and referred to as a „standard". „Medical standards" are defined as sets of recommendations referring to the entirety of preventive, diagnostic and therapeutic activities typically framed as guidelines of medical or paths of medical procedure[18]. In this approach, medical standards are not documenting of imperative nature, but for the doctor to comply with their rules is an example of medicine grounded in objective evidence[19]. (Evidence-Based Medicine, EBM). Medical standards are not only patterns of treatment supported by evidence attesting to their effectiveness; they are also underlain by economic analysis[20]. Some standards result from universally binding legislation — the Act on Therapeutic Activities[21] Four standards have been issued to date, as ministerial regulations, governing anaesthesiology, maternity care (two standards) and anatomical pathology

[17] Classification of Diseases (ICD), https://www.who.int/classifications/icd/en/ [dostęp 8 grudnia 2018]

[18] Lella A., Standardy medyczne, Gazeta Lekarska OIL w Warszawie, 2012, 4 http://www.oil.org.pl/xml/nil/gazeta/numery/n2012/n201204/n20120410 [dostęp 1 grudnia 2018]

[19] Zieliński P., Kilka słów o pojęciu oraz rodzajach błędu medycznego, Medyczna Wokanda, 2016, 8:191-192

[20] Konopka P., Opinie, Gazeta Lekarska OIL w Warszawie, 2012, 4 http://www.oil.org.pl/xml/nil/gazeta/numery/n2012/n201204/n20120410 [dostęp 1 grudnia 2018

[21] Art. 22 ust. 5 Ustawa z 15 kwietnia 2011 r. o działalności leczniczej (Dz. U. z 2013 r., poz. 217 z późn.zm.) [Act dated 15 April 2011 on Medical Activity (Journal of laws from 2013, item 2017, as amended]

(pathomorphology). Legislative standards define specific elements of health-care, such as the scope of the required diagnostics, prevention and therapy, or the location for providing them[22]. Once enacted, they become binding law, and failure to follow them exposes the practitioner to legal liability[23]. If, however, the scope of care defined by them no longer reflects current medical knowledge, it is evident that the latter take precedence over the regulation. In the event of any dispute, current medical knowledge will prevail; the Act on the Professions of Physician and Dentist, which refers to it, is a hierarchically higher legislative instrument compared to a ministerial regulation[24].

When it comes to standards enacted as regulations, the literature has not reached a consensus. On the one hand, practitioners' courses of action cannot be exhausted by legal norms, as they cannot be followed mechanically but need to consider the specific patient (including also any individual, atypical nature of the relevant disease) and the possibility of medical standards falling out of date due to recent scientific findings[25]. On the other hand, standards (understood as minimum levels) implement the patient's rights with regard to the safety of the procedures and ensure legal safety for the doctors[26]. Discussions as to the scope of the standards have led to an amendment of Article 22 of the Act on Therapeutic Activities, leaving the minister for health with the power to regulate only the organizational standards of health-care for select medical fields or therapeutic organizations[27]. From the rational point of view, that is the best solution, because it would be hardly acceptable for standards in medical science to be dictated by an administrator in a regulation, except only as a guaranteed regulatory minimum for the patients[28].

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22 Rek T., Hajdukiewicz D., Lekarz a prawa pacjenta. Poradnik prawny. Wolters Kluwer, Warszawa 2016

23 Zajdel J, Moc prawna standardów medycznych i wytycznych praktyki klinicznej, https://prawo.mp.pl/publikacje/prawomedyczne/52342,moc-prawna-standardow-medycznych-i-wytycznych-praktyki-klinicznej[dostęp 21 listopada 2018 r.]

24 Boratyńska M., Miejsce i rola standardów lekarskich w systemie prawa medycznego – teoria i praktyka, W: Górski A., Sarnacka E., Grossmman M.,[ed] Standard wykonywania zawodów medycznych, CH BECK, Warszawa 2019 [w druku]

25 Zieliński P., Kilka słów o pojęciu oraz rodzajach błędu medycznego, Medyczna Wokanda, 2016, 8:191-192, and: Karkowska D., Zawody medyczne, Wolters Kluwer, Warszawa 2012, and: Najbuk P., Znaczenie standardów postępowania dla odpowiedzialności prawnej lekarza, http://www.standardy.pl/newsy/id/94[dostęp 6 grudnia 2018]

26 Kamński B., Na marginesie reformy standardów medycznych i Europejskiej Konwencji Bioetycznej-refleksje klinicysty, Prawo i Medycyna, 1999, 3: 109

27 Najbuk P., Znaczenie standardów postępowania dla odpowiedzialności prawnej lekarza, http://www.standardy.pl/newsy/id/94[dostęp 6 grudnia 2018]

28 Boratyńska M., Miejsce i rola standardów lekarskich w systemie prawa medycznego – teoria i praktyka, W: Górski A., Sarnacka E., Grossmman M.,[ed] Standard wykonywania zawodów medycznych, CH BECK,

Upon this foundation two new organizational standards have been established — for anaesthesiology and intensive care[29], and anatomic pathology[30]. Currently, works have been wrapped up at the Ministry of Health on new standards for maternity care, to take effect from 1 January 2019. The most important changes are the abolishment of mandatory hospitalization following the 41st week of pregnancy, standardized antenatal education, screening for prenatal and *post-partum* depression risks, and encouragement of breastfeeding [27].

Medical standards — ethical aspects

In the Polish system, ethical norms relating to medical practice are gathered in the Code of Medical Ethics [28], which also contains provisions relating to the concepts of health and illness. Doubts, however, surfaced concerning the normative status of the Code. The matter came before the Constitutional Court [29] which unequivocally held that although the Code of Medical Ethics was not a source of law as understood by the Constitution of the Republic of Poland, and its norms are only in the nature of deontological ethics, the latter are still fit to narrow down the contents of norms contained in the Act on Medical Chambers [30]. Furthermore, compliance with the Code of Medical Ethics is required by the Act on Medical Chambers [31]. A practitioner may be held liable before medical disciplinary boards for conduct incompatible with medical ethics and deontology. One of the most important provisions from the point of view of establishing a standard — Article 8 of the Code — provides that doctors should complete all of the necessary diagnostics, therapy and prevention with due diligence, taking the necessary time. The Code calls attention to two elements of a proper doctor-patient relationship — diligence in the doctor's activities, and time dedicated to the patient [32]. It is worth recalling that the evaluation of due diligence in the doctor's work does not require specialist knowledge; it is based on life experience and common sense [18]. Diligence in the colloquial understanding means care, thoroughness, precision and conscientiousness. For a medical practitioner this means thorough

Warszawa 2019 [w druku]

[29] Rozporządzenie Ministra Zdrowia z 16.12.2016 r. w sprawie standardu organizacyjnego opieki zdrowotnej w dziedzinie anestezjologii i intensywnej terapii (Dz.U. z 2016 r., poz. 2218) [Regulation of the Minister of Health of 16/12/2016 on the standard of organizational health care in the field of anesthesia and intensive care (Journal of laws from 2016, item 2218)]

[30] Rozporządzenie Ministra Zdrowia z 18.12.2017 r. w sprawie standardów organizacyjnych opieki zdrowotnej w dziedzinie patomorfologii (Dz.U. z 2017 r., poz. 2435) [Regulation of the Minister of Health of 18/12/2017 on organizational standards of health care in the field of pathomorphology(Journal of laws from 2017, item 2435)]

preparation (preceded by interview and physical examination) of the diagnostic and therapeutic process. Conscientiousness and a sense of duty are the cornerstone of a medical practitioner's work. The literature notes the conscientious-doctor standard delimited by the provisions of the law and deontological norms. Conscientious conduct on the doctor's part also means conduct consistent with conscience[31].

A practitioner may be held liable before medical disciplinary boards for conduct incompatible with medical ethics and deontology. Professional responsibility for conduct incompatible with the principles of the Code of Medical Ethics is put by the Act on Medical Chambers on an equal footing with liability for a violation of the legal provisions regulating the medical profession (Article 53 of the Act on Medical Chambers)[32]. Proceedings concerning the professional responsibility of medical practitioners are instituted by the disciplinary prosecutor, who, if having sufficient evidence of the possibility of professional misconduct, brings a request for punishment before the disciplinary board. The lawmaker decided to have two tiers of medical disciplinary boards — regional medical disciplinary boards in the first instance and the Supreme Medical Disciplinary Board (SMDB) on appeal. There is also currently the possibility of an extraordinary appeal against the SMDB's decision to the Supreme Court, staffed by professional justices. Medical disciplinary boards, on the other hand, are composed of medical practitioners and not professional judges, in both instances. The Act on Medical Chambers, in Article 83(1) contains a tariff of penalties. Those include, without limitation, admonition, reprimand, fine, suspension of licence up to 5 years. The list also includes highly severe penalties, *viz.* licence revocation, even permanent (Article 83(1)(7) of the Act on Medical Chambers).

Decisions of medical disciplinary boards — practical examples

1. **BIRADS classifications and recommendations**

[31] Habreko J., Należyta staranność w zawodach medycznych, W: Sytuacja prawna osób wykonujących zawody medyczne, Ogólnopolska Konferencja Naukowa Dolnośląskiej Izby Lekarskiej i Uniwersytetu Wrocławskiego, Wrocław 22 września 2017

[32] Postanowienie Sądu Najwyższego z dnia11 lutego 2016 r., sygn. akt SDI 71/15 [Decision of the Supreme Court of 11 February 2016, Ref. act SDI 71/15]

One of the first standards formed in breast-cancer diagnostics. In 1992, the American College of Radiology developed the first Breast Imaging Reporting and Data System (BIRADS). The goal was to standardize and uniformize mammography reports, risk assessments of malignancy, and recommendations of further diagnostics. Subsequent versions were published in 1993, 1995, 1998 and 2003. It is worth emphasizing that years of experience in the application of BIRADS in mammography have confirmed its high utility in reports and report standardization. BIRADS should be familiar to all practitioners and especially those dealing with breast cancer. BIRADS is a system that, based on morphological characteristics of nipples and pathological changes to them, permits acute distinction between benign and malignant lesions, distinguishes a group of suspect changes, rates the malignancy risk on a percentage scale, and formulates clear recommendations as to further checks and diagnostics [35]. Unfortunately, good solutions such as BIRADS are not always correctly interpreted by doctors, or perhaps simply not even known. One of the cases before the Regional Medical Disciplinary Board in Warsaw involved a prompt diagnosis of breast cancer in a patient, but the lack of proper BIRADS analysis, in effect, delayed treatment. In May 2016 a gynaecologist working at the gynaecological clinic of an independent publish hospital received a patient complaining about breast ache of several weeks' duration. Even though the patient had not yet completed the 50th year of age, the doctor ordered mammography. The patient completed her mammography on 14 June 2016. The results showed glandular-adipose composition with densified glandular tissue in the central part of the left breast with ambiguous microcalcifications. No other changes were found in the examination, BIRADS 4 was done, and ultrasound recommended as a necessity. The ultrasound done on 21 June 2016 did not show solid lesions, only two microcysts 5mm in diameter. Retro areolar ducts and lymph nodes bilaterally not enlarged. The patient reported with these results back to the gynaecologist-obstetrician, who recommended continued observation. The patient was to report for follow-up examinations in 3 to 4 months. The patient, however, due to persistent pain in her left breast, approached a different practitioner, who referred her to another ultrasound on 3 December 2016. The results showed glandular-adipose composition, in the left breast, thickened subcutaneous tissue with 4 to 7cm thickening, oedema bordering adipose tissue, and increased vascularization with increased echogenicity. Oedema/infiltration with increased vascularization bordering retromammary adipose tissue and gland. In the lower floor of the left axilla several

hypoechogenic lymph nodes, up to 10mm long, were found. Further diagnostics was necessary, including mammography and urgent oncological consultation. Besides, several small simple cysts bilaterally. The right axilla was without any structural changes. The mammography confirmed large lesions in the left-breast area and lesions in lymph nodes, BIRADS 5 classification. As a result of the oncological consultation and further examinations the diagnosis was: locally advanced Her 2 positive left breast cancer, stage T3N1Mx. The patient filed a complaint with the disciplinary prosecutor. The gynaecologist- obstetrician faced charges of failure to observe due diligence in the patient's diagnosis and treatment process in that after receiving the results of the mammography and breast ultrasound order leading to BIRADS 4 classification the doctor failed to refer the patient urgently to further oncological diagnostics, thus exposing the patient to delay in receiving surgical treatment, and, in consequence, compromising her health status. The above charge constitutes professional misconduct under Article 4 of the Act on the Professions of Physician and Dentist and Article 8 of the Code of Medical Ethics. In his written opinion, the board's expert emphasized that the June mammography showing microcalcifications in the left breast certainly justified the radiologist in applying the BIRADS 4 classification. That clearly shows a lesion with suspected malignancy, for which the standard requires histopathological verification. In the expert's opinion, it was certainly correct to recommend an ultrasound due to the need to exclude other lesions requiring a biopsy, given the situation. However, mammography and ultrasound were complementary and not mutually exclusive examinations. The sensitivity and specificity of each is different — mammography is intended for microcalcification assessment, and ultrasound for cysts. It was possible, the expert wrote, for malignant lesions to be visible in the ultrasound despite not showing in the mammography. Where, however, the ultrasound fails to show any suspect lesions and the mammography results in BIRADS 4, the doctor absolutely ought to refer the patient to further diagnostics. The defendant evaluated the patient's examination incorrectly. The board found the defendant gynaecologist guilty and imposed on her a penalty. It must be emphasized that when assessing the severity of the penalty the board took into account the defendant doctor's apology to the patient for the situation[33].

[33] Orzeczenie Okręgowego Sądu Lekarskiego w Warszawie z dnia 18 października 2018 r., sygn. akt OSL.630.22/2018, niepublikowany [Decision of the Regional Medical Court in Warsw of 18 October 2018, Ref. Akt OSL.630.22/2018, unpublished]

2. Co-existing diseases — bruxism

According to the WHO, dysfunction in the temporomandibular-joint area occurs in 50% of the population. The above group of disorders is recognized as the third social disease in stomatology, after dental caries and periodontal diseases. A typical dysfunction of the temporomandibular joints is bruxism[34]. Bruxism is a coping mechanism for negative emotions in intensely stressful situations. If it is repeated and becomes habitual, the result is a solidified incorrect pattern of mandibular movement[35]. Bruxism is the involuntary (semi-voluntary) grinding or clenching of teeth with the use of very significant force (the jaw is clenched even 10 times more tightly than while eating)[36]. One of the most naiant problems to the sufferers is fatigue and loss of sleep. Most frequently the disorder occurs during the night, hence many of the sufferers are not aware. Bruxism is accompanied by sleep arousal. Masseter muscles are activated during sleep[37]. The disease leads to tooth mobility, crown abrasion, enamel fractures, changes — initially inflammatory and subsequently degenerative changes — in temporomandibular joints, followed by restricted mobility in those joints[38]. The cause, apart from occlusal factors, include psychic factors, that is simply long-term stress and strong anxiety. The above disorders occur at night during sleep, hence many sufferers are not aware of the condition.

At least one case of a patient with bruxism has also been addressed by a regional medical disciplinary board[39]. The disciplinary prosecutor received a patient's notification of possible professional misconduct on the part of a stommatologist in private practice. The complaint challenged the correctness of the execution and application of artificial dentures. Based on the

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[34] Ziębowicz A., Dysfunkcje układu stomatognatycznego: przyczyny i zapobieganie W: Zagrożenia i problemy cywilizacyjne XXI w. – przegląd i badania, Maciąg M., Maciąg K.,[ed] Wydawnictwo Tygiel, Lublin 2017

[35] Oleszek-Listopad J., Szymańska J., Dysfunkcja układu ruchowego narządu żucia – aktualny stan wiedzy, Medycyna Ogólna i Nauki o Zdrowiu, 2018, t. 24, 2: 82–88.

[36] Ziębowicz A., Dysfunkcje układu stomatognatycznego: przyczyny i zapobieganie W: Zagrożenia i problemy cywilizacyjne XXI w. – przegląd i badania, Maciąg M., Maciąg K.,[ed] Wydawnictwo Tygiel, Lublin 2017

[37] Onopiuk P., Dąbrowska Z., Rosłan K., Onopiuk B., Dąbrowska E., Bruksizm parasomicznym czynnikiem zaburzenia snu W: Krajewska-Kułak E., Łukaszuk R.C., Lewko J., Kułak W., Holistyczny wymiar współczesnej medycyny, Uniwersytet Medyczny w Białymstoku Wydział Nauk o Zdrowiu, 2018, t. IV: 453-464

[38] Ziębowicz A., Dysfunkcje układu stomatognatycznego: przyczyny i zapobieganie W: Zagrożenia i problemy cywilizacyjne XXI w. – przegląd i badania, Maciąg M., Maciąg K.,[ed] Wydawnictwo Tygiel, Lublin 2017

[39] Orzeczenie Okręgowego Sądu Lekarskiego w Łodzi z dnia 9 grudnia 2015 r., sygn. akt 16/Wu/2015, niepublikowany [Decision of the Regional Medical Court in Łódź of 9 December 2015, Ref. akt 16 / Wu / 2015, unpublished]

notice, the prosecutor completed an inquest and carried out an investigation. The prosecutor's factual findings were as follows. The patient approached the defendant for prosthetic dental treatment. After imaging (panoramic X-ray), the dentist proposed a scope of treatment — two teeth were extracted due to 4th-degree mobility, endodontic treatment of another two followed, as well as their reconstruction with glass-fibber inserts, repeat canal treatment with the installation of glass-fibber inserts. The scope of prosthetic treatment that was performed included a ceramic-faced metal bridge and upper cast partial with Bredent clamps. Missing back teeth were supplemented with a cast partial with clasp mount. However, adjustments were done on the cast partial during the patient's 8 visits in a one-month period.

In order to evaluate the correctness of the defendant doctor's diagnosis and therapy, the prosecutor approached an expert in general stomatology and prosthodontics. In the expert's opinion, the prosthodontic treatment had not been properly planned out, due to not having taken account of so-called co-existing conditions of bruxism, attested by such symptoms as pathological abrasion, overgrowth and increased tension in masseter muscles. Moreover, in the expert's opinion, the use of a cast partial reconstructing extensive missing back teeth as prosthetic structure was an error. Such type of solution, given extensive missing teeth and a co-existing illness, fell short of bio-mechanical requirements and quickly led to overstrain on the patient's own teeth, and their loosening, periodontal abscess, and overgrowth of gingival margin. In the expert's view, all of those factors led to overstrain on the patient's abutment teeth, and their loosening, loss of bone tissue, and periodontal abscess. The result necessitated the removal of the prosthetic restorations used, extraction of the loosened teeth and use of acrylic dentures with extensive palatal plate.

In the light of the situation the prosecutor filed a request for punishment, as the practitioner carried out the patient's treatment without due diligence, in particular without preceding it with proper diagnostics, hence without taking into account co-existing diseases such as bruxism, resulting in the use of the wrong prosthetic structure, failing to take account of the extensive missing teeth and biomechanical requirements, in the form of cast partial, and incorrectly qualified the patient's residual dentition for the prosthetic work performed, given the insufficient number of abutments for the structure, i.e. professional misconduct defined in Article 8 of the Code of Medical Ethics. At the defendant's request, an additional expert was appointed for the

case. The second expert opinion indisputably confirmed the conclusions of the first. In summary, the experts, in two independent opinions, concluded that the treatment plan applied by the defendant failed to account for diseases, i.e. bruxism, as attested by such symptoms as pathological abrasion of the residual dentition, overgrowth with increased tension in masseter muscles.

In the board's opinion, the prosthetic treatment applied by the defendant dentist was preceded by correct diagnostics. The doctor conducted a physical examination and evaluated the panoramic X-ray. Simultaneously, the board found that the failure to diagnose co-existing bruxism in the patient resulted not from failure to exercise due diligence but from the fact that the defendant reported for prosthetic treatment with extensive missing teeth. In that situation, determining whether the tooth abrasion resulted from bruxism or tooth wear was extremely difficult. The board noted that during the same time, at the University Stommatological Clinical, where the patient was consulted by several specialists, the bruxism was not diagnosed, either. For a patient with extensive missing teeth, diagnosing bruxism becomes more difficult. For this reason, in keeping with previous concepts of health, it becomes necessary to take a holistic look at the patient. Holistic stomatology is already beginning to develop. Stommatologists work with, among others, psychiatrists and physiotherapists[40].

Conclusion

The search for models of conduct consistent with current medical knowledge, i.e. good-doctor hypothetical figure, has led to the increasingly frequent introduction of medical standards. Medical standards should be based on somewhat consistent and precise definitions of health and disease (illness). For this purpose, the International Statistical Classification of Diseases and Related Health Problems, ICD-10, was developed, that is codes to identify a disease with several letters and digits. The standards are the work of expert teams across numerous medical fields, medical societies, and above all practitioners. Currently, we distinguish non-legal standards arising from medical practice, but also standards enacted in the form of regulations. In the event of a conflict between the different types of standards, the practitioner should first of all comply

[40] Onopiuk P., Dąbrowska Z., Rosłan K., Onopiuk B., Dąbrowska E., Bruksizm parasomicznym czynnikiem zaburzenia snu W: Krajewska-Kułak E., Łukaszuk R.C., Lewko J., Kułak W., Holistyczny wymiar współczesnej medycyny, Uniwersytet Medyczny w Białymstoku Wydział Nauk o Zdrowiu, 2018, t. IV: 453-464, and: Bętkowska – Bielach A., W stomatologii najważniejsze to wiedzieć, Stomatologia news. http://stomatologianews.pl/stomatologii-najwazniejsze-wiedziec/ [dostęp 4 grudnia 2018]

with the general criterion of state of knowledge in Article 4 of the Act on the Professions of Physician and Dentist, taking into account the patient's individual case. This is because the requirements of due medical diligence occur primarily from the current state of knowledge, to which the Act refers. The decisions of medical disciplinary boards are doubtless of assistance in establishing a standard based on current medical knowledge. Their educational role fits within the modern medical-education model.

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