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Model of a good paediatrician in judgements of medical courts

Wzorzec dobrego pediatry w orzeczeniach sądów lekarskich

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Abstract

The paper presents the responsibilities of paediatricians with regard to the diagnosis and treatment they should provide in compliance with the principle of due diligence. This principle – fundamental for the medical profession – stems not only from the regulations of law but also from deontological standards. For this reason, in addition to criminal and civil liability, physicians also bear professional liability, which is addressed in this paper. In the Polish legal doctrine, the professional liability of physicians is often considered to be quasi-criminal, adapted to the needs of specific institutions. Consequently, it is included in the framework of criminal law in the broad sense. Nevertheless, proceedings concerning the professional liability of physicians are held independently of criminal or other disciplinary proceedings pertaining to the same act. This paper addresses aspects related to the operation of medical courts. The issue is particularly important in view of the fact that judges sitting in medical courts of the first and second instance independently decide on factual and legal issues. With respect to the adjudication process, members of medical courts are subject to the provisions of the generally applicable law. A key element in court proceedings is the testimony of expert medical witnesses. Medical experts called by the court as expert medical witnesses show the medical context of a legal dispute based on their theoretical knowledge and practical expertise. The paper highlights the form and the elements that should be included in the expert opinion. Crucially, the preparation of expert opinions requires access to appropriate materials related to the case. Expert medical witnesses serving as court-appointed experts in disciplinary cases acquire such materials based on their personal examination of the injured party and comprehensive review of available documentation – or solely on the basis of medical records. The paper presents examples of such expert opinions.

Key words: paediatrician, medical court, due diligence

Streszczenie

W niniejszej pracy przedstawiono obowiązki lekarza pediatry dotyczące diagnozy i leczenia, które powinien wykonywać w odniesieniu do zasady należytej staranności. Ta fundamentalna dla zawodu lekarza zasada wynika nie tylko z przepisów prawa, ale także z norm deontologicznych. Z tego względu oprócz odpowiedzialności karnej i cywilnej lekarz ponosi również opisaną w tym artykule odpowiedzialność zawodową. W polskiej doktrynie prawniczej odpowiedzialność zawodową lekarzy często uznaje się za quasi-karną, dostosowaną do potrzeb określonych instytucji, i zalicza do prawa karnego w szerokim tego słowa znaczeniu. Jednak postępowanie w przedmiocie odpowiedzialności zawodowej lekarzy toczy się niezależnie od postępowania karnego lub innego postępowania dyscyplinarnego dotyczącego tego samego czynu. W niniejszej pracy mowa jest o tym, w jaki sposób funkcjonują sądy lekarskie. To o tyle istotne, że sędziowie sądów lekarskich w I i II instancji rozstrzygają samodzielnie zagadnienia faktyczne i prawne. Członkowie sądów lekarskich w zakresie orzekania podlegają przepisom powszechnie obowiązującego prawa. W tego typu postępowaniach kluczową kwestię stanowi opinia biegłego. Biegły lekarz, odwołując się do wiedzy i doświadczenia praktycznego, ukazuje kontekst medyczny sporu prawnego. W artykule zwrócono uwagę na formę i elementy, jakie powinna zawierać opinia biegłego, który musi dysponować odpowiednim materiałem do przeprowadzenia ekspertyzy. W przypadku opinii wydawanych w sprawach dyscyplinarnych lekarzy biegły pozyskuje materiał na podstawie osobistego badania pokrzywdzonego oraz analizy całości dokumentacji albo tylko na podstawie dokumentacji medycznej. W opracowaniu przedstawiono przykłady takich opinii.

Słowa kluczowe: lekarz pediatra, sąd lekarski, należyta staranność

INTRODUCTION

Parental concern over the child's health outweighs any concern that parents have for their own welfare.

Therefore, in addition to being friendly and warm towards the child, paediatricians must patiently resolve parents' uncertainty about their child's well-being. Therapeutic recommendations given by paediatricians must be very precise and leave no room for doubt. Medical errors may bring about dangerous consequences⁽¹⁾. In recent years, there has been an increase in the number of complaints filed by parents with the Regional Screener for Professional Liability (Polish: *Rzecznik Odpowiedzialności Zawodowej*, ROZ) in cases involving disagreements and conflicts⁽²⁾. After this step, a case may be submitted for resolution to a medical court. As the initial measure, the ROZ carries out verification and launches investigative proceedings. In the course of this procedure, the ROZ may refuse to initiate proceedings or discontinue proceedings already initiated if no evidence of professional misconduct is found. However, if the ROZ considers that such evidence exists, the case is referred to a medical court with a motion for penalty. The ROZ and medical court judges are physicians or dentists with at least 10 years' professional experience, elected by delegates of the district medical convention to a four-year term. Medical courts operate in a system of two instances. The first instance is District Medical Court (Polish: *Okręgowy Sąd Lekarski*, OSL) sitting in the composition of three judges, and the second instance (court of appeal) is Supreme Medical Court (Polish: *Naczelny Sąd Lekarski*, NSL) composed of five judges. It must be noted that since 2010 there has also been a possibility to lodge an extraordinary appeal against NSL rulings, i.e. file a cassation with the Supreme Court (Polish: *Sąd Najwyższy*, SN) composed of professional judges sitting in a three-judge panel. Under the cassation procedure, the SN received a total of 18 cases in 2016, 25 cases in 2017, and 37 cases in 2018.

MATERIAL AND METHODS

The aim of this study is to draw the attention of paediatricians to two fundamental provisions which highlight the importance of applying due diligence in the performance of professional activities. The issue of due diligence is provided for in legal regulations (Article 4 of the Act on the Professions of Physician and Dentist)⁽³⁾ and ethical standards (Article 8 of the Polish Code of Medical Ethics)⁽⁴⁾. It must be stressed that these provisions are of key importance for practising the profession of paediatrician, as they set out the basic directives to be followed by every medical doctor. Firstly, the regulations set out the principle that physicians should exercise their profession in accordance with the current state of medical knowledge, using the methods and means available to them. Secondly, they establish the obligation to observe the rules of professional ethics. Thirdly, the regulations referred to above introduce an

obligation to exercise due diligence⁽⁵⁾. Under Article 8 of the Polish Code of Medical Ethics, physicians ought to perform all necessary diagnostic, therapeutic and prophylactic procedures while exercising due care and devoting an appropriate amount of time to these activities.

The paper reviews violations of the above-mentioned regulations of the law and infringements of the Polish Code of Medical Ethics based on the files of cases ruled on by OSL and selected cases examined by the appellate instance (NSL). It needs to be stressed that OSL and NSL judgements are not published.

The first group of cases under analysis consists of OSL judgements examined on the basis of court records from the OSL in Łódź (2016), OSL in Poznań (2016), and OSL in Warsaw (2016, 2017 and 2018). The 2016 study was a cross-section of cases from different units referring to a comparable period. For the OSL in Warsaw, the cases under study covered three consecutive years: 2016, 2017 and 2018. In principle, the judgements under analysis were final and binding.

The studied judgements of the NSL as the appellate instance covered the years 2016 and 2017.

RESULTS

The examination of court files from 2016 resulted in a cross-section of cases from three Polish medical chambers, referring to a comparable period. In principle, the cases analysed were closed, and the judgements were final and binding. A review of cases ruled on in 2016 shows that the OSL in Łódź examined a total of 33 cases including 23 cases (69.7%) where physicians were charged with failure to exercise due diligence (with 3 cases involving paediatricians); the OSL in Poznań examined 9 cases including 2 cases (22%) claiming the lack of due diligence (1 case concerning a paediatrician); and the OSL in Warsaw heard a total of 55 cases, of which 39 (71%) involved the charge of failure to provide due diligence (including 4 cases involving paediatricians). A year later, the OSL in Warsaw examined 52 cases including 34 cases (65.4%) with the alleged lack of due diligence in the diagnostic/therapeutic management (with 2 cases involving paediatricians). In contrast, in 2018, the OSL in Warsaw considered 40 cases, of which 26 (65%) were related to allegations of failure to exercise due diligence. No charges were brought against paediatricians.

The material under analysis obtained from the Warsaw OSL shows certain tendencies covering a period of 3 consecutive years in a medical court with jurisdiction corresponding to that of the largest medical chamber in Poland. It follows that the number of cases examined by the OSL in Warsaw is small and steadily falling. However, the number of cases lodged with the NSL against paediatricians has remained at the same level. The NSL is the medical appellate court examining appeals from decisions made by OSLs all over Poland. In 2016, the NSL reviewed 161 cases. The allegation of failure to exercise due diligence had been made

in 134 cases (83%) including 17 cases involving paediatricians. In 2017, the NSL examined a total of 140 cases. The allegation of failure to exercise due diligence had been made in 101 cases (72%) including 16 cases involving paediatricians⁽⁶⁾.

SELECTED JUDGEMENTS OF MEDICAL COURTS

Pertussis (District Medical Court)

In January 2014, a concerned mother reported with her 5-month-old son to the hospital A&E (accident and emergency) department. The child had bursts of explosive coughing and choking accompanied by whooping sounds and reddening of the face. After the preliminary diagnosis of pertussis was determined, the boy was admitted to the hospital's paediatric ward. Following admission, the paediatrician (who was also the physician in charge) obtained the child's medical history from the parents. In the neonatal period, the boy was hospitalised with a urinary tract defect. After that hospital stay, he was under regular follow-up at a specialist urology and nephrology outpatient clinic. In addition, the child was exempt from certain vaccinations for neurological reasons. The boy was also followed up at a gastrology outpatient clinic because of suspected gastroesophageal reflux disease. Three weeks earlier, the child was hospitalised and diagnosed with affective apnoea. At the beginning of the month, the boy was treated with azithromycin and clarithromycin (among other drugs).

Upon admission, the paediatrician performed a physical examination which showed features of upper respiratory tract infection. During the boy's hospital stay, the physician ordered a number of additional examinations including laryngologic evaluation, chest X-ray, and diagnostic ultrasound examinations of the head and neck, and chest. In view of the signs of bronchial obstruction the bronchodilator Ventolin was administered. As the child did not have coughing spasms typical of pertussis, and the laboratory tests results were good, the physician in charge did not order serological tests. However, on the day of discharge from the hospital, following consultation with the boy's parents, blood samples were collected to conduct tests for *Bordetella pertussis*, *Chlamydia pneumoniae* and *Mycoplasma pneumoniae*. In addition, the paediatrician ordered a scheduled diagnostic appointment for the boy in a pulmonology department. A few days later, when the hospital discharge summary was issued, the physician in charge talked to the boy's mother. At that time, she only had the results of tests for IgG and IgM antibodies which were negative and did not indicate that the boy had whooping cough. However, in early May 2014, the child's parents received a letter from the Sanitary and Epidemiological Station (Sanepid) informing them that the child's test results were positive for pertussis. In view of these circumstances, on 13 May 2014, the parents filed a complaint against the paediatrician with the Regional

Screener for Professional Liability (ROZ). The doctor was charged with failure to carry out the diagnostic work-up for suspected pertussis despite the preliminary diagnosis of the condition in the A&E department by a physician who witnessed the child's coughing fit. It was claimed that the paediatrician's lack of proper care led to the patient not receiving appropriate treatment, and hence prolonged the duration of the disease, which represents a violation of Article 8 of the Polish Code of Medical Ethics in conjunction with Article 4 of the Act on the Professions of Physician and Dentist.

During the investigative proceedings instituted by the ROZ, the hospital management reported that the results of serological tests had been received on two separate sheets. One contained the results of IgG and IgM tests (negative), and the other the results of IgA tests (positive). Each sheet was delivered to the paediatric ward at a different time.

The evidence presented during the proceedings held before a medical court involved a testimony of a medical expert witness. The expert highlighted three major aspects of the case: clinical presentation, peripheral blood differential count, and applicable European guidelines. The latter document was developed by the EUpertgenomics/EUpertstrain expert group ("EUpert") in 2013 and recognised by the European Centre for Disease Prevention and Control (ECDC)⁽⁷⁾ as the accepted guidelines providing that the serological diagnosis of pertussis should be based exclusively on the determination of IgG-class antibodies to the pertussis toxin in juveniles and adults.

According to the medical expert witness, a key aspect to consider was that the patient's clinical presentation as described in the medical records provided no basis warranting the performance of diagnostic laboratory tests for pertussis. The patient had a long history of coughing (approximately 3 months). According to the World Health Organization (WHO) pertussis is diagnosed in a person with a cough lasting at least 2 weeks with at least one of the following symptoms: paroxysms of coughing, inspiratory whooping, and post-tussive vomiting (i.e. immediately after coughing) without another apparent cause (clinical criterion)⁽⁸⁾. The boy did not present symptoms typical of pertussis, as there was no cough with the characteristic high-pitched "whooping" sound. Moreover, the initiation of antibiotic therapy was not justified, as the patient had already received treatment with a macrolide antibiotic prior to hospital admission.

Also, after being shown the patient's CBC results during the court hearing the medical expert witness concluded that the lymphocyte count was below the age-normal range, while and the neutrophil count was elevated. These CBC abnormalities are opposite to those normally observed in patients with pertussis.

Thirdly, the medical expert witness argued that, based on the ECDC guidelines, serological diagnostic tests for pertussis have no diagnostic value in neonates, infants and young children.

The medical court regarded the expert's opinion as consistent and credible. It was recognised that the paediatrician had conducted the diagnostic and therapeutic process according to the current state of medical knowledge. Consequently, the court acquitted the paediatrician of the charges filed against her⁽⁹⁾.

***Klebsiella pneumoniae* (Supreme Medical Court)**

On 21 October 2014, a boy was admitted to the paediatric ward with vomiting, loose stools and subfebrile body temperature. The paediatrician, who was the physician in charge and, at the same time, the head of the paediatric ward, took a medical history and examined the child. The boy was born on 22 September 2014 by a caesarean section in the 34th week of pregnancy complicated by gestosis, with a body weight of 2,880 g, Apgar score 9. On admission to the ward, the physical examination revealed features of moderate dehydration and a faint systolic murmur over the heart. The results of laboratory tests were normal. The physician in charge prescribed probiotics and hydration therapy. After 3 days, the boy was discharged home in a good general condition with a list of prescribed medications including vitamin B₆, Actiferol Fe, BioGaia, and Floxal. A follow-up CBC was scheduled in 3–4 weeks. On 27 October 2014, the laboratory sent the results of bacteriological examination of samples collected by rectal swab to the paediatrician. The examination found the presence of *Klebsiella pneumoniae* ESBL (extended-spectrum beta-lactamases) (+). The physician in charge who met with the child's parents when they came to collect the hospital discharge summary informed them of the results and the diagnosis of colonisation by *Klebsiella pneumoniae* ESBL(+) strains.

On 31 October 2014, the parents became concerned about the baby's condition because of loss of appetite and frequent crying spells. The parents made an appointment with their general practitioner who diagnosed a gastrointestinal dysfunction, and suspected an infectious aetiology. She prescribed a probiotic and advised the parents to monitor the child's condition until the evening. She also issued a referral to hospital in case the parents thought a hospital consultation was required. However, the parents went to the hospital right away. The physician on duty was the same paediatrician who had previously supervised the child's treatment. The boy's condition was getting worse. The abdomen was large, distended. There was no audible peristalsis, and the stools were yellow and mushy. In the hospital, feeding was stopped and fluids were administered intravenously. Treatment with Biodacyna [Amikacinum] (1 × 70 mg) and Tartrikson [Ceftriaxonum] (1 × 200 mg) was started. Since no improvement was noted, the paediatrician decided to have the child transferred to a hospital of a higher referral level. On admission, the boy was in a state of severe shock, with pale, bluish skin, unresponsive. The pulse

was thready or undetectable; tachycardia 200 bpm, base excess (BE) (–10), very pronounced abdominal distension. The infant was immediately intubated and put on antibiotics. Norepinephrine (Levonor) infusion was started. An abdominal ultrasound examination was performed, revealing a large amount of dense free fluid within the peritoneal cavity, a lack of peristalsis, and oedema of intestinal wall with the presence of gas vesicles. Radiological examination showed distended intestinal loops and fluid build-up in the abdominal cavity. Despite therapeutic interventions metabolic acidosis progressed, and arterial pressure dropped. Adrenaline and hydrocortisone were administered, and transfusion of packed erythrocytes was performed. The patient's condition progressed to irreversible shock, cardiac arrest and ultimately death.

The OSL received a motion for penalty charging the paediatrician, who was the coordinator of the paediatric ward and, at the same time, the physician in charge of the infant, for failing to exercise due diligence in the therapeutic management of the child by discharging the boy home from the hospital without follow-up CBC results and without access to the bacteriological findings. This conduct, it was claimed, constituted a violation of Article 8 of the Polish Code of Medical Ethics in conjunction with Article 4 of the Act on the Professions of Physician and Dentist. The court decided to consider the allegations submitted by the Regional Screener for Professional Liability as two instances of potential professional misconduct, and assess and rule on each of them separately.

Two medical experts in neonatology and paediatrics, and infectious diseases, were consulted on the case. It should also be stressed that the medical experts did not assess the paediatrician's actions on 31 October 2014, as they were beyond the scope of the allegation. The subject of evaluation was the child's first hospitalisation. According to the experts, considering the general good condition of the infant, his weight gain, willingness to eat, no signs of fatigue during feeding, and normal CBC results, there were no indications for the transfusion of blood products. Also, it was not an error to discharge the baby in a good condition, passing normal stools, even though at that time there was no information about the rectal swab results. The culture test results can be interpreted as gastrointestinal colonisation. However, the use of antibiotics is indicated solely in cases of prolonged or very severe gastrointestinal symptoms. One of the medical experts underlined that *Klebsiella pneumoniae* ESBL was not a typical aetiological agent of diarrhoea. Bacterial carriage (including the carriage of alert pathogens) is not normally treated except for specific clinical situations. In the general population, the prevalence of *Klebsiella pneumoniae* in the nasopharyngeal cavity varies between 1 and 6%, and in the rectum between 5 and 38%⁽¹⁰⁾. The proportion is higher in hospitalised patients without respiratory symptoms, not receiving antibiotic therapy. Prolonging the hospitalisation of a child in a good general condition until the bacterial culture results were available

would – in the medical expert's opinion – be inappropriate, as it would expose the boy to the risk of infections. The experts stressed that the baby's condition did not deteriorate until 7 days after the hospital discharge, which shows that at the time of leaving the hospital the boy was just a carrier of the bacteria. In this scope, the medical court considered the explanations to be consistent and logical, and on their basis took a decision to acquit. When ruling on the second charge, the court shared the opinion of one of the medical experts, who draw attention to the fact that the boy had become significantly anaemic. The CBC parameters on the first day of life (22 September 2014) were: haemoglobin 13.2 g/dL, and haematocrit 40%. In contrast, upon hospital admission (21 October 2014), the haemoglobin and haematocrit levels were 8.4 g/dL and 24%, respectively. The paediatrician explained to the court that her belief was that the boy's anaemia represented a decrease in CBC parameters that was typical in a baby born prematurely by a caesarean section. The court did not accept the arguments presented by the physician. In the court's opinion, the examination results obtained on hospital admission did not represent an absolute indication to the administration of blood products, however, the CBC test should have been repeated before discharging the child home. In view of the above, the court found that the paediatrician was guilty of professional misconduct by discharging the child from the hospital without a follow-up CBC test⁽¹¹⁾.

The paediatrician's defence counsel filed an appeal against the court decision. He pointed out that the OSL had evaluated the evidence one-sidedly and selectively (violating the principle of objectivity), disregarding the opinion of one of the medical expert witnesses who stated explicitly that discharging the boy home from the hospital without a follow-up CBC was a correct decision. Instead, the OSL took into consideration the doubts that arose from the opinion presented by the second medical expert, and interpreted them to the paediatrician's disadvantage. The NSL considered the appeal to be justified. In its review of the case, the NSL indicated that the decision passed by the OSL depended crucially on expert testimony. Furthermore, the NSL emphasised that based on the conclusions reached by the medical experts it cannot be established unambiguously that there had been irregularities in the physician's performance. The medical expert witness merely stated that an *ex post* evaluation showed that repeat laboratory tests might have been considered before discharging the child home. However, these tests would not have yielded any relevant new information, while ordering them could be seen as exposing the patient to unnecessary medical procedures. Consequently, the NSL reversed the OSL's decision and referred the case back to that court for re-examination. According to the court of appeal, it was necessary to precisely determine the facts of the case, i.e. establish whether the physician was obliged to order a CBC test prior to the child's discharge home, and whether performing the test alone would have changed the medical

recommendations⁽¹²⁾. After re-examining the case, the OSL acquitted the physician of the charges. The judgement is final and binding⁽¹³⁾.

DISCUSSION

An analysis of medical court judgements from the period 2016–2018 showed a steady and fairly high number of cases involving the lack of due diligence (depending on the OSL jurisdiction: 22–71%). The group of physicians charged with failure to apply due diligence included 2–4 paediatricians. The results noted in Poland's largest medical chamber were similar. In the period 2016 to 2018, the charge of lack of due diligence was brought in 65–71% of cases examined by the medical court. The number of cases involving paediatricians was the highest in 2016 – 4, while in 2018 there were no cases against paediatricians. During the same period, the NSL (i.e. the appellate instance) examined a greater proportion of cases related to an alleged lack of due diligence (72–83%). The increase was also evident in the number of cases involving paediatricians: 16–17 physicians of this specialty in each of the examined periods. The current state of affairs, whereby paediatrics is a medical specialty encountered in the statistics of medical courts, is due to several reasons. Firstly, paediatricians as a rule work both with children (patients) and their parent(s). Secondly, there is no proper balance in the exchange of information between the doctor and the patient's parents. The paediatrician asks very detailed questions related to the child's condition without providing equally detailed information about the diagnosis and treatment. Therefore, paediatricians must, using not only their theoretical knowledge but also professional experience, consider certain decisions related to the child's treatment together with the parents (for example, whether it is better to discharge a child in a good general condition and wait for test results at home or leave the child in hospital while waiting for test results). Thirdly, it needs to be noted that a child's illness is associated with a far greater sense of threat and parental fear than cases involving adults and their medical conditions.

CONCLUSIONS

In view of contemporary advances in medicine both patients and their parents believe in the success of medical therapies and, as a result, have high expectations of medical practitioners. The high level of medical knowledge is also the reason why medical court judges increasingly request the opinion of medical expert witnesses. Medical expert testimony in proceedings held before medical courts represents a special type of evidence. This is mainly due to the object and purpose of expert opinions and the competencies of medical experts. Medical expert witnesses evaluate facts based on their medical expertise and in some cases also ascertain them, for example by examining the patient. From a legal point of view, it is clear that “in matters

requiring special knowledge – one of them being undoubtedly the question of existence of a medical condition – the court should rely on experts rather than take an independent position”⁽¹⁴⁾. After consulting an expert witness a medical court may not dispute his or her opinion. A medical expert opinion is either considered properly substantiated or not. A medical court may not make its own statements replacing the conclusions offered by medical expert witnesses – or resolve issues requiring special knowledge in a manner that contradicts the expert’s opinion⁽¹⁵⁾. In case of doubt, the medical court should admit a supplementary expert opinion or appoint another expert witness. The SN considers that if two expert opinions are mutually contradictory, another expert must be appointed⁽¹⁶⁾. Also, if expert opinions are conflicting, the court may confront medical experts just like witnesses. This happens when a court finds that an expert’s opinion contains significant gaps or is incomplete, unclear, insufficiently substantiated, unverifiable or unreliable. In such a situation, according to the current line of case-law, the court is obliged to admit evidence in the form of other expert testimonies. The practice of medical courts shows that nowadays – similarly to common courts of law – expert witness testimony is among the key evidence presented in examined cases.

Hence the *de lege ferenda* proposal that medical court judgements, and in particular medical expert opinions prepared in the course of court proceedings, should be used in the teaching of physicians both during their medical studies and in postgraduate training. The fact that the number of physicians (including paediatricians) brought before medical courts stayed at a steady level in the years 2016 to 2018 can be attributed to the lack of analysis of court judgements (together with expert medical opinions) throughout the process of medical education. The body of judgements passed by medical courts comprises extremely varied and interesting cases which should be examined not only by lawyers but primarily by physicians. Medical expert opinions drawn up in these cases are definitely of high educational value.

Conflict of interest

The author does not declare any financial or personal links with other persons or organisations that might adversely affect the content of the publication or claim any right to the publication.

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