

# The issue of legal protection of the intensive care unit physician within the context of patient consent to treatment.

## Part I — conscious patient, refusing treatment

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### Abstract

In daily clinical practice, physicians working in intensive care units (ICUs) face situations when their professional duty to protect the patient's life is in conflict with the obligation to respect the will of the patient and to assess his or her chances of treatment. Although the mere fact of conflict between these fundamental values for the ICU physician is a natural and obvious element in the chosen specialisation, many 'non-medical' circumstances make the given conflict not only very difficult but also dangerous for the physician. So far, the ethical and legal aspects of dying have been commented upon by a large group of lawyers and experts involved in the interpretation of the Polish regulations. The authors believe that a detailed analysis of the regulations should be carried out by persons of legal education, possessing a genuine medical experience associated with the specificity of end of life care in ICUs.

In this paper, the authors have compared the current regulations of legislative acts of the common law relating to medical activities at anaesthesiology and intensive care units as well as based on the judgements of the common court of law over the past ten years. In the act of dissuading an ICU doctor from a medical procedure, all factors influencing the doctor's responsibility should be taken into account in accordance with the criminal law. In the case of a patient's death due to a refusal of treatment with the patient's full awareness, and given proper notification as to the consequences of refusing treatment, the doctor's responsibility lies under article 150 of the Polish penal code.

**Key words:** intensive care unit, physician, criminal liability, patient, consent to treatment, patient refusal of treatment

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In everyday clinical practice, physicians working in anaesthesiology and intensive therapy departments intensive care units (ICUs) face situations in which their professional duty to protect the patient's life stands in conflict with the duty to respect the patient's will. Although physicians in intensive care units are used to facing such conflicts of fundamental values, and it is an obvious element of their speciality, there are however various 'non-medical' circumstances that make the conflict situation not only very difficult but also dangerous for physicians.

Ethical and legal aspects of dying have been discussed by a large group of both lawyers and experts interpreting

the Polish law. The authors of the present paper believe it to be important for the analysis of regulations to be done by persons with legal education as well as personal medical experience of observing the process of dying in intensive care units.

The aim of this paper was to determine the legal and criminal role of the ICU physician with respect to the process of taking therapeutic decisions that save or maintain the patient's life, especially the scope of his or her liability and protection in accordance with Polish law. The study focuses on legal acts on medical practice in intensive care units and related court rulings of the last decade. Determinations of

the legal state do not take into consideration the Code of Medical Ethics as a collection of rules that are not part of the common law system. The paper includes commentaries to the Criminal Code which interpret the Polish law in the given scope.

### SHORT CASE STUDY

In order to make legal conditions and medical circumstances that are the subject matter of this paper more precise, the authors decided to present briefly two clinical cases from their own practice that can be perceived as representative of the situation discussed.

#### CASE 1

A 37-year-old female patient with diagnosed severe systemic sclerosis, hospitalised repeatedly in the intensive care unit due to respiratory failure as a complication of tracheoesophageal fistula that underwent three unsuccessful surgical procedures. The patient's condition was severe. She was cachectic due to inability of oral feeding. She complained of chronic, strong pain and continuous intensive retching. In the presence of her husband and medical personnel, she categorically refused intubation, tracheostomy, parenteral nutrition and other invasive treatments, despite being aware that this could result in her death.

#### CASE 2

A 72-year-old male patient after two cardiac arrests caused by ventricular fibrillation with the underlying acute coronary syndrome. The history revealed long-term diabetes mellitus type 2 with generalised atherosclerosis as well as lower limb amputation due to acute ischaemia. During the ICU treatment, his left ventricular ejection fraction was 25%. The possibilities of invasive cardiac treatment were exhausted. The patient consciously manifested lack of will to live and repeatedly refused any therapeutic interventions such as insertion of the central venous catheter, supply of catecholamines, invasive measurements of arterial blood pressure (cannulation) or tracheotomy.

What is most important from the legal perspective in the described situations is that patients while performing a legal act by refusing treatment were:

- conscious,
- capable of independent and conscious consent to/ refusal of treatment in written or oral form,
- aware of the predictable effects of a lack of treatment based on information provided by their physicians.

### SPECIFICITY OF INTENSIVE CARE UNIT

In considering the circumstances related to the discontinuation of medical procedures due to open objection by the patient, it is worth reflecting on the specificity of the unit

in which the therapeutic decisions are taken, despite the fact that legal regulations are the same in all Polish medical centres. In the intensive care unit, the intensity of the conflict between the patient's will and protection of his right to live, which is a duty of every physician, is especially visible. This is because almost every medical procedure performed by intensive care unit personnel results from life saving indications, and as such determines the patient's survival. It is also possible to agree that only under the conditions of an intensive care unit can non-performance of medical procedures resulting from the patient's refusal of treatment lead to quick and almost inevitable death. In the light of binding legislation and court rulings, it is beyond doubt that the patient's will is an indispensable component of treatment and as such constitutes the basis for its legality [1]. This indispensable component, apart from the Article 192 of the Criminal Code, is also taken into account in the Act on Medical and Dental Professions [2], as well as the Act on Patient Rights and Ombudsman for Patient Rights [3]. The informed consent to treatment obtained from the patient is binding for the physician as much as the patient's refusal. Despite the possibility of death, the situation when a patient suffering from cancer with a poor prognosis consciously objects to surgical treatment in favour of a conservative one usually does not provoke any legal doubts. This clinical situation is not associated with the majority of situations happening in the intensive care units to conscious patients only due to the fact that the death of this patient will occur later in the future. In the light of binding law, other factors remain identical.

### BASIS OF PHYSICIAN'S LIABILITY IN LIGHT OF THE POLISH CRIMINAL CODE

The conflict of values expressed in the right to self-determination and the right to live results from the differences in interpretation of the regulations of the Criminal Code. Firstly, consideration of legal protection of a physician in respect to the patient's death should focus on the most important legal acts forming the basis of criminal liability.

In the 1990s, before the introduction of the Act on Medical and Dental Professions of 1996, the regulations that formed the basis of medico-legal and criminal liability were the rules of the Criminal Code formulated in 1969. Penalisation of medical treatment without the patient's consent was not included in the Criminal Code until 1997, introduced shortly after the Act on Medical and Dental Professions. It drew from Article 192 of the Criminal Code, which reads: "Anyone who performs a therapeutic procedure without the patient's consent is liable to a fine, the restriction of liberty or imprisonment for up to two years" [4].

Moreover, the Code includes a chapter devoted to crimes against life and health, with Article 150 stating: "Anyone

who kills a person at his or her request and out of compassion for that person is liable to imprisonment for between three months and five years" [5]. Article 150 in the Polish law system penalises a crime called in the legal doctrine 'euthanasia', i.e. "conscious action that leads to shortening of the patient's life" [6]. Commentaries to this act read "a person can be killed by action (active euthanasia) or by omission (passive euthanasia)" [7]. The notion of 'action' does not raise doubts. It is construed as the taking of actions that lead to shortening of the patient's life (e.g. administration of a drug in doses exceeding the therapeutic one or without medical indication in order to induce death) and will not be addressed in this paper.

'Omission' — remaining in the sphere of the authors' interest — meaning the discontinuation of medical treatment aimed at saving or maintaining the patient's life in order for the patient to die, is described as 'passive euthanasia' and as an act being an element of crime according to Article 150 of the Criminal Code may be wrongly viewed as basis of physician's criminal liability. According to A. Zoll, omission "means failure to take necessary actions in order to prevent the effect described in the Act" [8].

Current deliberations on legal determinants of acts related to the process of dying are chaotic due to the multitude of terms used. This fact is accentuated by J. Umiastowski: "In public opinion, the notion of resignation from (discontinuation of) persistent therapy is mixed with euthanasia — abandonment (omission) of persistent therapy is treated as passive euthanasia" [9]. Discussion is made difficult by such notions as "physician's passive approach to death" or "consent to death" [10]. While from the criminal law perspective they are of no importance, their impact on public opinion often results in terminological confusion as to specific acts and may suggest attributing guilt to a physician (in the criminal law sense), which is one of the formal reasons for criminal liability.

### **PASSIVE EUTHANASIA AND NON-PERFORMANCE OF TREATMENT AS A RESULT OF PATIENT'S REFUSAL OF TREATMENT**

There is a clear difference between the notion of passive euthanasia and non-performance of medical action as a result of the patient's objection, despite the fact that in both cases the effect observed from the outside involves discontinuation of medical treatment by the physician, and as a result the patient's death. The fundamental difference between the two actions, which sets the boundary between crime and observance and realisation of the patient's will, lies within the voluntary sphere (dependent on the will) of the physician. In the case of passive euthanasia, the basic mechanism of a doctor's actions, as well as the main aim, is accurately expressed by the phrase: "person A ends life

of person B, for the sake of the good of person B" [10]. This definition does not describe the action depending on its motive because the intention both in the case of a crime as provided by Article 150 of the Criminal Code as well as the lawful actions of the physician consisting in life protection is the patient's good. However, in the two cases, it is understood differently.

### **THE PATIENT'S GOOD**

In the definition of euthanasia formulated by Kuhse, the purpose of action of person 'A' performing the act of passive euthanasia is to end the life of person 'B' upon his or her request in order to alleviate his or her suffering. In such understanding of the patient's good, the necessary reasons for the action include not only compassion but also a conviction that the person asking for death suffers to such an extent that ending his or her life would be a blessing and that death can save him or her from this suffering" [11]. This perception of the good of person 'B' is completely different from the above-described patient-doctor relationships. In both cases, the doctor by offering the patient medical procedures sees the good of the patient in the possibility of protecting his or her life, even if those procedures cause the patient additional suffering. The physician is convinced that the patient's suffering does not justify the desire to die. For the physician, the patient's good manifests itself in protection of life despite suffering, whereas for the person performing the act of euthanasia, it shows itself in sacrifice of life for protection against suffering.

### **THE AIM OF ACTION**

In order to differentiate between criminal action described in Article 150 of the Criminal Codes as non-performance of treatment, and legal fulfilment of medical duty with observance of the will of the patient, it is essential to determine the aim of the subject's action (in this case a physician or a crime perpetrator).

The physician guided by the patient's good proposes certain medical procedures in order to protect his/her life. Hence, the aim of the physician's action is commencement or continuation of the treatment process. Material trait of a crime (social harm of an act) conditioned by the physician's motivation to act indicates in this case lack of premises for crime as stipulated by Article 150 of the Criminal Code. It remains in total contradiction with the aim assumed by the crime perpetrator, for whom the aim of action resulting from compassion remains the death of the person who demanded action that was to lead to this death.

### **OMISSION**

It should be stressed that 'omission' in the criminal law sense was described in detail in Article 2 of the Criminal

Code in its general part: “Only a person with a specific legal duty to prevent criminal consequences committed by omission bears criminal liability for an offence with such consequences”. This specific legal duty takes place when the physician fulfils his duties based on a special legal relation with regard to the profession performed within the public-legal contract of employment in the health care institution or a civil-legal contract with the patient, the physician is obliged to prevent adverse effects to the health and life of the patient [12].

It can be easily proved that in the case of an anaesthesiologist fulfilling his duties in the intensive care unit, it is he who bears a specific legal duty to prevent effects adverse to the health and life of the patient, making him a guarantor in accordance with Article 2 of the Criminal Code. One cannot however talk of ‘omission’ in light of the definition provided in this Article, since in both of the described situations the physician performs all the actions that he is obliged to by law. The obligations of the physician include assessment of the patient’s condition of health, diagnosis, preparation of personnel for medical procedures and securing the necessary equipment. Moreover, he has to fulfil the duties described in Article 192 of the Criminal Code and in Article 32 Paragraph 1 of the Act on Medical and Dental Professions by obtaining consent for the performance of medical procedures, which is indispensable for the medical procedure to be legal. In the case of the patient’s refusal, the physician cannot undertake treatment that he believes to be advisable and proper. The physician depending on his will facing the refusal. The only factor stopping the physician from performing the procedure is the refusal expressed by the patient. Since the physician is continuously ready to take actions, it seems groundless to make the notion of ‘omission’ an indispensable element of crime against the physician performing the duties imposed on him or her by the legislator.

### **PATIENT’S WILL AND ITS DECLARATION**

The patient’s will in the two situations discussed seems to be completely different and so is the perception of the patient’s good by the perpetrator. In the case of passive euthanasia, the patient’s request is for his or her life to be ended. “The element of demand by a future victim to be killed is the factor which distinguishes homicide described in Article 150 from the homicide in the general sense as provided in Article 148” [13]. In the case of lack of consent to a medical procedure, the patient consciously refuses to give the physician the right to act by exercising his or her right to self-determination. The assessment of the final effect of both declarations of will is similar. In both cases, the physician refrains from taking any action which may result in the patient’s death. However, from a criminal law perspective, the first declaration of will includes a demand for the

physician to take a legally forbidden action (cause death). Demanding to be killed, the patient demands commitment of an offence to which the physician cannot consent to. Whereas in the second case, the physician offers treatment of the patient and the patient’s declaration of will including refusal of this treatment remains in accordance with the law, making it impossible to undertake a therapeutic procedure. The second situation leads to the physician’s action “which may result in the shortening of life but his intention is not to shorten life” [14]. Despite identical results for the patient and the impression of the physician’s passivity, in the legal sense the two situations are different and cannot be considered in relation to Article 150 of the Criminal Code.

### **SUMMARY**

From the criminal law perspective while considering discontinuation of medical procedure by a physician in the intensive care unit, one should always take into account the factors mentioned above which condition the doctor’s liability. In the case of the patient’s death due to non-performance of treatment with the patient being fully aware and duly informed of the consequences of discontinuation of treatment, the physician’s criminal liability under Article 150 of the Criminal Code raises an objection of a logical and legal nature. “The greatest difficulty is to differentiate between observance of the patient’s objection and killing through passive euthanasia performed with conceivable intent (*dolus eventualis*)” [15].

The basic difference between the two discussed cases is that in the second situation the perpetrator is “aware of the fact that his or her action may result in committing a prohibited act” [16]. Furthermore, it is worth stressing that according to Professor Barbara Świątek even the taking by the physician of an action aimed at killing the patient should not be associated with privileged homicide according to Article 150 of the Criminal Code, since there is a serious doubt as to whether the physician due to his long-term professional practice is capable of compassion that would justify the performance of euthanasia.

The final interpretation of the issue discussed and maybe even a postulate is the opinion of B. Janiszewska who believes that “application of the regulations concerning the declaration of will to refusal as well as validity and effectiveness of such declarations would allow [...] to simplify the legal assessment of such a refusal and would ensure a certain symmetry in both possible actions of a conscious patient: allowing treatment and refusing it. [...] The described model of assessment of the patient’s behaviour should also bring clarity to the doctor-patient relationship” [17].

### **CONCLUSIONS**

1. The physician’s omission in the case of effective objection to medical procedures expressed by the patient

should be construed as devoid of features of illegality and as such consistent with the law, hence not meeting the prerequisites of an offence penalised in Article 150 of the Criminal Code.

2. Observance of the patient's will in cases of legally important objections to the medical procedures undertaken cannot constitute the basis for criminal liability of the physician.

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