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Why is the approach to discontinuing life-sustaining treatment different in the UK and Poland? Based on the case of RS

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Why is the approach to discontinuing life-sustaining treatment different in the UK and Poland? Based on the case of RS

[Running title: Two different approaches to discontinuing life-sustaining treatment]

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Abstract

The discontinuation of life-sustaining therapy has been the subject of dispute for many years. Despite the guidelines, which were created to facilitate the resolution of disputes between the doctor (hospital) and the patient (family, surrogate), new cases of seriously ill patients continue to emerge and stir up controversy. One such case was the RS case. A Polish citizen living in the UK suffered severe brain damage as a result of cardiac arrest. The hospital applied to the court to withdraw ventilation, hydration, and nutrition for RS. The judge ultimately ruled that it was in RS's best interest to withdraw ventilation and nutrition, but he left the decision on hydration to RS's wife and the hospital. The court's ruling has stirred up controversy among the Polish public. Some Polish doctors assessed the UK court's decision as "legal murder" and "euthanasia". I believe that it is worth examining the RS case for at least two reasons. Firstly, it provides a better understanding of the difference in approaches to

therapy cessation in the UK and Poland. Secondly, many Poles live in the UK, and therefore similar disputes may arise in the future. In this paper, I point out several differences between the British and Polish approaches to discontinuing life-sustaining therapy. These differences are focused on the definitions of medical futility and persistent therapy, best interest and dignity, and quality of life and sanctity of life.

Key words: best interest, dignity, medical futility, persistent therapy, sanctity of life, quality of life

Introduction

The discontinuation of life-sustaining therapy has been the subject of dispute between doctors (hospitals) and patients (families, surrogates) for many years. Despite the guidelines, which were created to facilitate the resolution of disputes, new cases of seriously ill patients continue to emerge and stir up controversy. For example, the case of Charlie Gard, a British boy suffering from a rare mitochondrial disease, was controversial and generated much emotion and public debate about medical ethics, parental rights, and the criterion of best interest [1–4]. The dispute over the cessation of his life support has involved not only the public, but also many authorities, including Pope Francis. Not all disputes over the discontinuation of life-sustaining therapy are as vociferous, which does not mean they are any less important.

The dispute that arose around the RS patient, a Polish citizen living in the UK, also had a tumultuous course, especially in the Polish media. Tens of thousands of people signed special petitions addressed to the UK government and demanded that RS be transported to Poland [5]. The physicians from the Alarm Clock Clinic offered to take care of the patient, and transport to Poland was offered by representatives of the Polish government. Dialogue with the British authorities, medical associations and religious associations was undertaken by a representative of the president of Poland, consuls and the Polish ambassador to the UK, the Speaker of the Sejm, the ombudsman and the president of the Polish Bishops' Conference [6]. Disapproval of the court's decision in the RS case was expressed by the Bishop of the Diocese of Plymouth and the Anscombe Bioethics Centre. Some Polish physicians assessed the UK court ruling as "legal murder" and "euthanasia" [7]. Emotions on the issue seem to have subsided. However, it is worth examining the RS case for at least two reasons. Firstly, it provides a better understanding of the difference in the approach to therapy cessation in the

UK and Poland. Secondly, many Poles live in the UK, and so similar disputes may arise in the future [8]. In this paper, I point out several differences between the British and Polish approaches to discontinuing life-sustaining therapy. These differences are focused on the definitions of medical futility and persistent therapy, best interest and dignity, and quality of life and sanctity of life.

Background

On 6 November 2020, RS suffered a cardiac arrest at home for at least 45 minutes. He suffered significant brain damage as a result of lack of oxygen. He was transported to the University Hospitals Plymouth NHS Trust, where he remained in a comatose state. On 25 November, the hospital applied for a declaration that RS lacks capacity to consent or refuse medical treatment, including ventilation and clinically assisted nutrition and hydration (CANH), and for an order that it is lawful and in his best interests for ventilation and for nutrition and hydration to be withdrawn. The hospital's proposal was supported by RS's wife, while his mother, two sisters, and a niece objected. During the court trial, more than five weeks after the cardiac arrest, RS remained in a coma, and doctors agreed that he would never regain the mental capacity to decide for himself. On 5 December, RS was examined by Dr. Dominic Bell, assisted by Dr. W. Dr. Bell stated that RS was not in a vegetative state during the examination and might progress to the lower end of a minimally conscious state (MCS). Dr. Bell estimated that RS had a 10 to 20 percent chance of reaching a MCS. Dr. W agreed with Dr. Bell's diagnosis. However, he considered the prognosis for RS reaching MCS as too optimistic. According to Dr. W, RS was in the process of transitioning from a comatose state to a vegetative state. The court process (along with the involvement of the European Court of Human Rights) lasted long enough that RS was disconnected and connected to life support several times. Taking into account the medical opinions expressed, the opinions of his wife and children, and his birth family, the court decided that it would be in RS's best interest to stop nutrition and ventilation. The court left the decision regarding hydration to RS's wife and the hospital. The patient died in the hospital on 29 January 2021 [9–12].

Different definitions: medical futility and persistent therapy

Studies have shown that there is no single acceptable definition of medical futility [13]. All definitions, starting from physiological futility to qualitative and quantitative futility, have been criticized [14]. The lack of consensus has led some scholars to use other terms [15], while others have turned to a procedural approach to medical futility [16–18]. However, some authors stress that even the procedural approach is a broad interpretation of medical futility, as

it involves a multi-step procedure based on medical, psychological, value-laden, religious, and other criteria [19]. The procedural approach ultimately concerns whether further treatment is futile. It may be the case that the “only clear definition of futile treatment on which there appears to be agreement is that of physiologically futile treatment, where there is no physiological mechanism by which treatment could work, and hence no chance of benefit” (p. 29–30) [20]. Most likely, physicians at the hospital decided that maintaining RS in a comatose state was futile, because there was no chance to improve his condition. Doctors decided that it was in RS’s best interest to discontinue ventilation and CANH. It should be noted that the cessation of CANH in the UK is treated like the cessation of other medical procedures. This observation is important, because it represents a significant difference from the medical standards used in Poland.

In the Polish literature, scholars generally use two terms: medical futility and persistent therapy [20, 21]. Some studies emphasize that although the term “medical futility” is similar in meaning to the term “persistent therapy”, there are differences between them [22]. It is worth noting that the term “persistent therapy” has been entrenched in Polish literature for many years. For instance, it appears in the Polish Code of Medical Ethics, which maintains that “in terminal states, a physician is not obliged to undertake and conduct resuscitation or persistent therapy and use extraordinary means” (Article 32) [23]. However, the definition of persistent therapy was introduced into the literature by the Polish Working Group on End-of-Life Ethics (PWG) in 2008 [24]. Moreover, this definition was accepted in the latest position of the Polish Society of Internists’ Working Group on Futile Therapy in Internal Medicine Departments (PSIWG) in 2023 [25]. According to the PWG, “persistent therapy is the use of medical procedures to maintain the life function of the terminally ill in a way that prolongs their dying, introducing excessive suffering or violating their dignity. Persistent therapy does not include basic care treatments, pain relief and other symptoms as well as nutrition and hydration, if they serve the well-being of the patient” [24]. Given the many misunderstandings and public concerns about end-of-life decision-making, the PSIWG emphasizes what kind of procedures are not part of therapy and therefore cannot be discontinued as therapeutically futile. Besides ordinary care and palliative care, therapy does not include nutrition and hydration (including through a feeding tube, if it will not harm the patient). According to the PSIWG, nutrition and hydration are part of basic care. In practice, only if during the dying period (the last days and hours) the patient cannot take liquids and food orally or through a feeding tube should the physician consider whether there are medical

indications for parenteral hydration or whether hydration will be a burden on the dying patient. The PSIWG maintains that discontinuation of nutrition and hydration cannot be the direct cause of a patient's death [25]. It seems that regardless of whether we consider artificial nutrition and hydration (enteral, subcutaneous, or intravenous) as a therapy or not, the abandonment of such measures will hasten the patient's death, and therefore should not be allowed. In the light of the latest guidelines, it has become understandable why disconnecting RS from CANH has been described by some Polish physicians as euthanasia. A patient in a coma, MCS, or PVS is not a dying person. According to Polish medical standards, CANH for RS was not, therefore, a futile therapy.

Best interest and dignity

The best interest criterion is a concept used in various legal contexts in the UK. The basic premise of this criterion is that all decisions regarding the patient should be made in the patient's best interest. The test of best interest plays an important role in medical decision-making, especially when the patient is unable to express their own will [26]. Physicians and medical staff seek to understand the patient's preferences and values and what actions are in the patient's best interest. In other words, best interest includes "consideration of the person's past and present wishes and feelings, and their values, beliefs and any other factors they would consider as relevant to their decision if they were able to do so (s. 4 [6] of the Mental Capacity Act 2005), but also puts weight on 'all the relevant circumstances' (s. 4 [2] of the Mental Capacity Act 2005), which might — and, in practice, regularly do — include diagnosis, prognosis, and sanctity of life" [27]. At the request of Plymouth Hospital, the court heard RS's case in accordance with s. 1 [5] and s. 4 of the Mental Capacity Act 2005 and therefore on the basis of best interest criterion. The judge considered the following factors: (a) "the prospects of obtaining a life that could bring RS any semblance of pleasure and quite how low those prospects are", (b) "the sanctity of life encompassing with it religious beliefs", (c) "the balance between pleasure and distress and the evidence of Dr. Bell that patients with very limited ability to show any emotion more often show distress than pleasure", (d) "the views of others near and dear to him and in particular those nearest and dearest to him, his wife and children", and (e) the views of the patient, which the judge tried to determine [9]. For the judge, the key issue was to determine the will of RS. He ultimately gave more weight to RS's wife's opinions than to RS's birth family's opinions and ruled that it was not in RS's best interest to sustain his life. Why would a different decision be made in Poland?

According to Polish medical standards, included in the PSIWG guidelines, the procedures that were applied to RS in the UK would not be considered futile or as being in the patient's best interest. It seems that in the Polish context, the well-being of the patient is closely related to the understanding of dignity [28]. The right to die with dignity concerns every patient if medical procedures are considered persistent. The Polish Code of Medical Ethics indicates that when therapy is considered persistent, "the physician should make every effort to provide the patient with humane terminal care and dignified conditions of dying" (Article 30) [23]. Moreover, the physician is not allowed to use euthanasia or help the patient commit suicide (Article 31) [23] Polish law does not provide for exceptions to the legal protection of human life by withdrawal of CANH from patients in a MCS or PVS [29], and the Polish Penal Code explicitly prohibits euthanasia (Article 150) [30]. According to the aforementioned definition of persistent therapy, medical procedures can be considered persistent, and can therefore be discontinued, if they are carried out on a patient who is terminally ill, suffers excessively, and dies. Respect for dignity refers to such circumstances. RS was not a dying patient. It also does not seem that he suffered excessively. Respect for the dignity of RS would therefore involve continuing CANH, which is part of basic care according to long-standing Polish medical practice [31].

It is worth noting one more important detail that allows one to capture the difference in the approach to discontinuing life-sustaining treatment in the UK and in Poland. Respect for the dignity of seriously ill patients is conditioned by the historical context, as pointed out by the Polish Association for Spiritual Care in Medicine: "The medical community in Poland is very sensitive to distortions of the goals of medicine and subordinating medical practice to ideologies. For several years, we have been analyzing the causes of the transition of doctors' attitudes 'from healing to killing' in totalitarian regimes, such as in Nazi Germany's Auschwitz death camp practice. Therefore, the protection of dignity, respect for autonomy and freedom of religion and conscience, and nondiscrimination are important values in Polish ethical and legal healthcare standards" [29].

The RS case demonstrates not only the differences in medical and legal standards for managing MCS or PVS in the UK and Poland, but also the different value systems that underlie the decision to discontinue life-sustaining therapy.

Quality of life vs. sanctity of life

Quality of life (QoL) in contemporary medicine is an important factor in patient care, but the term "quality of life" can be ambiguous. Who defines QoL, what constitutes high or

low QoL, and how such judgments should be used in medical practice are contested [32]. How QoL is understood by the treatment team can have serious implications for severely disabled patients, who are often perceived as those with low QoL and therefore less deserving of access to scarce resources [32]. According to some definitions of medical futility, physicians may determine that a therapy is futile if they consider the patient's QoL to be unacceptable. For example, Schneiderman et al. [33] propose that qualitative futility should be considered for those who are permanently unconscious and totally dependent on intensive medical care. Permanently unconscious patients are deprived of social interactions, feelings, thoughts, self-awareness, and awareness of their surroundings; and patients permanently dependent on intensive medical care cannot participate meaningfully in the community [34]. An example of qualitative futility could be the CANH of a patient in PVS or MCS. However, it seems that in many cases such a procedure is neither probabilistically nor physiologically futile, and the only reason for its withdrawal is the belief that PVS or MCS represents low QoL [35]. It is worth noting that RS was in a coma and therefore not dying, and CANH was necessary to keep him alive. The judge was aware of the consequences of the withdrawal of CANH, since he maintained that "if preserved with his current treatment RS could survive up to five years or more (…) but in the event of the removal of nutrition and hydration he will die within a matter of a couple of weeks" (p. 12) [9]. It can be assumed that QoL played an important, if not the most important, role in the RS case. It cannot be ruled out that one of the reasons the hospital went to court to withdraw CANH was the doctors' belief that RS experienced a low QoL. Moreover, Dr. Bell and Dr. W maintained that "RS [would] never achieve a meaningful quality of life" (p. 13) [9]. In turn, RS's wife told the judge that "the bare minimum recovery that could justify keeping RS alive would be one where he could interact with her and the children even if just to squeeze their hands or move a finger to acknowledge their presence" (p. 25) [9]. All these opinions may suggest that the QoL was one of the most important factors regarding the decision to withdraw CANH. Why would the principle of sanctity of life play a key role in the RS case if the accident occurred in Poland?

Although the concept of sanctity of life has been analyzed and described as ambiguous and misleading [27], it plays an important role in the decision to continue or discontinue life support, at least in some countries (e.g., Israel) [36]. To clarify misunderstandings about the meaning of "sanctity of life", some scholars point to certain ideas that underlie it: (a) "that as life is a gift from God, it is to be cherished"; (b) "all human beings are to be valued, irrespective of age, sex, race, religion, social status or their potential for achievement"; (c)

“the deliberate taking of human life is prohibited except in self-defense or the legitimate defense of others”; and (d) “human life is a basic good as opposed to an instrumental good: a good in itself rather than as a means to an end, whether that end be conceived of as life of a certain minimum ‘quality’, or the good of the state, or anything else” [37].

The strong belief about the sanctity of life among Catholics makes the cessation of CANH in PVS or MCS cases morally unacceptable. In the letter “*Samaritanus bonus* on the care of persons in the critical and terminal phases of life”, the Congregation for the Doctrine of the Faith maintains that “nutrition and hydration do not constitute medical therapy in a proper sense, which is intended to counteract the pathology that afflicts the patient. They are instead forms of obligatory care of the patient, representing both a primary clinical and an unavoidable human response to the sick person. Obligatory nutrition and hydration can at times be administered artificially, provided that it does not cause harm or intolerable suffering to the patient” (point V.3) [38]. In another place, the Congregation for the Doctrine of the Faith emphasizes that “the administration of food and water even by artificial means is, in principle, an ordinary and proportionate means of preserving life. It is therefore obligatory to the extent to which, and for as long as, it is shown to accomplish its proper finality, which is the hydration and nourishment of the patient. In this way suffering and death by starvation and dehydration are prevented (…). A patient in a ‘permanent vegetative state’ is a person with fundamental human dignity and must, therefore, receive ordinary and proportionate care which includes, in principle, the administration of water and food even by artificial means” [39]. There is a deep conviction among Catholics that as long as a person is alive they retain their value (dignity) even if the biological condition has a low QoL. This does not mean, however, that all Catholics must “die with a feeding tube” (p. 141) [40]. If CANH does not serve the patient’s good, as the PWG maintains, it can be discontinued. It should be noted that the dominant religion in Poland is Catholicism. Recent statistics show that 92.2 percent of the Polish population is Catholic (p. 360) [41]. Although RS was a practicing Catholic (confirmed by his wife) and his birth family (mother, sisters) appealed to the views of the Catholic faith, the judge ruled that these arguments were not strong enough to continue CANH. If RS’s case had occurred in Poland, CANH would not have been discontinued. This view is supported by Polish scholars: “In the case of patients in a VS/MCS, nutrition and hydration do fulfill their physiological functions. We are not aware of any reliable scientific evidence that feeding and hydration withdrawal in VS/MSC benefits patients. Therefore, it may be assumed that such

judicial decisions are based more on individual beliefs and convictions than on scientific evidence” [42].

Belief in the sanctity of life is strong in Poland. This is evidenced by the content of the latest PSIWG guidelines regarding seriously ill patients, as well as the fact that the president of the Polish Bishops’ Conference and representatives of the Polish government came out against the court’s decision in the RS case. There is a belief among many Polish doctors that any doubt about the management of a seriously ill patient should be resolved according to the principle *in dubio pro vita humana* [29].

Conclusions

The differences regarding the standards of patient management in PVS and MCS in Poland and the UK are clear. In this paper, I point out only a few of them to better understand the arguments that underlie decisions related to continuing or not continuing life-sustaining therapy. What seems indisputable, however, is that decisions to discontinue life support differ in the UK and Poland not only in terms of medical and legal standards; different value systems, as well as different ethical and anthropological considerations, underlie such decisions. However, it should be emphasized that in many cases of seriously ill patients, decisions to discontinue therapy are made in a context of epistemic and moral uncertainty. With this awareness, one should be cautious when making value judgments.

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Author contributions

Marcin Paweł Ferdynus — 100%.

Competing interests

The author declares that there is no conflict of interest.

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Supplementary material

None.

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