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Review

Psychosocial and legal aspects of oncological treatment in patients with cognitive impairment

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ABSTRACT

With society getting older and affected by many diseases, more and more people suffer from severe cognitive disorders. As practice shows, the legal situations of such people is often problematic. This is due to a number of factors, such as short time since the deterioration of patient's condition, initial symptoms ignored, social prejudice towards the idea of incapacitation or taking decisions for a patient, complicated procedures and, sometimes, insufficient knowledge of legal regulations. Cognitive disorders also occur in patients treated for cancer. To be effective, oncological treatment needs to be started as early as possible. This, however, does not meet the criteria of sudden threat to life. The present article relates to both the psychosocial and legal aspects of care of people suffering from intense disorders of memory, attention, problem solving, executive functions, and other. Surely, physicians know how to handle patients with the above dysfunctions. However, legal procedures aimed to protect patients' rights are often unclear and time consuming. In practice, this often amounts to a dilemma whether to treat or follow the applicable law. Certainly, solutions in this regard should be clearer and better adapted to the needs arising from specific treatment needs of particular groups of patients.

Cognitive impairment is a group of symptoms that often occur in patients treated for oncological diseases. Among these, are those who, due to cancer, experience sudden symptoms of brain damage, and those treated for cancers of different locations who have a history of brain damage or any sort of neurodegenerative disease. Such disorders may develop for months or even years, with effects covering virtually all functions. Cognitive dysfunctions also apply to patients treated psychiatrically, e.g. for affective disorders. Moreover, they may occur temporarily as symptoms of other somatic diseases or as a side effect of surgery, radiation therapy, chemotherapy or drugs applied in those therapies.[1–3] In many cases, they present as mild cognitive impairment, but sometimes make it very difficult to make a contact or exchange information with patients and prevent them from functioning by their own, including taking important decisions, such as those to start or continue treatment.[4]

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1. Psychosocial and medical aspects of oncological treatment of patients with cognitive impairment

Diagnosing cognitive dysfunctions in patients is of utmost importance, particularly when they are subjected to a long-term and traumatic treatment, as oncological treatment surely is. It is significant for medical reasons, as an important symptom that helps determine optimal treatment modality, to assess possibilities of cooperating with the patient, but also in view of the need to respect the existing legal regulations. A detailed interview concerning patient's life so far might prove very helpful here. Information is gathered mostly from patients themselves so as to obtain a preliminary picture of their difficulties in cognition, memory, thinking and speech, and then, in the second instance, from their caretakers. An essential role in the process is played by psychiatric consultation supported by a neuropsychological evaluation of cognitive function using test methods to deliver more detailed information in this regard. The most commonly used methods include: Wechsler Adult Intelligence Scale (WAIS-R(PL)) and Wechsler Intelligence Scale for Children (WISC-R(PL)), Right Hemisphere Language Battery (RHLB-PL), Boston Diagnostic Aphasia Examination (BDAE), a set of tests for patients brain damage, Bright Vision Therapeutic Riding (BVTR), Rey-Osterrieth Complex Figure, Auditory Verbal Lerning Test, Mini-Mental State Examination (MMSE), Clock Drawing Test (CDT), Verbal Fluency Test, Trail Making Test (TMT).[5,6]

The psychopathological conditions which are typical for cognitive impairment and which are most commonly diagnosed in cancer patients include: impairment of consciousness, dementia, depression and focal brain damage.

Cognitive disorders are general dysfunctions of the central nervous system which often occur suddenly and are potentially transient and reversible in nature. The literature divides conditions of impaired consciousness into quantitative and qualitative ones. The quantitative disorders include: clouding of consciousness, where a verbal contact with the patient is possible but limited to answers to simple questions due to a reduced thinking performance and coherence and uncertain orientation to time and place; or somnolence, semicoma and coma where the patient does not respond to any verbal or physical stimuli, their reflexes gradually disappearing. The qualitative category comprises: delirium, which may be the most common symptom of cognitive function deterioration in patients with somatic diseases; oneiroid syndrome which presents with hallucination and complex and severe memory disorders; obnubilation characterised by a total disorientation and disorders of perception, problem solving and psychomotor activity (slow-down or acceleration); as well as mental confusion with distinct and intense disturbance of auto and allopsychical orientation, train of thought, memory and verbal contact, and motor restlessness. Mental confusion mostly arises from patient's poor somatic condition.[7–9] As mentioned before, the most commonly occurring type of consciousness disorder in somatic patients, including those treated for cancer, is delirium. The definition contained in *the International Classification of Diseases (ICD-10)*, identifies such symptoms as disturbances of consciousness manifested by various sorts of difficulties in recognising the environment; limited ability to focus, maintain and re-direct attention; and disorders of cognitive processes which present primarily with difficulties in a direct and short-term memory, with relatively well-preserved long-term memory. Usually, confusion of time, place and/or person is also observed. Those symptoms are accompanied by psychomotor disorders, such as reduced or intensified activity, extended or intensified reaction of surprise, rapid or slowed speech. Frequently observed are also disturbances in the sleep-wake cycle and a varied intensity of the symptoms during the day, e.g. stronger disorders in the evening or at night and a much better performance at daytime.[10] Sometimes, changes occur and disappear within minutes. It is important to identify the background of the symptoms, as they can go in pair with life-threatening disease processes, such as stroke, increase of intracranial pressure, encephalitis and other.[7] As much as impaired consciousness is symptomatic of many diseases, the determination of its etiological background may prove difficult. Also in oncological patients treated with surgery, radio- and/or chemotherapy or other modalities, the identification of the reasons for rapidly growing symptoms is a problematic task, as they may be associated with many factors, directly preceding the disorders of conscience. These include: physical immobility, catheterisation, malnutrition, dehydration, a number of drugs and risk factors of a chronic nature, e.g. side effects of treatment, somatic diseases, conditions associated with acute pain, and many more.[7] It needs also to be borne in mind that disorders of conscientiousness are common symptoms in a variety of old-age diseases, and elderly people, as mentioned before, represent a large proportion of cancer patients. Therefore, distinguishing disorders of consciousness from cognitive impairment resulting from dementia may be a challenge, particularly at the first or single contact with the patient. The main distinguishing trait is the duration of the symptoms.[9]

In dementia alike the main symptoms are memory disorders, applying particularly to the direct, short-term and operating memory, attention and learning processes. However, the course and dynamics of the changes are different. The onset of dementive disorders is hard to discern, as this type of dysfunction advances very slowly as a long-term process contrary to impairments of consciousness which usually turn up suddenly and persist for some ten to twenty days.[9] Dementia usually affects thinking-reduced level of generalisation (disturbance in abstract thinking) and difficulty in executive functions, such as motivation, planning, coordination and control of actions and emotions. With symptoms highly intensified, the patient might find it difficult to answer questions concerning time and place or related to themselves or people from their close circle. Dementive disorders occur for instance in Alzheimer's disease, cardiovascular diseases and other diseases affecting the cerebral circulation, Lewy bodies dementia, or due to frontotemporal degeneration. They may also result from focal injuries and other focal damage or the activity of toxic agents. In contrast to disorders of consciousness, dementia is irreversible and deepening in time, although the course of the disease may vary depending on the cause: primary degenerative processes will differ from dementia induced by a vascular process, toxic agent or injury (spurting progression, often marked with a sudden onset).[8–10]

Since the development of dementia symptoms is often slow, it tends to go unnoticed with symptoms difficult to understand as they appear.

Depressive disorders, as syndromes of different aetiology, are widely described in literature.[8,11] This article focuses rather on cognitive disorders that stem from them. Most commonly reported are issues related to direct, short-term memory, delayed recall of memorised material, attention, train (slow-down) of thought and executive functions. The severity of symptoms varies, although mostly presents with mild cognitive impairment.[11,12] The functioning of the patient may be affected by both the improvement or worsening of mood, however, in oncological patients mood is mostly observed to be down. It needs to be remembered that mood disorders, especially deterioration of mood, is a common symptom with certain types of damage to the central nervous system (e.g. to the basal and medial frontal lobes)[13,14] (Table 1).

Another group of disorders occurring in oncological patients are focal damages where the type and intensity of cognitive dysfunctions depend on the site and size of the lesion. They can, but do not need to, affect the ability to function independently and take decisions. Sometimes, the essence of disorders is hard to capture. The difficulties experienced by the patient may be strongly affected by their pre-disease level of functioning. Evaluating the dysfunction may be complicated due to speech disorders, concomitant paresis and peripheral issues, e.g. those involving the sight and hearing. In some patients, part of the cognitive difficulties subside in time causing their functioning to improve. In other cases, the dementive process may develop.[14,15] A particular focus should be given to disorders of mnestic processes (mainly short-term and operative memory, as well as orientation to time and place), attention, learning, problem solving and abstracting, aphasia due to the ability to understand speech and communicate verbally, or executive functions, including those related to planning, predicting consequences and controlling one's behaviour. Individuals with such dysfunctions may be assumed to be able to function or take decisions on their own. As regards other most common ways of communicating with the patient, the ability to read and write should also be assessed. Those skills may be limited or none as a result of memory deficit and visual gnosia (recognition of letters, meaning of words and graphic representation of words), vision field restriction of spatial, executive or attentive nature (unilateral neglect).[10,14,16]

Other symptoms, which are of less prevalence in oncological patients but must not be overlooked, include mental retardation and schizophrenia.

Mental retardation is caused by inborn factors or developed at an early stage of life. For that reason, the presentation of disorders is relatively steady, although it can be modified by diseases occurring in the course of life or ageing-related processes. These often lead to a general reduction of cognitive functioning. Difficulties in thinking and abstracting come to the forefront in this regard. Mental retardation is diagnosed based on psychological tests to determine the intelligence quotient (Wechsler Adult Intelligence Scale, Wechsler Children Intelligence Scale).[10] The ability to function and take decisions independently varies considerably based on the intensity of a dysfunction (mild, moderate, severe and profound).

Schizophrenia, as many studies show, is a condition where cognitive functions, much more often than in healthy people, are disturbed to a varied extent affecting the ability to evaluate situations and take decisions. The process is further complicated by productive symptoms, disorganisation of activities and dysphoria. Cognitive impairment in schizophrenia patients are observed regardless of the clinical presentation and duration of untreated disease. Dysfunctions may occur already in the period preceding the first episode of schizophrenia. They become more severe not so much with the duration of the disease as with the age of the patient. A significant deterioration of the functioning has been observed in patients above 65 years of age. They have been found to show reduction in executive functions and cognitive processes responsible for the processing of complex information.[8,11,17,18]

Deterioration of the cognitive function is a very difficult experience. Many cancer patients, particularly those treated with chemo-, radio- or hormonotherapy, report the occurrence of cognitive deficits which are typically mild and temporary. Very often, emotions at the moment of cancer diagnosis are strong enough to disrupt the functioning of attention, memory or other functions. Many patients who are not diagnosed with any cognitive impairment report difficulties in remembering the information provided by the doctor. Therefore, it is very important to check what the patient actually understood and remembered.[19,20] Boykoff et al. examined a group of 74 women treated for breast cancer who had finished their adjuvant therapy (chemo- and/or radiotherapy) at least a year before. Some of them were in the process of hormonotherapy. As many as 70% complained about various kinds of dysfunction related to the cognitive area. The patients described their symptoms as destabilising, frustrating, alarming. In some of the women, the disorders led to reduced independence, including financial, lost of previous social functions, difficulties in resuming employment, completing study, loss of authority in their families or among friends.[2] In patients who have experienced a sudden brain damage, especially when combined with a substantial reduction in various aspects of memory, learning, problem solving, speech or other cognitive functions, the life line is suddenly broken. All of a sudden, one loses control of one's own life, falling into confusion and despair. The situation of people who retain their ability of critical thinking and awareness seem to be particularly difficult emotionally. On the other hand, patients suffering from progressive diseases, such as Alzheimer's disease and vascular dementia, need to face the process of gradual worsening of their performance and independence, a perspective of losing control over their own life, growing dependence upon other people and the sense of being a burden to their beloved ones and friends. What those two groups of patients have in common is that changes occurring in their way of functioning (whether sudden or progressive) apply not only to themselves. They reach much further, affecting the life of the whole family.[19] But the impact reaches beyond the family, too, to members of therapeutic teams in clinics and oncology departments as they can experience difficulties arising from patient's disturbed functioning. First, noticing dysfunction in the areas of orientation,

Table 1 – Disorders of consciousness versus dementia and depressive disorders [by Wells 1979 and Ham et al. 1997].[8]

Disorders of consciousness	Dementia	Depressive disorders
Sudden, often clearly identifiable onset, Concurrent significant medical factors,	Gradual onset, hard to identify, Gradual intensification over months, years,	Complaints about memory disorders, Frequently reported prior depressive disorders,
Duration: days – less often weeks,	Duration: months, years,	"I don't know" is a common answer at interview,
Usually reversible, Early disorientation,	Usually irreversible, often progressive process, Disorientation at a late stage,	Memory and recall are similarly impaired, Depressive mood usually precedes other symptoms associated with the cognitive area.
High variability of the presentation/in particular hours, days/, Clear physiological changes, Variable level of consciousness, Heavy reduction of attention,	Relatively stable presentation (in particular days), Less distinct physiological changes, No disorders of consciousness, No significant changes in attention in clinical examination,	
Disturbance of the hourly sleep-wake rhythm, Large psychomotor changes,	A shift or reversal of a daily sleep-wake rhythm, Psychomotor disorders become worse in the course of disease.	
Lack of perceived memory disorders, Frequent absence of reported psychopathological disorders, Answers are often "close to the truth", More severe memory disorders, Memory dysfunctions are among the first symptoms.		

memory, understanding, problem solving or even speech may be difficult, particularly within a short time. Then, doctors may be tempted to ignore the above symptoms to implement oncological treatment as soon as possible acting in patient's 'best interest'. However, such symptoms are likely to be predictive of the deterioration of patient's health status and, therefore, taking them into consideration and implementing appropriate treatment may be of great importance for the success of the therapy.[7,10] One also has to remember about the need to maintain a humanitarian approach towards the patient and to respect their rights, including the right to decide about themselves.[5,20]

Taking decision is of adaptive value for individuals and, as such, requires them to be able to integrate sensory information, motivate themselves and predict potential effects of their actions. In psychology, taking decisions is described as a process made up of cognitive, emotional and motivational components. The process may be divided into three phases: the pre-decision phase where a problem is defined and information collected about possible actions to be taken; the decision-making phase where the leading option is gradually identified and final decision taken; and the post-decision phase which involves the evaluation of the choice made. In 1956, Simon designed a theory of limited rationality which has become the foundation of the current approach to decision-making processes. According to that theory, individuals take decisions which are aimed to help them adapt to the environment, but in doing so they have a limited information about the environment they live in and limited possibilities of processing that information. Of note is also the so-called 'framing effect' described by Kahneman and Tversky in 1979. The authors argue that a mental representation of the decision problem (which certainly dependents on the efficiency of cognitive system), largely determines the human decision making process.[4] This shows that the way of perceiving and solving the problem is influenced by a number of factors of both external (e.g. understanding of the 'language code', information noise) and internal nature. Creating perfect conditions for decision making is essential for an individual's further emotional functioning. This relates to the sense of having control over oneself. To restore this sense of control is one of the objectives that oncology psychologists focus on. Observations show that a person who is deprived of significant information or the possibility to decide finds it much harder to adapt to a new difficult situation. They may try to pass the responsibility to others, "because it was not by their choice, after all, and it is the deciding person that holds the responsibility for the effects". This approach can also be seen in individuals who have started treatment against their will, under a strong influence of their families. Inability to decide about oneself gives rise to the frustration of one of human basic needs, which may lead to the worsening of mood, anger and aggression.[21–24] That is why, every human must be given a chance to have an impact on their own life. Should this be very difficult or impossible due to cognitive impairment or other factors, it is of great importance that affected individuals are supported and protected in such a way that someone else (be it court, care-takers or family) could participate in the process. This purpose is served by specific legal solutions.

2. Legal aspects of treating patients with cognitive disorders

From the legal point of view, cognitive disorders are often combined with the inability to give a valid consent for being

Table 2 – Kind of agreements on treatment.

Own consent	Parallel consent	Substitute consent
- taken by the patient themselves, adult and not incapacitated (partly or entirely) - taken by a woman who is above 16 years of age and legally married,	- taken both by the patient and another entity, - in the case of contradictory decisions, the consent for treatment may not be deemed to be valid, - used for example in the case of patients who are above 16 years of age (additional consent of a statutory representative is required)	- taken on patient's behalf by another person or institution

Source: own study based on the Act of 5 December 1996 on Professions of Doctor and Dentist.

provided medical services. A possibility to agree to (or refuse) medical treatment is one of patient's essential rights, guaranteed by the Act on Patient Rights and Patient Ombudsman of 6 November 2008 (Journal of Laws from 2009 No. 52(417) as amended). The issue of consent is specifically regulated by the Act on Professions of Doctor and Dentist of 5 December 1996 (Journal of Laws from 2011 No. 277(634) as amended) by specifying doctors' obligations in this regard. That right may also be derived from the Constitution which, in its Article 41, guarantees freedom and physical integrity to all and, with Poland's being a party to the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, the Article 5 of that Convention prohibiting medical intervention without patient's free and informed consent should also be taken into account. Those legal acts are further supplemented by the Medical Code of Ethics which, in its Article 15, imposes the duty to respect patient's will in the treatment process.

The aforementioned laws and professional standards illustrate a far-reaching transition of the relations between the doctor and the patient. There has been a clear departure from the once dominant paternal concept to the rule of partnership, whereby the patient co-decides about the length and scope of treatment. In consequence, the doctor is required to inform the patient of the disease status, method of treatment, equivalent treatment methods and possible complications in such a way as to enable them to understand each stage of treatment and consequences of their refusal to be treated. The attending doctor is responsible for assessing to what extent the patient is able to understand the information provided to them. This may involve the necessity to spend more time or use the assistance of another specialist to provide the information properly. Only then does patient's consent authorise the doctor to act, while setting the limits and conditions of the accepted medical intervention.[20,25]

Depending on whether the consent is given personally by the patient or by another person acting on their behalf, the following types of consents may be distinguished (Table 2):

Informed consent may only by given by the patient whose health status enables them to understand information provided by the doctor and take, according to the information received, a decision allowing or not specific medical actions to be taken.[25] What is more, not every consent given by the patient is correct. A consent improperly given is legally invalid and thus involving patient's civil or criminal liability. A proper consent for treatment must meet all of the following conditions:

(a) received before the onset of a medical action,
(b) well informed, that is preceded by doctor's information as set out in Article 31(1) of the Act on Professions of Doctor and Dentist,
(c) expressed in an appropriate form (a consent for surgical procedures, medical procedures and other activities of high risk must be given in writing),
(d) issued by an authorised entity,
(e) positively approved; patient's silence does not mean consent.[26]

It needs to be underlined that law specifies the categories of patients who are unable to give their consent for medical intervention. These include minors, incapacitated patients and patients who are unable to give an informed consent. The former two categories comprise patients with a de lege incapability, as minority and incapacitation are determined by law. The third group are patients who are de facto incapable, as their incapability is caused by factual circumstances (e.g. patients who are unconscious, mentally ill, intoxicated with alcohol or drugs).[27] It may be assumed that patients with cognitive disorders will mostly fall into the third category.

Pursuant to Article 32(2) Act on Professions of Doctor and Dentist, in the case of a patient unable to give their informed decision, a permission of their representative is necessary, and in the absence of such a representative, a consent for medical intervention issued by the guardianship court (substitute consent). It should be remembered, however, that diagnosed cognitive disorders may not be automatically regarded as the inability to give an informed consent, which happens in medical practice. As an example, one may refer to the general provisions of the Polish Civil concerning the declaration of will (it should be borne in mind that a consent for a medical service is a declaration of will under the Civil Code, subject to any differences arising from the Act on Professions of Doctor and Dentist). According to Article 82 of the Civil Code, being in a state of inability to take an informed decision and declare one's free will is a fault of the declaration of will causing it to be invalid. The case law defines such a state as the inability to recognise, the inability to understand one's own and other people's actions and the inability to realise the meaning and effects of one's own conduct (sentence of the Supreme Court of 7 February 2006, IV CSK 7/05 Lex, No. 180191). According

to another ruling (sentence of the Supreme Court of 30 April 1976, III CRN 25/76 OSP 1977 4(78) "it is, therefore, of decisive importance to determine the extent of reduced consciousness in a person's actions, the level of mental disturbance at the moment of making the declaration of will". It is of no relevance whether the state was of a permanent or temporary nature, as it is the relation between that state and a specific declaration of will that matters.[28] What is relevant is that the state occurs at the moment of making the declaration of will. It should be stressed that a mere indication of patient's being affected by a mental disease is not enough to deem their declaration of will to be invalid. On the other hand, the indication that the declaration was made in the state identified as excluding consciousness, causes that declaration to be null and void.

The Act on Professions of Doctor and Dentist grants some rights even to incapacitated persons. Pursuant to its Article 32, with regard to persons fully incapacitated, the right to give consent is awarded to a statutory representative. However, if the patient is capable of consciously expressing their opinion about treatment, their consent must also be taken into account.

Moreover, the Act in its Article 32(6) permits an effective objection to be submitted against medical action being taken by minors above 16 years of age, incapacitated patients and the mentally retarded, if they are "sufficiently conscious". In such cases, the provision of medical services will depend on the guardianship court permission.

It is worth mentioning at this point what the procedure of obtaining court permission actually involves. It should be resorted to in cases when the doctor finds the patient to be unable to give their informed consent. The guardianship court permission is applied for by a family member or doctor. The jurisdiction is held by a guardianship court of a district court with competence over the place of residence or stay of the person to be treated. The application must indicate both the applicant and the participant, i.e. the patient. A properly completed application should include the indication of the type of document (e.g. application for a medical procedure consent); reasons for applying; and necessary relevant supporting documents; opinions; medical records; description of circumstances; and applicant's signature. The reasons should include a precise description of who the patient is, what kind of disorders prevent them from giving their informed consent and how it threatens their life and health. Information of regular control by a mental health care clinic should also be included, if available.

With regard to fully incapacitated individuals, the guardianship court may only permit a surgical procedure or a high risk modality or diagnosis. The provision of Article 32(4) in conjunction with Article 34(3) of the Act on Professions of Doctor and Dentist imposes a limitation on the court. The limitation in this case seems to be a legal gap that may prevent the doctor from requesting the court, for example, to permit examination in the absence of a statutory representative or inability to communicate with the patient. It is a significant matter as doctors face that issue in their daily practice.

The institution of a full or partial incapacitation allowed by low in justified cases calls for a separate discussion. Causes for full incapacitation may be divided as follows:

- formal: above 13 years of age,
- substantial:

(a) mental disease, mental retardation or other mental disorder found in the person concerned,
(b) inability to manage one's conduct (Article 13 of the Polish Civil Code). The first substantial cause being a prerequisite for further stages of the procedure.

After the existence of a mental disease, mental retardation or other mental disorder is proved probable e.g. by submission of a relevant medical certificate or witnesses reports, a court-ordered medical examination may be carried out and opinion issued by a certified psychiatrist or neurologist and psychologist.

As most mental diseases are characterised by periods of relapse and remission, the Supreme Court has rightly ruled that the health status at the moment of ruling should be taken into consideration. The fact of inevitable deterioration of the health status in the future does not provide grounds for full incapacitation. Such decision is, however, possible when the normal mental state is of a temporary nature, while the very disease is permanent. The court may then rule incapacitation in the period of remission. In any other cases, e.g. short-term periods of mental disorders, the occurrence of such disorders may only constitute a fault of a declaration of will due to the lack of consciousness rendering the consent to be null and void.

The above list of causes is of exemplary nature only and has been in the course of time supplemented by the Polish case law to include other conditions, such as Senile psychorganic dementia (sentence of the Supreme Court of 13 January 1975 I CR 787/74 Lex No. 7642). The Supreme Court in its ruling of 25 November 1976 (IICR 471/76, Lex No. 7881) raised that the arteriosclerotic process alone in the extent according to age should not be regarded as a mental disease. The mere fact of forgetting of the most recent event from daily life, the lack of plans for the future or being unaware of certain events and effects do not justify incapacitation. For example, for persons suffering from Parkinson's and Alzheimer's disease, the court may establish a guardian under Article 183 of the Family and Guardianship Code.

It should be remembered that the inability to manage one's conduct must be permanent rather than temporary. Apart from mental health, the court evaluates the extent of a given person's ability to independently manage their conduct and matters (the court considers whether such a person has means to support for themselves or family, how they handle daily decisions, etc.). The point of incapacitation is to legally protect the person concerned. The negative reception of that institution is somewhat surprising then. Notably, the Polish case law does not modify the causes of incapacitation but rather highlights the aim of that institution. The Legislator has given courts some freedom in evaluation of those causes.

The court procedure in incapacitation cases is as follows:

(a) jurisdiction is held by a district court with competence over the place of residence or stay of the person concerned. That court is also competent in the case of previously

issued rulings being repealed or modified. Court rulings are made by four judges,
(b) proceedings are initiated on the request of an authorised person, i.e. spouse, direct relative, sibling or statutory representative of the person concerned. This authorised group also comprises the prosecutor and social organisations whose statutory responsibilities include the protection of persons with disabilities
(c) proceedings may be oral or written,
(d) proceedings must include the hearing of the person concerned in the presence of a certified psychologist, psychiatrist or neurologist,
(e) expert examination (single or multiple) to, be the basis of the opinion, is also obligatory. The expert opinion and reasons of the application constitutes the basis for the court decision.

The law does not allow for incapacitation to be established for a definite period of time as it should apply as long as the underlying disease persists. The court ruling incapacitation sends a copy of the final decision to the guardianship court in order for it to establish care of the person concerned. If an incapacitation request is repealed the civil law court notifies the guardianship court of the need to appoint a guardian for the disabled person.

Full incapacitation should be distinguished from partial incapacitation the causes of which are as follows:

(a) 18 years of age,
(b) mental disease, mental retardation or other mental disorder, in particular alcohol or drug abuse, if such a person may not be fully incapacitated by a court indicating at the same time that they are in need of assistance to manage their matters.

A partly incapacitated person, as a person with a limited legal capacity, may perform on their own all activities other than related to management or obligation. Viewed from that perspective, such a person seems to be entitled to give their consent for treatment proposed to them.[28]

Applicable laws, however, in particular Article 33 of the Act on Professions of Doctor and Dentist, allow an exception from the absolute rule of patient consent. Those cases relate to medical treatment or service provided to the patient requiring an immediate medical aid in an urgent matter where, due to patient's health status or age, they are not able to give their consent and it impossible to contact their statutory representative or actual guardian. If such circumstance occur, the decision to take medical intervention should be consulted with another doctor. Such a situation should be recorded in patient's medical documentation. This particular measure may be applied in exceptional cases, when patient's life or health is threatened. A proper application of this rule indemnifies the doctor from the responsibility under Article 192(1) of the Polish Criminal Code, whereby who performs a medical procedure without patient's consent is subject to a fine, restriction of liberty or imprisonment of up to 2 years.

The provision of Article 34(7) of the Act on Professions of Doctor and Dentist provides doctors with an option to perform surgery or high risk treatment (diagnosis) methods without patient's statutory representative's consent or without the competent court's permission, if the delay caused by the consent procedure might pose a threat to the patient's life, physical integrity or health. In that case, the doctor is also obliged to consult another doctor, preferably of the same speciality. Statutory representative, actual guardian or competent court need, however, to be immediately notified of the procedure performed.

A particular exception is provided by Article 35(1) of the Act on Professions of Doctor and Dentist which permits the doctor to legally act without having to re-apply for consent if a modification of medical intervention is necessary. The doctor is entitled to change the scope of surgery, diagnostic or curative procedure in such a way as to take into account the circumstances that have appeared during treatment, if the failure to make such a change might pose a threat to patient's life, physical integrity or health. This case covers a situation where the consent has already been given but its scope has proved to be insufficient, and the need for going beyond that scope occurred only during the medical intervention. The consent of other authorised persons could not be immediately obtained.

3. Conclusion

The change in the approach to the patient, treating them as full-right partners and empowering them with a set of rights under the Act on Patient Rights and Patient Ombudsman all form a very important legislative step towards the meeting of needs arising from practice. Hopefully, rational legislation will go even further. Legal regulation presented in this study still contain a number of substantial and formal imperfections. Laws regulating the issue of consent are contained in several acts, some of which are imprecise. To be applied and respected, law must be clear and transparent.

But it takes more than just to revise the law. Changing the approach to patients with cognitive deficit is equally important. On the one hand, one has to remember about the key role of a properly obtained consent for treatment, without which treatment may involve civil or criminal liability. On the other hand, one has to act in the best interest of patients who, for different reasons, are not able to manage their conduct and take decisions of relevance to their life and health. It seems a very good idea then to extend the competences of the e-court to include the issuing of substitute consents by the guardianship court in order to shorten and simplify the procedure. This proposal is very important for both doctors and patients. The issue may be well illustrated by the situation of patients with heavy cognitive dysfunctions treated for cancer, for whom the time of treatment onset is of paramount importance.

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