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THE WITHHOLDING OF RESUSCITATION IN POLAND IN THE LIGHT OF THE NEW REGULATIONS OF THE MEDICAL CODE OF ETHICS AND LEGAL PROVISIONS

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Abstract. The paper deals with the issue of withdrawing from resuscitation in terminally ill patients. According to the Medical Code of Ethics, withholding of resuscitation efforts in terminally ill patients is permissible. It should be noted that the Polish legal system currently lacks clear regulations regarding the conditions under which resuscitation may be foregone. In practice, decision-making in such cases is typically guided by deontological norms and clinical practice. The article proposes *de lege ferenda* changes aimed at increasing the legal security of the physician.

Keywords: resuscitation; patient; terminally ill patient; legal security.

INTRODUCTION

The amendment of the Medical Code of Ethics,[1] and in particular the new wording of Article 33 concerning the withholding of resuscitation in terminally ill patients, motivated the authors to write this article. It is a truism to state that all medical actions should comply both with ethical standards

[1] See The Medical Code of Ethics, https://nil.org.pl/uploaded_files/art_1716532029_kel-2024.pdf [accessed: 27.01.2025].

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and with universally binding law. At the outset, it should be noted that the Polish legal system currently lacks clear regulations regarding the conditions under which resuscitation may be foregone. However, the provisions of the Medical Code of Ethics indicate that withholding resuscitation in terminally ill patients is permissible. In practice, decision-making in such cases is typically guided by deontological norms and clinical practice [Morończyk 2011, 49].

An attempt to interpret the Article 33 of the Medical Code of Ethics and to compare ethical and legal norms arises from the needs of clinical practice. In the era of increasingly frequent claims by patients or their families, the possibility of withholding resuscitation in terminally ill patients should not jeopardize the legal security of the physician [Węglińska 2022, 9]. It should be clarified here that legal security of the physician refers to a situation in which the provisions of universally binding law contain effective solutions concerning the principles of medical practice, as well as the requirements imposed on the physician. Moreover, legal security exists when legal norms clearly define the scope of civil, criminal, and disciplinary liability [ibid.]. Given the exceptional nature of the medical profession, which is associated with the protection of particularly important values such as health and life, the legislator should provide legislative mechanisms that guarantee physicians a sense of legal. It is worth noting that the growing number of lawsuits against physicians is currently the cause of a phenomenon referred to as defensive medicine [ibid.]. This term denotes medical actions undertaken to avoid the risk of potential legal proceedings, while the patient's best interests are relegated to the background [ibid., 14]. For this reason, the introduction of appropriate legislative solutions defining the conditions under which resuscitation may be forgone appears to be justified.

1. THE POSSIBILITY OF WITHHOLDING RESUSCITATION

The primary aim of this article is to determine whether, within the Polish legal system, the possibility of withholding resuscitation is permissible. Accordingly, the paper seeks to address the following question: in cases where resuscitation is not undertaken in a terminally ill patient, is the physician adequately protected by the relevant normative acts?

In order to analyse this issue, it is essential to discuss several key aspects, namely: a) the identification of legal provisions relating to the physician's duty to provide medical assistance; b) the indication of criminal law norms that penalize the failure to undertake life-saving measures for patients; c) the interpretation of the deontological principles contained in the Medical Code of Ethics regarding the withholding of resuscitation in patients; d) the determination of the legal nature of the Medical Code of Ethics and the hierarchy between ethical regulations and universally binding legal provisions.

The examination of the above areas will aim to determine whether, under the applicable legal provisions, there exists a lawful possibility of withholding life-saving measures in terminally ill patients. Finally, the article will formulate *de lege ferenda* conclusions with respect to the Act on the Professions of Physician and Dentist.[2]

The starting point for considerations related to this issue will be the amended Medical Code of Ethics. In particular, the analysis will focus on the provisions defining the conditions under which resuscitation may not be undertaken in certain clinical situations. According to Article 33(1) of the Medical Code of Ethics, a physician is not obliged to initiate or continue resuscitation in terminally ill patients. Paragraph 2 of this provision stipulates that the decision to discontinue resuscitation rests with the physician or a team of physicians and is based on a negative assessment of therapeutic prospects. Taking into account the entirety of the regulation concerning the withdrawal of treatment, it is worth referring also to paragraph 3 of the new Article 33 of the Medical Code of Ethics, which states that a physician must not employ futile therapy. The decision to classify therapy as futile rests with the treatment team and should, as far as possible, take into account the patient's wishes. It should be noted that, with regard to the permissibility of withholding resuscitation, only the Medical Code of Ethics provides for such a solution. Ethical codes of other medical professions do not contain analogous provisions.

In the preliminary considerations, it is necessary to clarify the meaning of the term "terminal condition". In both medical and legal literature, various definitions can be found. According to one definition, a terminal condition is a phase of illness in which the patient's condition undergoes definitive deterioration, posing a life-threatening risk, without any possibility of improvement or halting the organism's decline [Aszyk 2006, 134]. In the terminal phase, there is no justified hope for the patient's recovery [ibid., 135]. It is important to emphasize the need to distinguish between a terminal condition and a critical condition. In a critical condition, the patient may die, whereas in a terminal condition, death is inevitable, the patient is already dying. Considering the moral dimension of life, it is difficult to justify the notion of striving at all costs for every possible second or minute of life in terminally ill patients, as death is an unavoidable part of the natural cycle [Aszyk 2006, 138]. In contemporary times, the dying process often occurs under different circumstances than in previous historical periods, with individuals frequently dependent on the life-sustaining equipment. Although advances in medical technology may postpone the precise moment of death, it is impossible to ultimately avoid death, even though the desire to do so often remains within humans [Aszyk 2024].

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[2] Act of 5 December 1996 on the professions of physician and dentist, Journal of Laws of 2024, item 1287 as amended.

2. RECOMMENDATIONS ISSUED BY SCIENTIFIC SOCIETIES REGARDING FUTILE THERAPY

Due to the lack of legal norms permitting the withholding of life-saving measures, individual decisions regarding the discontinuation of futile therapy in terminally ill patients, including cardiopulmonary resuscitation, are primarily based on recommendations issued by scientific societies. The key principles related to this matter are outlined in the Guidelines of the Polish Society of Internal Medicine on the prevention of futile therapy in adult patients dying in hospitals, dated 31 March 2023.[3] The guidelines pertain to dying patients who are not legally incapacitated but are unable to make conscious decisions regarding treatment in situations where the medical therapy is deemed futile.[4] It should be emphasized that these recommendations have been approved by the Supreme Medical Council, the Supreme Council of Nurses and Midwives, as well as numerous scientific societies in the field of medicine.

Further recommendations concerning the appropriate management of terminally ill patients are provided by the Polish Society of Anaesthesiology and Intensive Therapy [Kübler, Siewiera, Durek, et al. 2014, 229-34]. These guidelines outline a standardized procedure for patients who have lost the ability to make conscious declarations of will in intensive care units, in situations where life-sustaining interventions may be considered futile [ibid.]. Among the possible procedures is also the decision not to initiate or to discontinue organ-supporting measures, including cardiopulmonary resuscitation [ibid.].

According to the position established by the Working Group of the Polish Society of Internal Medicine on Futile Therapy in Internal Medicine Wards, pursuant to Article 4 of the Act on the Professions of Physician and Dentist, a physician is obliged to practice medicine in accordance with current medical knowledge, professional ethical principles, and due diligence. In the case of dying patients, the lack of possibility for effective treatment only prolongs the patient's agony and should not be employed by physicians, as it constitutes futile therapy.[5]

3. THE LEGAL REGULATIONS RELATED TO THE PHYSICIAN'S DUTY TO PROVIDE ASSISTANCE

Turning to the discussion of legal regulations related to the physician's duty to provide assistance, it should be noted that the key provision

[3] See https://www.mp.pl/etyka/kres_zycia/320177,zapobieganie-terapii-daremnej-u-doroslychchorych-umierajacychw-szpitalu [accessed: 04.02.2025].

[4] Ibid.

[5] Ibid.

imposing this obligation is Article 30 of the Act of 5 December 1996 on the Professions of Physician and Dentist. According to Article 30, a physician is required to provide medical assistance in every case where a delay in its provision could result in the risk of loss of life, serious bodily injury, or serious health disorder. The legal doctrine emphasizes that the norm derived from Article 30 imposes an absolute duty on the physician to provide assistance, as the provision does not foresee any exceptions [Bagińska, Bączyk-Rozwadowska, Drozdowska, et al. 2021].

For comparison, it is worth noting that the previous Act on the Profession of Physician of 28 October 1950.[6] in Article 12, allowed for the possibility of a physician's exemption from the duty to provide help [Kubicki 2003, 4]. Article 12 of the previously binding Act stipulated that a physician authorized to practice the profession was obliged to provide medical assistance in every case where a delay could result in loss of life or permanent disability, unless, in the given case, it was practically possible to obtain immediate medical assistance from an emergency medical service or another institution designated to provide urgent medical care. The currently applicable Act on the Professions of Physician and Dentist does not include such an exception.

In addition to the regulations discussed above, the failure to provide assistance is sanctioned under criminal law. Article 162(1) of the Polish Penal Code states: "Whoever fails to provide assistance to a person in a situation posing an immediate threat to life or serious health damage, while being able to provide such assistance without endangering themselves or another person, shall be subject to imprisonment for up to three years." Using the rules of linguistic interpretation, it can be assumed that one of the addressees of the norm established in Article 162(1) may be a physician. However, it is reasonable to accept the view that a doctor, as a person exercising a medical profession, is particularly obliged to protect human life and health, and therefore, in a life-threatening situation or serious health damage, he will always be treated as a guarantor. In situations where the physician is a guarantor of safety, a failure to provide assistance may result in liability under Article 160(2) of the Polish Penal Code, or para. 3 in conjunction with para. 2 [Konarska-Wrzosek 2025]. Furthermore, from practical medical experience, it appears that Article 160 of the Penal Code is actually applied in Prosecutor's proceedings in the context of para. 2, which specifically refers to guarantor, namely the doctor.

Since the withholding of resuscitative measures in terminally ill patients is based on the conviction that additional interventions will not permanently restore the functions of organs and systems necessary for the patient's independent functioning [Aszyk 2006, 138], it is worth noting the position

[6] Act of 28 October 1950 on the profession of physician, Journal of Laws item 458.

of the judiciary expressed in the judgment of the Court of Appeal in Szczecin – II Criminal Division, dated 21 November 2018.[7] In this judgment, the court held that "for the existence of the offense under Article 162(1) of the Polish Penal Code, it is irrelevant whether the action omitted by the perpetrator would actually have provided rescue. What is decisive is that the perpetrator, seeing the persistent or even increasing threats to the life or health of a person, fails to undertake all available measures that could avert or at least mitigate the aforementioned threats"[8]. The literature of the subject also emphasizes that the duty to provide medical assistance, as stipulated in Article 30 of the Act on the Professions of Physician and Dentist, applies even when there is no positive prognosis regarding the effectiveness of such help [Wierzchoń 2017, 465]. Despite the differences in the interpretation of Article 162(1) of the Polish Penal Code presented above, it is indisputable that a physician's failure to provide assistance in life-threatening situations constitutes a criminal offense under the Penal Code. In addition to the liability under Article 162 of the Penal Code, one can also consider liability for the commission of the crime specified in Article 148, 156 or 157 of the Penal Code.

The failure to undertake resuscitation may also result in civil liability (general principle under Article 415 of the Civil Code,[9] liability for health impairment under Article 444 and 445 of the Civil Code, liability for the death of a patient under Article 446 of the Civil Code). It should also be noted that in such a case, the doctor may also be liable for violating the patient's rights (such as the right to health services, based on Article 4(1) of Act of 6 November 2008 on patients rights and the Ombudsman for Patient Rights,[10] in conjunction with Article 448(1) of the Civil Code.

Additionally, the significance of professional responsibility should be emphasized as it serves as a practical mechanism for enforcing deontological norms. A doctor can face disciplinary consequences before medical courts solely based on violation of professional ethics, regardless of any potential civil or criminal liability.

With regard to the aim of this article, it should be noted that the legislator does not explicitly provide for the possibility of withholding assistance or discontinuing resuscitative measures in terminally ill patients. Such a norm exists solely in the Medical Code of Ethics; therefore, it is necessary at this point to refer to the legal nature of deontological norms.

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[7] Ref. no. II AKa 148/18, Legalis no. 2180626.

[8] Ibid.

[9] Act of 23 April 1964, the Civil Code, Journal of Laws of 2025, item 1071 as amended.

[10] Journal of Laws of 2022, item 1876 as amended.

4. THE LEGAL CHARACTER OF THE NORMS OF MEDICAL CODE OF ETHICS

In the legal doctrine, there is an ongoing discussion regarding whether the norms contained in the Medical Code of Ethics can be treated as universally binding – that is, whether the medical self-government is an authority empowered to establish norms of such character, or whether the ethical code should be regarded merely as an internally binding act [Daniluk-Jarmoniuk 2018, 81]. In a democratic state governed by the rule of law, executive authorities may act only on the basis of an explicit legal foundation, which means that they can issue only those legal acts for which they are authorized by the Constitution or the statutes [ibid., 81-82]. The previously binding Act on Medical Chambers,[11] in Article 4(1)(2), and the currently applicable Act on Medical Chambers, in Article 5(1), by obliging the medical self-government to establish professional ethical principles, created a competence norm [ibid., 82]. However, it should be noted that during the period when the previous Act on Medical Chambers was in force, an open system of sources of law applied; therefore, recognizing the Medical Code of Ethics as an implementing act to the statute was at that time legally permissible [ibid.].

It should be emphasized that the Constitution of the Republic of Poland of 2 April 1997,[12] in Article 87, sets out a closed catalogue of sources of law, in which the Medical Code of Ethics is not included [Wrześniewska-Wal 2016, 152]. As stressed by the Constitutional Tribunal in its judgment of 28 June 2000,[13] the legislator, in a fully intentional and unequivocal manner, established in the Constitution a closed system of universally binding[14] sources of the law. Although Article 17(1) of the Constitution of the Republic of Poland grants professional self-government bodies certain authoritative powers, these cannot be regarded as including the competence to enact universally binding legal provisions [Daniluk-Jarmoniuk 2018, 82]. In legal scholarship, it is even argued that since, under the Constitution, an internally binding legal act may not apply to entities outside the organizational structure of the subordinate entity, the Medical Code of Ethics cannot be regarded as an internally binding source of the law either, given that its norms affect the legal situation of patients [ibid., 82-83].

Taking the above considerations into account, it must be concluded that the legislator does not establish a competence norm authorizing professional self-government authorities to create universally binding legal acts Moreover, the provisions of the Medical Code of Ethics extend beyond the

[11] Act of 2 December 2009 on Medical Chambers, Journal of Laws of 2021, item 1342.
[12] Journal of Laws No. 78, item 483 as amended.
[13] OTK 2000, No. 5, item 141.
[14] Ibid.

structures of the medical corporation, which means that the Code cannot be regarded as an autonomous normative act [ibid.]. Furthermore, the literature indicates that the Assembly of Physicians does not establish new norms but rather codifies, organizes, and systematizes already existing principles derived from general ethical standards [ibid.].

During analysis of the legal nature of the Medical Code of Ethics, it is necessary to refer to the position of the Constitutional Tribunal on this matter. Even before the entry into force of the currently binding Constitution, there were doubts in the doctrine as to whether the Medical Code of Ethics could constitute a source of the law [Wrześniewska-Wal 2016, 152]. In its decision of October 7, 1992,[15] the Constitutional Tribunal, addressing the scope of its jurisdiction and, in particular, whether the norms established by a professional self-government body fall within this scope, held that "the subject of the Tribunal's assessment cannot be the ethical norm itself, but only the legal norm which the ethical norm specifies."[16] In the cited decision, the Constitutional Tribunal held that the norms of the Medical Code of Ethics (MCE) may be incorporated into the system of universally binding law through the Act on Medical Chambers.[17] A similar position was expressed by the Constitutional Tribunal in its judgment of April 23, 2008,[18] which concerned the constitutionality of provisions prohibiting public statements regarding the professional activities of doctors. In this judgment, the Constitutional Tribunal found that the norms of the Medical Code of Ethics acquire the status of legal norms within the sphere of universally binding law through the Act on Medical Chambers.[19] Importantly, the doctrine holds that despite the fact that these rulings of the Constitutional Tribunal were issued under the previously binding Act on Medical Chambers, this interpretation remains valid today [ibid., 153].

In attempting to answer the question posed at the beginning of this article, namely, whether in the case of not undertaking resuscitation procedures for a terminally ill patient, the physician is adequately protected by normative acts it can be concluded that such protection is incomplete. The legislator does not provide an explicit provision that authorizes refraining from resuscitation procedures in a terminal state. The determination of circumstances that exempts a physician from the duty to provide assistance in such situations is possible only through the application of complex interpretative methods, which in turn creates legal uncertainty [Boratyńska and Koniecznak 2019, 598]. If correct interpretation is often difficult even for legal scholars, can one

15 Ref. no. U 1/92, OTK 1992, No. 2, item 38.
16 Ibid.
17 Ibid.
18 Ref. no. SK 16/07, OTK 2008, No. 3, item 45.
19 Ibid.

reasonably expect physicians to properly apply the rules of legal hermeneutics? It is rightly emphasized in the literature that the provisions of the Polish medical law should be formulated with sufficient clarity so that physicians have no doubts as to how they ought to proceed [Dukiet-Nagórska 2008, 172].

Thus, the circumstances in which a physician must make a decision to withhold resuscitation in certain clinical situations are not straightforward, as the lack of explicit regulation in statutory law results in legal uncertainty.

Although the legislator refers to ethical norms when defining the duties of a doctor, as is the case in Article 8 of the Act on patients rights and the Ombudsman for Patients Rights and in Article 4 of Act on the professions of physician and dentist, it does not establish legal provision authorising a doctor to withholding of resuscitation in terminally ill patients.

In advocating for legislative regulation of this matter, one may refer to a principle of Roman legal thought, expressing the timeless idea of the simplicity of the law – *Leges ab omnibus intellegi debent* – according to which the laws should be understandable by all [Zabłocka 2024, 133-34].

CONCLUSIONS

In the light of the considerations presented above, a discussion can be initiated regarding a *de lege ferenda* solution aimed at strengthening the role of ethical, and above all clinical, norms in decisions concerning the withholding or withdrawal of resuscitation in terminally ill patients. In such cases, a thorough medical analysis of the specific patient's condition should form the foundation for subsequent legal reasoning concerning whether a physician's actions comply with legal norms. Since legal provisions explicitly refer to deontological standards, a determination that a physician's conduct aligns with medical knowledge and professional ethical principles should carry significant weight in assessing its conformity with the law.

In conclusion, it is worth emphasizing, against the background of the previously noted differences in legal and ethical regulations, and in the context of a physician's adherence to the norms of the Medical Code of Ethics, it is worth recalling the aforementioned decision of the Constitutional Tribunal, case no. U 1/92, according to which legal norms and ethical norms constitute two independent sets, with the law rather than ethics holding ethical legitimacy.[20] In this context, a *de lege ferenda* approach that prioritizes clinical and ethical assessment could enhance both the legal security of physicians and the quality of patient-focused decision-making.

[20] Decision of the Constitutional Court of 7 October 1992, ref. no. U 1/92, OTK 1992, No. 2, item 38.

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