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Legal and Ethical Aspects of Discontinuing Futile Medical Care in Poland, the United Kingdom and Italy. A Comparative-Legal Perspective[3]

Abstract: Futile care encompasses a range of medical procedures that serve to sustain the vital functions of a terminally ill person, thus prolonging their dying process. This paper aims primarily to arrive at a legal and ethical characterization of the institution of futile care. In the light of pertinent laws in other countries (the United Kingdom, Italy), the authors demonstrate that it is necessary to take legislative action concerning futile care in Poland, including e.g. the institution of advanced decision and lasting power of attorney. There are certain obstacles to introducing legal norms that pertain to futile care. For one thing its normative definition is lacking while the applicable law, such as the Act on the Medical Profession, imposes an obligation on the physician to provide medical assistance in each case where delay could expose the patient to the risk of loss of life, grievous bodily injury or serious disturbance of health.

Keywords: futile care, living will/advanced decision, lasting power of attorney, human dignity

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Introduction

Doctors and lawyers in Poland confront a major issue with respect to the cessation of futile care, given the absence of both a normative definition of the latter and legal institutions which would allow the patient to decide on their own to discontinue treatment when it is known to have no positive effect and merely serves to maintain vital functions (resulting in excessive suffering). As medical law experts attempt to define the concept, it is often highlighted that the scope of futile care is difficult to determine.[4] According to the definition formulated by the Polish Working Group on End-of-Life Issues, published in *Paliatywna Medycyna w Praktyce* (2008), futile care should be understood as "the application of medical procedures to sustain the vital functions of a terminally ill patient that prolongs their dying, involving excessive suffering or violation of the patient's dignity."

In Poland, the process of legal change that would establish a framework in which discontinuation of futile care could lawfully operate is still ongoing, with no normative regulation yet in place. A number of European countries have statutorily provided for advanced decision, i.e. a declaration of will regarding further medical treatment in the event of incapacity to make decisions. Under such legislation, persons may also appoint an attorney to make decisions related to the treatment on behalf of the principal (otherwise known as the donor), as well as appoint a guardian, in such cases where a person incapable of making decisions has not appointed an attorney.[5]

Given the ethical and emotional aspect which directly affects the terminally ill as well as their relatives, there is an evident need to establish procedures which ensure dignified last moments of life in a manner that is safe and underpinned by law.[6]

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4 Jacek Siewiera and Andrzej Kübler, *Terapia daremna dla lekarzy i prawników* (Edra Urban & Partner, 2015), 15.

5 Siewiera and Kübler, *Terapia daremna dla lekarzy i prawników*, 16.

6 Rzecznik Praw Pacjenta, *Standardy postępowania w terapiach medycznych stosowanych w okresie kończącego się życia* (Rzecznik Praw Pacjenta, 2021), 24.

Thus, this paper will examine the initiatives undertaken to date to introduce legislation on futile care in Poland and subsequently compare them with the equivalents in force in the United Kingdom and Italy. These countries have been chosen in view of the fact that their respective legislations provide in detail for futile care procedures, thus ensuring dignified last moments for both the patient and their family.

The aim of this paper is to characterize the legal institution of futile care in relation to foreign legal systems by means of the comparative-legal method. In the United Kingdom—or more specifically in England and Wales—these affairs are regulated at present under the Mental Capacity Act of 2005[7] and in Italy by the Law of 22 December 2017, no. 219, Rules on Informed Consent and Advance Directives for Treatment.[8] The analysis will make it possible to draw conclusions *de lege lata* and *de lege ferenda*, and subsequently formulate certain proposals concerning the incorporation of futile care into Polish law.

Attempted Regulations of Futile Care in Polish Law

In the Polish legal system of universally applicable law, there are no solutions governing the discontinuation of futile care.[9] Also, no legal definition of such care has been introduced into the Polish legal system by the lawmaker.[10]

Even so, the adoption of such provisions may be argued for in the light of the constitutional value of unassailable human dignity.[11] Article 30 of the Constitution of the Republic of Poland clearly asserts that human dignity is acquired at birth and remains inalienable throughout life, which also includes

7 John Taggart, "Powers of Attorney and 'Lack of Capacity' under the Mental Capacity Act 2005: A Narrowing of the s 44 Offence? *R v Kurtz* [2018] EWCA Crim 2743," *The Journal of Criminal Law* 84, no. 1(2020): 74–82, https://doi.org/10.1177/0022018319883146.

8 Marco Di Paolo et al., "A Review and Analysis of New Italian Law 219/2017: 'Provisions for Informed Consent and Advance Directives Treatment'," *BMC Medical Ethics* 20, 1(2019): 1, article 17, https://doi.org/10.1186/s12910-019-0353-2.

9 Siewiera and Kübler, *Terapia daremna dla lekarzy i prawników*, 53.

10 Siewiera and Kübler, *Terapia daremna dla lekarzy i prawników*, 53.

11 Siewiera and Kübler, *Terapia daremna dla lekarzy i prawników*, 61.

terminal states, when any improvement in health is no longer possible. Since public authorities are responsible for respecting and protecting dignity, it is incumbent on them to lay down specific provisions.[12]

Since the legislation was lacking, pertinent guidelines have been developed by bodies specializing in medical sciences. The possibility of discontinuing treatment which does not result in improvement but only causes suffering to the patient is referred to exclusively in Article 32 of the Code of Medical Ethics: "In terminal states, the physician is not obliged to undertake and administer resuscitation, futile care, or emergency measures. The decision to discontinue resuscitation rests with the physician, based on the assessment of therapeutic prospects."[13]

The earliest initiative in terms of futile care legislation should be attributed to the Polish Working Group on End-of-Life Issues, in that the body advanced a definition of futile care which explicitly stated that it aims at sustaining the vital functions of a terminally ill patient and entails excessive suffering and violation of the patient's dignity.[14] This became the basis for the bill of the Bioethics Law of 17 December 2008.[15]

A definition of futile care was to be included in the Act of 6 November 2008 on Patients' Rights and the Patients' Ombudsman. It was argued that the right to dignity also encompasses the right to die in peace, from which it may be inferred that the patient should be able to decide on their own or through an attorney whether to continue or discontinue a treatment that offers no chance of improvement but merely prolongs the dying process.[16]

A 2013 bill submitted by the Warsaw Hospice for Children Foundation envisaged a number of rules which governed lasting powers of attorney, ad-

12 Article 30, Constitution of the Republic of Poland of 2 April 1997, Journal of Laws of 1997, no. 78, item 483.

13 Article 32 *Kodeks etyki lekarskiej*, II Krajowy Zjazd Lekarzy, 1991, as amended.

14 Wojciech Bołoz et al., "Definicja Uporczywej Terapii. Konsensus Polskiej Grupy Roboczej ds. Problemów Etycznych Końca Życia," *Medycyna Paliatywna w Praktyce* 2, no. 3(2008): 77.

15 Małgorzata A. Świderska, "Aspekty prawne terapii daremnej w okresie końca życia," *Białostockie Studia Prawnicze* 28, no. 3(2023): 73, https://doi.org/10.15290/bsp.2023.28.03.04.

16 Consolidated text: Journal of Laws of 2022, item 1876.

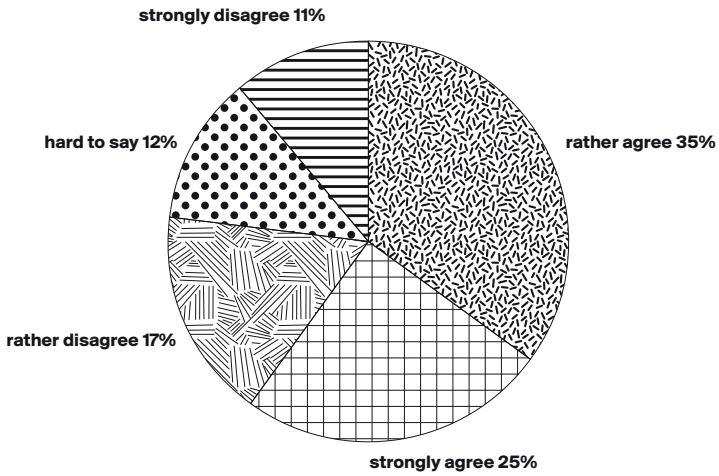

Fig. 1. In Some Countries, It Is Possible To Sign a So-Called 'Living Will', a Declaration in Which a Person Declares That, in the Event of a Permanent Incapacity, He or She Does Not Want Life-Sustaining Measures to Be Applied to Him or Her. Should Such a Solution Be Introduced Into Polish Law?
Source: Centrum Badania Opinii Społecznej, *Komunikat z badań. Zaniechanie uporczywej terapii a eutanazja* (Fundacja Centrum Badania Opinii Społecznej, 2013), 15 (the graph translated by the authors).

vanced decisions and other *pro futuro* declarations.[17] According to a CBOS survey conducted after the draft law had been created, the majority of respondents believed that having the advance decision introduced in Polish law would enable individuals to decide on the last moments of their life.[18]

The above graph shows how the public view the adoption of advanced decisions in Polish law. The majority of respondents (60%) declare that they do not want life-sustaining treatment to be applied in the event of permanent incapacity.[19]

17 Sławomir Zagórski, *O zaniechaniu uporczywej terapii i reanimacji. Czekamy na dobre prawo*, OKO.press, published February 21, 2024, https://oko.press/o-zaniechaniu-uporczywej-terapii-i-reanimacji-czekamy-na-dobre-prawo.

18 Centrum Badania Opinii Społecznej, *Komunikat z badań. Zaniechanie uporczywej terapii a eutanazja* (Fundacja Centrum Badania Opinii Społecznej, 2013), 15.

19 Centrum Badania Opinii Społecznej, *Komunikat z badań*, 15.

Presented in 2014, *Guidelines on the Management of Ineffective Organ Function Support (Futile Care) in Patients Incapable of Making Conscious Declarations of Will in Intensive Care Units* proposed that certain methods of organ function support may be abandoned if the patient cannot be successfully treated.[20] The document included a template protocol which would serve to state that, in the current clinical condition, a specific patient is incapable of declaring their will regarding treatment consciously, on the grounds of which responsible physicians may discontinue organ function support modalities listed in the document, as they will constitute futile care.[21]

The *Standards of Practice for End-of-Life Medical Treatments* introduce the possibility of withholding futile care *pro futuro*. In its decision of 27 October 2005 (III CK 155/05), the Supreme Court also spoke in favour of prior declarations of will, stating that such instruments should be binding on the physician if the patient has formulated them explicitly and unequivocally; the Court also found that they should be followed through should communication with the patient be no longer possible.[22] It was underscored in the decision that in Poland, the patient's consent or lack thereof is not regulated under any universally applicable laws by virtue of which patient's will is respected, e.g. laws on declarations made *pro futuro*, as is the case in other countries (e.g. living will, advanced directives). Specifically, this concerns situations where the (potential) patient expresses their will with respect to the future actions of the physician in the event that the patient is incapacitated. Isolated cases of such declarations have been reported in Poland, and the very fact demonstrates that it would be impossible to prohibit them from being made. How-

20 Andrzej Kübler et al., "Wytyczne postępowania wobec braku skuteczności podtrzymywania funkcji narządów (terapii daremnej) u pacjentów pozbawionych możliwości świadomego składania oświadczeń woli na oddziałach intensywnej terapii," *Anestezjologia Intensywna Terapia* 46, no. 4(2014): 231.

21 Kübler et al., "Wytyczne postępowania wobec braku skuteczności podtrzymywania funkcji narządów (terapii daremnej) u pacjentów pozbawionych możliwości świadomego składania oświadczeń woli na oddziałach intensywnej terapii," 232.

22 Rzecznik Praw Pacjenta, *Standardy postępowania w terapiach medycznych stosowanych w okresie kończącego się życia*, 25.

ever, the institution is not expressly provided in law, but tends to be interpreted on the grounds of general provisions. This is because advanced decisions are approached as classic declarations of will under civil law, reifying the patient's right of choice (Art. 60 et seq., Civil Code).[23]

Even so, the declaration should meet certain strict conditions: its validity period must not exceed five years, and it has to be made by way of a notarial act or an appropriate form.[24] From the standpoint of Polish law, it is also vital to establish the institution of an attorney, who would be authorized to make decisions from the moment that their principal loses the capacity to decide about medical procedures relating to their health.[25] The attorney is also subject to requirements: they should be of age, have the capacity to act, and have no professional connection with the medical treatment of that patient.[26] Another important option to consider is appointing a guardian for a person who has lost the ability to make independent decisions but has not appointed an attorney. Current law in Poland does not permit filing a one-off petition to the court to have a person appointed to make decisions throughout the treatment. It may therefore be reasonable to limit the practice of requesting permission from the court to carry out particular health services.[27]

The most recent document which advances regulatory proposals regarding futile care is *Prevention of Futile Care in Terminal State Adult Patients in Hospitals. Position Paper of the Polish Society of Internal Medicine Working Group for Futile Care in Internal Medicine Departments*. The document contains guidelines concerning patients when care has become futile.[28]

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23 Decision of the Supreme Court of the Republic of Poland of 27 October 2005, III CK 155/05, https://www.sn.pl/sites/orzecznictwo/orzeczenia1/iii%20ck%20155-05-1.pdf.

24 Rzecznik Praw Pacjenta, *Standardy postępowania w terapiach medycznych stosowanych w okresie kończącego się życia*, 26.

25 Rzecznik Praw Pacjenta, *Standardy postępowania w terapiach medycznych stosowanych w okresie kończącego się życia*, 27.

26 Rzecznik Praw Pacjenta, *Standardy postępowania w terapiach medycznych stosowanych w okresie kończącego się życia*, 28.

27 Rzecznik Praw Pacjenta, *Standardy postępowania w terapiach medycznych stosowanych w okresie kończącego się życia*, 28.

28 Wojciech Szczeklik et al., "Zapobieganie terapii daremnej u dorosłych chorych umierających w szpitalu – stanowisko Grupy Roboczej Towarzystwa Internistów Polskich ds. Tera-

The above draft laws and non-normative documents have all been intended to prompt legislative solutions which would regulate the discontinuation of futile care. It is therefore necessary to discuss pertinent procedures and institutions adopted in other countries, where patients are entitled to declare their will or have decisions on their medical treatment taken by appointed attorneys. Subsequently, one should consider whether it might be possible to introduce such solutions in the Polish legal order.

Legal Regulation of Futile Care in the United Kingdom

The lack of adequate regulations concerning futile care in Poland calls for an examination of other legal systems, in which one can lawfully discontinue treatment that is not aimed at recovery, but only at sustaining one's vital functions without prospective improvement. One of the countries where such provisions exist is the United Kingdom or, more specifically, England and Wales. The principal piece of legislation governing the procedures applicable to incapacitated persons is the Mental Capacity Act (hereinafter: MCA) of 2005, which came into effect in 2007.[29] Persons who have lost mental capacity are defined as individuals who are unable to comprehend and remember the decision-making process and the resulting consequences. It cannot be presumed that a person has lost their mental capacity merely based the fact that their decisions appear illogical, or judging by external characteristics such as age and appearance.[30]

The above date is important because Poland at the time saw the early-stage proposals, which have not resulted in a normative regulation to this day. Al-

pii Daremnej na Oddziałach Internistycznych. Część 1: chory umierający nieubezwłasnowolniony, niebędący w stanie podejmować świadomych decyzji co do leczenia w sytuacji daremności medycznej stosowanej terapii," *Medycyna Praktyczna*, no. 4(2023): 121.

29 Dominic Bell, "The Legal Framework for End of Life Care: A United Kingdom Perspective," *Intensive Care Medicine* 33, no. 1(2007): 158–59, https://doi.org/10.1007/s00134-006-0426-9.

30 "Mental Capacity," Menal Health Foundation, https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/mental-capacity.

though the MCA does not pertain to the end-of-life period or the discontinuation of futile care directly, it introduces procedures that may also apply at the final stage of the life of an incapacitated patient.[31] Another relevant aspect is that England and Wales rely on the common law system, in which precedents established by judicial decisions carry substantial importance. Hence, it would be advisable to examine which procedures adopted in UK law might be introduced in Poland.

There are two distinctive instruments which may readily apply in the case of futile care, namely Advance Decision to Refuse Treatment (ADRT) and Lasting Power of Attorney (LPA) for health and care decisions.[32] ADRT is otherwise known as the living will, although the latter is a colloquial term rather than a notion recognized under English law.

An advance decision to refuse treatment enables one to specify beforehand what medical treatment one does not wish to receive if one becomes incapacitated in the future. If the ADRT concerns refusal of life-sustaining treatment, a written form is mandatory.[33] The two factors which determine whether one may make an advance decision are being at least 18 years old and having full legal capacity at the time of making the declaration. An ADRT must not request the performance of an act that is unlawful; refuse consent to acts that constitute standard of care (e.g. the administration of analgesics); request the performance of a specific medical act; or refuse the treatment of a mental illness if the criteria of the Mental Health Act 1983 are met.[34] The ADRT does not require a physician to be in attendance when such a statement is made or to be involved in the process. However, if the ADMR is made by a terminally ill individual, it is advisable to consult a professional to understand the consequences of such a declaration and assess the mental state of the person concerned at the time of making it.[35]

31 Bell, "The Legal Framework for End of Life Care," 158–59.
32 Age UK, "Advance Decision, Advance Statements and Living Wills," *Factsheet*, no. 72(2023): 3.
33 Age UK, "Advance Decision, Advance Statements and Living Wills," 5.
34 Age UK, "Advance Decision, Advance Statements and Living Wills," 6.
35 Age UK, "Advance Decision, Advance Statements and Living Wills," 6.

Furthermore, such a declaration is only valid when signed by the person making it, which they shall do before a witness.[36] When refusing life-sustaining treatment, where another declaration has already been made, a new document must be signed and dated by both the person concerned and a witness.[37]

Another institution which sanctions discontinuation of life-sustaining treatment is the lasting power of attorney (LPA); that particular institution was also introduced into the legal system of the England and Wales by way of the Mental Capacity Act of 2005.[38] The LPA pertains to two areas, namely financial as well as health-related decisions,[39] both of which are relevant to this inquiry. In a situation where an LPA has been granted following a previous advance decision, the attorney cannot require any of the medical acts stated in the advance decision to be performed if any of those has been designated by the maker as an act not to be undertaken by medical practitioners after they have lost the capacity to decide for themselves.[40]

The UK legal system relies heavily on precedent, also where the procedures relating to discontinuation of futile care are concerned. For a starting point in deliberations, one should draw on a 1990 case,[41] in which it was expressly held that there is no obligation to administer medical procedures that are futile. Subsequent rulings endorsed the aforementioned holding. It has been affirmed that a patient with full legal capacity may not be compelled to undergo treatment and may refuse to have medical procedures performed, even if this would result in death.[42] The physician, on the other hand, is obliged to

36 Age UK, "Advance Decision, Advance Statements and Living Wills," 8.
37 Age UK, "Advance Decision, Advance Statements and Living Wills," 8.
38 Mental Capacity Act 2005, legislation.gov.uk, https://www.legislation.gov.uk/ukpga/2005/9/contents https://www.legislation.gov.uk/ukpga/2005/9/notes/division/6/1/3?view=plain.
39 Mental Capacity Act 2005, Sections 9–14, https://www.legislation.gov.uk/ukpga/2005/9/notes/division/6/1/3?view=plain.
40 Mental Capacity Act 2005, Sections 9–14.
41 Great Britain. England. Court of Appeal, Civil Division, "Re J (A Minor) (Wardship: Medical Treatment)," *All England Law Reports*, no. 3(1990): 930–45.
42 Great Britain. House of Lords, "Airedale NHS Trust v. Bland," *All England Law Reports*, no. 1(1993): 821–96, at page 860 per Lord Keith and page 866 per Lord Goff.

respect the will of the patient and refrain from attempting treatment if the person with full legal capacity has refused it; should the physician dissent, they are obliged to find another physician who will comply with the patient's will.[43]

A special type of discontinuation of futile care which generally requires court approval concerns patients in a vegetative state, for whom even essential procedures such as feeding and hydration will be considered treatment.[44] As demonstrated earlier, pursuant to the Mental Capacity Act, a patient who makes a declaration of will in the event of loss of capacity to make decisions (advance decision) or appoints an attorney may not waive the performance of essential care activities. However, in the light of the judicial ruling, such a possibility exists if three conditions are met at the same time: the provisions of the Mental Capacity Act 2005 have not been breached; the relevant professional guidelines have been followed; and there is no doubt that it is in the best interests of the patient.[45]

Regulation of Futile Care in Italy

Until 2018, the legislation in Italy had not provided for discontinuation of futile care, i.e. a treatment that does not produce positive clinical results, improve the patient's quality of life or offer a reasonable chance of survival.[46] At first, Italian case law was not in favour of approving the patient's advance decisions, as in the case of Piergiorgio Welby who, as a terminally ill patient, made a declaration of will to have futile care discontinued. On 16 December 2006, a court in Rome found such a request "inadmissible" and the physician

43 *Re Ms B v a NHS Hospital Trust* [2002] EWHC 429 (Fam), United Kingdom High Court of Justice.

44 "Legal Annex," General Medical Council, https://www.gmc-uk.org/professional-standards/the-professional-standards/treatment-and-care-towards-the-end-of-life/legal-annex.

45 "Legal Annex."

46 Cesare Triberti and Maddalena Castellani, *Libera Scelta sul fine vita. Il testament biologico. Commento alla Legge n.219/2017 in materia di consenso informato e dispozioni anticipate di trattamento* (goWare, 2018), 39.

in charge was charged with "murder under consent." It should be noted that the physician was acquitted on 14 July 2007.[47]

The context of futile care was invoked by the National Ethics Committee in the 1995 document entitled *Ethical Issues Concerning the End of Life*, which further stressed the need to discontinue treatment which does not improve the patient's condition. It was also observed that withholding such a treatment is a duty of physicians, notably in extreme situations, whereas patient declarations of will—whose introduction the document advocated—should not be treated merely as guidance to inform the actions undertaken by medical professionals.[48] A 2003 document concerned with advance decision asserted that statements of will are not only an instrument to legitimize treatment, but also a fundamental human right.[49] Considerable emphasis was placed on the importance of treating an unconscious patient in accordance with their will, but advance decisions were approached somewhat conservatively, as it was argued that an advance decision may not be respected if there are chances for the patient to recover.[50]

The New Code of Medical Ethics of 2014 acknowledged that advance decisions are statements of will which nevertheless were not legally binding on medical professionals. Thus, with respect to discontinuation of futile care, the main problem was that patients' declarations of will in which they refused to undergo further ineffective treatment were not statutorily recognized. The matter of appointing attorneys and guardians for incapacitated persons was also insufficiently elaborated and provided for; admittedly, the decree of 9 July 2008 did introduce the institution of guardian, but the authority of the latter to make declarations on behalf of another was confined to patients in a vegetative state.[51]

47 Triberti and Castellani, *Libera Scelta sul fine vita*, 11.

48 Nereo Zamperetti and Rodolfo Proietti, "End of Life in the ICU: Laws, Rules and Practices: The Situation in Italy," *Intensive Care Medicine*, no. 32(2006): 1620, https://doi.org/10.1007/s00134-006-0330-3.

49 Denard Veshi, "End-of-Life Decisions in Italy: An Overview of the Currentsituation," *Liverpool Law Rev*, no. 38(2017): 233, https://doi.org/10.1007/s10991-017-9200-z.

50 Veshi, "End-of-Life Decisions in Italy," 234.

51 Triberti and Castellani, *Libera Scelta sul fine vita*, 13.

It may be noted that prior to the enactment of Law no. 219/2017, three bills which sought to introduce the living will (*testamento biologico*) were submitted. The first was rejected in 2009 by the President, while the bill of 2011 did not enter into force; the last one was dated 2014.[52] On 14 December 2017, the Italian Parliament adopted a law which expands on the right to self-determination by establishing the institution of advance decision, and also protects the autonomy of choice and the dignity of the patient—construed as fundamental human right—through the validation of the declaration of will and the appointment of a guardian.[53]

Article 1 of Law no. 219/2017, *Rules on Informed Consent and Advance Directives for Treatment*, states that "in compliance with the principles laid down in Articles 2, 13 and 32 of the Constitution and Articles 1, 2 and 3 of the Charter of Fundamental Rights of the European Union, [this law] protects the right to life, health, dignity and self-determination of the person and sets out that no health treatment may be commenced or continued without the free and informed consent of the person concerned, except in cases expressly provided for by law."[54] It augments the relationship of care and trust between the patient and the physician in which the autonomy of the patient's decision-making and the responsibility of the physician are beneficially aligned through consent to treatment. Informed consent should be obtained using means which are most suited to the patient's condition as well as by appointing a guardian who expresses the will of an incapacitated patient.[55]

The matter of advance directives is addressed in Article 4, in which it is construed as a preliminary instruction regarding treatment. Article 4 (1) states that "Every person of full age and capacity, in anticipation of a possible future incapacity to self-determine and after having acquired adequate medical information on the consequences of his or her choices, may, through the advance

52 Enkelejda Koka and Denard Veshi, "A New Law of 'Living Will' in Italy: A Critical Analysis," *Liverpool Law Rev*, no. 40(2019): 115, https://doi.org/10.1007/s10991-019-09224-0.

53 Koka and Veshi, "A New Law of 'Living Will' in Italy," 116.

54 Article 1, Law no. 219/2017 *Rules on Informed Consent and Advance Directives for Treatment.*

55 Triberti and Castellani, *Libera Scelta sul fine vita*, 107.

directive, express their will with regard to medical treatment, as well as consent to or refuse diagnostic tests or therapeutic choices and specific medical treatments. They also designate a person whom they trust, hereinafter referred to as 'trustee', to act on their behalf and represent them in relations with the physician and healthcare institutions."[56]

The declaration of will enables taking competent decisions on the type of treatment the patient wishes to receive prospectively, which means that such decisions remain valid at a future point in time, when the patient may not have the capacity to make informed decisions.[57] Although it is not specified what an advance directive should contain, it is explicitly stated that the patient should first obtain "adequate" medical information about the consequences of their choices, which ensures that the decision—albeit taken in advance—does not result from inaccuracies or outdated and non-medical information obtained from unauthorized sources.[58]

Such a declaration of will empowers an individual to self-determine regarding their health and life in cases where treatment becomes futile, having no positive impact on their condition and their quality of life. The article entitles one to elect an adult guardian with full legal capacity, who represents the patient in relations with healthcare institutions and, moreover, has the authority to alter the patient's decision in cases where the treatment offers a chance of recovery.[59] The physician, on the other hand, is statutorily obliged to respect the patient's declaration of will, even in the case of conscientious objection. However, if the patient's decision is at odds with current medical knowledge, it is the physician—in consultation with the guardian—who shall suggest a treatment that reasonably improves one's quality of life.[60]

56 Article 4(1), Law no. 219/2017 *Rules on Informed Consent and Advance Directives for Treatment*.
57 Di Paolo et al., "A Review and Analysis of New Italian Law 219/2017," 4.
58 Di Paolo et al., "A Review and Analysis of New Italian Law 219/2017," 4.
59 Triberti and Castellani, *Libera Scelta sul fine vita*, 109.
60 Di Paolo et al., "A Review and Analysis of New Italian Law 219/2017," 5.

Until 2018, the institution of advance directive was not statutorily regulated in Italy. Since the matter was addressed only in recommendations as opposed to formal provisions, declarations of will had no legal foundation. Given the need for the issue to be regulated, the legislature ultimately enacted Law No. 219/2017, *Rules on Informed Consent and Advance Directives for Treatment*, which sanctioned advance directives and the informed consent related thereto, and created the institution of a guardian to act as the patient's representative.

Conclusions

To date, the institution of discontinuation of futile care remains unregulated in Poland. Consequently, no provisions in the Polish legal order allow individuals to make a prior declaration of will so as to waive medical procedures that do not benefit them but only prolong their suffering. Moreover, no statute authorizes the appointment of an attorney who would be empowered to make decisions on patient's behalf when the latter has lost the capacity to act independently.

The guidelines for the discontinuation of futile care that have been published so far are not binding. Functioning as no more than suggestions or recommendations, they contain information on advisable or preferred practices in a particular field. Even so, the guidelines are crucial in terms of introducing new futile care regulations in the Polish system, including the institution of attorney and advance decision. They constitute a major point of reference for legislators, as well as for medical professionals, patients and other stakeholders, helping to shape future medical law and practice. They can support the legislative process since they offer tested solutions and directions that are worth considering when drafting new laws. The introduction of guidelines concerning futile care, along with the institutions of attorney and advance decision, aims to standardize medical practice and ensuring better protection of patients' rights. These guidelines may serve as a basis for the education and training

of medical personnel, as well as for raising public awareness of patients' rights and the ethical aspects of healthcare.

The above study demonstrates that, in view of the need to bring the Polish legal system up to date with regard to protection of patients' rights, it would be reasonable to introduce several key institutions and definitions that reflect contemporary standards and respect human dignity. One of the solutions is to establish the institution of attorney, i.e. a person authorized to represent the patient in the decision-making process concerning health and treatment in situations where the patient is unable to express their will. The attorney, acting on the basis of the lasting power of attorney granted beforehand, will thus be empowered to decide in accordance with the patient's will and best interests. Another important measure is to sanction advance decision, a document in which the patient may, at an early stage, state their wishes regarding medical care in the event that they are unable to make decisions for themselves in the future. Advance decision enables the patient to express their preferences regarding the treatment and medical procedures which they would or would not like to receive. In addition, it is necessary to define futile care, i.e. medical procedures that do not have the expected therapeutic effect and only prolong the patient's suffering. A clear-cut definition of futile care would facilitate decisions to discontinue ineffective medical interventions on the part of medical professionals. Furthermore, consideration should be given to introducing the institution of a guardian, who could be appointed in disputable situations or when no attorney has been appointed. This guardian would act in the interest of the patient, ensuring that their rights are respected and that treatment-related decisions correspond as closely as possible to the expressed or implied will of the patient. These changes, inspired by legal solutions adopted in the United Kingdom and Italy, should be aligned with the characteristics of the Polish legal order as well as applicable standards and procedures. It is crucial that they take into account the dignity of the patient and the right to autonomy in making decisions regarding their own health, even in circumstances where the patient is incapable of freely articulating their will.

The legislative process in that regard should be preceded by an extensive information campaign, so as to ensure that the public is acquainted with the notion of futile care as well as its legal, ethical and moral ramifications.

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