Pol. Ann. Med., 2010; 17(1): 149–157.

OVERVIEW PAPER

PROBLEMS IN QUALIFYING HEALTH SERVICES PROVIDED BY PHYSICIANS AND INFORMED CONSENT TO TREATMENT

Leszek Frąckowiak[1,3], Kamil Frąckowiak[2]

[1] *Chair of Public Health, Hygiene and Epidemiology, Faculty of Medical Sciences, University of Warmia and Mazury in Olsztyn, Poland*
[2] *Chair of Criminal Law, Faculty of Law and Administration, University of Warmia and Mazury in Olsztyn, Poland*
[3] *Department of Oncology and Gynecologic Oncology, ZOZ MSWiA with the Warmia and Mazury Oncology Center in Olsztyn, Poland*

ABSTRACT

Introduction. Under the provisions of the Act on Patients' Rights and Patients' Rights Ombudsman of November 6, 2008, the patient has the right to receive health services adequate to current medical knowledge. The patient has the full right to give consent to medical procedures performed on him/her or to refuse such consent. By this consent, the patient legitimizes in a legal sense the physician's interference with a patient's fundamental rights and freedoms. Acting without consent is usually illegal, thus the physician risks disciplinary action, civil and criminal liabilities.
Aim. The aim of this work was to provide guidelines to assist in distinguishing between concepts concerning health services provided by physicians.
Discussion. In practice, the most significant difficulties arise from fluid boundaries between two legal terms "surgical procedure or therapeutic method posing an increased risk to life and health" and these same activities "posing the risk of causing loss of life, grievous bodily harm and grievous health disorder". In the former case, the physician must obtain informed consent to treatment, whereas in the latter case the consent is not required for providing health services.

On the basis of legal literature overview, legal acts and Polish courts judicature, the article presents a comparative legal classification stemming from the provisions

Corresponding address: Leszek Frąckowiak, Zakład Opieki Zdrowotnej MSWiA, al. Wojska Polskiego 37, 10-228 Olsztyn, Poland; e-mail: sekretariat@poliklinika.olsztyn.pl

Received 07.05.2010, accepted 28.06.2010

of the Criminal Code of 1997, which contains the notion of causing "health disorder", along with the recent judicature of the Supreme Court. This is an attempt to make up for the lack of statutory definitions of particular elements that contribute collectively to the concept of health services.

Conclusions. The classification discussed poses interpretative problems, although the knowledge of the statutory division of health services and correct differentiation between terminological concepts are essential for physicians because they enable a correct assessment with regards to the informed consent required in a particular situation and determining those individuals authorized to providing such consent.

Physicians are legally obliged to qualify their actions according to the abovementioned classification each time they provide health services, which is difficult for them to cope with. Medical law has not kept pace with constant developments in medicine; however, a complex regulation addressing this matter seems to be impossible to arrive at presently.

Key words: informed consent, health services, criminal liability of physicians.

INTRODUCTION

General comments

Under the provisions of the currently binding Act on Patients' Rights and Patients' Rights Ombudsman of November 6, 2008 [7], the patient has the right to receive health services adequate to current medical knowledge, and when the availability of providing proper health services is limited, the patient has the right to a transparent, objective procedure based on medical criteria, indicating the order of availability for these services.

The patient also has a full right to give consent to medical procedures performed on him/her or to refuse such consent. It may be claimed that one of the most important rights of a patient is the opportunity to give or refuse consent for health services to be performed.

The obligation to obtain a patient's consent to medical procedures is a means of empowering the patient concerning the therapeutic and diagnostic processes [1]. It is to the patient's benefit, but also to that of the physician, that said consent should not be treated instrumentally and purely formally. Informed consent legitimizes in a legal sense the physician's interference with a patient's fundamental rights and freedoms. Acting without consent is usually illegal, thus the physician risks disciplinary (professional) action, civil and criminal liabilities.

When discussing the subject-matter of a patient's consent to offered health services, it should be first determined which procedures the patient may give consent to.

Analyzing Article 3 of the Act on Health Care Institutions of August 30, 1991 [8], it may be stated that health services are understood as all activities aimed at maintaining, saving, restoring and improving health.

The Medical Profession and Stomatologist Profession Act of December 5, 1996 [6] allows for classifying health services – as regards the obligation of obtaining informed consent to treatment – into:

- examination;
- surgical procedure and therapeutic or diagnostic method posing an increased risk, but not necessarily the risk of loss of life, grievous health disorder, grievous bodily harm;
- surgical procedure and therapeutic or diagnostic method, posing the risk of loss of life, grievous health disorder, grievous bodily harm;
- medical experiment;
- other medical procedures.

It should be noted that the aforementioned classification poses interpretative problems, although the knowledge of the statutory division of health services and the correct differentiation between terminological concepts are essential for physicians because they enable a correct assessment in terms of the consent required in a particular situation and in determining those individuals authorized to providing such consent.

Physicians are thus legally obliged to qualify their actions according to the aforementioned classification each time they provide health services, which is difficult for them to cope with.

Notion, subject-matter and legal nature of informed consent

Informed consent may be defined as an act of a patient's or his/her statutory representative's volition, freely undertaken and expressed according to the rules of communication and meaning understandable by other parties in the medical process, on the basis of thorough information provided by the physician with regards to all stages of medical treatment [5]. Informed consent must be specific and detailed. It refers fully to the consent to a surgical procedure [4].

As a rule, a patient specifies his/her will as regards every medical procedure performed on him/her, in the form of consent or refusal. The exception to this rule involves situations in which a patient's autonomy is limited. In particular, it refers to compulsory medical procedure and patients who because of their ages or health conditions are unable to independently make decisions concerning the therapeutic process [15].

Consent given by the patient for undertaking therapeutic activities may be subclassified as regards:

- type of consent, i.e. entity authorized to giving consent for providing health services;
- form of consent in which it must be expressed [15].

There are three types of consent that may be given for performing medical procedures. Legal doctrine divides the discussed consent into: consent proper (personal), parallel consent (cumulative) and substitute consent [1, 6, 15].

Generally, the patient expresses consent to suggested health services personally – in this case it is regarded as consent proper. This form of consent concerns:

- an adult person, enjoying full legal capacity;
- a woman who, by consent of the Guardianship Court, got married at the age of 16;
- a person who is partially legally incapacitated as regards medical procedures not posing an increased risk.

Parallel consent (consent given by two authorized entities) is required in the case of:

- patient between 16 and 18 years of age and this patient's statutory representative;
- fully legally incapacitated person who understands the situation and this person's statutory representative;
- legally partially incapacitated person and this person's statutory representative (court appointed guardian), with regards to diagnostic procedures posing an increased risk and surgical procedures.

Finally, substitute consent is given by a statutory representative of a patient less than 16 years of age, or a fully incapacitated person who does not understand the situation or by the Guardianship Court.

As regards the form of consent, it should be noted that the general rule provisioned by Article 32, §7 of the Medical Profession Act is that – unless the Act specifies otherwise – a patient's consent to treatment may be expressed orally or implicitly (*per facta concludenta*), that is by any conduct which unambiguously indicates the patient's will to undergo a particular medical procedure. Moreover, when there is no patient's refusal, it allows the physician to perform other medical procedures which do not pose risk and which are necessary for disease diagnosis [1].

There are, however, exceptions to this rule. The requirement of the written form – according to the aforementioned classification of health services – is compulsory in two cases, namely: a surgical procedure and therapeutic or diagnostic methods posing an increased risk for the patient and a medical experiment.

On the other hand, when a delay in providing medical assistance by a physician might result in the risk of loss of life, grievous bodily harm or grievous health disorder, according to Article 30 and Article 34 §7 of The Medical Profession and Stomatologist Profession Act, a physician may provide health services such as a surgical procedure or therapeutic or diagnostic method posing an increased risk for the patient without obtaining the consent of the patient's statutory representative or proper Guardianship Court.

It is worthwhile reviewing at this point the judgment in the case of the Supreme Court – Civil Chamber, case reference number 396/2006, which indicated that "health services referred to in […] Article 30 of the Medical Profession and Stomatologist

Profession Act of December 5, 1996, involve, generally, emergency and unexpected conditions which cannot be predicted (e.g. patients with stroke, myocardial infarction, road accident casualties). These services do not involve life-saving procedures which are performed on chronically treated patients and which require undergoing medical procedures systematically" [14].

The physician's activity described above is formally conditioned by obtaining an opinion of a second physician, preferably of the same specialization. Next, the physician should make an adequate note in the patient's medical documentation.

AIM

The aim of this work is to provide guidelines to assist in distinguishing between concepts concerning health services provided by physicians.

DISCUSSION

Qualification of health services provided by a physician with regards to informed consent

According to the authors of this article, in practice, the most significant difficulties arise from fluid boundaries between "surgical procedure or therapeutic method posing an increased risk to life and health" and these same activities "posing the risk of causing loss of life, grievous bodily harm and grievous health disorder". In the former case, the physician must obtain informed consent to treatment, whereas in the latter case – under conditions specified before in this article – consent is not required for providing health services.

It is obvious that physicians would prefer to have clear legal guidelines referring directly to procedures that they perform, which would allow them to easily qualify particular health services and define the required form of a patient's consent to treatment. However, due to constant progress in medicine, such a law would always lag behind, and a complex regulation concerning this issue would require creating a list of health services in a volume greater than a multi-volume universal encyclopedia.

In practice, when distinguishing between the described concepts of medical procedures, it is helpful to follow the classification devised in the Criminal Code of 1997, which contains the notion of causing "health disorder" and an unambiguous notion of a medical experiment, whose legal interpretation was provided by the legislators. This is an attempt to make up for the lack of statutory definitions of those particular elements that contribute collectively to the concept of health services.

In the Criminal Code, the concept of "health disorder and bodily harm" is used alternatively with the uniform term "injury". According to the Criminal Code, a severe bodily injury means:

- causing loss of sight, hearing, speech, and reproductive ability;
- other serious disability, serious incurable disease or long-lasting disease;

– truly life threatening disease;
– permanent mental disease;
– complete or significant permanent occupational incapacity;
– permanent, significant bodily disfigurement or marring.

On the basis of the principle of non-contradiction of law it must be assumed that remaining threats (effects) – other threats of increased or decreased significance – connected with a surgical procedure or therapeutic or diagnostic method performed by a physician lie within the scope of an increased risk rather than a risk of loss of life, grievous health disorder and grievous bodily harm.

It seems useful to review at this point specific judgments of the Supreme Court which indicated specific premises enabling the differentiation between particular notions making up the term of "serious injury".

According to the judgment of the Court of Appeal in Krakow of May 27, 1997, serious disability as defined in Article 156 §1 item 2 of the Criminal Code, does not refer to any bodily injury of permanent effect, but to disability comparable to the loss sight, hearing, speech, etc, thus leading to "serious" limitations in the functions of a human body [3].

Serious disability as understood in Article 156 items 1 and 2 of the Criminal Code should be understood as a complete discontinuation or a very significant limitation in the function of an important organ. For instance, a discontinuation of the function of one testicle, even with retained functional activity of the reproductive organ as such, should be considered a serious disability because it is an important organ in human life, of an independent, highly specialized function. If nature provided a human being with a number of parallel organs significant for life, the loss of one of these organs means the failure, to a large degree, in the functional activity in terms of the purpose of this important organ [11, 14].

It should be noted that the Criminal Code does not define the notion of disease. Still, if the term "disease" generally means "a pathological process, resulting in abnormal functioning of the organism or its part" [3], it must be assumed that the Criminal Code employs the notion of "long-lasting disease" according to this concept.

On the other hand, "serious incurable disease or long-lasting disease", another effect of the crime referred to in Article 156 §1 of the Criminal Code, in fact refers to two distinct concepts: "serious incurable disease" and "serious long-lasting disease", whereas in some situations a particular disease may simultaneously fulfill both premises, being "a serious disease" both "incurable" and "long-lasting".

Consequently, causing a serious long-lasting disease does not have to be, according to Article 156 §1 item 2 of the Criminal Code, connected with a serious "incurable" disease or truly "life threatening" disease, as this regulation defines these types of disease as alternative effects of the crime [12].

"Incurable disease" refers to a disease which cannot be cured according to current medical knowledge because of the lack of effective medication or the impossibility

of performing an effective surgical treatment (e.g. paralysis of lower limbs caused by spinal cord injury) or other medical procedure. This concept refers directly to current medical knowledge because only a specialist in a given section of medicine may specify a prognosis concerning the possibility of curing a particular patient. According to Article 156 §1 item 2 of the Criminal Code, such a disease must be not only "incurable" but also "serious", and such an evaluative premise of the effect of the crime may mean that it refers both to diseases of a sudden course (as in acute diseases) and of a long-lasting, devastating course, as in chronic diseases, but also diseases which are accompanied by significant functional disturbances.

"Serious long-lasting disease" is a disease which should fulfill both of these premises simultaneously. Its course, symptoms and the patient's ailments, etc., must support terming the disease as "serious".

With regards to the notion of an "truly life threatening disease", this is of a more subjective nature. Adopting such a qualification is conditioned by determining whether the disease is truly life threatening, rather than posing a theoretical threat. In other words, it must involve a real threat to a specific patient's life. Consequently, it does not have to be a disease whose features suggest that "it usually is life threatening" in an abstract way, but a disease which may not be characterized by such features but in a specific case it poses an actual (real) threat to a specific patient's life. "Truly life threatening disease" does not have to be either serious or long-lasting, it may be, however, "incurable" [2].

Consequently, in medical practice it is possible that a disease which from a theoretical point of view does not pose a threat to a patient's life, may in specific circumstances, e.g. at a lowered individual immunity, another disease existing earlier, etc., create a real threat for the person of such qualities.

Generally, however, a truly life threatening disease should be understood as a condition in which a serious disturbance of basic functions of systems of organs is observed, e.g. central nervous system, respiratory or circulatory systems, because of which the insufficiency and failure of their function may occur, leading to a patient's death [11].

The notion of a "permanent mental disease" referred to in Article 156 §1 item 2 of the Criminal Code may involve some problems in medical practice because in psychiatry, the etiology of the majority of mental diseases has not been in fact unambiguously explained. Thus, it is highly doubtful to attribute such an effect to the offender. In practice, such a possibility refers only to a small number of mental diseases, e.g. post-traumatic epilepsy.

The qualification of the patient's condition as "complete or significant permanent occupational incapacity" may be connected with some other effect referred to in Article 157 of the Criminal Code, e.g. "serious disability" (such as causing the loss of sight to a professional driver simultaneously results in complete permanent work

incapacity in this profession). Professional incapacity should be understood as an inability to perform work for which a given person is qualified professionally, even if he/she is able to perform other jobs.

Serious injury refers also to "permanent, significant bodily disfigurement or marring" listed in Article 156 §1 item 2 of the Criminal Code. Marring generally refers to causing significant, visible changes to the skin, but this category may involve also the loss of some parts of the body, e.g. auricle, nose. When determining the significance of this effect, the location of damages to the skin may be important. Changes involving the skin on the face should be treated differently from those in other, covered parts of the body. In practice, when performing the evaluation, it is more important whether the effect is "permanent" and also "significant".

Bodily disfigurement refers to causing such changes to the body which are visibly different from anatomical norms, i.e. kyphosis following the spinal fracture.

Permanent, significant bodily disfigurement or marring, is a notion which refers to esthetic criteria. This effect may be qualified only together with some other effects listed in Article 156 §1 items 1 and 2 of the Criminal Code, e.g. serious disability.

The described attempt to review and explain judgments of the Supreme Court as regards discussed definitions of medical procedures is definitely not fully satisfactory. However, due to the absence of judicature made on the basis of the provisions of the Medical Profession and Stomatologist Profession Act, the aforementioned judgments should be treated as specific guidelines in distinguishing between "surgical procedure or therapeutic method posing an increased risk to life and health" and these same activities "posing the risk of causing loss of life, grievous bodily harm and grievous health disorder".

CONCLUSIONS

The classification discussed poses interpretative problems, although the knowledge of the statutory division of health services and correct differentiation between terminological concepts are essential for physicians because they enable a correct assessment with regards to the informed consent required in a particular situation and determining those individuals authorized to providing such consent.

Physicians are legally obliged to qualify their actions according to the abovementioned classification each time they provide health services, which is difficult for them to cope with. Medical law has not kept pace with constant developments in medicine; however, a complex regulation addressing this matter seems to be impossible to arrive at presently.

REFERENCES

1. Ignaczewski J.: *Zgoda pacjenta na leczenie*. Warszawa 2003: 12, 23, 27.
2. *Kodeks karny. Komentarz do części szczególnej*, Andrzej Wąsek (ed). [Internet]. C.H.Beck, 2006. Available from: www.legalis.pl
3. *Słownik języka polskiego*, Warszawa 1958: 898.
4. Sośniak M.: *Znaczenie zgody uprawnionego w zakresie cywilnej odpowiedzialności odszkodowawczej.* ZNUJ 1959, Prace Prawnicze; 6: 127.
5. Świderska M.: *Zgoda pacjenta na zabieg medyczny*. Toruń 2007: 19, 37.
6. Ustawa z dnia 5 grudnia 1996 r. o zawodach lekarza i dentysty [The Medical Proffession and Stomatologist Proffession Act of 5 December 19966] (Dz. U. 1997 Nr 28, poz. 152, tekst jednolity z dnia 21 lipca 2008 r. – Dz. U. Nr 136, poz. 857).
7. Ustawa z dnia 6 listopada 2008 r. o prawach pacjenta i Rzeczniku Praw Pacjenta [Act on Patients' Rights and Patients' Rigts Ombudsman of 6 November 2008] (Dz. U. 2009, Nr 52, poz. 417).
8. Ustawa z dnia 30 sierpnia 1991 r. o państwowym ratownictwie medycznym [Act on Health Care Istitutions of 30 August 1991] (Dz. U. Nr 91, poz. 408, tekst jednolity z dnia 8 stycznia 2007 r. – Dz. U. Nr 14, poz. 89).
9. Wyrok Sądu Apelacyjnego z 27 maja 1997 [The Judgments of the Supreme Court of 27 May 1997r.], II AKa 36/97, Prok. i Pr. 1998, Nr 1, poz. 22.
10. Wyrok Sądu Najwyższego z 10 listopada 1973 [The Judgenemt of Supreme Court of 10 November 1973], IV KR 340/73, OSNPG 1974, Nr 3, poz. 42.
11. Wyrok Sądu Najwyższego z 15 września 1983 [The Judgment of the Supreme Court of 15 September 1983], II KR 191/83, OSP 1984, Nr 9, poz. 192.
12. Wyrok Sądu Najwyższego z 18 sierpnia 1975 [The Judgment of the Supreme Court of 18 August 1975], IV KR 7/75, OSNKW 1975, Nr 7, poz. 88.
13. Wyrok Sądu Najwyższego z 31 marca 1978 [The Judgment of the Supreme Court of 31 March 1978], IV KRN 42/78, OSNKW 1978, Nr 7–8, poz. 83.
14. Wyrok Sądu Najwyższego – Izba Cywilna z dnia 4 stycznia 2007 r. [The Judgenemt of Supreme Court – Civil Chamber of 10 November 1973], V CSK 369/2006.
15. Zajdel J.: *Prawo w medycynie dla lekarzy specjalności zabiegowych*. Progress 2008: 23, 83.