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Should a doctor stop rendering medical services? Principles of conduct towards patients attempting to commit suicide. Part 1 – The Polish perspective

Justyna Zajdel[1], Radoslaw Zajdel[2], Anna Krakowiak[3]

[1] *Department of Medical Law, Inter-Department of Human Sciences, Medical University, Lodz, Poland*
[2] *College of Medical Informatics and Statistics, Faculty of Health Sciences, Medical University, Lodz, Poland*
[3] *Division of Toxicology, J. Nofer Institute of Occupational Medicine, Lodz, Poland*

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Abstract

Introduction: According to the general idea a doctor can start the medical management process in an adult and not legally incapacitated patient after the patient has given consent to initiate such a process. The patient's refusal makes rendering medical services impossible, irrespective of their scope and kind. It should be emphasized that such a refusal is respected if it is expressed fully, clearly and consciously. Cases in which such a refusal is expressed by an intoxicated suicidal patient, remaining under the influence of narcotics, drugs or medicaments which characterize with a similar activity should be particularly analysed. Although such a person is able to verbally declare his objection, his ability to process the information given by the doctor before initiating medical procedures is limited, or even non-existant. The refusal therefore cannot be regarded as reliable, which results in rendering medical services to the patient.

Materials and methods: An analysis was made of Acts of Law and the opinions of the judiciar by comparing and excluding contradictory and incoherent elements.

Results: Despite the lack of clear regulations of a patient rejecting procedures aimed at saving the patient's life, or the prevention of serious health impairment or sustaining injury, it should be assumed that the objection expressed by the patient who does not demonstrate the ability to process the information provided by the doctor is not reliable, and the doctor is therefore still obliged to render medical services. External factors, such as consumption of alcohol, narcotics and drugs, which characterize with a similar activity impair perception and make the taking of a conscious decision impossible. Not providing medical help and introducing direct compulsion would mean neglecting provision of due diligence in the process of treatment and, as a consequence, placing the patient's health at risk, and suffering from negative implications for the patient's life and/or health in the future.

Conclusions: Current provisions should directly regulate the negligence of respecting a refusal expressed 'unconsciously' by a patient who remains under the influence of alcohol, narcotics, drugs or medicaments which characterize with a similar activity. Moreover, apart from legal provisions, the law providers should consider introducing a direct compulsion in patients who are unable to make a conscious decision in the treatment process.

Key words

alcohol intoxicated patient, influence of narcotics, refusal to save life, suicidal attempt, direct compulsion, providing due diligence, legal highs, smarts

INTRODUCTION

In everyday medical practice there are many controversies concerning whether each objection expressed by a patient should be absolutely respected by a doctor, and whether there are situations in which such respect can be, or even should be, neglected from the legal point of view. Neglecting a patient's refusal is especially important when the patient has already come of age and is legally capacitated, and who therefore enjoys autonomous decisions during overall medical treatment, including decisions on abandoning activities essential in saving life and/or health. Respecting the patient's objection to the performance of activities to save life or protect from serious damage to health is controversial. It is even more controversial when it refers to an intoxicated patient, remaining under the influence of narcotics, drugs or medicaments, which characterize such behaviour.

According to the general idea, a doctor can start the management process after the patient has given consent to initiate such a process. It can therefore be concluded that any objection expressed by a patient renders the process impossible, irrespective of the kind and character of the medical procedure. The situation is more complicated as both the consent and refusal can be considered binding (making the doctor stop rendering medical services) only when such a consent or refusal is declared consciously.

In compliance with current provisions, the patient can declare explicit consent or objection only when clearly informed by the doctor about the possible consequences of complications, and prognoses for rendering or not rendering

Address for correspondence: Radoslaw Zajdel, College of Medical Informatics and Statistics, Medical University, Hallera 1, 90-647 Lodz, Poland.
E-mail: radoslaw.zajdel@umed.lodz.pl

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medical services. Receiving the information, its analysis, and as a consequence, expressing an explicit refusal or consent, depend on the patient's condition and ability to do so. A temporary condition (e.g. intoxication, impairment of cognitive functions) in many cases considerably reduces perception.

As for intoxicated patients, remaining under the influence of alcohol or drugs, who have attempted to commit suicide, it is doubtful whether such patients are able to process the information given by the doctor, and thus whether they are able to make a clear decision about accepting life-saving medical management. Because of the topic, which is so extensive, the presented study was divided into two parts.

The first part thoroughly analyses the ability of drunk patients who have already come of age and are not legally incapacitated to comprehend the information given by the doctor, and consequently, the effectiveness of the objection to suggested medical management essential for saving life and health.

The second part explains the importance of such objection expressed by a minor, as well as determining the scope of legal responsibility of the doctor who has rendered medical services despite the patient's objection.

In order to present the contents of the study clearly, the following terminology has been used:

Medical services – 'any activities aimed at maintaining, saving and improving health, as well as any other medical activity connected with medical treatment (…)'.
– Article 2, Paragraph 1, Point 10 of The Act on Medical Activity [1].

Patient – 'the person asking for medical services or already using such services by a party whose task it is to render medical services, or a person performing a medical job'.
– Article 3, Paragraph 1, Point 4 of The Act on Patients' Rights and Patients' Rights Spokesman [2].

Close person – 'a spouse, relative or kin remaining in relation by affinity up to the second degree, statutory agent, cohabiting with the patient, or a person designated by the patient'.
– Article 3, Paragraph 1, Point 2 of The Act on Patients' Rights and Patients' Rights Spokesman.

Annulment of declaration of will – 'a declaration of will is not valid if it was made by a person who remained in a state which disallowed him from making a conscious declaration or take an independent decision. It particularly refers to mental disease, retardation or other imbalance, including temporary disorder of psychic activity'.
– Article 82 of The Civil Code [3].

AIM OF THE STUDY

- In the context of the issue of rendering medical services to intoxicated persons, who are under the influence of narcotics or drugs and who have attempted to commit suicide, the following questions were posed:
- Is the objection expressed by an intoxicated patient who has attempted to commit suicide binding, and therefore is it grounds for not rendering medical services?

Is a doctor allowed to force the patient to accept treatment so that such management would save his life and/or health (direct compulsion, e.g. rendering the patient immobile)?

It should be stressed that no provisions refer to these controversies. The grounds for proper conduct can exclusively be analysis of the general provisions on rendering medical services, expressing an explicit consent or refusal to accept such services by the patient, and the opinion of the judiciary and doctrine.

MATERIALS AND METHODS

The material in the presented study included current provisions on the way of rendering medical services on the grounds of consent or objection expressed by a patient, as well as the jurisdiction of Polish courts. Analysis of judicial decisions, doctrine, and current provisions is presented in the context of actual clinical cases selected by one of the authors. It should be emphasized that the provisions of current normative acts are not coherent and can be interpreted in many ways. Bearing that in mind, a research method was used in the study which involved analysis of the Acts of Law and the opinions of members of the judiciary, excluding contradictory elements and creating a common element which would allow for uniform interpretation.

RESULTS AND DISCUSSION

The **Medical and Dental Practitioners' Act** [4] and The Act on Patient's Rights and Patient's Rights Spokesman are basic regulations referring to the declaration of will with which the patient expresses consent or objection. Under Article 2 of The Act on Patients' Rights and Patients' Rights Spokesman, the patient has a right to accept or refuse suggested medical services, having received information within the scope described in Article 9 [2]. Corresponding regulations can be found in The Medical and Dental Practitioners' Act. Under Article 32 of the latter Act, 'a doctor can make an examination or render other medical services with the reservation of exceptions provided by the Act, after the giving of consent by the patient [4].

This implies that rendering medical services is possible only after the patient gives his consent to perform such services, irrespective of their kind and scope. It should be pointed out that the provision of Article 32 of The Medical and Dental Practitioners Act is a general one and there are strictly defined exceptions to the provision. A detailed analysis of these exceptions beyond the scope of the presented study. Considering the exceptions to the provision included in Article 32 of The Medical and Dental Practitioners Act it must be stressed that rendering medical services is possible in the case of minors, legally incapacitated patients and compulsory conduct.

However, the ground for not rendering medical services is a declaration in which the patient expresses an objection. The objection is regarded as binding when expressed consciously, i. e. when the patient is able to process the information given by a doctor within the scope described in Article 31 of The Medical and Dental Practitioners Act and Article 9 of The Act on Patients' Rights and Patients' Rights Spokesman. Under Article 31 of The Medical and

Dental Practitioners Act the doctor is obliged to inform the patient or the patient's statutory guardian on his state of health, diagnosis, recommended and possible diagnostics, treatment, complications which might appear after rendering or not medical services, as well as prognoses [4]. Article 31, Paragraph 6 of The Medical and Dental Practitioners Act provides that 'the doctor informs the close person on the patient's state of health if the patient himself remains unconscious or is incapable of understanding the importance of such information'. The ground for the doctor's conduct is Article 3, Paragraph 1, Point 2 of the Act as of 6 November 2008 on patients' rights and patients' rights spokesman [4].

Article 31, Paragraph 6 of The Medical and Dental Practitioners Act provides that in the case of the patient's inability to understand the information, because of the temporary state which impairs his perception and disallows taking conscious decisions, the doctor has a right to give such information to the patient's close person (e.g. spouse, adult son/daughter) if the close person is in the presence of the patient. The fact that the close person is informed on the patient's state of health does not entail the right of such a person to accept or refuse the planned management on behalf of the patient who has already come of age and is not legally incapacitated, but who, because of his temporary state impairing his conscious conduct (e.g alcohol intoxicated) cannot make a conscious decision. In such a situation the decision is always taken by the doctor who, as a professional, has the knowledge required to carry out medical treatment aimed at saving the patient's life or protecting against serious detriment to health.

Is the refusal expressed by an intoxicated patient who attempted to commit suicide binding for the doctor, and can it be the ground for not rendering medical services?

Below there are examples of clinical cases experienced by one of the authors (A. Krakowiak) which can be the answer to the above question. In both cases, adult and legally capacitated patients refused recommended medical treatment. Despite their objections the doctors initiated medical management procedures, which resulted in the improvement of the patients' state of health and prevented unavoidable negative implications for her health and life.

Case 1. Female patient, aged 44, admitted to the Toxicology Unit in the Department of Occupational Diseases and Toxicology of the Institute of Occupational Medicine in Łódź because of suicidal intoxication with carbamazepine. Carbamazepine is widely used as an antiepileptic drug. It also has confirmed therapeutic properties in alcohol withdrawal syndrome, maniac-depressive states and idiomatic neuralgias of trigeminal nerve. The patient's family stated she might have taken about 50 tablets of the drug two hours earlier.

The patient was admitted to hospital in a moderate state, obnubilated, with reduced logical contact, unable to maintain balance, with alcohol content detected with a breathalyzer test. She was respiratory and circulatory sufficient, with regular heart action (96/min) and arterial tension 140/100 mmHg.

On admittance to the Toxicology Unit the patient did not agree to undergo toxicological analysis and physical examination, and asked to be discharged from hospital. She constantly expressed suicidal thoughts and tendencies. Because of the number of tablets she took, the possibility of demonstrating serious symptoms of intoxication with carbamazepine, such as disturbance of the central nervous system, respiratory and cardiovascular systems, the doctor on duty decided to introduce direct compulsion – the patient was forced to remain in the Toxicology Unit despite her refusal to be treated.

After carrying out sedative treatment, the patient was intubated and underwent gastric lavage. Laboratory analysis showed the level of ethanol in blood to be a 2.7 mg%, and a concentration of carbamazepine of 3.5 mg% (therapeutic level – up to 1.2 mg%). Intensive conservative therapy was implemented. After a few days of hospitalization the state of the patient improved. She was diagnosed by a psychiatrist. The result was suicidal intoxication with drugs. The patient was referred to a psychiatric hospital to continue the treatment process.

Case 2. A 29-year-old male patient was admitted to the Toxicology Unit in the Department of Occupational Diseases and Toxicology of the Institute of Occupational Medicine in Łódź because of intoxication with digoxin. The toxic activity of digoxin includes, apart from disorders of the stimulus-conducting system, side-effects in the digestive and central nervous systems. The patient had carefully planned the suicide. He had taken 90 tablets of digoxin, at a dose of 22.5 mg about 4.5 hours before. On admittance, he denied having taken ethanol. He was weak, conscious, and remained in logical and verbal contact but demonstrated psychomotor and balance disturbances. A physical examination showed skin pallor. The patient was respiratory sufficient, heartbeat was irregular with a ventricular rate of 40/min, heart sounds were audible and arterial blood tension 120/90 mmHg. Just after admittance to hospital the patient asked to be discharged.

Because of the number of tablets he had taken, the possibility of demonstrating serious symptoms of intoxication with digoxin, such as considerable slowing or accelerating of the heartbeat, and rhythm disorders which might have posed a threat, the doctor on duty decided to introduce direct compulsion – the patient was forced to remain in hospital despite his refusal to be treated. Vomiting was provoked and he was administered activated carbon.

Laboratory analysis did not prove there was ethanol in blood; digoxin level was determined with an immuno-enzymatic method and it was 6.75 ng/ml (reference range 0.9-w.0 ng/ml). Since the doctor did not manage to accelerate the heartbeat he decided to use an endocavitary electrode. The endocavitary stimulation was discontinued only after 65 hours of hospitalization. Because of the suicidal reasons for the intoxication, the patient was also examined by a psychiatrist. After seven days he was discharged home in a good health condition.

While analyzing the problem of objections about initiating procedures aimed at saving life and health, the decision of the Supreme Court of 27 October 2005 should be quoted, which stated that

> the law does not require the patient to accept medical intervention and the doctor to act against the patient's will by performing activities which the patient has not agreed to, or demand that the court deem the patient's objection invalid [5].

It must be explicitly stressed that the opinion presented by the Supreme Court refers only to adult patients who enjoy full legal capacity and who are aware and capable of processing the information received from the doctor, and thus able to make independent decisions on not accepting planned medical services.

The two authors presenting the two cases imply that refusals expressed by the above-mentioned suicidal patients are not reliable. The fact that the patients attempted to commit suicide might imply they were not fully aware when they made the decision to reject medical assistance. At that moment,their cognitive functions were disturbed and they were not able to evaluate the situation at that time. From the legal point of view, a suicidal attempt does not entail limitation of formal capability of expressing an objection.

It is beyond any doubt that people who enjoy full capacity to act (those who have come of age and are legally capacitated) posses autonomy to make independent decisions, irrespective of their temporary state (consumption of alcohol, drugs, narcotics, a state of shock), which impairs reasonable thinking. In most cases, alcohol intoxicated patients, those remaining under the influence of narcotics, drugs or other medications which characterize with similar properties, can verbally express their consent or refusal which, however, cannot be identified with the ability to make a reasonable decision.

In the case of adult and legally capacitated patients, remaining under the influence of narcotics, drugs or other medications, and who had made a suicidal attempt, one should distinguish between the ability of expressing their refusal (verbal and implied) and conscious processing of information given by the doctor followed by taking a reasonable, thought-over decision. The problem in common, and not a trivial one, concerns the large variety of substances that alter the mental and psychological status that are presently available on the market. These substances are legal but act as illegal narcotics [6]. Their effect on the central nervous system can be easily underestimated, thus causing special diagnostic difficulties in estimating the level of a patient's consciousness [7].

In the next paragraph we will try to answer a question whether an objection expressed by an alcohol intoxicated patient, or remaining under the influence of narcotics, drugs or other medications, is a reliable declaration of will in which the patient requests the abstention of the doctor from rendering medical services.

Under Article 82 of The Civil Code a declaration of will is not valid if it was made by a person who remained in a state which disallowed the making of a conscious declaration, or make an independent decision. It particularly refers to 'mental disease, retardation or other imbalance, including temporary disorder of psychic activity' [3]. The word 'particularly' implies that reasons excluding a conscious declaration of will are not limited to impairment of psychic functions, mental disease or mental disorder.

The Supreme Court, in a decision of 30 April 1976, pointed out that the state of being unconscious includes:

> lack of discernment, incapacity to comprehend one's own behaviour and the behaviour of others, and not realizing the importance and effects of one's own behaviour. Such a state must be the result of an internal cause, so that the state in which the person making the declaration of will remains unchanged, and not as the result of an external circumstance in which the person found himself [8].

It can be concluded that the state of excluding consciousness should be identified with circumstances which exert extreme influence on the process of making decisions. Colloquially, the notion 'excluding consciousness' means total absence of consciousness, which renders the taking of any decisions impossible. In the context of agreeing to accept treatment, the exclusion of the state of consciousness might result from disorders which make the reception of information impossible, or perception disorders caused by a disease or temporary inhibition of cognitive activities, resulting from alcohol consumption, drug administration or intoxication with narcotics.

From the legal point of view, the basic obligation of a doctor is to take medically justified interventions aimed at minimizing or eliminating negative consequences for life and health. However, rendering medical service depends on the consent of the patient, and in particular situations on other authorized subjects (e.g. statutory agent for a minor or legally incapacitated person). In strictly defined cases it is possible to make an intervention without consent, or despite an expressed objection of the authorized subject. While analyzing the problem of consent and refusal expressed by alcohol intoxicated patients or remaining under the influence of narcotics and drugs, one should refer to the decision of the Supreme Court of 23 November 2007 [9] which does not refer to the refusal expressed by a suicidal patient, although such situations should be referred to. It must be emphasized that Polish courts have not considered cases of refusal to undergo medical treatment expressed by suicidal patients.

The case referred to a 26-year-old man, who while under the influence of alcohol, fell down the stairs and after which he complained about spinal pain in lumbar segment. Despite the injuries sustained, the man refused to be hospitalized. Next day, he called an ambulance and agreed to be treated in hospital. In spite of swift and immediate intervention, which included surgery, the man suffered from serious detriment to health, i.e. he was partially paralysed. A few months following the surgery, the patient filed a complaint in court against the doctor who had given him first-aid. The plaintiff demanded compensation, satisfaction and benefit. The courts of the first and second instance dismissed the case, stating that in the period of time when the prognosis was certainly the most promising, the plaintiff himself had decided to refuse hospitalization. In the verdict it was claimed that 'it was a mistake to think that the plaintiff was able to refuse to be hospitalized although he remained in a state which disallowed making a conscious decision'.

The decision was reversed by the Supreme Court reversed and referred back to the courts of the second instance to be reconsidered. The Supreme Court also pointed out that:

> while providing the first aid the patient should be informed (…). The doctor should understand the obligation of informing the patient differently if he refuses be hospitalized. In such cases, the doctor is required to provide the patient with extensive information about his doubts, his intention to apply more thorough diagnostic methods during hospital stay, and any possible health complications which might result from the refusal or delayed initiation of recommendations.

The state in which the patient remained may not have made it possible to make a conscious decision. Nevertheless,

it definitely made taking such a decision more difficult. Moreover, while providing first aid it is hardly possible to state objectively whether the patient's perception is sufficient enough for such a decision to be made. The fact that the patient is able to remain in verbal contact does not necessarily mean he can consciously express his consent or refusal. His refusal should not be considered reliable because the patient was not aware enough to express a conscious objection. The grounds for such an opinion is the reason for justification of the verdict, which stated that 'under the influence of alcohol the plaintiff did not fully feel pain and therefore, despite the defendant's recommendations, he refused to be taken to hospital'.

It would be difficult to limit the patient's autonomy; however, having considered the facts presented in the verdict of the Supreme Court, it can be concluded that the decision concerning the refusal was taken on the premises, which would probably have been evaluated differently if the patient had not been under the influence of alcohol.

In the situation where the patient did not really feel much pain, he was able to assess the circumstances of the event, and was aware of the fact that something serious had happened. The internal process of making a decision did not arise. Besides, it cannot be stated what decision he would have taken if he had felt the full effects of pain. Analysing the case objectively, it could be concluded that the patient's refusal was unreliable because of the injury, and the future potential consequences for not accepting hospitalization at that time when the prognosis was the most promising, despite the fact the patient was able to verbally express his refusal.

Summing up, it should be pointed out that in every case in which the patient is under the influence of alcohol, narcotics or other drugs, no refusal he expresses can be regarded as being made consciously. This means that the doctor is obliged to initiate a medical procedure that will protect the patient from negative implications for his life and health.

In some professional literature, opinions can be found in which a refusal should be respected in the case of adult suicidal patients whose declaration of rejecting help is beyond any doubt [10]. M. Filar shares that opinion and states that 'the patient's declaration should be respected if the physical and mental state allows him to make a clear, conscious decision (…)' [11]. It should be emphasized that the presented opinions refer only to situations in which the refusal is taken fully consciously and deliberately after the doctor has informed the patient before initiating necessary medical procedures.

Other authors admit that physician should be very active in establishing patients' opinion regarding their rights related to making even end-of-life options [12]. S. Cameron et al., proposed a dedicated test for mental capacity evaluation in patients requesting assisted suicide [13]. Perhaps a similar proposal could be adopted for more general purposes. As mentioned before, the ability to receive and process information depends on full capability which, however, is impaired when the patient is intoxicated with alcohol, narcotics or other drugs which characterize with similar activity. In the authors' opinion, suicidal patients hardly ever express a clear, fully conscious refusal. From their own experiences they can state that such refusal never appears.

In order to gain evidence, the doctor who renders medical services to the patient expressing 'unaware' objection should write the following statement in the patient's records:

> On the basis of the patient's state (e.g. consumption of alcohol, narcotics, drugs, and limited verbal-logical contact) the decision has been made on the optimal method of treatment to protect the patient's life and health and to eliminate health risk in the future.

Can the doctor use direct compulsion (immobilization, holding) on patients who raise objections to medical services aimed at saving life and/or health?

In compliance with the present regulations, imposing direct compulsion is possible only in strictly defined cases that have been described in separate regulations. Direct compulsion may be imposed on hospitalized patients (according to The Act on the Protection of Psychic Health) [14], and on those who are suspected or accused of traffic offence after drinking alcohol, and who refuse to submit to a blood test in order to determine the alcohol concentration [15, 16]. Therefore, the question arises whether, despite the lack of definite regulations allowing the use of force, the doctor may apply direct compulsion in suicidal patients to implement medical services to save their lives and/or health.

To answer this question, reference should be made to the medical obligation of doctors to do their utmost to help the patient. Under Article 4 of The Medical and Dental Practitioners Act:

> the doctor is required to perform his profession in compliance with the doctrine of contemporary medical knowledge, using available methods and preventative measures, as well as diagnosis and treatment of diseases in line with professional ethical rules and proper diligence [4].

Article 4 of the Act states that each doctor is obliged to carry out optimal diagnostic and therapeutic management to protect the patient against negative consequences for their lives and health, and/or eliminate or reduce the risk of deterioration of the health of the patients.

Polish courts have raised the issue of management based on optimal methods of therapy.

In the decision as of 15 July 2003, the District Court in Radom emphasized that it is the doctor who bears the blame for maltreatment in cases in which the recommendations of contemporary medical knowledge have been violated and optimal treatment methods neglected [17].

In the context of due diligence, Article 30 of The Medical and Dental Practitioners Act is of great significance, according to which 'the doctor is obliged to provide medical help in each case of the utmost urgency, since its delay could pose a threat to life, severe health impairment, or injury of the body' [4]. Thus, the doctor's obligation is to render medical service in every case in which the lack of such help might result in negative consequences for the patient's health or life. This is particularly important when the patient is unable to make a conscious decision about necessary treatment, and respecting his 'unconscious' will might cause negative results for the patient's health or life.

In compliance with the current adjudication schemes of the Polish courts, the doctor is obliged not only to do his best through implementation of treatment protecting the patients against health disorders and injuries of the body, but also to perform therapy that will eliminate health risk.

In the decision as of 29 September 2005, the Court of Appeal in Lublin declared that:

> the doctor and medical personnel are obliged to undertake such a method of treatment which should guarantee, according to the current state of knowledge and diligence principles, predictable effects in the form of curing. But above all, they should not expose the patient to the risk of health deterioration [18].

Although the law does not directly provide applying direct compulsion, the norms concerning these situations should be used in a wider range. In patients under the influence of alcohol, narcotics and drugs, who express 'unconscious' objection regarding medical services which could save their lives, then direct compulsion should be identified with providing due diligence in the process of treatment, which is the basis for rescuing the patient's health and life.

In some studies, an opinion can be encountered in which the paternal attitude of the doctor has become an 'insurance policy', particularly when a person eligible to possess certain virtues (i.e. life and health) in not able to appreciate the value of these virtues, or to understand and properly assess the risk [19].

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REFERENCES

1. The Act on Medical Activity, date of issue 15.04.2011, OL 2011 r., nr 112, item 654.
2. The Act on Patient's Right and Patient's Right Spokesman, date of issue 6.11.2008; DzU 2009, No. 52, item 417; No. 76, item 641 with futher changes.
3. The Civil Code, date of issue 23.04.1964, OL DzU 1964, No. 6, item 93 with further changes.
4. The Medical and Dental Practitioners Act, date of issue 5.12.1996, uniform text OL 2011, No. 277, item 1694 with further changes.
5. Decision of the Supreme Court, date of issue 27.10.2005, III CK 155/05, OSN Izba Cywilna (Civil Chamber) 2006, Nos. 7-8, item 137.
6. Kapka-Skrzypczak L, Kulpa P, Sawicki K, Cyranka M, Wojtyła A, Kruszewski M. Legal highs – legal aspects and legislative solutions. Ann Agric Environ Med. 2011; 18(2): 304-309.
7. Żukiewicz-Sobczak W, Zwoliński J, Chmielewska-Badora J, Krasowska E, Piątek J, Sobczak P, Wojtyła A, Fornal E, Kuczumow A, Biliński P: Analysis of psychoactive and intoxicating substances in legal highs. Ann Agric Environ Med. 2012; 19(2): 309-314.
8. Decision of the Supreme Court, date of issue 30.04.1976, III CRN 25/76, OSPiKA 1977 r., No. 4, item 78.
9. Decision of the Supreme Court, date of issue 23.11.2007, IV CSK 240/07, OSNC 2009, No. 1, item 16.
10. Zielińska E. Doctor's duties in case of disagreement on the treatment and in terminal condition patients. Law Med. 2000; 1(5): 82-96 (in Polish).
11. Filar M. Medical treatment in patient incapable to express consent. Law Med. 2003; 11(13): 41-52 (in Polish).
12. Mueller PS. The Terri Schiavo Saga: ethical and legal aspects and implications for clinicians. Pol Arch Med Wewn. 2009; 119(9): 574-81.
13. Cameron S, Carmelle P, Draper B, A test for mental capacity to request assisted suicide. J Med Ethics. 2011; 37: 34-39.
14. The Act on Protection of Psychic Health, date of issue 19.08.1994, OL 1994, No. 111, item 535 with further changes.
15. The Penal Code, date of issue 6.06.1997, OL 1997, No. 88, item 553 with further changes.
16. The Road Traffic Act, date of issue 20.06.1997, uniform text OL 2005, No. 108, item 908 with further changes.
17. Decision of the District Court in Radom, date of issue 15.07.2003, I C 955/98. In: Law and Medicine 2007;2 (27) (in Polish).
18. Decision of the Court of Appeal in Lublin, date of issue 29.09.2005, I ACa 510/05, Law and Medicine 2006; 3(24) (in Polish).
19. Dworkin G. Paternalism [in]: ed, Gorovitz S, Jameton LA, Macklin R, et al. *Moral Problems In Medicine*, Englewood Cliffs, NJ, Prentice-Hall, 1983: 196-199.