

# Institution of the health care agent in Polish legislation: position of the Polish Working Group on End-of-Life Ethics

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## KEY WORDS

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## ABSTRACT

**INTRODUCTION** In numerous countries legislation has been put in place allowing citizens to appoint persons authorized to make medical decisions on their behalf, should the principal lose such decision-making capacity.

**OBJECTIVES** The paper aimed to prepare a draft proposal of legal regulations introducing into Polish legislation the institution of the health care agent.

**PATIENTS AND METHODS** The draft proposal has been grounded in 6 expertise workshops, in conjunction with several online debates.

**RESULTS** The right to appoint a health care agent should apply to all persons of full legal capacity, and to minors over 16 years of age. Every non-legally incapacitated adult person would be eligible to be appointed a health care agent. Appointment of substitute agents should also be legally provided for. The prerogatives of health care agents would come into effect upon the principals' loss of their decision-making capacity, or upon the principals' waiving their right to be provided with pertinent information on their health status. The health care agents would make decisions in all matters pertaining to medical treatment, while remaining under no obligation to perform any hands-on caring duties for their principals. The term of medical power-of-attorney should be discretionary, while its revocation or resignation should be possible at any time. In the event of health care agents' inactivity, or in the event that their actions should appear contrary to the principals' best interests, an attending physician should notify a pertinent court of law whose prerogatives would facilitate revocation of a medical power-of-attorney.

**CONCLUSIONS** Statutory appointment of a health care agent allows every citizen to appoint in this capacity a person who, to the best of his or her knowledge, would best represent his or her interests in the event that the principal should ultimately lose the capacity to make medical decisions on his or her own behalf.

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**INTRODUCTION** The issue of making medical decisions on behalf of the patients incapable of doing so on their own behalf, or have waived their rights to be furnished with information on their health status, requires that appropriate legislation be put in place. One of the feasible proposals consists in the introduction into Polish law the notion of a health care agent, whilst strictly regulating the principles of appointment, as well as attendant prerogatives and liabilities, as referenced in Recommendation No. 11 of the Council of Europe of 2009.<sup>1</sup>

A health care agent is a person personally selected by the patient and appointed specifically to represent his or her will, position, and interests in a situation whereupon the patient can no longer do so on his or her own behalf, or for whatever reason no longer wishes to do so. The institution of the health care agent already functions in the legal systems of a number of countries.<sup>2-11</sup> Presently, there is no legislation in Poland providing for a power-of-attorney fully compliant with the specific provisions of Recommendation No. 11.<sup>12</sup>

The Polish Working Group for the End-of-Life Ethics initiative was prompted by the conviction of its members that the concept of health care agent would become to a large extent instrumental in resolving practical problems with securing consent to medical treatment with regard to the 2 groups of patients:

**1** Persons unable to make independent decisions on their own behalf (eg, those who are unconscious, remain on strong medications, suffer from variable or established cognitive impairment), whilst not represented by a statutory representative (ie, non-legally incapacitated adult persons). This in fact makes a rather numerous group of patients, for example, those treated in intensive care units.

**2** Persons who do not wish to be informed about their health status. Even though they may indeed name a person who may become the recipient of any such information on their behalf, that person may not be vested with any decision-making prerogatives in that regard, in line with currently applicable legislation. Consequently, we are faced with a paradoxical situation whereby one person possesses the required body of knowledge that might facilitate effective decision-making on any further course of medical treatment, whereas the other person, namely, the patient, not actually privy to this knowledge, is legally eligible to do the actual decision-making.<sup>13</sup> With regard to such patients, no decisions may be made on their behalf by their legal representatives (as none have been appointed), nor by a court of law, as they do not remain unable to furnish the court with their informed consent for medical/biological reasons, but owing exclusively to the lack of pertinent information that they do not actually wish to receive.

**PATIENTS AND METHODS** The present draft proposal is based on the studies pursued by the Polish

Working Group for the End-of-Life Ethics, drawing extensively upon the expertise of health care professionals, philosophers, and lawyers, as well as some contributions made by members of the clergy. The Project was pursued in the years 2013 and 2015, comprised of 6 meetings held by the Working Group members, and was further augmented by several online debates (FIGURE 1). The works were pursued until the final draft was unanimously approved by all members of the Group.

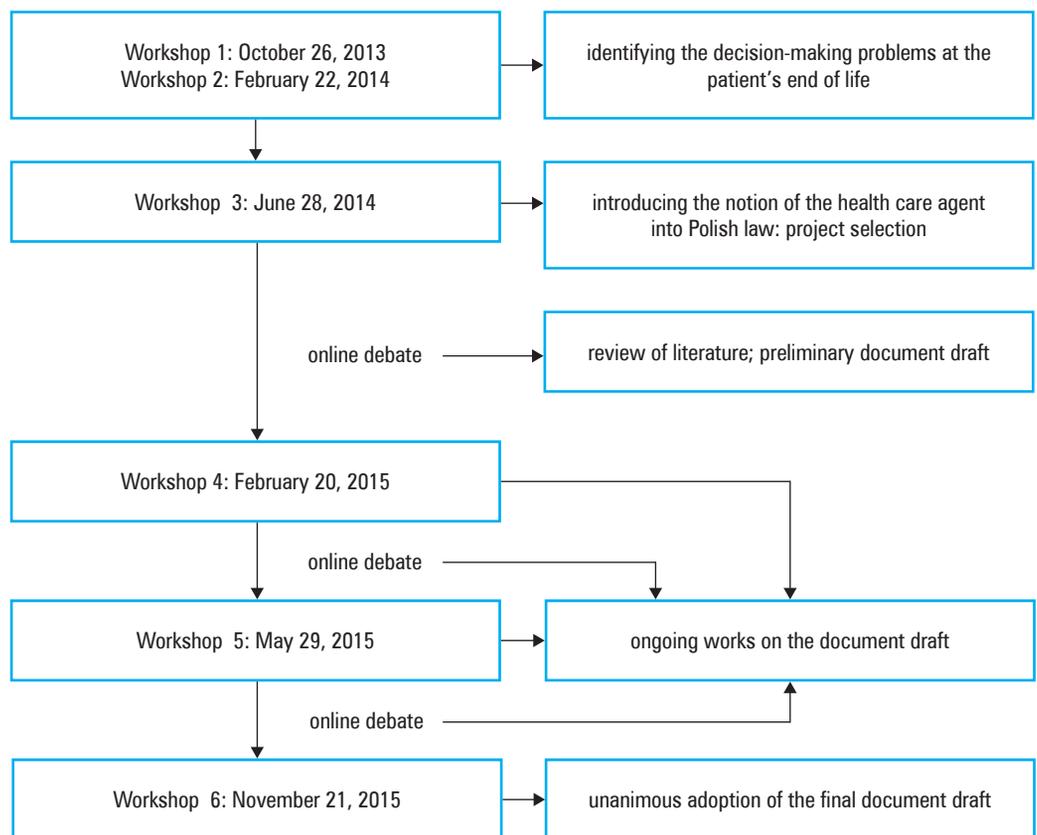
**RESULTS** The right to appoint a medical representative (health care agent) should apply to all persons of full legal capacity, and to minors over 16 years of age. A health care agent would be in a position to exercise his or her statutory prerogatives in the event that a patient loses capacity to make medical decisions on his or her own behalf, or in the event that a patient waives the right to be provided with pertinent information on his or her health status. Every non-legally incapacitated adult person would thus be fully eligible to be appointed a health care agent, this also allowing for the appointment of substitute agents. The actual granting of such a specific power-of-attorney would require a written form or a verbal one, duly endorsed by 2 witnesses.

A medical power-of-attorney would come into effect upon the principal's loss of decision-making capacity, or upon the principal's waiving the right to be provided with pertinent information on his or her health status. A health care agent would make medical decisions in all matters pertaining to managing the principal's treatment, although the agent would be under no obligation to perform any hands-on caregiving tasks to the principal's benefit. The assumption of the prerogatives of a health care agent requires either written consent of the person to whom pertinent power-of-attorney is being granted, or a verbal one, duly endorsed by 2 witnesses. The actual term of the power-of-attorney should be fully discretionary, while its revocation or a resignation from the position of a health care agent should be admissible at any time. In the event of a health care agent's inactivity, or in the event that his or her actions should appear contrary to the principal's best interests, an attending physician should duly notify a pertinent court of law whose prerogatives facilitate revocation of the power-of-attorney, as originally granted to the health care agent.

**DISCUSSION** Considering currently applicable legislation, the eligibility to appoint a health care agent should be restricted to persons of full legal capacity. This fully complies with generally applicable constraints of civil law. Legally incapacitated persons cannot be vested with the prerogative of appointing a health care agent, who would in turn make decisions on their behalf for making which they are noneligible themselves.

It follows that the prerogatives of adult persons to appoint a health care agent should be assessed in terms of them either possessing full

**FIGURE 1** The works pursued by the Polish Working Group for the End-of-Life Ethics



legal capacity for doing so, or not. As a matter of principle, this prerogative should not be limited in due consideration of the actual capacity of a person appointing a health care agent. In the circumstances, however, when such a person should happen to be in a physical/mental condition ruling out the actual ability to freely express a fully cognizant declaration of intent, any such declaration would be deemed invalid, in line with generally applicable statutory constraints for expressing a personal declaration of intent, although this would still be subject to an endorsement by a pertinent court of law.<sup>14</sup>

A health care agent appointed prior to the principal having been made legally incapacitated should not therefore lose all legal prerogatives originally vested in him or her, although all decision-making of strictly medical character should remain outside his or her statutory remit.

On the other hand, a health care agent appointed by a minor would effectively be invested with his or her prerogatives, once the following 2 conditions have been satisfied: 1) the principal has reached legal adulthood; 2) the principal has lost the actual capacity to make any decision regarding the course of his or her medical treatment.

Even though minors aged from 16 to 18 years possess limited legal capacity, in view of the reasons set out further below they should nevertheless be granted the legal right to appoint health care agents. This solution effectively provides for a future situation with regard to a minor suffering from a progressive disease and approaching adulthood, whereupon he or she would no longer

be capable of appointing, for medical reasons, a health care agent when he or she has ultimately reached adulthood. This would effectively eliminate the need to have such a health care agent appointed by a court of law. This ensures all due respect for the minor patient's autonomy shortly before reaching adulthood.

The acquisition by a health care agent of all due statutory prerogatives to act on behalf of the principal upon reaching by him or her the age of 18 years effectively precludes potential conflicts with the principal's legal representatives, as by law their powers of representation expire upon the minor's 18th birthday. In the event when a minor should lose the actual ability to co-decide the course of medical treatment before turning 18 years of age, all pertinent decisions in that regard are made by his or her statutory representatives, although upon turning 18 years of age those prerogatives are automatically transferred onto a health care agent. This obviously does not apply to any legally incapacitated minors.

It might well be assumed that the patient might like to choose a like-minded person (or even suffering from similar medical disorders) to make decisions on his or her behalf with regard to the course of medical treatment, even though in certain situations such decision-making, pursued consistently with the patient's views, might be regarded by other persons (eg, family members, medical staff) as not serving the patient's best interest. On the other hand, protection of the patient's autonomy, who is well within his or her right to make erroneous and even potentially

harmful (in the view of others) decisions regarding his or her own health and life, requires that the patient be granted a chance to choose such a representative (health care agent) who will make decisions fully consistent with the beliefs and views espoused by the patient by whom the agent has originally been appointed.

A health care agent may not be a legally incapacitated person, for the simple reason that since the agent is unable to make any legally binding decisions in the matters regarding his or her own medical treatment, on no account should he or she be allowed to be vested with such decision-making prerogatives with respect to another person.

Only in the case where there is a single agent appointed and vested with the prerogatives for medical decision-making, is there no attendant hazard of disputes as to which specific decision should be made with regard to a particular medical procedure. The problem arises when a person acting as a health care agent becomes unavailable, or is no longer capable of making informed and independent decisions, has resigned his or her legal capacity, or died. In any such circumstances, there is only one avenue open to have this issue effectively resolved, that is, going through pertinent proceedings in a court of law, with a view to having a statutory legal representative established through a judicial order.

This problem may be effectively resolved through the option of indicating (appointing) substitute health care agents. A substitute agent would have his or her prerogatives automatically activated in a situation in which the principal agent would have dropped out for any of the above referenced reasons. A chain of consecutive substitute agents may also be appointed, whose prerogatives would become activated in turn. Activation of any such decision-making powers by a substitute agent should be strictly dependent upon the factual status. In the event that the attending physician should find himself unable to contact the principal agent, he or she should be obligated to contact another agent from the list, and if that attempt has also failed, yet another one.

Given the importance of the decisions that a health care agent would be making on behalf of the principal, and the impact any such decisions would subsequently have on the life of the latter, it is recommended that an agent should be fully aware of the attendant burden of responsibility vested in him or her before freely agreeing to embrace this function. Hence the validity of the power-of-attorney granted to such person should be strictly dependent upon this person's express consent. This consent need not be expressed at the time the above referenced power-of-attorney is being granted, but it should nevertheless be enclosed with it, and made available to the attending physician when the power-of-attorney is shown to him or her for the first time. It should also be duly registered (ie, recorded in the patient's medical documentation) by the attending physician.

It is also recommended that the principal, intent on granting a medical power-of-attorney, inform a potential agent and secure his or her tacit (preliminary) approval. This appreciably reduces the risk of appointing a health care agent who would subsequently refuse to embrace this function. This is of particular importance when the time frame for the appointment of a health care agent is rather limited, due to the rapidly deteriorating health of the principal.

Any such consent should be expressed in writing (longhand), although a computer printout is also acceptable, when bearing a handwritten signature, or enclosed with an electronically authenticated one, or expressed verbally in the presence of 2 witnesses, if a health care agent at the time of expressing his or her consent is unable to write or read. One of the witnesses, immediately after such consent has been expressed, should make dated confirmation in writing, which must be duly signed off by the 2 witnesses.

Neither the attending physician nor a nurse, nor another person currently in charge of providing medical care to the principal, nor indeed the principal himself or herself may act as a *bona fide* witness to this procedure; neither may any illiterate persons, nor any persons with mental or intellectual disabilities who would thus be rendered incapable of understanding and fully appreciating the significance of this legal act. All substitute health care agents should give their respective consent to embracing their function in line with the same principles as the principal agent. Their personal data should be duly recorded, in due consideration of the order of precedence in consecutively discharging their statutory duties, as implied by the terms of the originally granted medical power-of-attorney.

The preferred manner of appointing a health care agent is through a written statement endorsed by 2 witnesses. The verbal form endorsed by the 2 witnesses is available to persons unable to read or write, regardless of the actual cause of their condition. A written power-of-attorney should be drafted by the principal and duly signed off both by the principal and the 2 witnesses. The verbally granted power-of-attorney should be immediately recorded by one of the witnesses, and then also duly signed off both by the witnesses and the principal, provided he or she is capable of doing so. A computer printout, also rendered in Braille, is also admissible, subject to being duly endorsed by the handwritten signatures, or the electronically certified ones. Any such a power-of-attorney must also be duly dated. Both the principal, as well as any of the appointed health care agents, should hold an original copy of the power-of-attorney accompanied by the agent's written consent to embrace this function.

Attendance of the witnesses facilitates effective verification of the patient's condition upon granting the medical power-of-attorney. Neither the attending physician nor a nurse, nor another

person currently in charge of providing medical care to the principal, nor indeed the principal himself or herself may act as a *bona fide* witness to this procedure; neither may any illiterate persons, nor any persons with mental or intellectual disabilities who would thus be rendered incapable of understanding and fully appreciating the significance of this legal act.

The medical power-of-attorney is valid without registration immediately after the sign-off. Before a medical power-of-attorney may be deemed legally valid in a specific medical situation, an attending physician must be prior familiarized with its terms. Copies of a medical power-of-attorney accompanied by a health care agent's consent to embrace his or her function should duly be enclosed with the patient's medical history files. The attending physician who had first been shown the document and then had it enclosed with the patient's medical documentation, should also have it electronically registered in the patient's medical records, should such documentation be routinely maintained. The electronic system of medical records should actually facilitate the possibility of self-registration of any such a medical power-of-attorney, be that by the principal or by the agent, subject to the inclusion in the electronic records of the copies of both a medical power-of-attorney and the agent's consent to embrace this function.

The medical power-of-attorney comes into effect when the patient (principal) becomes incapable of any decision-making on his or her own behalf. A health care agent should be empowered to represent the principal also upon his or her momentary incapacity to do so on his or her own behalf, that is, making informed and free decisions. The very concept of holding the medical power-of-attorney pertains to chronic medical conditions, but for the sake of convenience in everyday medical practice, it also seems highly advisable to admit the possibility of making such representations on patients' behalf in all medical circumstances (also those of a transient character), whenever patients remain unable to make any decisions on their own behalf.

It should be down to the attending physician to assess on medical grounds whether there are sufficient reasons for making representations on behalf of the patient by a health care agent, whilst taking into consideration objective medical and psychological constraints, very much like in the situation of acquiring consent to a specific medical procedure, which should be duly recorded in the patient's medical documentation.

The medical power-of-attorney would come into effect also when the patient (principal) expresses his or her wish not to be advised on the health status and indicates the health care agent as a *bona fide* decision-maker in this regard. The patient's autonomy is then fully respected, should the patient not wish to be informed about his or her health condition, and consequently cannot make decisions in matters of life and health, as any decisions regarding medical procedures or

interventions may be expressed by the patient only on the condition that he or she has previously been comprehensively informed of their nature, as well as fully appreciates all attendant implications for himself or herself (ie, informed consent). A health care agent becomes active when the patient (principal) advises the attending physician that he or she so wishes, and stops acting on behalf of the patient, when the patient, whilst acting with full discernment, wishes to make an informed decision.

The scope of the health care agent's prerogatives does not exceed the patient's (principal's) own. The attending physician is legally bound by the agent's opposition to a proposed medical procedure; nevertheless, the physician remains under no obligation to implement any medical treatment proposed by the agent that he or she should disagree with on medical grounds. The decision granting consent to the implementation of a specific medical intervention, or an objection to it, as expressed on the patient's behalf by a health care agent, is deemed valid, as if it were the patient's own.

In the event that a health care agent should be opposed to a certain medical procedure, there is no option available to appeal to a court of law for a substitute consent (which does not exclude the possibility of carrying out a judicial review over the manner in which a particular health care agent discharges his or her prerogatives and obligations). This approach fully upholds the patient's autonomy.

A health care agent is a decision-maker with regard to the patient's medical matters only, and does not carry out any hands-on caregiving duties. This is a legal construct fully consistent with the underlying concept of a medical power-of-attorney. A health care agent would be liable to the principal only in the circumstances when he or she should make any misrepresentations on the principal's behalf (ie, tantamount to acting against his or her will), whereby the principal might be put to some detriment. The agent does not pursue any caregiving functions, nor does he or she become a guarantor of the principal's health and life. Consequently, the agent cannot be held legally liable, should he or she in any way fail in discharging his or her duties, especially the agent cannot be held legally liable, should he or she object to introducing a life-saving/life-sustaining therapy for the patient (so as to avoid the pursuit of any persistent therapeutic management), unless the attendant circumstances should make it clear that the agent has done so against the principal's will.

A health care agent may not make any decisions with regard to any matters already expressly resolved in the patient's previous statements of intent. Any written statements previously made by the patient are deemed to take precedence over the will of a health care agent, which only goes to show the respect due for the autonomy of the former. Polish legislation currently in place does not explicitly provide for prior declarations of

intent regarding medical procedures. In the light of the case law of the Supreme Court, there is no impediment to the recognition of any such statements as valid consent, or objection to specific medical treatment, even though it would seem prudent to have crystal-clear regulations introduced.<sup>15</sup> All prior statements of intent made by the patient are therefore fully binding for his or her health care agent.

The term of a medical power-of-attorney should be in full conformity with the patient's will, as duly indicated in its provisions. Both kinds of medical power-of-attorney, that is, those granted for an unlimited period of time (as very comfortable for the patients), and those issued for a specifically stipulated period of time, should be deemed equally admissible. The type of empowerment granted to a health care agent should actually depend upon the patient's will. A health care agent whose empowerment has expired after the principal has already lost his or her capacity to have it extended, should therefore be invested with the right to petition a court of law to have himself or herself duly established as a medical curator for the former principal (ie, a person vested with the same prerogatives as a health care agent, although not appointed by the same principal, but by a court of law instead).<sup>15</sup>

A medical power-of-attorney is subject to be revoked at any time, both by the principal and the health care agent who may resign his or her function. It is vitally important, though, that any third parties concerned, including the attending physicians, should be advised accordingly. The actual form of revocation should be left fully optional to the parties, as well as should be left open to both the principal and health care agent. If any such a medical power-of-attorney has already been registered in the patient's medical records, the party revoking it should ensure that appropriate information on it having been revoked has also been put there for general reference. Otherwise, it must be presumed, in the absence of any evidence to the contrary, that the said medical power-of-attorney still remains valid.

In the case of a health care agent remaining inactive with regard to his or her brief, or in any situations whereby his or her actions remain contrary to the best interests of the principal, the attending physician should advise a pertinent court of law accordingly, which may in due course have an agent dismissed. Recommendation No. 11 requires the introduction of specific regulations providing for supervision over the way a health care agent discharges his or her duties.<sup>16</sup> In the case of a health care agent with whom no communication can effectively be established, or who fails to make any decisions regarding the medical treatment offered to the principal, or when in the attending physician's view the agent's actions remain contrary to either the will or the wellbeing of the principal, the attending physician should advise a pertinent court of law accordingly.

In line with any such official notification, a court of law should be obligated to instigate the proceedings aimed at making an objective, comprehensive assessment of the agent's actions, being in a position to have the agent dismissed, should the assessment prove unfavorable, whilst appointing in his or her place a medical supervisor. At the same time, a court of law should be obligated to appoint a medical supervisor for the patient at issue immediately after the receipt of a formal notification. A medical supervisor should be appointed for the patient for the duration of the court proceedings, so as to preclude a situation whereby no person is legally capable of any medical decision-making on behalf of the patient, or that the existing health care agent continues to exercise his or her prerogatives on the patient's behalf despite having previously acted in open contravention of the best interests of the patient.

**Conclusions** The basic rationale for the endeavors pursued by the Polish Working Group for the End-of-Life Ethics with the aim of introducing into the Polish legislation the institution of the health care agent consisted in safeguarding the interests and the rights of the persons incapable of making informed decisions with regard to their own health, or giving up their decision-making prerogatives in that regard (or waiving their right to be provided with pertinent information on their health status to enable any such decision-making endeavors on their part).

The need to exercise relevant decision-making prerogatives with regard to one's health condition stems from a vast range of presently available medical interventions of varying effectiveness. It is for this reason precisely that there should always be a person or an institution that would be capable of making such decisions on behalf of an incapacitated patient. The presently proposed solution is well anchored in basic respect for every person's right to decide their own destiny, and is reflected in granting every person the right to ensure that it is that person, and not someone else, who can appoint an agent who would then represent that person's best interests and espouse their values, whilst deferring to their outlook.

We subscribe to the view that it is the patient who actually knows better than anyone else, or any institution, who would be best suited to represent his or her vital interests in any matters related to medical care. The proposed solution does not introduce any obligations to have a health care agent appointed. Making it a legally viable option, though, should effectively increase the chances for making medical decisions in the patient's best interest.

**Contribution statement** Each author certifies that he or she has participated sufficiently in the intellectual content, analysis of data, if applicable, and the writing of the manuscript to take public responsibility for it. Each author has reviewed the final version of the manuscript,

believes it represents valid work, and approves it for publication.

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# Pełnomocnik medyczny w Polsce – stanowisko Polskiej Grupy Roboczej ds. Problemów Etycznych Końca Życia

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- 6 Zakład Medycyny Paliatywnej, Gdański Uniwersytet Medyczny, Gdańsk, Polska
- 7 Katedra Prawa Karnego, Zakład Bioetyki i Prawa Medycznego, Wydział Prawa i Administracji, Uniwersytet Jagielloński w Krakowie, Polska
- 8 Collegium Bobolanum, Papieski Wydział Teologiczny w Warszawie, Warszawa
- 9 Instytut Filozofii, Uniwersytet Kardynała Stefana Wyszyńskiego w Warszawie, Warszawa
- 10 Zakład Bioetyki i Humanistycznych Podstaw Medycyny, Warszawski Uniwersytet Medyczny, Warszawa
- 11 Centrum Opieki Paliatywnej im. Hildegardy, Bazylea, Szwajcaria
- 12 Instytut Ekologii i Bioetyki, Uniwersytet Kardynała Stefana Wyszyńskiego w Warszawie, Warszawa

## SŁOWA KLUCZOWE

kompetencje  
decyzyjne,  
pełnomocnik  
medyczny,  
podejmowanie decyzji  
medycznych

## STRESZCZENIE

**WPROWADZENIE** W wielu krajach powstały uregulowania prawne umożliwiające obywatelom powoływanie osób uprawnionych do podejmowania w ich imieniu decyzji medycznych wówczas, gdy sami utracą zdolność do takiego działania.

**CELE** Celem pracy było przygotowanie projektu regulacji prawnych ustanawiających w Polsce instytucję pełnomocnika medycznego.

**PACJENCI I METODY** Niniejszy dokument powstał w oparciu o 6 warsztatów podsumowujących pracę ekspertów oraz debaty internetowe.

**WYNIKI** Uprawnienie do ustanowienia pełnomocnika medycznego powinno dotyczyć osób posiadających pełną zdolność do czynności prawnych oraz małoletnich od 16 rż. Każda nieubezpieczona osoba dorosła mogłaby zostać pełnomocnikiem medycznym. Możliwe powinno być także powoływanie pełnomocników substytucyjnych. Pełnomocnictwo zaczynałoby obowiązywać z momentem utraty przez mocodawcę kompetencji decyzyjnych lub z momentem wyrażenia woli o nieinformowaniu o stanie własnego zdrowia. Pełnomocnik medyczny podejmowałby decyzje w sprawach związanych z postępowaniem medycznym, ale nie miałby obowiązku pełnienia funkcji opiekuńczych wobec pacjenta. Czas obowiązywania pełnomocnictwa powinien być dowolny, a odwołanie pełnomocnictwa lub rezygnacja z funkcji pełnomocnika medycznego możliwe w każdym czasie. Przy braku działania pełnomocnika albo, gdy jego działanie wydawałoby się sprzeczne z interesem mocodawcy, lekarz prowadzący powinien zawiadomić sąd, który może pełnomocnika odwołać.

**WNIOSKI** Powołanie instytucji pełnomocnika medycznego umożliwia każdemu obywatelowi samodzielne uprzednie wyznaczenie osoby, która w jego opinii będzie najlepiej reprezentowała jego interesy w sytuacji gdyby utracił zdolność do podejmowania decyzji medycznych.

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