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Conflicts of Doctor's Duties in the Case of an Extreme Shortage of Intensive Care Beds and the Good Samaritan Clause from the Perspective of Criminal Law

Abstract: The Covid-19 pandemic has exposed many weaknesses of healthcare systems. An example of a crisis situation is the case of a doctor who has to make a decision about qualifying a patient with COVID-19 for an intensive care bed when there are not enough such beds and when, out of the many obligations to save lives, he can choose and fulfil only one. The aim of this paper is to analyse the criteria of establishing the priority in access to intensive care, to settle the conflict of obligations in regard to criminal liability, with respect to Art. 26 § 5 of the Polish penal code regarding the doctor's decision to provide, or to not provide, healthcare services including intensive care given the extreme shortage of the beds, to determine the scope of legal safety guarantees laid down in the good Samaritan clause and the relationship between the conflict of duties and the clause. The work is theoretical with the use of a formal-dogmatic and functional analysis of Polish criminal law.
Keywords: criminal responsibility, intensive care, prioritising, rationing, triage

Introduction

Due to the Covid-19 pandemic, it has become necessary to redefine many social interests and relations and, in consequence, to adapt to the present situation the scope of their criminal law protection. Among other things, it has exposed many weaknesses of healthcare systems, including the Polish health care system. Its variable course, which is only partly predictable, forces each legislative body to regulate the ways and means of controlling the spread of SARS-COV–2, and its death toll, in a swift but rational manner. However, such regulations are not always sufficient.

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Healthcare professionals have found themselves at the very centre of the fight against the pandemic, taking personal risks and working at the "Covid wards" with the highest commitment. When discussing the risks, one cannot mean only the potential for catching the infection, as the decisions the doctor takes regarding the patient care can be subject to assessment with regard to criminal law, which exposes the doctor to liability. The care for the patient's life and health is intertwined with the need to keep one's conduct within the limits provided for by the law. A shortage of equipment, including personal protection equipment and – most importantly – medical personnel, creates situations when such boundaries are relatively easily crossed. It is extremely important to guarantee legal safety to people who take decisions on human life and health on a daily basis when it is under constant threat.

Among the drawbacks of the Polish healthcare system, which have become manifest in the current situation, there is the lack of sufficient regulations (laws, standards, guidelines) regarding different areas of healthcare, including public health. Healthcare professionals seem to be concerned about the lack of sufficient guarantees regarding the exclusion of the criminality of an act in the event of a conflict of duties when only one can be fulfilled at a time. Intensive care (IC) is one of the clearly "underregulated" areas of healthcare in Poland.

Examples of crisis situations include desperate doctors in Italy, and Spain, who – faced with an insufficient number of ventilators – had to decide which of the patients would be given a chance to survive. In the face of such experiences, healthcare professionals in Poland demanded from the first months of the pandemic that doctors should be given regulatory support rather than left to themselves and being forced to rely only on their individual "conscience"[1]. In an attempt to meet their expectations, and fearing a similar scenario in Poland, the Polish authorities introduced the "good Samaritan clause", but – for many reasons – it does not provide a full guarantee of the legal safety to healthcare professionals who have to make tough decisions regarding the protection of human life and health.

The absence of a consistent system of regulations justifies an attempt to analyse the existing legislation concerning the doctor's criminal liability if he or she has to take a decision to qualify a COVID-19 patient for intensive care when there are not enough beds and when, out of the many obligations to save lives, a doctor can choose and fulfil only one.

1 W. Galewicz, O potrzebie sformułowania wytycznych na wypadek dramatycznego niedostatku zasobówratujących życie w polskich oddziałach intensywnej terapii: Wprowadzenie do dyskusji, (in:) Intensywna terapia w warunkach kryzysu, Interdyscyplinarne Centrum Etyki UJ (INCET), „Debata" 2020, DOI: 10.26106/BWDC-A853, p. 2; F.R. Trabucco, The COVID -19 Post – lockdown Italian Scenario from an Eco – Socio – Legal Perspective, "Białostockie Studia Prawnicze" 2020, vol. 25, no. 3, pp. 99–116.

The aim of this paper is to analyse the criteria of establishing the priority in access to intensive care, to settle the conflict of obligations in regard to criminal liability, with respect to Art. 26 § 5 of the penal code regarding the doctor's decision to provide or to decline to provide healthcare services including intensive care given the extreme shortage of the beds, to determine the scope of legal safety guarantees laid down in the good Samaritan clause and the relationship between the collision of duties and the clause.

Therefore, the analysis is based on two research problems:

1) What are the leading criteria for determining the priority of access to intensive care in the event of an extreme shortage of equipment and medical personnel during an epidemic? and
2) Does the Good Samaritan clause replace the general institution of a conflict of duties specified in Art. 26 § 5 of the penal code?

Two hypotheses were formulated for such research problems:

1) Only medical criteria may be used to assess the priority in providing a medical service in the above-mentioned situation and
2) the Good Samaritan clause cannot replace the general structure of the conflict of duties.

The formal-dogmatic method and the functional method coupled with it (in the integration model) were used in the work[2]. The first was used to reconstruct the norms on the basis of the provisions of applicable law in the field of the conflict of duties and the so-called the Good Samaritan clause, and the second for the legal and ethical assessment of the facts relating to the normalized area of social life, which is the issue of the doctor's criminal liability for failing to provide assistance to the patient in the event of an extreme shortage of intensive care beds.

1. Criteria of Establishing Priority of Access to Intensive Care in COVID-19

The epidemic situation in many countries has necessitated discussions and decisions regarding the priorities and rationing (in the language of economics and bioethics – allocation) of medical technologies. Prioritising denotes establishing the priority in access to resources for specific individuals (groups of individuals), rationing – restriction of access to scarce goods, and allocation – distribution of material resources assigned for specific purposes[3].

2 D. van Kędzierski, Metodologia i paradygmat polskich szczegółowych nauk prawnych, "Transformacje Prawa Prywatnego" 2018, no. 3, p. 59.

3 J. Pawlikowski, Etyczny wymiar decyzji priorytetyzacyjnych i alokacyjnych dotyczących stosowania zaawansowanych technologii medycznych w kontekście pandemii COVID-19,

All activities associated with prioritisation and rationing of medical resources is sometimes called "triage". It is a procedure of patient segregation, originating in military medicine, where it was applied in the categorisation of the wounded; it is now conducted in rescue medicine and disaster handling. The pandemic necessitates the segregation of patients with indications for intensive care, in particular for access to mechanical ventilation, *i.e.*, allocation of ventilators. This is often tantamount to the choice between life and death. The egalitarian criteria are replaced by utilitarian criteria in an epidemic situation, as the latter provide an opportunity for a beneficial effect of intensive care[4], which is controversial, to say the least.

The utilitarian criteria include the patient's age as an isolated factor. Taking a decision based only on the patient's age is tempting, as this criterion does not usually require any special verification, but it is deeply unethical as a manifestation of age discrimination. Indeed, the patient's age also affects their health status, their weaker immune response, comorbidities and the body's regeneration capabilities. Prioritisation based solely on the age criterion without a comprehensive evaluation of the patient's health status should be strongly opposed.

Another utilitarian criterion is one related to the patient's social value[5], which – unlike the previous criterion – is not associated with the patient's health status. It involves an assessment of the patient's social usability, performing a specific profession or a significant role in the community. It seems contrary to the principles of egalitarianism, although, in a specific situation of a threat to the life of a public, widely respected person, or simply a popular figure, it is difficult to imagine that it would be disregarded. The doctor's motives regarding their individual decision must be taken into consideration, whereas giving this criterion an official form has to be opposed. It is deeply unethical and downright unconstitutional. The application of the aforementioned criterion, due to the fact that it would lead to the objectification of a human being, would not only obviously violate the constitutional principle of equality, but would also, in an unacceptable manner, violate the expressed in Art. 30 of the Basic Law the principle of protection of inalienable and inherent human dignity, prohibition of discrimination under Art. 32 (2), and the order to protect the life of every human being expressed in art. 38 of the Polish Constitution[6].

"Medycyna Praktyczna" 2020, no. 4, https://www.mp.pl/etyka/terapia_chorob/231724,etyczny-wymiar-w-kontekscie-pandemii-covid-19 (21.06.2021).

4 A. Kübler, Stanowisko w sprawie racjonowania intensywnej terapii w sytuacji niedoboru zasobów ratujących życie, (in:) Intensywna …, *op. cit.*, pp. 9–10.

5 Report by Semicyuc Los Profesionales del Enfermo Crítico: Recomendationes éticas para la toma de decisionesen la situación excepcional de crisis por pandemia COVID-19 en las unidades de cuidados intensivos, p. 12, www.semicyuc.org (21.06.2021).

6 Konstytucja Rzeczypospolitej Polskiej z dnia 2 kwietnia 1997 r. (Dz.U. z 1997 r., Nr 78 poz. 483 ze zm.).

However, in an extreme situation, a situation may occur in which the priority in access to a health service should be granted to healthcare professionals, given their insufficient number.

An assessment of the legal and factual situation in Poland leads one to the conclusion that the "first come, first served" rule is a common, although not too ethical, priority criterion. It arises if only from Art. 20 (1) of the Act on health services financed from public funds of 27 August 2004, which states that providing healthcare in hospitals, specialist services in ambulatory healthcare, and in-patient and 24-hour health services other than hospital-based ones are provided on the "first come, first served" basis on the days and at a time when they are provided by the service provider, which has concluded an agreement for healthcare service provision[7]. It is obvious that this criterion favours patients who live close to healthcare facilities, while it discriminates against those who live a long way from hospitals.

According to medical ethics, prioritisation should be based only on medical criteria, *i.e.*, those arising from the need to apply a given technology and its predicted positive effects (benefits) for the patient's life and health[8]. Therefore, aid should be given first to those for whom it is necessary to survive, and those with the greatest chances for survival should be selected from among this group. In an epidemic or mass disaster situation, the scope of aid should be minimised so that as many people as possible should be able to use it[9].

When establishing priority in access to intensive care in COVID-19, one can consider only expected short-term benefits for the patient, as the delayed effects of the disease are still unknown. The medical criteria should provide the basis for assessment of the opportunities and benefits and, therefore, in establishing the priorities in access to medical procedures. Adopting the medical criteria as the basis is a burden for doctors, who must make such decisions based on scientific research and clinical studies[10].

Decisions to refuse mechanical ventilation, or to abandon such treatment, are without doubt the most dramatic as they usually mean the choice between life or

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7 Ustawa z 27.08.2004 r. o świadczeniach opieki zdrowotnej finansowanych ze środków publicznych (Dz.U. z 2019 r. poz. 1373 ze zm.).

8 In the World Medical Association's (WMA) Declaration of Lisbon on the Rights of the Patient (1981), we read: "In circumstances where a choice must be made between potential patients for a particular treatment that is in limited supply, all such patients are entitled to a fair selection procedure for that treatment. That choice must be based on medical criteria and made without discrimination", point 1e, https://www.wma.net/policies-post/wma-declaration-of-lisbon-on-the-rights-of-the-patient (21.06.2021).

9 K. Marczewski, Rozważania o etyce medycznej czasu wojen i katastrof, (in:) K. Marczewski (ed.), Notatki do ćwiczeń z etyki medycznej, czyli jak i po co odróżniać eutymię od eutanazji, Lublin 2003, pp. 305–310.

10 P.G. Nowak, Terapia daremna i racjonowanie opieki w dobie kryzysu. Dlaczego niektórych pacjentów należy odłączać od respiratora?, (in:) Intensywna …, *op. cit.*, p. 37.

death of the patient. At the same time, the decision to initiate the treatment engages the technical resources for several weeks, which excludes their use for the benefit of other patients, and the dynamics of the situation and the size of the population whose lives are threatened require quick decisions. As P.G. Nowak rightly claims, that – psychologically – a decision to refuse treatment is easier than one to discontinue it, which emphasises the importance of the preliminary assessment and the need to develop algorithms with proper procedures[11].

Regarding the possibility of taking a decision to disconnect a patient from the ventilator, two positions can be noted in the legal and medical doctrine. According to A. Paprocka-Lipińska, no legal or ethical regulations are in force in Poland which would provide the basis for a decision to disconnect the patient from a ventilator, except when the patient is confirmed to be brain dead[12]. A different opinion is presented by A. Kübler, who claims that withdrawing futile therapy, including therapy with a ventilator, can have "(...) a form of withholding, or not implementing a new treatment, or failure to increase the intensity of the treatment method already applied, or withdrawing the applied treatment"[13]. In another text, the author and co-workers claim that the ventilator treatment was withheld in the case of one patient[14].

This is the place where the issue of futile therapy should be brought up. It is a therapeutic procedure which brings no benefit to the patient or a situation when the burden far exceeds the progress in therapy – it is a known situation in contemporary medicine. In practice, this term usually applies to life-sustaining treatment. Intensive care is an area where futile therapy is so common because the vital functions of the body are so easily maintained. As a result, maintaining the blood circulation, breathing, or kidney function becomes the purpose in itself, without a defined direction of the therapy in line with the patient's interest. The organ function can be maintained to avoid a confrontation with the family till the end of the doctor's duty time or until someone else takes over the responsibility for the patient, *etc*. This has nothing to do with good clinical practice or with the principles of medical ethics, or with the general ethical principles, *e.g.*, arising from Christian ethics. A. Kübler claims that, given the shortage of life-saving resources in intensive care units, futile therapy becomes extremely harmful in that it restricts access to intensive treatment for patients with actual chances for survival dramatically[15].

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11 *Ibidem,* p. 37.

12 A. Paprocka-Lipińska, Głos w debacie, (in:) Intensywna …, *op. cit*., p. 13.

13 A. Kübler, J. Siewiera, G. Durek, K. Kusza, M. Piechota, Z. Szkulmowski, Guidelines Regarding the Ineffective Maintenance of Organ Functions (Futile Therapy) in ICU Patients Incapable of Giving Informed Statements of Will, "Anaesthesiology Intensive Therapy" 2014, no. 46(4), pp. 215–220; (Polish version: "Anestezjologia Intensywna Terapia" 2014, no. 46(4), pp. 229–234.

14 P.G. Nowak, Terapia …, *op. cit*., p. 36.

15 A. Kübler, Stanowisko…, *op. cit*., p. 8.

The ability to take a decision to withdraw futile therapy and extraordinary measures in terminal states based on an assessment of the therapeutic chances is also provided for by the Medical Ethics Code (Art. 32). It does not release the doctor from the duty to make an effort to provide the patient with humanitarian terminal care and conditions of dignified death or to care about the quality of the last moments of the patient's life (Art. 30)[16].

It is understandable in the current, exceptional, situation that applying IC, especially mechanical ventilation, can be regarded as an extraordinary measure, from which one can withdraw if it gives no benefits, replacing it with ordinary measures and palliative care. However, treatment at intensive care units (ICUs) in other circumstances, when the shortage of life-saving equipment is not so severe, can be part of the standard of care treatment. These comments also apply to the Extra Corporeal Membrane Oxygenation (ECMO), which should also be regarded as an extraordinary measure due to the novelty of the technology, its cost, limited availability, a small practical experience, and a limited number of personnel skilled in its use[17].

Some solutions taken from the Italian, and Spanish guidelines are worth quoting, which provide criteria for using mechanical ventilation and hospitalisation at intensive care units, with three characteristic levels taken into account, such as:

- "micro" level – prioritising and rationing as a result of the doctor's individual decision regarding the application of specific medical technologies;
- "meso" level – rational allocation during the epidemic as a result of the hospital management's decision to deploy personal protection or specialist equipment between the emergency department, infectious disease ward, intensive care unit, and
- "macro" level – referring to the national government's decision to create a network of infectious disease hospitals, subsidising and providing specialist equipment to selected centres, and determination of the population to be tested for the presence of the virus.

These guidelines also took into account important ethical issues concerning the withdrawal of extraordinary measures and futile therapy, respecting the autonomy (the patient and their relatives co-deciding whether the therapy should be continued or abandoned, taking decisions "not to intubate" and the obligation to justify and document them, and to communicate them to the patient and to their relatives), taking decisions jointly and their being open to verification, gradation of advanced

16 Uchwała Nadzwyczajnego II Krajowego Zjazdu Lekarzy z dnia 14 grudnia 1991 r. w sprawie Kodeksu Etyki Lekarskiej podjęta na podstawie art. 33 pkt 1 w związku z art. 4 ust. 1 pkt 2 ustawy z dnia 17 maja 1989 r. o izbach lekarskich (Dz.U. Nr 30, poz. 158, z 1990 r. Nr 20, poz. 120).

17 Extracorporeal Life Support Organization (ELSO): Guidance Document: ECMO for COVID-19 patients with severe cardiopulmonary failure, http://elso.org/covid19 (21.06.2021).

medical technologies applied in the ICU, and taking into account the interest of other patients waiting for help (not only those with COVID-19 symptoms, but also those with other diseases requiring immediate intervention, hospitalisation, and intensive care)[18].

There are no such detailed recommendations in Poland. It is noteworthy that the difficulty of taking an individual decision by the doctor on the micro-level depends on the way organisational decisions are taken regarding technological and human resources on the meso-level, which, in turn, depend on the government decisions on the macro-level. The widely adopted life-saving procedures and guidelines regarding withdrawing futile therapy in standard situations can be helpful in such decisions to some extent, but they require at least an attempt to supplement them[19]. According to guidelines, withdrawing life-sustaining therapy cannot depend on "organisational aspects (*e.g.*, vacating an intensive care bed for another patient)"[20]. Therefore, the organisation must provide for the need to supply more IC beds and, further, for using the hospital network to which a patient can be transported. This organisational mechanism has to be very precise and discussed in advance. Otherwise, an "organisational fault" may occur, which lies with the healthcare provider[21]. Organisational negligence creates an immediate threat to human life and health[22]. A doctor who takes an individual decision is not to blame for this threat, which may create a collision of duties which must be settled on the basis of criminal law.

2. Settling a Conflict of Doctor's Duties in the Case of an Extreme Shortage of Intensive Care Beds in Light of Art. 26 § 5 of the Penal Code

The starting point for assessing the legality of a doctor's behaviour in a specific case is the pattern of a rational (using the available knowledge, skills, organizational possibilities, and tools) representative of a given medical profession. It allows to rationally determine the legality of an act, even before the stage of examining the implementation of the statutory features of crimes related to failure in treatment. It is not always the case in question that the statutory criteria of a crime are realized and then it is not possible to speak of an attack on the object of protection at all. A doctor's

18 J. Pawlikowski, Etyczny…, *op. cit*.
19 J. Suchorzewska, Głos w debacie, (in:) Intensywna …, *op. cit*., p. 17.
20 A. Kübler, J. Siewiera, G. Durek et al., *op. cit*., s. 231.
21 A. Paprocka-Lipińska, Głos w debacie, (in:) Intensywna …, *op. cit*., p. 14.
22 M. Werbel-Cieślak, Kolizje obowiązków i wina organizacyjna na tle nieumyślnego spowodowania uszczerbku na zdrowiu – art. 156 §2 k.k. (case study), (in:)W. Cieślak, J.J. Zięty, M. Romańczuk-Grącka (eds.), Glosator Warmiński. Olsztyńskie miniatury. Z zagadnień stosowania prawa, Olsztyn 2021, pp. 65–76.

procedure with the good of the patient's health and life based on medical knowledge and the objective availability of treatment measures is then completely legal.

Only when the chosen method of treatment is considered excessively risky (unacceptable), will it be possible to establish the unlawfulness of the doctor's behaviour. However, for the assignment of criminal liability, it will be necessary to demonstrate that other elements of the offense structure have also been realised[23].

For example, in terms of assessing the implementation of the statutory features of crimes, the deficit of knowledge about the treatment, course, and consequences of COVID-19 makes it difficult to demonstrate a normative relationship between a medical error and the effect of a prohibited act. In order to assign the characteristics of the subjective side (assuming that it is an unintentional crime) it is necessary, *inter alia*, to demonstrate that the caution required under "given circumstances" was not observed (Art. 9 § 2 of the penal code). Therefore, also in this case, the circumstances generated by the pandemic influence the assessment of the medic's action. A reference can also be made to an open clause of guilt in Art. 1 § 3 of the penal code, and any criminal responsibility can be excluded because of an abnormal motivational situation.

Only in the last place, in order to exclude criminal liability, one should refer to the circumstances of the secondary exclusion of the offense of an act (fault and unlawfulness), such as *error facti*, *error iuris* and error as a circumstance excluding unlawfulness or blame, state of necessity, conflict of duties, or the Good Samaritan clause that has been specially designed for this purpose[24].

Each of the above-mentioned circumstances requires a separate analysis, but due to the limited framework of the study, it is not possible for all of them. The last two of the above-mentioned ones will be discussed, which results from the subject of this work defined in the same way.

If a person has duties that cannot be fulfilled simultaneously, one cannot be obligated to fulfil them at the same time. Therefore, it should be assumed that the person has only one duty to fulfil. A person to whom a legal norm applies cannot be required to take actions that are impossible to perform (*impossibilium nemo obligatur/ultra posse nemo obligatur*)[25].

The most general criminal law construction based on which the criminal responsibility of a doctor can be excluded in the event of a refusal to perform a healthcare service in the ICU, is a conflict of duties specified in Art. 26 § 5 of the penal code: "The provisions of § 1–3 are applied accordingly when only one duty

23 S. Tarapata, Problem rozstrzygania prawnokarnej kolizji dóbr w trakcie wykonywania świadczeń zdrowotnych, "Palestra" 2020, no. 6, p. 177.

24 E. Plebanek, Wyłączenie odpowiedzialności karnej za niewłaściwe leczenie w czasie pandemii COVID – 19 a klauzula dobrego Samarytanina, "Palestra" 2021, no. 1, p. 61, 74.

25 S. Tarapata, Problem rozstrzygania … *op. cit.*, p. 177.

out of the several imposed on the offender can be fulfilled". This provision has been raising concerns in the legal doctrine for years. Due to reference to various situations specified in Art. 26 § 1–3 of the penal code, it is a conglomerate of circumstances that make the act illegal (§ 1), place the blame on the offender (§ 2) or make the act punishable (§3). Given the unclear relations between these provisions, it has even been proposed that Art. 26 § 5 of the penal code should be eliminated[26]. In such a case, satisfying results could be achieved by reference only to Art. 26 § 2 of the penal code, according to which whoever rescues any interest protected by law in order to avoid an immediate threat to any interest protected by law, if such a threat cannot be avoided in a different way, sacrifices an interest which does not represent a value manifestly greater than the interest being rescued, he shall be deemed to have not committed an offence.

One may agree that Art. 26 § 5 of the penal code is not particularly necessary, but as it has been introduced to the system, it must not be regarded as *non est*. Only a rational and consistent interpretation of the provision should be introduced[27]. Such an interpretation should start with the phrase "is applied accordingly" included in the provision and juxtaposed with the preceding norms defining the forms of states of necessity. Depending on the relation between the interest sacrificed and the one protected, they exclude the criminal illegality or guilt, which allows for the conclusion that a clash of duties is not a countertype or a situation that excludes guilt, but rather a specific situation that excludes criminal responsibility, whose essence lies in a conflict of norms that specifies the duties[28].

Obviously, such an approach breeds another question, mainly on the number and type of norms that affect the formulation of a duty and the inter-relations between them (two or more norms that impose a duty, a duty to act or to not act, the relationship of equality, superiority or subordination), as well as potential sequences of performing them as a function of time and the criteria for the choice of the duty which should be given priority in a clash situation[29].

As M. Kulik rightly observes, the clash of duties is in fact a clash of certain legal goods. Therefore, it should be assumed that its assessment should take place through the prism of good, the protection of which is served by the duties that remain in the clash. Therefore, in the event of a conflict of obligations regarding the protection of goods of different values, the priority is given to the one that protects the more

26 J. Majewski, Tak zwana kolizja obowiązków w prawie karnym, Warsaw 2002, pp. 240–248; Ł. Pohl, Prawo karne. Wykład części ogólnej, Warsaw 2012, pp. 271–272.

27 S. Tarapata, Problem …, *op. cit*., p. 179.

28 J. Majewski, Tak zwana kolizja … *op. cit*., p. 25; A. Zoll, (in:) A. Zoll (ed.) Kodeks karny. Część ogólna. Komentarz, t. I, wyd. II, Zakamycze, 2004, p. 509; J. Lachowski, (in:) M. Królikowski, R. Zawłocki (eds.) Kodeks karny. Część ogólna. Komentarz do art. 1–31, t. I, , Warsaw 2010, pp. 26–27.

29 M. Werbel-Cieślak, Kolizje …, *op. cit*., pp. 353–355.

valuable. Such a conflict of obligations excludes the unlawfulness of the prohibited act[30].

As in the case of a state of necessity, first of all, the weight of the endangered good and the probability of the damage should be taken into account[31]. As P. Zawiejski rightly emphasizes, therefore, as a rule, life should be saved first, and then health. However, it may happen that the threat to life is minor or distant (rescue may wait) – in this case, priority should be given to protecting health against significant (especially severe) damage. In this context, it is necessary to refer to the thought present in the subject literature, that in the case of goods of equal importance, one should save the good for which the chance of effective rescue is greater. If, however, we are dealing with people exposed to the same danger, it is justified to save the person in relation to whom the chance of saving him is greater (it is easier to reach him or it is better to help him)[32].

Referring to the situation specified at the beginning of this study, in assessing the degree of probability of saving a given person, specialist criteria relating to medical knowledge and the actual state of functioning of the health service should be used. Therefore, the issue of medical prioritisation and rationing is of key importance for the exclusion of a doctor's criminal responsibility.

Looking at the problem of allocating resources or medical equipment in a situation of shortage from the perspective of the theory and doctrine of criminal law, it is easy to find a number of statements on how to solve this type of accidents based on variously constructed rules of priority used to solve cases of conflicts of values and norms, as well as clashes of duties. . In particular, it is indicated that the clash of duties is in fact a clash of goods assessed *in concreto*, to which these duties relate[33].

Taking these criteria into account is to optimize the protection of converging socially and legally significant interests. In a situation of a conflict of duties relating to goods of different importance, the one that protects the good of greater value should be executed. In the case of equal value of legal goods, it is necessary to save the good which has a better chance of being saved[34].

The method of resolving the clash of duties is therefore always entangled in certain philosophical and ethical choices. Therefore, resolving a conflict of obligations

30 M. Kulik, (in:) Kodeks karny. Komentarz aktualizowany, ed. M. Mozgawa, LEX/el. 2021, art. 26.

31 M. Filar, Wyłączenie odpowiedzialności karnej (in:) Nowa kodyfikacja karna. Kodeks karny. Krótkie komentarze, Warsaw 1998, no. 18, p. 31; J. Majewski, Tak zwana kolizja ..., p. 247.

32 P. Zawiejski, Kolizja obowiązków, (in:) T. Dukiet-Nagórska, A. Liszewska, E. Zielińska (eds.), System Prawa Medycznego. Tom III. Odpowiedzialność prawna w związku z czynnościami medycznymi, Warsaw 2021, Lex/el.

33 J. Majewski, Tak zwana kolizja ..., *op. cit*., p. 159; P. Kardas, Konstytucyjne podstawy rozstrzygania kolizji obowiązków i konfliktów dóbr w czasie epidemii, "Palestra" 2020, no. 6, p. 16.

34 A. Zoll, (in:) Kodeks karny. Część ogólna, t. 1, Komentarz do art. 1–52, Warsaw 2016, p. 590.

requires referring to specific optimization directives. With regard to these rules, it is indicated that, in principle, their source may be: a) legal provisions (of different status, both statutory and sub-statutory); (b) principles of specialist knowledge as well as deontological and ethical rules adopted in a given sphere of activity; c) *ad hoc* benchmarks, standards or rules[35]. Medical standards of prioritization and rationing are therefore important criteria for rating goods in resolving clashes of duties.

S. Tarapata rightly claims that it is similar to the rules of conduct concerning the legal interest (principles of caution). The principles of caution are applied to determine the conduct of a personal model of an ideal citizen in a given situation. This figure is used to establish the limits of acceptable risk for a legally protected interest. Meanwhile, the criteria of preference are used to identify the choice regarding the action that should be taken in a given situation that would be made by the average citizen[36].

The author also rightly points out that – like the rules of conduct with the legal interest – the criteria of preference can arise from three sources: a legal act, a different normative act (legal regulations) or agreements (legal sources); from a specific field of knowledge (*e.g.*, medicine); from a specific situation in which they are developed *ad hoc*[37].

A large number of scientific studies regarding control of SARS-COV–2 spread are being conducted, which makes it difficult to provide universal guidelines. They require constant updating, due to which the preference is most often based on the individual knowledge of the doctor who decides *in concreto* to provide or to refuse to provide a specific medical service.

The situation becomes complicated if it is objectively impossible to provide the service at the same time to many people whose health status justifies the use of IC measures. B. Chyrowicz uses the term "moral residuum" to describe such a situation[38]. If a duty is beyond our capabilities, it cannot be morally binding on us, and an assessment of an action should depend on whether its performance lays within our capabilities. The moral residuum dilemma refers to an internal effect of

35 P. Kardas, Konstytucyjne podstawy …*op.cit*., p. 16.

36 S. Tarapata, Dobro prawne w strukturze przestępstwa. Analiza teoretyczna i dogmatyczna, Warsaw 2016, pp. 279–320; S. Tarapata, Przypisanie sprawstwa skutku w sensie dynamicznym w polskim prawie karnym, Cracow 2019, pp. 187–212; K. Lipiński, Wzorce osobowe w prawie karnym, Warsaw 2020, p. 119.

37 S. Tarapata, Problem …, *op. cit*., p. 181.

38 B. Chyrowicz, Głos w dyskusji podczas zebrania naukowego Katedry Prawa Karnego Uniwersytetu Jagiellońskiego na temat: Kolizje obowiązków w medycynie w stanieepidemii, 17.04.2020, https://karne24.com/kolizje-obowiazkow-w-medycynie-w-stanie-epidemii-zebranie-naukowe-i-dyskusja/ (21.06.2021).

an act, the subject's discomfort, which comprises: regret, remorse, or the feeling of guilt[39].

Such discomfort appears not only on the moral or ethical levels, but it raises doubts regarding whether it was legal or illegal. Although formalised guidelines could provide a kind of guarantee of legal safety for the doctor, one should expect non-standard situations, in which failure to follow the guidelines, though rational from the doctor's perspective, could expose them to liability (if only disciplinary)[40]. According to R. Zawłocki, the normative matrix is usually a simplification of a complex reality. A situation in which a doctor finds him- or herself almost never corresponds exactly to the normative state[41]. This opinion is shared by E. Plebanek, who claims that the normativisation of ethical standards creates the danger of it being violated in a non-typical situation[42].

From the legal perspective, the broader the scope of a regulation, the less space for individual decisions. The regulations applicable to intensive care procedures may have been developed without reference to extraordinary situations, but – in the opinion of some doctors – even the epidemic situation does not justify creating "superregulations"[43]. The words of K. Kusza are worth quoting here: "Recommendations and guidelines developed for unpredictable times, for the case of no-one-knows-what war, with an unknown enemy, prepared in a hurry, do not necessarily provide support to those on the front line"[44].

Therefore, how to settle a moral residuum dilemma? According to B. Chyrowicz, emphasis should be shifted from formal rules to a subjective reconstruction of medical knowledge by the doctor *in concreto*. If the decision is rational and taken with a view to saving as many people as possible, it settles the conflict of duties correctly and excludes criminal liability[45]. S. Tarapata also reminds that if no rules of conduct regarding the legal interest are formulated, one should refer to the figure of the good and competent doctor, who makes rational decisions[46].

39 B. Chyrowicz, O sytuacjach bez wyjścia w etyce. Dylematymoralne, ich natura, rodzaje i sposoby rozstrzygania, Cracow 2008, p. 146.

40 W. Wróbel, Pytanie w dyskusji podczas zebrania naukowego Katedry Prawa Karnego Uniwersytetu Jagiellońskiego na temat: Kolizje obowiązków w medycynie w stanie epidemii, 17.04.2020, *op. cit.*

41 R. Zawłocki, Głos w dyskusji podczas zebrania naukowego Katedry Prawa Karnego Uniwersytetu Jagiellońskiego na temat: Kolizje obowiązków w medycynie w stanie epidemii, 17.04.2020, *op. cit.*

42 E. Plebanek, Głos w dyskusji podczas zebrania naukowego Katedry Prawa Karnego Uniwersytetu Jagiellońskiego na temat: Kolizje obowiązków w medycynie w stanie epidemii, 17.04.2020, *op. cit.*

43 A. Paprocka-Lipińska, Głos w debacie, (in:) Intensywna terapia…, *op. cit.*, p. 13.

44 K. Kusza, W odpowiedzi na apel do polskich lekarzy o sformułowanie rekomendacji na wypadek dramatycznego niedostatku zasobów na oddziałach intensywnej terapii, (in:) Intensywna terapia…, *op. cit.*, p. 33.

45 B. Chyrowicz, Głos w dyskusji…, *op. cit.*

46 S. Tarapata, Przypisanie..., p. 191–193; S. Tarapata, Problem …, *op. cit.*, p. 183.

Given the dynamic development of medical knowledge on handling infections with SARS-COV–2, an assessment of whether the rule of priority was applied adequately must be made *ex-ante*. Therefore, if a doctor correctly follows the rule of priority, they cannot be made criminally liable even if the *ex-post* assessment shows that they made a wrong choice[47].

It is also necessary to develop an objective directive on proceeding with good faith referring to the figure of a model doctor. If a model doctor in conditions of knowledge and equipment deficit would use a given device or apply a specific method, assessing it *ex ante* as acceptable, then such a procedure should be considered legal. The model doctor is not a uniform figure. High specialization within the profession, as well as dividing the medical education process into stages, forces the diversification of the pattern. It seems that it is necessary to distinguish between the standards of a specialist and non-specialist physician (criterion of the type of specialization) or a specialist and trainee physician (criterion of the education stage). This issue is important because the epidemic situation may involve the need to redirect doctors of other specializations to work in infectious or intensive care units. As part of their work, they will have to make decisions in the field of therapy, which they do not have in-depth knowledge of[48].

If the doctor did not violate the norm of Art. 26 § 5 of the penal code, *i.e*., performed only one of the duties imposed on them in the conflict situations presented above, their criminal liability – as long as they focused on protecting the interest whose value is obviously lower than that of the sacrificed one – should be excluded, even if the choice criteria were contested from the point of view of their optimisation based on ethical, praxeological or economic grounds[49].

3. Good Samaritan Clause

The Good Samaritan clause is contained in Art. 24 of the act amending some acts in relation to preventing the crisis situations associated with COVID-19 of 28 October 2020[50]. According to the clause, a person does not commit the offence mentioned in Art. 155 of the penal code (causing death unintentionally), Art. 156 § 2 (causing a crippling injury unintentionally), Art. 157 § 3 (causing a bodily injury or impairment to health unintentionally) or Art. 160 § (exposing another person

47 S. Tarapata, Problem …, *op. cit*., p. 183.

48 D. Zając, Modyfikacja reguł sztuki lekarskiej w czasach epidemii Covid – 19, "Palestra" 2020, no. 6, pp. 105–106.

49 J. Giezek, Kolizja obowiązków spoczywających na pracownikach opieki medycznej w dobie pandemii COVID-19, "Palestra" 2020, no. 6, pp. 29–50.

50 Ustawa z dnia 28.10.2020 r. o zmianieniektórychustaw w związku z przeciwdziałaniem sytuacjom kryzysowym związanym z wystąpieniem COVID- 19 (Dz.U. poz. 2112 ze zm.).

to danger unintentionally) if this person, during a state of pandemic threat or a pandemic state, when providing health services under the Act on the profession of physician and dentist of 5 December 1996[51], the Act on the profession of paramedic of 20 July 1950[52], the Act on the profession of nurse and midwife of 15 July 2011[53], the Act on State Medical Rescue Service of 8 September 2006[54] or the Act on prevention and controlling infections in humans of 5 December 2008 as part of preventing, diagnosing, or treating COVID-19, and acting in extraordinary circumstances committed an offence, unless the effect was a consequence of a gross failure to exercise caution in those circumstances.

This regulation was intended to introduce to the Polish legal system a measure aimed at protection against criminal responsibility for some acts of healthcare professionals during the COVID-19 epidemic because of a higher risk of making a mistake in this specific situation. The Good Samaritan clause is of considerable importance for healthcare professionals. However, it has some gaps.

Limiting the clause only to offenders providing medical services related to the diagnosis or treatment COVID-19 is too narrow an approach. The COVID-19 pandemic has caused a disturbance in the whole healthcare system. One should not differentiate between the situation of these individuals and those diagnosing or treating COVID-19 from the perspective of the penal code[55]. It should be noted that a conflict of duties can also apply to patients who are not infected with SARS-COV–2. Given the currently restricted access to healthcare services, doctors attending to patients dying from a heart attack or another cardiological disease are unaffected by this regulation[56]. Regarding the scope of the clause, it leaves out laboratory diagnosticians for unknown reasons. They take actions related to diagnosing COVID-19, so they can certainly face special circumstances which justify a violation of the principles of caution.

It is not clear whether the clause excludes the illegality of an act or the guilt. According to J. Potulski[57], this is a countertype. M. Kwiatkowska[58] and P. Bielska-Siudzińska[59] are of a similar opinion. This is certainly supported by the reference to

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51 Dz.U. z 2020 r. poz. 514, 567, 1291 i 1493.

52 Dz.U. z 2018 r. poz. 2150 oraz z 2020 r. poz. 1291.

53 Dz.U. z 2020 r. poz. 562, 567, 945 i 1493.

54 Dz.U. z 2020 r. poz. 882 i 2112.

55 P. Zawiejski, Tak zwana klauzula dobrego Samarytanina, (in:) T. Dukiet-Nagórska, A. Liszewska, E. Zielińska (eds.), System Prawa Medycznego. Tom III. Odpowiedzialność prawna w związku z czynnościami medycznymi, Warsaw 2021, Lex/el.

56 M. Burdzik, Obecne przepisy nie chronią wystarczająco lekarzy, Lex/el. 2021.

57 J. Potulski, Polski model "Klauzuli dobrego samarytanina" – perspektywa karnoprawna, "Studia Prawnicze KUL" 2021, no. 3(87), pp. 163–164.

58 M. Kwiatkowska, Odpowiedzialność za błąd medyczny w czasie epidemii, klauzula dobrego Samarytanina, LEX/el. 2020.

59 P. Bielska-Siudzińska, Klauzula dobrego Samarytanina, "Monitor Prawniczy" 2021, no. 13, p. 709.

the types of prohibited acts listed in the clause, the crime of which would be excluded. However, it is noteworthy that it excludes the criminality of violation of the principles of caution, as long as it happened in special circumstances, and it was not a gross violation. Therefore, P. Zawiejski rightly notes that although special circumstances may be associated with a clash of interests, typical of countertypes, as well as with the related circumstances justifying the offender that exclude the guilt, because of which they did not fulfil the duties imposed by the law, the gradation of violation of the principles of caution introduced in the last fragment of the clause is typical of a circumstance that excludes guilt[60].

Such "special circumstances" may include shortage of equipment, inadequate organisation, too many patients, *etc*. Such conditions may also include those affecting the offender themselves (fatigue, illness, old age, *etc*.)[61]. Special circumstances will include all real obstacles which make following the rules of medicine in diagnosing or treatment of COVID-19 significantly more difficult than in typical situations[62].

Finally, the legislation requires that the effect should not be caused by gross failure to exercise the caution necessary in the specific circumstances. The point is that the special circumstances of diagnosing or treating COVID-19 should not lead to the exclusion of guilt in extreme situations. These occur only if the offender disregards clear rules of caution (rules of the medical profession) without a reasonable justification[63].

Doubts are also raised by the time stamp defined with the words "when announcing the threat of an epidemic or state of epidemia", which in the light of Art. 46 of the Act of December 5, 2008, on preventing and combating infections and infectious diseases in humans, assumes that the announcement of the indicated states may be not only temporary, but also territorial[64].

Regardless of the aforementioned doubts as to the subjective and objective scope of the clause, its *ratio legis* is questioned in the subject literature. E. Plebanek claims that the Good Samaritan clause does not substantially affect the situation of a medic in criminal proceedings. The universal institutions existing in the Penal Code make it possible to terminate any criminal proceedings at an earlier stage than the clause in question[65]. J. Potulski, on the other hand, points out that the regulation in question

60 P. Zawiejski, Tak zwana …, *op. cit*.

61 M. Kwiatkowska, Odpowiedzialność za błąd medyczny w czasie epidemii, klauzula dobrego Samarytanina, LEX/el. 2020; K. Izdebski, K. Kolankiewicz, Niezbyt dobra klauzula dobrego Samarytanina, https://www.infodent24.pl/lexdentpost/niezbyt-dobra-klauzula-dobrego-samarytanina,116615_4.html (21.06.2021).

62 P. Zawiejski, Tak zwana …, *op. cit*.

63 *Ibidem*.

64 J. Potulski, Polski model …, *op. cit*., p. 168.

65 E. Plebanek, Wyłączenie …, *op. cit*., p. 75.

was created and is applied. Therefore, there is no doubt that this provision is important from the perspective of criminal liability of health care system employees[66].

Conclusions

Decisions on the priority in access to advanced life-saving technologies as well on allocation and rationing of limited medical resources should be based only on medical, rather than on social or economic criteria. It should be desirable that such decisions should be taken jointly to relieve one person from the sole responsibility for other people's life or death[67].

The Good Samaritan clause was introduced to guarantee legal safety when a decision is taken to provide healthcare services of intensive care in the event of an extreme shortage of IC beds. It may exclude the guilt, but only of selected healthcare professionals, only for four offences listed in the act, and only in relation to diagnosing, treating, and preventing COVID-19, and not other diseases. In consequence, the Good Samaritan clause fails to provide the promised effective protection to healthcare professionals during the COVID-19 pandemic.

When answering the research question about the criteria for prioritizing access to intensive care in the event of an extreme shortage of equipment and medical personnel in the state of an epidemic, it should be clearly stated that in order to assess the priority in providing medical services in the above-mentioned situation, no utilitarian criteria can be adopted, and only the medical criteria are appropriate. The hypothesis in this regard was fully confirmed.

In response to another problem, whether the Good Samaritan clause can replace the general institution of a collision of obligations set out in art. 26 § 5 of the penal code as a result of the analysis carried out, this possibility should be clearly denied. Therefore, this hypothesis was also positively verified.

While not contesting the clause in question totally, one must point out that it reproduces a typical course of a medical error under extremely difficult conditions of the epidemic. When it comes to the relation between the clause and exclusion of guilt in the case of a clash of duties, one can claim that the Good Samaritan clause is a *lex specialis* in relation to the conflict of duties specified in Art. 26 § 5 of the penal code, which is a more general and flexible solution, although one which sometimes raises concerns. Therefore, one should, first, follow the clause, and if it proves to be insufficient to release one from criminal responsibility because of its obvious flaws, there are general code measures that can be applied. However, it should be clearly emphasized that such a situation may occur relatively often, because the clause is intended to limit liability for unintentional acts specified in the closed directory, and

66 J. Potulski, Polski model, *op. cit.*, p. 175.
67 J. Pawlikowski, Etyczny …, *op. cit*.

the collision of duties has a much wider objective and subjective scope. It is worth emphasizing that the subjective side in a counter-type situation defined by a clash of duties relies on intent, because the will and awareness of saving one good at the expense of another is needed. When referring to the rational medic model, we are also convinced that his action is deliberate, so there is no mistake or violation of the precautionary principles.

E. Plebanek is right to say that a model medic does not need the Good Samaritan clause[68]. In a situation of extreme shortage of equipment and medical personnel, there should, in principle, not be a need to exclude the unlawfulness or guilt of a physician failing to undertake one of the many irreconcilable duties. The behaviour of a rational medic should always be initially legal. But this statement does not provide legal certainty for doctors. Therefore, any guarantee instruments specified in the Act should not be rejected. However, efforts should be made to improve them.

We cannot forget about pre-crime prevention as well. Taking into account the dramatically limited access to treatment in Poland, it is difficult to suggest directions for the development of technologies in medicine[69]. However, in order to relieve the stress associated with a choice between two interests, the criteria of prioritisation and allocation should be moved to the macro level. It should not mean that a doctor or a group of doctors would have to behave in a specific manner, but that they could make a decision under conditions favourable to protecting human life and health.

The proposed solutions include reform of the intensive care system in Poland, at least doubling the number of intensive care beds, including so-called "intermediate beds", at least doubling the number of trained personnel by propagation and development of interdisciplinary training[70]. These measures will contribute to preventing offences related to the provision or refusal to provide healthcare services involving intensive care, providing a better guarantee of human life and health protection than any specific measures related to criminal law.

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68 E. Plebanek, Wyłączenie…, *op. cit*., p. 64.

69 A. Breczko, Human Enhancement in the Context of Disability (Bioethical Considerations from the Perspective of Transhumanism), "Białostockie Studia Prawnicze" 2021, vol. 26, no. 3, p. 107.

70 A. Kübler, Stanowisko…, *op. cit*., p. 8.

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