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Piotr Jakubów
Medical University of Białystok, Poland
piotr.jakubow@umb.edu.pl
ORCID ID: https://orcid.org/0000–0002-5680–9146

Karolina Niedźwiecka
Medical University of Białystok, Poland
karolina.niedzwiecka3@wp.pl
ORCID ID: https://orcid.org/0000–0001- 9211–4328

Julia Kondracka
Medical University of Gdańsk, Poland
kondrackajulia@gmail.com
ORCID ID: https://orcid.org/0000–0001-8742–7047

Aleksander Turczynowicz
Medical University of Białystok, Poland
aleksander.turczynowicz@udsk.pl
ORCID ID: https://orcid.org/0000–0002-6344–5096

Szymon Kocańda
Medical University of Białystok, Poland
kardiochirurgia@wp.pl
ORCID ID: https://orcid.org/0000–0003-1156–0284

Agnieszka Malarewicz-Jakubów
University of Bialystok, Poland
malarewicz@uwb.edu.pl
ORCID ID: https://orcid.org/0000–0001-5964–4546

Legal and Medical Aspects of the End of Human Life from the Perspective of Palliative Medicine Related to Cardiac Surgery

Abstract: Despite the impressive developments in modern medicine, the healthcare system is still associated with human death. Medicine has made great strides in the treatment of many diseases. The procedures are particularly advanced in, e.g., cardiac surgery, vascular surgery, and other fields.

However, despite these efforts, not all patients are cured, and the use of aggressive treatment often contributes to their suffering. This does not mean that patients should be left unattended at the end of their lives.. Palliative medicine deals with patients coming to the end of their lives, concentrating on alleviating suffering and improving quality of life. It is a medical speciality focused on a wide range of interventions, including symptom management, communication, and psychosocial and spiritual support for patients. Patients undergoing highly qualified procedures, for whom causal treatment is not possible, should have the right to such care before death. However, according to medical practice and national legal regulations, it is not always possible to provide this care, despite the anticipated death. This article presents the legal and medical aspects of the end of life from the point of view of the European and Polish healthcare systems.
Keywords: cardiac surgery, end of life, palliative medicine

Introduction

Despite the impressive developments in modern medicine, the healthcare system is still associated with human death. Medicine has made great strides in the treatment of many diseases. The procedures are particularly advanced in, for example, cardiac surgery, vascular surgery, and other fields. However, despite these efforts, not all patients can be cured, and the use of aggressive treatment often contributes to their suffering. This does not mean that patients who cannot be helped causally should be left unattended at the end of their lives. Palliative medicine deals with patients coming to the end of their lives, and focuses on alleviating suffering and improving quality of life.[1]

Palliative medicine is a medical speciality focused on a wide range of interventions, including symptom management, communication, and psychosocial and spiritual support for patients.[2] The modern field of palliative medicine has its roots in the hospice movement that began in the mid-20th century. Hospice care is a form of palliative care provided at the patient's home or in a hospice facility, the purpose of which is to help people in the final phase of a terminal illness, giving them the most comfortable and painless life possible.[3]

In the early 21st century, palliative organizations from around the globe published a joint document stating that palliative medicine should be available at all levels for all types of diseases. Patients undergoing highly qualified procedures, for whom causal treatment is not possible, should have the right to such care before death. However, according to medical practice and national legal regulations, it is not always possible to implement this care, despite the anticipated death.

1 (Kearney, 2021).
2 (Zehnder, 2022).
3 (MacDonald, Herx and Boyle, 2022).

1. The history of palliative care

The palliative care and hospice movement was started by Dame Cicely Saunders, a British nurse, social worker, and physician who is often referred to as the 'founder of the modern hospice movement'. Saunders opened the first hospice, St Christopher's Hospice, in London in 1967. The hospice model quickly gained traction, and hospices began to spring up around the world.[4]

In the 1980s and 1990s, the field of palliative medicine began to expand beyond hospice care and into the broader healthcare system. Palliative care teams began to be established in hospitals and other healthcare settings, and palliative medicine became recognized as a medical speciality. Today, palliative medicine is an important part of healthcare systems around the world, and it is recognized as a key component of quality care for individuals with serious or terminal illnesses.

2. A right to palliative care

Access to palliative care is a legal obligation, as acknowledged by United Nations conventions, and has been advocated as a human right by international associations, based on the right to the highest attainable standard of physical and mental health. Palliative care can effectively relieve or even prevent suffering and can be provided at comparatively low cost.[5] Despite worldwide legal obligations, the governments of many countries have not taken adequate steps to ensure that patients with incurable illnesses can realize the right to access palliative care.[6]

In 2009, the world's palliative organizations published a joint document, the Prague Charter, stating that palliative medicine should be available at all levels for all types of disease. The Prague Charter was based on the 2009 Joint Declaration and the 2009 IAHPC and WPCA Declaration of Commitment to Palliative Care and Pain Management.[7] According to the Prague Charter and the EAPC (European Association for Palliative Care), IAHPC (European Association for Palliative Care), WPCA (Worldwide Palliative Care Alliance), and HRW (Human Rights Watch), access to palliative care is a basic human right. It has been established that the main causes of death in developed countries around the world are diseases such as cancer and cardiovascular diseases, while infectious diseases such as HIV/AIDS, malaria, and tuberculosis account for a large percentage of deaths in developing countries. Gov-

4 (Kowalik, 2013).
5 (Huenchuan, 2017).
6 (The Prague Charter, 2013).
7 (Radbruch et al., 2013).

ernments of most countries around the world have failed to act to ensure that patients can exercise the right to palliative care called for in the charter.[8]

3. The legal and medical aspects of the end of life in the world health professionals' community

Although world health organizations have established common rules of conduct, different countries and regions of the world have different approaches to providing palliative medicine.[9] There are both legal and medical aspects to consider when it comes to the end of human life from a palliative medicine perspective. From a legal perspective, there are several important documents that can help ensure that an individual's wishes are respected and carried out during the end-of-life process. In the US and Canada, these legal documents include:

- Advance directive: This is a document in which an individual specifies their wishes for medical treatment in the event that they are unable to make decisions for themselves. This can include a living will, which specifies the types of medical treatment the individual does or does not want, and a durable power of attorney for healthcare, which designates a trusted individual to make medical decisions on the individual's behalf.[10]
- Do Not Resuscitate (DNR) order: This is a medical order that instructs healthcare providers not to perform CPR if the individual's heart stops or they stop breathing.[11]
- Medical Orders for Life-Sustaining Treatment (MOLST): This is a medical order that specifies the types of life-sustaining treatments an individual does or does not want in the event of a terminal illness or end-of-life situation.[12]

From a medical perspective, there are several options that may be considered during the end-of-life process, including:

- Palliative care: This is specialized medical care that focuses on relieving and managing the symptoms, pain, and stress of serious illnesses. The goal of palliative care is to improve quality of life for both the patient and their family.[13]
- Hospice care: This is specialized medical care for individuals who are in the final stages of a terminal illness and have a life expectancy of six months or

8 (Schmidlin, 2015).
9 (Maetens, Cohen and Harding, 2020).
10 (House, Schoo and Ogilvie, 2022).
11 (Vranick et al., 2022; Goldstein and Morrison, 2013).
12 (Boerner et al., 2018).
13 (House, Schoo and Ogilvie, 2022).

less. The goal of hospice care is to provide comfort and support for both the patient and their family.

– Withdrawing or withholding treatment: In some cases, it may be determined that it is in the best interest of the patient to withdraw or withhold certain medical treatments, such as mechanical ventilation or dialysis. This decision is typically made with the input of the patient, their family, and the healthcare team.[14]

It is important to discuss end-of-life options and to have clear communication about possibilities for medical care. This can help ensure that a patient's preferences are respected and carried out during this challenging time.[15]

In US regulation, palliative care is not the same as hospice care. Hospice care is a specialized form of palliative care that is provided to individuals who are in the final stages of a terminal illness and have a life expectancy of six months or less. From this perspective, hospice care means end-of-life care. The goal of hospice care is to provide comfort and support for both the patient and their family, rather than attempting to cure the underlying illness. Palliative care, on the other hand, can be provided at any stage of an illness and can be given along with curative treatment.[16]

4. European legal and medical aspects of the end of human life from a palliative medicine perspective

In Europe, the legal and medical aspects of the end of life in the context of palliative care are the same as those in other parts of the world, but are different from those in the US and Canada. Palliative care, as specialized medical care that focuses on relieving and managing the symptoms, pain, and stress of serious illnesses. Palliative care is provided by a team of healthcare professionals, including doctors, nurses, social workers, and chaplains, who work together to coordinate and provide care. The goal is to improve quality of life for both the patient and their family by addressing physical, emotional, social, and spiritual needs. In Europe, the basic difference in the approach to the patient is that there is no difference between palliative medicine and hospice care: hospice and palliative care have the same approach in end-of-life human care.[17]

In Europe, there is a strong emphasis on respecting the autonomy and dignity of the patient, and on ensuring that their wishes are respected and carried out during the end-of-life process. Many European countries have laws in place to protect

14 (Penders et al, 2020).
15 (Manalo, 2013).
16 (Vitas Healthcare, 2022).
17 (Radbruch and Payne, 2009).

the rights of patients and to ensure that they are involved in decision-making about their care. It is important to be aware of these laws and to understand one's rights as a patient in order to ensure that one's wishes are respected and carried out during the end-of-life process.

From a legal perspective, there are several important documents that can help ensure that an individual's wishes are respected and carried out during the end-of-life process in the context of palliative care.[18] These include:

- Advance directive: In Europe, the laws surrounding advance directives vary by country. In some countries, such as the United Kingdom and Germany, advance directives are legally binding, while in others, such as France and Italy, they are not.[19]
- Do Not Resuscitate (DNR) order: This is a medical order that instructs healthcare providers not to perform CPR if the individual's heart stops or they stop breathing. The laws surrounding DNR orders also vary by country in Europe. In some countries, such as the United Kingdom and Germany, DNR orders are legally binding, while in others, such as France and Italy, they are not.[20]
- Medical Orders for Life-Sustaining Treatment (MOLST): This is a medical order that specifies the types of life-sustaining treatments an individual does or does not want in the event of a terminal illness or end-of-life situation. MOLST orders are not commonly used in Europe, but some countries, such as the United Kingdom, have similar documents known as 'clinical treatment plans' or 'advance care plans'.[21]

From a medical perspective, the goal of palliative care in Europe is similar to that in other parts of the world: to provide comfort and support to the patient and their family during the end-of-life process. This may involve managing symptoms such as pain, shortness of breath, and fatigue, as well as providing emotional and spiritual support to the patient and their loved ones. Palliative care may also involve coordinating care with other healthcare providers, including hospice care if appropriate.[22]

5. European Commission regulation for palliative and hospice care and end-of-life care

The European Union (EU) has several initiatives and policies in place that aim to improve the availability and quality of palliative and hospice care and end-of-life

18 (Huenchuan, 2017).
19 (Penders et al., 2020).
20 *Ibidem*.
21 (House, Schoo and Ogilvie, 2022).
22 (Radbruch and Payne, 2009).

care for citizens across the EU.[23] One such initiative is the European Palliative Care Strategy, which was adopted by the EU in 2014. This strategy aims to improve access to palliative care for all EU citizens, with a particular focus on ensuring that palliative care is integrated into mainstream healthcare systems. It also aims to improve the training and education of healthcare professionals in palliative care, and to increase awareness of palliative care among the general public. The wording is as follows:

> Palliative care should be available not just to patients at their end-of-life stage – such as terminally ill cancer patients – but also to those who are seriously ill and chronically ill. According to the parliamentarians, Member States should consider palliative care as an integral part of the healthcare system and dedicate the necessary resources to it, while removing legal and regulatory obstacles that restrict access to pain-relieving medication.[24]

In accordance with the provisions of the EU Committee on Social Affairs, Health and Sustainable Development, it is necessary to ensure access to palliative care for everyone who needs it.[25]

In addition to the European Palliative Care Strategy, the EU has also adopted a number of other initiatives and policies related to end-of-life care. For example, the EU has adopted a directive on the rights of patients in cross-border healthcare, which aims to ensure that patients have access to high-quality healthcare when they receive treatment in another EU Member State. The EU has also adopted a number of initiatives related to the quality of end-of-life care, including the European Charter on Patients' Rights in Palliative Care, which sets out the rights of patients receiving palliative care.[26] Overall, while the EU does not have a specific regulation addressing palliative and hospice care and end-of-life care, it has a number of initiatives and policies in place that aim to improve the availability and quality of such care for citizens across the EU.

On 1 March 2022, the European Commission issued a call for evidence on the development of a European Care Strategy, which aims to strengthen long-term care and early-childhood education and care, as envisaged under the European pillar of social rights. The need for high quality, accessible, and affordable care services for children and people in need of long-term care was stressed. The initiative proposes two Council Recommendations, one on childcare (revision of the Barcelona targets) and one on long-term care.[27]

Under EU rules, in some cases, palliative care providers may also work with patients and their families to discuss end-of-life options, such as hospice care or with-

23 *Ibidem.*
24 (Mullen, 2018).
25 (The Prague Charter, 2013).
26 (Mullen, 2018).
27 (European Commission, 2022).

drawal or discontinuation of treatment. These decisions are usually made with the participation of the patient, family, and healthcare team and are based on the patient's preferences and best interests. In general, the aim of palliative care is to provide comfort and support to people suffering from a serious or terminal illness and to help them and their loved ones move through the end-of-life process with dignity and respect.[28] The EU committee added that the lack of palliative care services also resulted in higher costs for the healthcare system, as it leads to unnecessary hospital admissions and inappropriate recourse to expensive emergency services.

6. Polish regulation of palliative and hospice care and end-of-life care

The history of palliative care in Poland dates back to the late 1970s, when the first hospice in the country was established in Krakow. In the following decades, the number of hospices in Poland increased, and palliative care became more widely recognized as an important aspect of healthcare.[29] One of the earliest organizations to provide palliative care in Poland was the Hospice Foundation, which was founded in 1989. The foundation was established in response to the need for hospice care in the country and initially focused on providing inpatient hospice care for individuals with terminal cancer. Over time, it expanded its services to include outpatient palliative care and support for patients and their families in their own homes.[30]

In the early 2000s, palliative care in Poland began to shift from a focus on cancer patients to a more broad-based approach that included individuals with other serious or chronic illnesses, especially children. This shift was driven partly by the recognition that palliative care could improve the quality of life for patients and their families, regardless of the underlying diagnosis.[31] Nowadays, palliative care in Poland is provided by a variety of organizations, including hospitals, hospices, and community-based organizations. It is an essential aspect of healthcare in the country and is supported by the Polish government and various foundations and charitable organizations. It is provided to individuals with a wide range of serious or chronic illnesses, including cancer, heart disease, dementia, and kidney failure. The goal of palliative care in Poland is to improve the quality of life for the patient and their family by addressing physical, emotional, social, and spiritual needs.[32]

Despite the large hospice movement and the very good organization of palliative care, not all patients receive the care they should. This applies in particular to

28 *Ibidem.*
29 (Bogusz, 2017).
30 *Ibidem.*
31 (Bartko and Pawlikowski, 2016).
32 (Ciałkowska-Rysz and De Walden-Gałuszko, 2022).

non-cancerous patients who have undergone complicated procedures before their death which did not bring a therapeutic effect.[33]

7. Palliative care in cardiac surgery from an end-of-life perspective

Treatment of patients in cardiac surgery usually involves surgery to repair or replace damaged or diseased heart tissue. The specific type of surgery performed will depend on the patient's specific medical condition and the cause of the heart problem.[34] Some common types of cardiac surgery include coronary artery bypass grafting, heart valve surgery, and heart transplant. The latter procedure is used in patients with advanced heart failure who are not responding to other treatments.[35] There are many other types of cardiac surgery that can be used to treat specific heart conditions that may result from, cause, or contribute to heart failure, such as atrial fibrillation surgery, aneurysm repair surgery, defect repair surgery to congenital heart defects, and implantation of an artificial heart pump or ventricles.[36]

It is important to note that cardiac surgery is not a replacement for heart failure treatment and is usually only used in conjunction with other treatments, such as medications and lifestyle changes to treat heart failure. Transcatheter aortic valve implantation (replacement) (TAVI, TAVR) is performed in patients with heart failure in cardiac surgery and valvular stenosis. It is a type of heart surgery that is a less invasive alternative to traditional open-heart surgery and may be an option for people who are very frail or who are at high risk of post-operative complications. TAVI may be an effective treatment for aortic stenosis and may improve symptoms and quality of life for people with heart failure. However, this operation is associated with a high risk of complications due to the condition of qualified patients. Patients who have not undergone the TAVI procedure or who are complicated after traditional surgeries are candidates for further long-term care or hospice care.[37]

Balloon aortic valvoplasty (BAV) is a procedure used to treat aortic stenosis and in highly comorbid patients. Aortic stenosis can cause heart failure if left untreated, as it can make it harder for the heart to pump enough blood to meet the body's needs. BAV is a less invasive alternative to traditional open-heart surgery and may be an option for people with heart failure who are not candidates for traditional surgery or who are at high risk of post-surgery complications.[38] BAV can be used as a palliative

33 (Najwyższa Izba Kontroli, 2019).
34 (Singh et al., 2019).
35 (Sobanski, Krajnik and Goodlin, 2021).
36 (Goodlin and Rich, 2015).
37 (Sobanski, Krajnik and Goodlin, 2021).
38 (Hentsch et al., 2022).

treatment in people with heart failure who are not candidates for more aggressive treatment or who have a limited life expectancy.

After heart surgery, patients usually receive follow-up care to monitor their recovery and make sure their heart is working properly. This may include medications, lifestyle changes, and rehabilitative therapy. In some cases, palliative care may also be necessary to manage symptoms and improve the quality of life for patients who have complications or who are at high risk of developing complications after surgery.[39] Palliative care in cardiac surgery is also specialist medical care that focuses on relieving and treating the symptoms, pain, and stress of serious illnesses and can be an important aspect of caring for people with heart failure. The goals of palliative care for heart failure are to relieve symptoms and improve quality of life, support decision-making, coordinate care, and plan care in advance.[40]

Cardiac surgery is not usually performed on oncology (cancer) patients. However, there are certain situations where cardiac surgery can be used to treat or control the effects of cancer on the heart. For example:

- Cancers affecting the heart: Some types of cancer, such as sarcomas and lymphomas, can directly affect the heart by growing in or spreading to it from another part of the body. In these cases, surgery may be used to remove the tumours or to repair the damage caused by them.[41]
- Cancers affecting the blood vessels: Some types of cancer, such as breast cancer and colon cancer, can affect the blood vessels that supply blood to the heart. In these cases, surgery may be used to repair or bypass damaged blood vessels to improve blood flow to the heart.
- Cardiac surgery can also be performed after heart damage caused by cancer treatment. Some cancer treatments, such as chemotherapy and radiotherapy, can cause damage to the heart. In these cases, surgery may be used to repair the damage or manage the effects of this damage.

It is important to note that cardiac surgery does not replace cancer treatment and is usually only used in conjunction with other cancer treatments such as chemotherapy, radiotherapy, and surgery. It is very important to determine the potential benefits and risks of cardiac surgery in a specific situation when making decisions regarding treatment and possible palliative care.

39 (Kovacs et al., 2015).
40 (Sobanski, Krajnik and Goodlin, 2021).
41 (Hentsch et al., 2022).

Treatment of heart failure with the principles of palliative medicine:

Heart failure is a condition in which the heart is unable to pump enough blood to meet the body's needs. It is often a chronic and progressive condition, and it can be managed but not cured[42]. Palliative care can be an important aspect of treatment for individuals with heart failure.[43]

Worldwide, more people die from cardiovascular disease, including heart failure, than from cancer. Therefore, in world guidelines, including of the UN and palliative organizations, it is believed that palliative medicine dealing with the end of life should also include patients with heart failure.[44] Cardiac surgery may be an option for some people with heart failure, depending on the cause and the patient's overall health and prognosis.

The introduction of palliative medicine management can improve the condition of patients through the following actions:[45]

- Relieving symptoms and improving quality of life: Palliative care can help manage symptoms such as shortness of breath, fatigue, and swelling, and can address other physical, emotional, social, and spiritual needs that may arise as a result of heart failure.[46]
- Decision support: Palliative care can provide support and guidance to people with heart failure and their families when making decisions about their care and treatment. This may include helping them understand their options, set treatment goals, and develop a care plan that aligns with their values and preferences.
- Coordination of care: Palliative care can help coordinate care with other healthcare professionals, such as cardiologists, primary-care physicians, and physiotherapists, to ensure that all of the patient's needs are met.
- Ensuring advance-care planning: Palliative care can help people with heart failure and their families think and plan for the future, including completing a pre-directive and discussing their wishes with their family or spouse.[47]

There are several types of cardiac surgery that may be used to treat heart failure, including: BAV, (balloon aortic valvuloplasty), MIDCAB (Minimally Invasive Direct Coronary Artery Bypass), surgery cancer pericardial effusion, implantable ventricular-assist devices VADs -destination therapy and other. They are all palliative operations.

42 (Sobański et al., 2020: 3).
43 (Zehnder, Pedrosa Carrasco and Etkind, 2022).
44 (Goldstein and Morrison, 2013).
45 (House, Schoo and Ogilvie, 2022).
46 (Goodlin and Rich, 2015).
47 (Maciver and Ross, 2018).

Palliative care in cardiac surgery refers to the medical care provided to patients who are undergoing medical procedures for a cardiac condition but who are not expected to fully recover. Palliative care focuses on providing relief from the symptoms, pain, and stress of a serious illness, and it can be provided alongside curative treatment also in the end-of-life period.[48]

In the field of palliative medicine, the legal and medical aspects of the end of life are closely intertwined.[49]

From a legal perspective, there should be implemented documents that can help ensure that an individual's wishes are respected and carried out during the end-of-life process in the context of palliative care in a cardiac surgery department. These include palliative care advance plans, which outline the patient's preferences for medical treatment and end-of-life care. These plans may include documents such as a living will or a durable power of attorney for healthcare, which can help ensure that the patient's wishes are respected and carried out.[50]

In the context of circulatory disease in cardiology and cardiac surgery, palliative care may be appropriate for patients with advanced heart failure or other terminal cardiac conditions who are undergoing surgery to alleviate symptoms or to improve quality of life, rather than to cure their condition. Palliative care may also be appropriate for patients who are not candidates for surgery due to high risk or a low likelihood of success.

Despite the well-known principles of palliative care, an important question arises: why are cardiac surgery patients not covered by palliative care?[51] In Poland, it is rare that patients receive palliative care before or after cardiac surgery.[52] In countries with highly developed palliative medicine, such as the USA and Canada, this is not uncommon. However, there may be some circumstances in which cardiac surgery patients will not receive palliative care, for example when the patient does not experience any symptoms or distress that would justify palliative care; when the patient is treated and is not at the end of his or her life; if the patient or his or her family did not ask for palliative care; or if the patient is not a candidate for palliative care due to a health condition or prognosis.[53]

48 (Leeds and Smith, 2020).
49 (Aszyk et al., 2018).
50 (Crespo-Leiro et al., 2018).
51 (Maciver and Ross, 2018).
52 (Sobański et al., 2020).
53 (Truby and Rogers, 2020).

Legal and medical aspects of the end of human life in the perspective of palliative medicine used in cardiac surgery patients:

The legal and medical aspects of the end of life in the context of palliative care for cardiac surgery patients are largely similar to those for individuals with other serious or terminal illnesses. From a legal perspective, there are several important documents that can help ensure that a cardiac surgery patient's wishes are respected and carried out during the end-of-life process in the context of palliative care. These include:

- Advance directive: This is a document in which an individual specifies their wishes for medical treatment in the event that they are unable to make decisions for themselves. The advanced directive focuses, inter alia, on potentially hospice patients who do not have a curable disease. This can include a living will, which specifies the types of medical treatment the individual does or does not want, and a durable power of attorney for healthcare, which designates a trusted individual to make medical decisions on the individual's behalf.
- Do Not Resuscitate (DNR) order: This is a medical order that instructs healthcare providers not to perform CPR if the individual's heart stops or they stop breathing.
- Medical Orders for Life-Sustaining Treatment (MOLST): This is a medical order that specifies the types of treatment life limiting disease.

8. Legal and medical status of end-of-life patients after cardiac surgery in Poland

In recent years, recognition in Poland of the role of palliative care in improving the quality of life of seriously ill patients and their families has been increasing. Palliative care is now delivered by many health professionals, including doctors, nurses, social workers, and chaplains, who work together to coordinate and deliver care. Palliative care can be provided in a variety of settings, including hospitals, clinics, nursing homes, and the patient's home.

In 2002, the Sejm of the Republic of Poland passed the Act on the Right to Die with Dignity, recognizing the patient's right to refuse treatment and palliative care. The act also established a National Bioethics Advisory Council to issue guidelines and recommendations on end-of-life care. Despite these advances, access to palliative care in Poland is limited; this applies to certain parts of the country and to certain types of disease.

Who can benefit from palliative medicine services in Poland? The regulation of the Minister of Health states that palliative care can be provided to people of all

ages who live with a serious or terminal illness. Palliative care can be provided at any stage of the disease in the paediatric population, but is limited for adults and can only be provided under certain conditions. The Regulation of the Minister of Health also stipulates that palliative care should be provided with respect for the autonomy and dignity of the patient and taking into account his or her wishes and preferences. Palliative care should be coordinated with other healthcare providers as needed and should involve the patient and family in care decisions. However, the detailed guidelines of the regulation narrow down the group of people who can be treated under general health insurance.

Although access to palliative care is declared in the United Nations Convention, and is also provided for by standards drawn up by the European Commission, in Poland this access is limited,[54] and is related to specific diseases that are subject to palliative medicine services (see Table 1).[55]

Table 1. List of incurable, progressive, life-limiting, and cancers and non-cancers for which services are provided under palliative and hospice care for adult patients

	ICD-10 code	Diseases qualifying for treatment
1	B20-B24	Human Immunodeficiency Virus (HIV) disease
2	C00-D48	Cancers
3	G09	Sequelae of inflammatory diseases of the central nervous system
4	G10-G13	Systemic primary atrophy affecting the central nervous system
5	G35	Multiple sclerosis
6	I42–I43	Cardiomyopathy
7	J96	Respiratory failure not elsewhere classified
8	L89	Pressure ulcer

There are no cardiovascular diseases in the list presented in Table 1, such as end-stage heart failure or heart failure which disqualifies the patient from surgical treat-

54 Opieka paliatywna i hospicyjna. Rozporządzenie Ministra Zdrowia z dnia 29 października 2013 r. w sprawie świadczeń gwarantowanych z zakresu opieki paliatywnej i hospicyjnej Dz.U. z 2013 r., poz. 1347 (Waligórska, 2017) (Palliative and hospice care. Regulation of the Minister of Health of 29 October 2013 on guaranteed services in the field of palliative and hospice care, Journal of Laws of 2013, item 1347 (Waligórska, 2017)).

55 Rozporządzenie Ministra Zdrowia w sprawie świadczeń gwarantowanych z zakresu opieki paliatywnej i hospicyjnej z dnia 29 października 2013 r. (Dz.U. z 2013 r. poz. 1347) tj. z dnia 28 marca 2018 r. (Dz.U. z 2018 r. poz. 742) (Regulation of the Minister of Health on guaranteed services in the field of palliative and hospice care of 29 October 2013 (Journal of Laws of 2013, item 1347), i.e. of 28 March 2018 (Journal of Laws of 2018 item 742)).

ment; there are no end-stage cardiac surgeries, no complicated circulatory failures or systemic failure from myocardial infarction; there is no way to treat patients who are disqualified from heart transplantation. There are also no patients on machine-assisted therapy, and yet such patients are in their final years of life and will not be cured. Cardiomyopathy, which is extremely rare, usually genetically related, and not representative of the general population who die from a range of cardiovascular diseases, is in the table. Therefore, it seems that the indications for palliative treatment, especially in heart diseases and in cardiac surgery patients, should change. This situation applies to the adult population, as children have a separate qualification and a wide range of diagnoses qualifying for palliative treatment.

In Poland, the gap in benefits for patients not covered by the regulation is ensured by so-called long-term care. According to the Ordinance of the Minister of Health, long-term therapy is medical care provided to people suffering from chronic diseases, such as diabetes, hypertension, or asthma. The goal of long-term therapy is to control the symptoms of the disease and to prevent or delay its progression. Long-term therapy may include medication, lifestyle changes, and other interventions. It is provided by nurses without intervention from a physician or team; eligibility is limited to patients who are completely or almost completely disabled according to the Bartel scale.

On the other hand, palliative care is defined as specialist medical care provided to people suffering from a serious or terminal illness such as cancer, heart disease, or respiratory failure. It can be provided at any stage of the disease, can be provided along with treatment, and is provided by a team of people working together. The main difference between long-term therapy and palliative care is the provision of care. Long-term therapy focuses on treating the symptoms of a chronic disease and preventing or delaying its progression, while palliative care focuses on relieving and treating the symptoms, pain, and stress of a serious or fatal disease, and improving the quality of life.

Conclusion

In Europe, the legal and medical aspects of the end of life in the context of palliative care are largely similar to those in other parts of the world. In Poland, there is a limitation in palliative care provided at the end of life in relation to cardiological and cardiac surgery patients. From a legal point of view, several important documents are also missing that can help ensure that the individual's wishes are respected and implemented during the end-of-life process in the context of palliative care. They include advance directives, DNR orders, and MOLST documents. While it is important to discuss these documents with one's healthcare professional and to communicate clearly with loved ones about one's wishes for medical care, helping to ensure

that one's preferences are respected and implemented during this difficult time, such a document is also not binding and is not commonly acted on.

In Poland, patients are commonly referred to palliative care. However, from a legal point of view, there is also a limitation related to the ministerial list of diseases subject to this care.

It should be stated that in the end-of-life medical context, patients with heart disease and non-cancer patients are subject to the same rules and procedures as in other countries. In a formal context, patients are not regulated by law, which exposes them to unnecessarily lengthy procedures and limits access to specialist end-of-life care, such as palliative care.

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