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Informing the Patient about Palliative Care: Legal Considerations

Abstract: The obligation of a doctor to provide information about a patient's health is a frequently discussed topic in Polish literature on medical law. To date, publications have focused on the topics of providing information about the diagnosis or about possible treatment options and discussing test results, and rarely discuss the termination of causal treatment, giving information instead on specialized symptomatic management and palliative care for patients with a chronic disease or a disease with an unfavourable prognosis. Providing honest and reliable information in this area increases patients' awareness of their current health status, and thus allows them to make appropriate decisions related to the abandonment of futile therapy, and also reduces the distress associated with a fear of a lack of specialized medical care and physical, social and spiritual suffering. This article presents legal considerations for informing patients about specialist palliative care.

Keywords: information, law, palliative care, patients, Poland

Introduction

The beginnings of the hospice movement in Poland were based mainly on voluntary activities in the 1980s, followed by the rapid development of palliative care within healthcare structures in the 1990s. This increased the interest of the academic community and representatives of the healthcare system in the problems and needs of people with incurable and progressive diseases, who required palliative care due to the presence of troublesome symptoms and psychosocial and spiritual problems of patients and their families, in order to provide them with a dignified existence and optimal quality of life (Jakubów et al., 2023; Krakowiak et al., 2016; Leppert, Sesiuk et al., 2022; Miller et al., 2022). In Poland, international recommendations for the management of pain and other symptoms as well as non-medical support for patients and their families have been implemented, and the healthcare system has introduced organizational and legal solutions for the provision of palliative and hospice care services, which have been included in the catalogue of guaranteed services.

The observed increase in morbidity and mortality due to malignancies and other chronic diseases, as well as the ageing of the population, calls for modifications in the healthcare system to allow patients to have broad access to specialized palliative care and its integration with other medical specialities (with the aim of providing palliative care elements in all healthcare units), as well as taking into account the specific legal situation of patients receiving palliative care, including, in particular, the provision of information in this particular context (Leppert, Grądalski et al., 2022).

As defined by the WHO (World Health Organization, 2023) and International Association for Hospice & Palliative Care (IAHPC) (Radbruch et al., 2020), palliative care is a holistic approach that aims to improve the quality of life of patients with life-limiting illnesses that cause severe suffering for them and their families. Palliative care includes the prevention, early identification, comprehensive assessment and treatment of pain and other distressing symptoms, as well as the alleviation of the mental, social and spiritual suffering of patients and their families. Palliative care can be implemented throughout the course of the disease, in accordance with the patient's needs. It provides support for patients until death and also for families during bereavement, ensures effective communication and helps patients and their families define the goals of care. It is provided in conjunction with disease-modifying therapies when needed, can positively influence the course of the disease, is not intended to hasten or delay death, is life-affirming and recognizes dying as a natural process. Palliative care may be provided in different ways:

- A palliative care approach from all professionals, ensuring good communication, goal setting and symptom management,
- Generalist palliative care from those more often involved in the care of people with life-limiting illness,

- Specialist palliative care from a specific team with ongoing training and supervision, who can be involved in the care of people with more complex issues. This is the area for discussion within this paper (Payne et al., 2022).

According to the recommendations of the European Association for Palliative Care (EAPC) on Advance Care Planning (ACP), the patient should be informed about the diagnosis, the course of the disease and possible treatments, as well as their effects and side effects, along with the consequences of withholding or withdrawing potentially curative or life-prolonging treatment, and the prognosis (Rietjens et al., 2017). Provision of this information by the physician is the first step of the ACP process that empowers the patient to make a decision regarding future care and treatment (Pawłowski et al., 2019). From a psychosocial perspective, providing high-quality health-related information to the patient decreases anxiety and improves their quality of life, as well as being recognized as informational support (Borski, 2023; Luciani et al., 2025; Sutherland, 2019; van der Velden et al., 2020).

1. Information about palliative care against the background of the scope of information that a doctor should provide to a patient

The Law on Patients' Rights and the Patients' Ombudsman (Sejm of Poland, 2022c) (the LPR) stipulates in Article 9 the patient's right to information about their health, the scope of which includes information about their state of health, diagnosis, proposed and possible diagnostic and therapeutic methods, the foreseeable consequences of their application or omission, the results of treatment and the prognosis (Janiszewska, 2020). The above-mentioned scope of information is also provided for in Article 31(1) of the Law of 5 December 1996 on the Professions of Physician and Dentist (Sejm of Poland, 1996) (the LPPD), according to which the obligation to provide information is included in the principles of practising in the medical profession. In this way, Polish law has exhaustively defined (*numerus clausus*) the elements that make up the information provided to the patient, and has provided for the obligation to communicate each of these elements. This includes information about proposed and possible treatments, including both the method recommended by the doctor and other methods that can be used in light of the principles of medical knowledge, even if they are not available at the healthcare unit providing services to the patient (Lis, 2020). Moreover, the law obliges physicians and the other healthcare professionals to deliver the mentioned scope of information in a clear and understandable way for the patient (Borowska et al., 2023).

The diagnostic and treatment methods about which the doctor should inform the patient include methods covered by the scope of guaranteed services, specified mainly in the Law of 27 August 2004 on Healthcare Services Financed from Public Funds (Sejm of Poland, 2022a) and in the executive acts issued on its basis. These include the Regulation of the Minister of Health of 29 October 2013 on Guaranteed Benefits in the Field of Palliative and Hospice Care (Polish Ministry of Health, 2022) (the Regulation), which justifies the obligation to inform the patient about the diagnostic and treatment methods included in the guaranteed services in the field of palliative and hospice care. The provisions of this Regulation stipulate in particular that the scope of guaranteed benefits provided in inpatient and at-home conditions includes pain treatment in accordance with current medical knowledge, using drugs available in the territory of the Republic of Poland (§ 5 point 4 in conjunction with § 6), treatment of other somatic symptoms (§ 5 point 5 in conjunction with § 6), diagnostic tests ordered by a physician employed in an inpatient hospice or palliative medicine unit (§ 5 point 9), tests ordered by a physician employed by a home hospice for adults or for children under 18 years of age (§ 6), as well as the prescription of medications, including pain medications, and the provision of necessary diagnostic tests at a palliative medicine clinic or in the recipient's home (§ 7(2)(3)–(4)). It should be emphasized that for patients requiring pain management, the information provided should include both pharmacological and non-pharmacological methods (such as psychological support) (Zimmermann et al., 2018). Information about the possible place of care (in the patient's home, a day-care facility, an inpatient hospice or a hospital) is in conjunction with methods of treatment and should be delivered by the physician (Grądalski et al., 2010; Grądalski et al., 2012).

Guaranteed specialist palliative and hospice care services are provided by a multi-professional team, which, according to the provisions of the Regulation, should consist of at least a doctor, a nurse, a physiotherapist and a psychologist, while a physiotherapist is not required in a palliative medicine clinic. Article 9(2) of the LPR applies to the information provided to the patient by medical professionals, according to which the patient has the right to obtain information within the scope of the health services provided by these professionals and in accordance with their authority. In light of this provision, the information on specialized palliative care services should take into account both the scope of guaranteed services provided by these persons, as determined by the Regulation, and the scope of their professional competence, resulting from the regulations governing the practice of these professions.

2. Information about palliative care: Authorized and obliged entities

Legal regulations in Poland define both the circle of persons entitled to receive information and those obliged to provide it. According to Article 9(2) of the LPR and Article 31(1) and (5) of the LPPD, access to the full range of information is available to patients from the age of 16, and therefore information on palliative care should also be provided to both patients of legal age and those without full legal capacity who are 16 years of age or older. Restrictions on the obligation to provide information apply only to those aged below 16, because in the light of Article 9(7) LPR and Article 31(7) LPPD, these patients have access to information in the scope and form necessary for the proper conduct of the diagnostic or therapeutic process. The reference point for determining the information provided to children under 16 is the range established for older patients, taking into account the age and developmental stage of the patient. However, it should be taken into consideration that patients under 16 should generally be informed about palliative care, because without this information, the provision of health services to these individuals, including palliative and hospice care, may be hindered. Excluding a young patient from the decision-making process through lack of information limits his or her autonomy and sense of self-agency, and can also cause or exacerbate anxiety (Critoph, Cable, et al., 2024; Critoph, Taylor, et al., 2024).

In addition to the patient being informed, the law also provides for informing persons authorized by the patient, their legal representative and, in special circumstances, relatives, which goes beyond the scope of this article. It should be taken into account that if the patient him – or herself does not limit the scope of information provided to other people, they should receive full details, which also applies to palliative care. The circle of those obliged to inform the patient primarily includes medical professionals, who, in light of Article 9(2) of the LPR, provide information within the scope of the health services they provide and in accordance with their licences. The scope of these powers has been determined by the regulations governing the practice of the various medical professions, an analysis of which leads to the conclusion that, according to Article 31(1) of the LPPD, in conjunction with its Article 2(1), the obligation to provide information rests primarily with the doctor. This is also confirmed by the provisions of the Regulation, according to which only a physician who delivers services paid by the National Health Fund is authorized, and at the same time obliged, to refer a patient for guaranteed palliative and hospice care services.

Among other medical professions involved in palliative care, we can distinguish nurses, who, in the light of Article 9(8) of the LPR, are obliged to inform the patient about his or her care and nursing procedures; the scope of their professional rights is regulated by Article 4 of the Law of 15 July 2011 on the Professions of Nurse and Midwife (Sejm of Poland, 2022b). These include recognizing a patient's health conditions and needs, as well as his or her nursing issues, which to some extent may also apply to palliative and hospice care services. Based on Article 16(2) of this law, the nurse provides the patient with information about his or her health to the extent necessary for nursing care. In turn, a physiotherapist, who is also part of the multi-professional team in palliative care, according to Article 9(2) of the Law of 25 September 2015 on the Profession of Physiotherapist (Sejm of Poland, 2023), informs the patient to the extent necessary for the health services they provide. In addition, under the aforementioned laws, both nurses and physiotherapists are required to inform the patient of his or her rights as defined in the LPR.

3. The timing of palliative care information delivery against eligibility criteria for palliative care

The requirement to inform the patient about the possibility of initiating palliative care arises as soon as they can be found to meet the eligibility criteria for such care. Determining the circumstances under which this obligation arises requires a physician's assessment of the patient's condition through examination and analysis of medical records, particularly the results of diagnostic tests and medical history. The occurrence of indications that a patient should be covered by guaranteed palliative and hospice care services also triggers an obligation on the part of the physician who delivers services paid by the National Health Fund who should ascertain this fact to refer the patient for such care. This assessment is increasingly seen in terms of the holistic needs of a person with a life-threatening illness, rather than just on the prognosis.

The eligibility criteria for palliative care in Poland are regulated by the provisions of the Regulation of the Minister of Health of 29 October 2013. They are applicable to specialized palliative care, which in the Polish healthcare system is provided to patients as part of guaranteed palliative and hospice care services. In contrast, the law does not regulate the criteria for applying the elements of palliative care, which, according to the EAPC recommendations, should be implemented for patients in all healthcare facilities (Grądalski, 2022; Payne et al., 2022). According to the Regulation, patients suffering from incurable, progressive and life-limiting diseases with no hope of a cure are eligible for guaranteed palliative and hospice care services. These are strictly indicated in the annex to the Act, which includes a list of diseases with the designations of the International Classification of Diseases (ICD-10), at least one of which should occur in adult patients (Table 1) or in individuals under the age of 18 (Table 2). In addition, eligibility criteria for perinatal palliative care have been separately identified; these include severe and irreversible disability or an incurable life-threatening disease which arose during the prenatal period of child development or during birth, and in particular developmental disorders leading to spontaneous miscarriage, premature birth or intrauterine death, or developmental disorders leading to the premature death of a live-born child, defined in particular as selected conditions beginning in the perinatal period and congenital malformations, deformities and chromosomal aberrations (P00–P96, Q00–Q99) (the Regulation).

Table 1. List of diseases that qualify adults for palliative care

Source: Regulation of the Minister of Health of 29 October 2013

No.	ICD-10 code	Diseases qualifying for treatment
1	B20–B24	Human immunodeficiency virus [HIV] disease
2	C00–D48	Neoplasms
3	G09	Sequelae of inflammatory diseases of the central nervous system
4	G10–G13	Systemic atrophies primarily affecting the central nervous system
5	G35	Multiple sclerosis
6	I42–I43	Cardiomyopathy
7	J96	Respiratory failure not elsewhere classified
8	L89	Pressure ulcer

Table 2. List of diseases that qualify individuals under 18 years of age for palliative care

Source: Regulation of the Minister of Health of 29 October 2013

No.	ICD-10 code	Diseases qualifying for treatment
1	A81	Atypical virus infections of the central nervous system
2	B20–B24	Human immunodeficiency virus [HIV] disease
3	B90–B94	Sequelae of infectious and parasitic diseases
4	C00–C14	Malignant neoplasms of lip, oral cavity and pharynx
5	C15–C26	Malignant neoplasms of digestive organs
6	C30–C39	Malignant neoplasms of respiratory and intrathoracic organs
7	C40–C41	Malignant neoplasms of bone and articular cartilage
8	C43–C44	Melanoma and other malignant neoplasms of skin
9	C45–C49	Malignant neoplasms of mesothelial and soft tissue
10	C50	Malignant neoplasms of the breast
11	C51–C58	Malignant neoplasms of female genital organs
12	C60–C63	Malignant neoplasms of male genital organs
13	C64–C68	Malignant neoplasms of the urinary tract
14	C69–C72	Malignant neoplasms of the eye, brain and other parts of the central nervous system
15	C73–C75	Malignant neoplasms of the thyroid and other endocrine glands
16	C76–C80	Malignant neoplasms of ill-defined other secondary and unspecified sites
17	C81–C96	Malignant neoplasms of lymphoid, hematopoietic and related tissue
18	C97	Malignant neoplasms of independent (primary) multiple sites
19	D00–D09	*In situ* neoplasms
20	D32	Benign neoplasm of meninges
21	D33	Benign neoplasm of the brain and other parts of the central nervous system

22	D37–D48	Neoplasms of uncertain behaviour, polycythaemia vera and myelodysplastic syndromes
23	E70–E90	Metabolic disorders
24	F84	Pervasive developmental disorders
25	G09	Sequelae of inflammatory diseases of the central nervous system
26	G10–G13	Systemic atrophies primarily affecting the central nervous system
27	G23	Other degenerative diseases of basal ganglia (in particular Hellervorden–Spatz disease)
28	G70–G73	Diseases of myoneural junctions and muscle (in particular G71.0 Muscular dystrophy, including severe [Duchenne] muscular dystrophy, G71.2 Congenital myopathies, G71.3 Mitochondrial myopathy not elsewhere classified)
29	G80–G83	Cerebral palsy and other paralytic syndromes (in particular G80 Cerebral palsy)
30	G90–G99	Other disorders of the nervous system
31	I50	Heart failure
32	I69	Sequelae of cerebrovascular disease
33	J96.1	Chronic respiratory failure not elsewhere classified
34	K72	Hepatic failure not elsewhere classified
35	K74	Fibrosis and cirrhosis of the liver
36	N18.0	End-stage renal disease
37	P10	Intracranial laceration and haemorrhage due to birth injury
38	P11	Other birth injuries to the central nervous system
39	P21	Birth asphyxia
40	P27	Chronic respiratory disease originating in the perinatal period (in particular P27.1 Bronchopulmonary dysplasia of perinatal onset)
41	P35	Congenital viral diseases
42	P91	Other disturbances of the cerebral status of the new-born (in particular P91.0 Neonatal cerebral ischemia)
43	Q00–Q07	Congenital malformations of the nervous system (in particular Q03 Congenital hydrocephalus, Q03.1 Dandy–Walker syndrome, Q04.2 Holoprosencephaly, Q04.3 Other brain defects with loss of tissue, e.g. lissencephaly, Q04.8 Other specified congenital malformations of the brain, Q04.9 Congenital malformation of the brain, unspecified, Q05 Spina bifida, Q05.0 Spina bifida cervicalis with concomitant hydrocephalus, Q05.2 Spina bifida lumbaris with concomitant hydrocephalus, Q07 Other congenital malformations of the nervous system, Q07.0 Arnold–Chiari syndrome)
44	Q20–Q25	Congenital malformations of the circulatory system – applies to children not qualified for surgical treatment
45	Q31	Congenital malformations of the larynx
46	Q32	Congenital malformations of the trachea and bronchus
47	Q44	Congenital malformations of the gallbladder, bile ducts and liver (in particular Q44.2 Biliary atresia, Q44.7 Alagille syndrome)

48	Q60	Renal agenesis and other reduction defects of the kidney (in particular Q60.4 Renal hypoplasia, bilateral)
49	Q61.1	Polycystic kidney, autosomal recessive
50	Q77	Osteochondrodysplasia with defects of growth of the tubular bones and spine (in particular Q77.4 Achondroplasia – foetal chondrodystrophy)
51	Q78	Other osteochondrodysplasias (in particular Q78.0 Ossification imperfecta – osteogenesis imperfecta)
52	Q79	Congenital malformations of the musculoskeletal system not elsewhere classified
53	Q81	Epidermolysis bullosa
54	Q85	Phacomatoses not elsewhere classified
55	Q87	Other specified congenital malformation syndromes affecting multiple systems
56	Q89	Other congenital malformations not elsewhere classified (in particular Q89.7 Multiple congenital malformations not elsewhere classified)
57	Q90–Q99	Chromosomal abnormalities not elsewhere classified
58	R40.2	Coma, unspecified
59	S06	Intracranial injury (in particular S06.7 Intracranial trauma with a prolonged period of unconsciousness)
60	T90	Sequelae of injuries of the head
61	T91	Sequelae of injuries of the neck and trunk
62	T94	Sequelae of injuries involving multiple and unspecified body regions
63	T96	Sequelae of poisoning by drugs, medicaments and biological substances
64	T97	Sequelae of the toxic effects of substances, chiefly non-medicinal
65	Y85–Y89	Sequelae of external causes of morbidity and mortality (in particular Y85 Consequences of road accidents, Y87.0 Consequences of intentional self-harm, Y88.0 Consequences of the adverse effects of a drug, pharmacological agent and biological substance used for therapeutic purposes, Y88.1 Consequences of an accident to a patient during surgical and medical procedures, Y89 Consequences of other external causes)

4. Information about palliative care: Assessment of the applicability of therapeutic privilege

Being informed about the possibility of receiving palliative care, depending on the circumstances, may be perceived by the patient as well as the doctor and other medical personnel as conveying favourable or unfavourable information (Bandieri et al., 2024; Kaminska et al., 2022). The principles of delivering bad news are included in the Polish Code of Medical Ethics (the CME) and legal regulations. The CME's Article 18 requires a physician to convey information about a poor prognosis to a patient with tact and caution. In addition, the CME stipulates that news of the diagnosis and poor prognosis may be withheld from the patient only if the doctor is firmly convinced that its disclosure will cause very serious suffering to the patient or other adverse health consequences.

The possibility of limiting the information provided by a doctor to a patient, referred to as therapeutic privilege, has also been regulated in Polish law. In light of Article 31(4) of the LPPD, in exceptional situations, if the prognosis is poor for the patient, the doctor may limit information about their health status and prognosis if, in his or her judgement, the patient's best interests warrant it. The law allows for the possibility of limiting unfavourable information about one's health status and prognosis, unlike the CME, which in addition authorizes a doctor to limit information about a diagnosis, significantly expanding the scope of application of therapeutic privilege. According to opinions presented in doctrine and jurisprudence, to the extent that the principles contained in the CME contradict the law, the criteria of the law apply, which supports the rejection of the possibility of limiting information on diagnosis (Ambroziak, 2021; Hajdukiewicz, 2023; Karcz-Kaczmarek & Maciejewski, 2015). Also, the literal wording of Article 31 of the LPPD, taking into account the relationship of paragraph (1) to paragraph (4), leads to the conclusion that withholding information about a diagnosis is unacceptable.

Information on a patient's health status is not defined in law. In the light of the wording of Article 31(1) of the LPPD, it should be emphasized that it does not cover the diagnosis, diagnostic and therapeutic methods, the consequences of their application or omission, the results of treatment or the prognosis. It may constitute general information presenting the patient's health situation, which, in the case of an unfavourable prognosis, defines his or her condition, for example, as very serious, serious or critical, as well as a more detailed description of the symptoms and problems. Information about an unfavourable prognosis, on the other hand, refers specifically to what the course of the disease will be, as well as to impending death. Information about health status and prognosis, understood in this way, may be limited only in exceptional situations where the prognosis is unfavourable for the patient and, as judged by the doctor, it is in the patient's best interest. The complete exclusion of information covered by the scope of therapeutic privilege may raise doubts, while Article 31(4) of the LPPD only provides for the possibility of limiting it. It is worth underlining that information about palliative care cannot be classified as information about health status as well as prognosis, because it constitutes information about available treatment options.

There are also different views in the doctrine of law which question the literal interpretation of Article 31(4) of the LPPD presented above and allow the possibility of extending therapeutic privilege, especially to include information about the diagnosis (Kubiak, 2017). The inadmissibility of limiting information about the diagnosis is supported both by linguistic interpretation and by the way therapeutic privilege is structured in Polish law, as an exception to the obligation to provide the patient with full information. In light of the general principles of legal interpretation, exceptions must be interpreted strictly, and, as Boratyńska rightly points out, it is not permissible to expand the scope of therapeutic privilege by invoking states of emergency or general clauses (Boratyńska, n.d.; Boratyńska, 2013). Bączyk-Rozwadowska (2011) also justifies the necessity of communicating the diagnosis, confirming that information about a serious, life-threatening disease cannot be withheld from the patient.

With the assumption that therapeutic privilege entitles the doctor to restrict information only within a narrow and well-defined scope, the issue of how to convey unfavourable information which is not subject to restriction comes to the fore. As Dukiet-Nagórska (2008) rightly notes, the essence of the problem is not whether to inform the patient, but how to convey the information. There are communication techniques that make the process of conveying unfavourable information easier for doctors and reduce the risk of iatrogenic effects of such a conversation in the psychological sphere of the patient (Jarosz, 2013). The most proven and also the most widely used technique in clinical practice is the SPIKES protocol; its use according to the indicated stages requires providing the right conditions for the conversation, checking what the patient already knows about his or her situation, exploring what he or she wants to know, gradually conveying information, responding to the patient's emotions, summarizing and establishing a plan of action (Baile et al., 2000).

Providing information to chronically ill patients is a complex process that needs to be considered at various stages of illness, diagnosis and treatment, and with the participation of doctors of various specialities and other medical professionals. The scope of the information provided and the application of therapeutic privilege can shape the patient's situation in the course of subsequent treatment, including palliative care. For an autonomous decision to be made, the person should be aware of the benefits and risks of potential treatments – and these issues need to be openly discussed. Information about the possibility of providing palliative care constitutes information about possible treatment methods, which is not subject to restriction under the terms of therapeutic privilege. Indeed, there is no doubt in the doctrine that the patient has the right to know possible methods of treatment and the consequences of their application, even when they are not used in the institution where he or she is staying (Nesterowicz, 2021; Szafran, 2016). A broad interpretation of the scope of therapeutic privilege can lead to a limitation of information about the diagnosis of a serious illness, making it difficult for the patient to realistically assess the situation and make a choice of treatment appropriate to his or her condition and in accordance with his or her preferences. In such circumstances, the patient may consider the initiation of palliative care to be unjustified, leading to it being abandoned or delayed, resulting in suffering that could be effectively alleviated.

The way in which therapeutic privilege is regulated indicates that Polish law guarantees the patient broad access to information even when the prognosis is unfavourable and when, according to the doctor, the patient's best interests justify limiting such information. Information about the diagnosis, proposed and possible diagnostic and treatment methods, the predictable consequences of their use or omission, and treatment results is obligatory in these circumstances, which also includes information about the possibility of providing the patient with palliative care.

The above considerations do not apply to the specific situations in which the patient has expressed a desire to obtain information, as well as the circumstances in which he or she has objected to being informed. It should be emphasized that in each case, the patient should receive the requested information on his or her health status, to the extent specified in Article 31(1) of the LPPD. A patient's request for information excludes the possibility of applying therapeutic privilege and obliges the doctor to provide the requested facts. In accordance with the above considerations, these special circumstances do not affect the provision of information about the possibility of palliative care, which the physician cannot limit as part of therapeutic privilege. On the other hand, the effect of the patient's request is that they must be fully informed about his or her health status and prognosis. The doctor is obliged to provide information about the diagnosis, proposed and possible diagnostic and treatment methods, the foreseeable consequences of their use or omission, and the results of treatment, even if the patient has not requested these details.

In turn, in accordance with Article 31(3) of the LPPD, the patient's objection releases the doctor from the obligation to provide information, which, depending on the patient's will, may apply to everything or selectively. An unambiguous and unquestionable demand by a patient who does not want to be informed leads to a situation in which the patient will not be familiarized with possible treatments, including palliative care, which will result in the abandonment of treatment and its consequences (such as suffering or hastening the patient's death). It should be emphasized that in circumstances where the patient does not want to be informed, Article 31(3) of the LPPD does not explicitly provide for an obligation on the part of the physician to refrain from providing information, but only exempts the doctor from having to inform. Also, Article 9(4) of the LPR does not explicitly provide for the patient's right not to be informed, but only for the right to present the medical professional with such a request. Even if the patient does ask not to be informed, there may be arguments that they need to be, as there may be consequences of this decision – such as being at risk of future harm or not benefiting from a suitable treatment. Such a solution may lead to absolving the doctor from responsibility for informing the patient against his or her will, which confirms that Polish law primarily aims at the ultimate goal of providing information to the patient for them to make the decision.

5. Liability for violation of the duty to provide information on palliative care

The above considerations indicate that providing information about the possibility of providing palliative care to a patient is a physician's duty, which is not subject to limitation under the terms of therapeutic privilege. Refraining from providing information is permissible only if the patient explicitly requests it and understands the implications of not receiving it. In other cases, limiting information about the possibility of providing the patient with palliative care or completely concealing such an option constitutes a violation of the law and may lead to the legal liability of the doctor.

The professional liability of a physician is regulated in the Law of 2 December 2009 on Medical Chambers (Sejm of Poland, 2021) (the LMC), which provides in Article 53 that a physician may be punished for professional misconduct if he or she has violated the rules of medical ethics and regulations related to the practice of the medical profession. With that said, it is sufficient for one of the listed violations to occur for a doctor to be liable to a medical court (Kania, 2019). Restricting information on possible treatments, including palliative care, is a violation of both the obligation to provide information under Articles 31(1) of the LPPD and 9(1) and (2) of the LPR and of the principles of medical ethics, particularly Article 13(3) of the CME, which obliges a doctor to provide information on the possibility of another medical procedure. The situation is somewhat different with regard to information about the diagnosis, the concealment of which from the patient constitutes a violation of the law, although, under special circumstances (Article 17 of the CME), it is permissible in light of the principles of medical ethics. Nevertheless, the norms contained in the CME do not exclude or limit the professional liability of a doctor, the sufficient basis for which is the fulfilment of the premise of violation of the law. Determining a violation of the obligation to provide information about the possibility of providing the patient with palliative care may result in the medical court imposing a penalty from the list provided for in Article 83(1) LMC, which includes a warning, a reprimand, a financial penalty, a ban on holding managerial positions in healthcare for a period of one to five years, limitation of the scope of activities in practising the medical profession for a period of six months to two years, suspension of the right to practise medicine for a period of one to five years or deprivation of the right to practise medicine.

The obligation to inform the patient about the possibility of palliative care also stems from the patient's right to information, regulated by Article 9(1) and (2) of the LPR, and is primarily addressed to the doctor. The restriction or complete exclusion of this information is a prerequisite for civil liability for violation of a patient's rights, which may be incurred by a doctor or healthcare provider who provides healthcare services to a patient under the terms of Article 4(1) of the LPR. According to this provision, in the case of a culpable violation of a patient's right, the court may, under Article 448 of the Civil Code, award the injured party an appropriate sum as monetary compensation for the harm suffered. This claim is independent of other measures needed to remove the consequences of the violation. It should be emphasized that a doctor may also be liable for failure to provide information on treatment methods even if there are no consequences in the form of bodily injury or health impairment (Drozdowska, 2021).

Restricting information about the available option of palliative care coverage for a patient can also lead to the liability of the doctor or treatment provider for violating other patient rights. This includes, in particular, the right to treatment of pain, as set forth in Article 20(a) of the LPR, the right to health services that meet the requirements of current medical knowledge, as regulated in Article 6(1) of the LPR, and the right to die in peace and dignity, as set forth in Article 20(2) of the LPR. Failure to provide information could result in the patient suffering, resulting from the fact that he or she was not provided with palliative care at all or received it later than he or she was entitled to in light of the qualification criteria. If the lack of information or its late provision resulted in the patient suffering while dying, which could have been effectively alleviated as part of palliative care, the doctor may be liable for violating the right to die in peace and dignity. Then, in accordance with Article 4(2) of the LPR, the patient's spouse, his or her relatives or in-laws up to the second degree in the direct line, or a legal representative may demand an appropriate sum of money for a social purpose indicated by them, pursuant to Article 448 of the Civil Code. In turn, the violation of the right to treatment of pain or the right to healthcare services meeting the requirements of current medical knowledge, in circumstances where the patient is not provided with palliative care, allows the patient to claim monetary compensation before a court (Article 4(1) of the LPR).

Conclusions

Information about palliative care is part of the information that the doctor is obliged to provide to the patient and cannot be limited even if the doctor believes that it is in the patient's best interests. The need to provide it in conditions of unfavourable prognosis requires special attention to the manner of informing the patient and the application of the principles of communicating unfavourable information. These principles should be considered as standards of medical practice, the violation of which may result in civil or professional liability.

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