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PRIORITY CRITERIA FOR THE PROVISION OF MEDICAL ASSISTANCE VERSUS PROTECTION OF HUMAN DIGNITY

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Abstract

The article deals with the potential infringement of human dignity through the choice of priority criteria for the provision of medical assistance in an emergency situation, when the treatment can only be provided for one person. The lack of sufficient equipment during the SARS-Cov-2 pandemic is a key example, but examples of acute shortage of medical personnel and various types of equipment are also analysed. The assumption made in the article is that selection guidelines need to be established for medical personnel.

The text presents the concept of violation of human dignity and the issue of inability to provide assistance to an adequate number of patients. Then, with the use of the dogmatic-legal method, the proposed patient selection criteria such as age, social position, physical condition, and occurrence of comorbidities are analysed.

As a result of the analysis, it is concluded that, due to the protection of human dignity, it is unacceptable to take away the assistance already provided for a patient (disconnection from the apparatus) in order to save the health of another patient. The criterion of assessing the patient's health condition is unquestionable, whereas the choice of other decisive factors, such as a person's social standing, may lead to unjustified discrimination and inequality.

Keywords: human dignity, pandemic, hierarchy of legal goods

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INTRODUCTION

It seems obvious that there are borderline cases in which a man is forced to choose between two equally undesirable types of conduct. Such circumstances include all types of natural catastrophes but also those caused by people. Local events or hypothetical scenarios do not attract much interest and do not provoke deeper reflection. However, when a real situation concerns most countries of the world and poses a threat to health and life of many people, we start observing problems that were not noticed before. The pandemic caused by SARS-Cov-2 virus at the turn of 2020 undoubtedly changed the social views on many aspects of life.

In the course of an epidemic, it is much easier to imagine a situation in which medical personnel are forced to choose one of two patients that need treatment because they cannot rescue both (limited amount of medical equipment is a widely commented example of such situations).[1] A medic is faced with a choice then:[2] should he/she choose to rescue a person with a higher chance of survival, a person who needs specialist equipment to survive, a younger person, or perhaps a person who used to be his patient?[3]

This text presents issues concerning the selection of a person who should be provided with assistance taking into account the proposal to develop criteria for this choice. It is a controversial issue because Poland, like other European countries, ensures legal protection of human dignity, and therefore laying down fixed "priority" criteria for the provision of medical assistance may raise doubts connected with potential infringement of human dignity.[4]

The case regarding lack of a respirator analysed in the doctrine is only one of many scenarios of the situation in which a medic is forced to choose a patient for whom he will provide assistance. The problem concerning inability to provide assistance for everybody who needs it is not new, and it is not going to disappear with the end of the pandemic; it will remain relevant for a long time.[5] This document analyses two types of situations: failure to provide assistance to a patient due to the shortage of medical personnel (medics may deal with a limited number of patients at the same time), and due to insufficient amount of equipment (a patient is provided with a medic's assistance but it is insufficient due to the need to use specialist equipment). The lack of both: personnel and medical equipment may pose a threat to a patient's life and health. Therefore, most of these situations are treated similarly and the possibility of providing assistance to one person constitutes the main issue at hand.[6]

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[1] Giezek, J., 'Kolizja obowiązków spoczywających na pracownikach opieki medycznej w dobie pandemii COVID-19', *Palestra*, 2020, No. 6, p. 29.

[2] Not only physicians but also other representatives of medical professions may face such dilemmas and that is why they are referred to in this paper as medics or medical personnel.

[3] J. Giezek gives various examples of reasoning in this regard: Giezek, J., 'Kolizja obowiązków spoczywających na pracownikach…', op. cit., pp. 39–40.

[4] Tarapata, S., 'Problem rozstrzygania prawnokarnej kolizji dóbr w trakcie wykonywania świadczeń zdrowotnych', *Palestra*, 2020, No. 6, p. 187.

[5] Kulesza, J., 'Kolizja obowiązków pomocy (art. 162 k.k.)', *Prokuratura i Prawo*, 2007, No. 2, pp. 28–29.

[6] The type of necessary medical equipment is not taken into consideration in this article.

It is obvious that such situations should not occur in a perfectly governed state (as well as a hospital managed in a model way), and shortages and problems with medical services result from organisational negligence, which J. Giezek highlights.[7] This observation is accurate and it is necessary to emphasise the role of resources managersin the healthcare system. Nevertheless, it is difficult to imagine states or institutions fully be prepared for such critical situations, even if they do not concern a world pandemic but a sudden increase in demand for particular medical services.[8] Thus, the discussion regarding the application of law at the time of the pandemic is not aimed at analysing errors in health care management (which is an important issue but deserves a separate analysis conducted by specialists[9]) and preventive activities, but at attempting to answer the question how to respond to the already existing crisis-related situation.

SITUATION ASSESSMENT FROM THE PERSPECTIVE OF CRIMINAL LAW

As a rule, refusal to provide assistance to one of the patients may result in the criminal liability of a medic who is obligated to provide assistance. Medical personnel may be liable for an act of failure to provide assistance laid down in Article 162 PC because, according to the representatives of the doctrine, as people with specialist medical knowledge, they are obligated to provide assistance in a wide range of areas.[10] On the other hand, if a medic has to guarantee that a consequence in the form of harm to the health of his/her patient will not occur, he may be subject to criminal liability under Article 160 § 2 PC.[11] In addition, a medic may be responsible for the future fate of their patient who has been refused assistance. As COVID-19 is a potentially lethal disease, in the context of possible penal consequences, it should

[7] Giezek, J., 'Kolizja obowiązków spoczywających na pracownikach…', op. cit., pp. 34–35.

[8] It may concern shortage of specialist personnel in every field (e.g. obstetrics or cardiology), life rescue equipment, or access to relevant infrastructure making it possible to operate on a patient in sterile conditions.

[9] For example, reference can be made to: Kubiak, R., 'Odpowiedzialność karna za błąd medyczny popełniony w zespołowym działaniu', *Medycyna Praktyczna*, 2012, No. 2; Skowronek, R., Chowaniec, C., 'Odpowiedzialność karna lekarza w zespołowym działaniu – ocena medyczno-sądowa skrajnie odmiennych przypadków klinicznych zakończonych zgonem pacjentów', *Medycyna Praktyczna*, 2016, and Kubiak, R., 'Odpowiedzialność karna za błąd organizacyjny w ochronie zdrowia. Część I: Niedomogi kadrowe', in: *Medycyna Praktyczna*, http://www.mp.pl/social/article/288749, 5.01.2022 (accessed on 11.10.2022); Kubiak, R., 'Odpowiedzialność karna za błąd organizacyjny w ochronie zdrowia. Część II: Nieodpowiednie warunki techniczne i sanitarne', in: *Medycyna Praktyczna*, http://www.mp.pl/social/article/291000, 7.02.2022 (accessed on 11.10.2022); Kubiak, R., 'Odpowiedzialność karna za błąd organizacyjny: Część III: brak procedur bądź ich nieprzestrzeganie', in: *Medycyna Praktyczna*, http://www.mp.pl/social/article/297361, 5.05.2022 (accessed on 11.10.2022).

[10] Giezek, J., in: Gruszecka, D., Lipiński, K., Łabuda, G., Muszyńska, A., Razowski, T., Giezek, J., *Kodeks karny. Część szczególna. Komentarz*, Warszawa, 2021, Article 162, p. 316.

[11] Zoll, A., in: Wróbel, W. (ed.), *Kodeks karny. Część szczególna. Tom II. Część I. Komentarz do art. 117–211a*, Warszawa, 2017, Article 162, p. 425; Kędziora, R., *Odpowiedzialność karna lekarza w związku z wykonywaniem czynności medycznych*, Warszawa, 2009, pp. 143–144.

be assumed that depriving sick person of proper care (including access to medical equipment) is connected with exposing them to the risk of losing life. Thus, it is potentially possible that the described act can be recognised as one causing serious harm to health or unintentionally causing death.

It is obvious that not every action performed by medical personnel may be recognised as a criminal offence. As indicated in the doctrine, when assessing behaviour, it is necessary to evaluate its various aspects. It is also important whether a potential perpetrator can be attributed a consequence in accordance with the established rules of objective attribution of an effect.[12] In the case discussed herein, the predictability of an effect does not raise doubts, however, other criteria can be differently evaluated. What is important in case of the activities within health care, is first of all taking appropriate precautions, which may differ depending on patient's health condition and the borders of admissible risk. Thus, the behaviour consisting in failure to provide assistance would have to contribute to the occurrence of a negative effect as well as be in conflict with the rules of dealing with a given legal good. The latter issue is described in more detail in the other part of the article. A separate issue that needs assessment within the given case is the possibility of avoiding an effect (e.g. in the form of a patient's death) if all the precautions are taken. However, this requires an analysis of a patient's health condition and circumstances in each individual case.

Obviously, in the case analysed herein, a member of medical personnel does not refuse to provide assistance to a patient because of ill will but because he/she needs to make the choice of providing assistance to one of the two patients. The problem of choosing one good at the expense of another is nothing new in the criminal law dogmatism, because rules of excluding liability of perpetrators of forbidden acts in extraordinary situations are laid down in statute. These scenarios definitely include state of absolute necessity and conflicting duties.

The state of absolute necessity may also be applicable in case of refusal to treat one of the patients and providing a respirator for another one, however, both the rescued an sacrificed goods are human life and health. Sacrificing a legal good of the same quality in accordance with Article 26 § 2 PC, cannot lead to the exclusion of lawlessness of an act but to the exclusion of an infringement perpetrator's guilt.[13] A perpetrator's act remains illegal, which may entail relevant consequences, although a perpetrator cannot be charged with culpable conduct.[14] Thus, the application of the state of absolute necessity will not always be favourable to a person making a choice as in the case discussed the conflict concerns the same type of legal good.

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[12] Giezek, J., 'Teorie związku przyczynowego oraz koncepcje obiektywnego przypisania', in: Dębski, R. (ed.), *Nauka o przestępstwie. Zasady odpowiedzialności. System Prawa Karnego. Tom 3*, Warszawa, 2017, p. 482 et seq.

[13] Kulik, M., in: Mozgawa, M. (ed.), *Kodeks karny. Komentarz aktualizowany*, LEX/el. 2022, Article 26; Giezek, J., in: Gruszecka, D., Lipiński, K., Łabuda, G., Giezek, J., *Kodeks karny. Część ogólna. Komentarz*, Warszawa, 2021, Article 26, p. 255.

[14] J. Lachowski draws attention to the possibility of effective use of necessary defence; Lachowski, J., *Stan wyższej konieczności w polskim prawie karnym / Jerzy Lachowski.*, Warszawa, 2005, pp. 122 and 176.

The concept of conflicting duties referred to in Article 26 § 5 PC does not solve the problem connected with the choice of a patient who is provided with a medical service because a medic is obliged to rescue both patients. According to J. Majewski's opinion widely shared in the doctrine, the occurrence of conflicting duties is often superficial and in reality only one duty incriminates a given person.[15] In case of providing assistance to patients, the simplest example of this reasoning is a scenario in which providing assistance to one patient is not possible (e.g. due to his specific needs). Thus, a medic cannot be charged with a failure to fulfil an obligation it was impossible to comply with. In accordance with this interpretation, conflicting duties will not occur when the subject of the obligation has access to clear criteria for choice, a specific hierarchy of obligations. Then, potentially conflicting duties consist in performing the duty with a higher priority.[16]

Both, the concept of conflicting duties and the state of absolute necessity assume a lack of a perpetrator's criminal liability, although on different grounds. According to J. Majewski's conception, conflicting interests occur seemingly, and a perpetrator's conduct will be lawful. If a perpetrator does not sacrifice a good of a higher value than the good rescued, in accordance with Article 26 § 2 PC, he will not be liable. Both conceptions assume evaluation of goods and lack of a perpetrator's liability. In the case at hand, unfortunately, it does not constitute a sufficient guideline on the desired conduct, because the rescued and sacrificed goods are a patient's health and life; it is not possible to predict with certainty which good is going to be sacrificed: a patient's life or "only" health.[17] For the person obligated, other guidelines concerning the method of choosing between duties would be useful.

Potentially, it is also possible to make a choice in the conditions for an error in judgement on the circumstance excluding criminal liability, which is stipulated in Article 29 PC. It may take place when a medic takes a decision based on a criterion that is not commonly accepted or because of misconception that such a criterion does not exist.[18] The issue concerning "justification" of an error may depend on the type of the final criterion and circumstances, including a common belief in medics' appropriate conduct in a given healthcare institution.

It is worth pointing out that in relation to the pandemic caused by SARS-Cov-2 virus, the Polish legislator decided to introduce a solution that excludes liability for acts connected with the exposure of patients to a loss of health in the circumstances discussed above. This liability at the time of a pandemic or a state of epidemic threat has been considerably limited under Article 24 of the Act of 24 October 2020 amending some acts in connection with combating crisis situations related to the occurrence of COVID-19 (Journal of Laws, item 2112) to cases of a flagrant failure to exercise obligatory caution. The solution may be recognised as too general or

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[15] Kulesza, J., 'Kolizja obowiązków pomocy…', op. cit., p. 29.

[16] Majewski, J., *Tak zwana kolizja obowiązków w prawie karnym*, Warszawa, 2002, pp. 150–151.

[17] In some situations a person who has not been provided with sufficient assistance will survive but may suffer from ill health. It is also unknown whether a person who has been provided with medical assistance would or survive without it or not.

[18] Giezek, J., in: Gruszecka, D., Lipiński, K., Łabuda, G., Giezek, J., *Kodeks karny. Część ogólna. Komentarz*, Warszawa, 2021, Article 29, p. 289 et seq.

adopted too hurriedly, however, as J. Potulski rightly observes, it is an expression of the will of the legislator who wishes to avoid application of criminal law towards people who provide assistance.[19] On the other hand, E. Plebanek believes that the solution is useless because of the existing criminal law regulations that exclude liability in atypical situations.[20] For sure, the solution does not resolve a dilemma faced by a medic who must choose a patient, because it does not indicate what criteria should be applied to make that choice and its action is considerably limited. Nevertheless, the concept of the so-called "good Samaritan laws" ensures that no choice made at the time of an epidemic or an epidemic threat will result in criminal liability, which may improve the comfort of rescuers' work.

PRELIMINARY THOUGHTS ON THE SHAPE OF THE CRITERION FOR CHOICE

In public discourse there is an on-going debate on the criteria for choosing a patient that should be rescued. The proposal to determine the priority of access to medical care needs a moment's reflection because at first glance it carries negative connotations of dividing patients into better and worse ones. Meanwhile, the adoption of clear criteria for choice would facilitate acting in difficult situations. There are reasons why in crisis situations medics apply the so-called triage, i.e. division of patients into those who need assistance immediately and those who can be provided with assistance a few hours later.[21] This hierarchical division of patients is not based on any discretionary criteria but on determining the needs-based order of providing assistance.[22] The application of triage optimises the process of providing medical assistance and really makes it possible to rescue more people. This worked-out procedure may be helpful in solving the above-mentioned dilemma as it indicates the category of urgency awarded to a patient after a medical interview and initial assessment of the situation. A triage nurse, medical rescuer or triage physician carries out the evaluation.[23] In spite of the hierarchy of patients, under normal circumstances, triage does not infringe human dignity. The category of urgency is not applicable to a patient personally but their health condition and

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[19] Potulski, J., 'Polski model »Klauzuli dobrego samarytanina«', *Studia prawnicze KUL*, 2021, No. 3, p. 175.

[20] Plebanek, E., 'Wyłączenie odpowiedzialności karnej za niewłaściwe leczenie w czasie pandemii COVID-19 a klauzula dobrego Samarytanina', *Palestra*, 2021, No. 1–2, https://palestra.pl/pl/czasopismo/wydanie/1-2-2021/artykul/wylaczenie-odpowiedzialnosci-karnej-za-niewlasciwe-leczenie-w-czasie-pandemii-covid-19-a-klauzula-dobrego-samarytanina (accessed on 22.02.2023), p. 63.

[21] § 6 subsections 7–9 Regulation of the Minister of Health of 27 June 2019 concerning Hospital Emergency Ward stipulates that a patient admitted to a hospital emergency ward shall be awarded one of five "urgency categories" marked with a relevant colour.

[22] In accordance with Article 33a para. 2 of the Act of 8 September 2006 on the State Medical Rescue (consolidated text, Journal of Laws of 2021, item 2053, as amended), the category awarded shall influence the period of waiting for the provision of the medical service.

[23] Article 33a para. 1 Act of 8 September 2006 on the State Medical Rescue (consolidated text, Journal of Laws of 2021, item 2053, as amended).

the assistance they need. The red category can be interpreted as the "worst" health condition but, on the other hand, it ensures the fastest provision of assistance, i.e. it "privileges" a patient. This simple comparison shows that in case of choosing the order of assistance provision, it is necessary to take into consideration more than the method of marking. Dividing patients into groups within this meaning does not infringe their dignity but helps to determine the order in which assistance should be provided.

The issues discussed in the article concern not only the choice of order but also a person who will be provided with this assistance because, under these assumptions, it is not possible to provide assistance to both patients. The triage system does not prevent such problems entirely, as there is always a possibility that there are two patients who should be provided with assistance at the same time or who need access to the same medical equipment.

In the meantime, it is worth determining a few rather obvious statements: in the situation discussed, two patientscannot be provided with assistance at the same time; it is necessary to choose a patient who can be provided with assistance. A choice made by a member of medical personnel in various scenarios concerns two people with a few different characteristics: these are age, present health condition, and probability of survival without appropriate personnel support. A decision should be taken quickly, and it concerns the potential future of both patients.

The lack of any criteria for acting in a crisis situation may have numerous negative consequences. For most people, the prospect of deciding about the life and death of two people is difficult to imagine. What is more, we should consider a quite real possibility of a medic being prosecuted after taking a decision with tragic consequences. For medical personnel who must face many different problems during a pandemic, additional fear that they could be charged with a medical error may be a paralysing factor. It is easy to imagine that such a person, trying to avoid potential accusations, provides only necessary assistance, which may be insufficient. On the other hand, acting in compliance with established guidelines may be recognised as observing necessary precautions, which influences the imputation of an effect, and thus, also a possibility of the decision-maker's criminal liability.[24]

Therefore, the issue of determining criteria for providing assistance to patients is very important, not only for pragmatic reasons. The choice is unavoidable and leaving the decision to the medics discretion does not eliminate doubts. What constitutes the main axis of the problem is not the question *whether* it is necessary to determine those criteria but the question *how* to determine them, how thoroughly they should be described, and how much discretion should be left to medical personnel.

Illustrative solutions to the lack of access to medical assistance are connected with patients' health condition, their characteristics (such as age or gender) or objective circumstances (such as time of arriving at hospital or another place of assistance provision). It would also be possible to draw lots to choose one of those

[24] Giezek, J., 'Teorie związku przyczynowego…', pp. 498–499.

who need assistance.[25] In practice, there may also be other, more individualised criteria, such as patient's job, family situation or good opinion of society. Various comparisons of the two patients' situations also take place: is it better to rescue a younger person or the one that was first to request assistance (was admitted to hospital earlier)? Perhaps the life of a social activist or a scientist working on tasks related to combating a pandemic should be worth rescuing first of all. In the caste system cultures, it is also important to which social group a patient belongs.

In the context of developing the criteria for choice, a question is raised who could be the authority responsible for determining them. J. Giezek is right to point out that lawyers are not more competent to do that than other people.[26] If those criteria were to comply with ethical requirements, it would be more appropriate to ask philosophers or moral philosophers to determine them, and medics to specify "rules of conduct". Lawyers, on the other hand, may assess whether the proposed criteria are in compliance with the legal system, in particular constitutional norms and legal principles. The crucial issue here is not only the assessment of formal legitimacy, but also recognition whether the proposed solutions result in unjustified discrimination against a certain social group or not.

PROTECTING HUMAN DIGNITY VERSUS DETERMINING THE CRITERION FOR CHOOSING A PATIENT

Prima facie, determination of strict criteria for the choice of a person who is provided with medical assistance infringes the principle of protecting human dignity. One of the reasons for such doubts may be an assumption that criteria, due to their nature, establish a hierarchy of people and divisions into better and worse ones. When analysing the infringement of human dignity caused by determining the criteria for the choice of priority assistance we must specify what this infringement may consist in and how to assess the infringement of human dignity principle, as well as what are the possible criteria for choice. It is also necessary to consider two issues at the same time, i.e. the very presence of criteria for the choice of a patient to be provided with medical assistance, and the shape of those criteria.

While the concept of human dignity alone does not have a single established meaning in the legal system, the concept of the infringement of human dignity can be specified based on court judgments and doctrinal opinions. It is commonly believed that the infringement of human dignity occurs when a person's individual value is negated and when a person is objectified and not subjectified.[27]

In accordance with the established meaning, the infringement of human dignity by public institutions may consist in such development of legal regulations that

[25] Tarapata, S., 'Problem rozstrzygania prawnokarnej kolizji…', op. cit., p. 184.

[26] Giezek, J., 'Kolizja obowiązków spoczywających na pracownikach…, op. cit., p. 29.

[27] The Constitutional Tribunal judgment of 15 October 2002, case No. SK 6/02 (OTK ZU, No. 5/A/2002, item 65); the Constitutional Tribunal judgment of 7 March 2007, case No. K 28/05, OTK-A 2007, No. 3, item 24; Piechowiak, M., *Filozofia praw człowieka. Prawa człowieka w świetle ich międzynarodowej ochrony*, Lublin, 1999, pp. 343–345.

deprives individuals of their own subjectivity. This does not mean, however, that each action of the state without a citizen's consent constitutes the infringement of their dignity.[28] To be recognised as one infringing human dignity, a regulation should be related not only to a person's humiliation but also to depriving a person of the possibility of choice and a top-down way of deciding about his/her fate without relevant justification. The concept of a regulation infringing human dignity is very difficult to define and in most cases the assessment of a regulation consists in listing the reasons for infringing human dignity and presenting an individual analysis of regulations.

In case of choosing a person who is to be provided with medical assistance, the infringement of dignity may occur when one of the persons encounters a temporary obstacle in the way of a hospital or another medical service provider's employees fulfilling their duties. It is also important that a person is not cast aside and their symptoms are not ignored even if the provision of assistance is delayed. Abandoning the provision of assistance completely and potentially causing patient's death would, for sure, constitute a threat to patient's dignity.

A top-down way of determining priority of medical assistance provision may be equivalent in meaning to the statement that it is admissible to sacrifice the life of a certain category of citizens; and such a possibility was ruled out as a result of the judgment of the Constitutional Tribunal of 30 September 2008, in which it was recognised that Article 122a Act of 3 July 2002: Aviation Law (on a possibility of shooting down an aircraft with passengers on board) is unconstitutional and infringes Article 30 of the Constitution, i.e. the principle of the protection of human dignity. The judgment concerned the possibility of shooting down a passenger airplane hijacked for the purpose of a terrorist attack. According to J. Kulesza, it is important that the Tribunal emphasises there is no possibility of weighing the value of life, which is important not only in connection with the provision analysed at that time but also in the context of other legal solutions, including the state of necessity.[29] It might seem that the judgment should end discussions concerning the issue of sacrificing the life of a group of people for the sake of rescuing others. However, the situation analysed in the judgment concerned a reversal of a threat to the life of many people by causing the death of others. In its judgment, the Tribunal referred to a hypothetical situation concerning a hijacked airplane with passengers on board; in such a situation, innocent passengers involuntarily become related to the object of an illegal assault.[30] They do not pose a threat to others but if there is no response, e.g. on the part of the state authorities, other people will be actively attacked. In case of providing medical services, it is not the first patient who is a direct source of threat to the second patient's life, but rather the health condition of the second

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[28] For example, the Constitutional Tribunal stated that the obligation to fasten seat belts in a vehicle does not infringe citizens' rights (the Constitutional Court judgment of 9 July 2009, SK 48/05, OTK-A 2009, No. 7, item 108).

[29] Kulesza, J., 'Zakres swobody organów administracji publicznej w podjęciu decyzji o zniszczeniu cywilnego statku lotniczego. Glosa do wyroku TK z dnia 30 września 2008 r., K 44/07', *Państwo i Prawo*, 2009, No. 9, pp. 126–127.

[30] Judgment of Bundesverfassungsgericht of 15 February 2006, 1 BvR 357/05, BVerfGE 115, 118.

patient when it is impossible to provide him with assistance. The need to provide assistance to one patient is not a source of health problems of another patient but can affect the increase in danger by limiting the possibility of providing assistance.

In case of earlier provision of assistance to one person, it can be stated that it was impossible to provide assistance to another patient in the same way as in case of the lack of medical equipment (or its damage). Barring the intervention, the situation might develop in a way that results in one person (or group) posing a kind of threat to the health and life of another person (or group).[31] W. Zontek cittes examples of an injured Himalayan climber who may pull his partner down a precipice, a hijacked airplane or conjoined twins of which only one sibling can survive separation. In the above-mentioned situations, a threat to health and life is not caused by human activities but stemms from them. On the other hand, in the situation, analysed in this article, where it is impossible to provide medical assistance for everyone, the direct threat to both patients does not consist in other patients but a disease and, indirectly, the lack of properly organised medical assistance.[32] This is what results in a difference between the above-mentioned example of a hijacked passenger airplane and patients during a pandemic. Two conclusions may be drawn from this comparison: the judgment of the Constitutional Tribunal should not be directly applied to the situation of patients during a pandemic and, what is more, if one of the patients is not a source of threat, the concept of necessary defence cannot be applied in the situation.

Inter alia, S. Tarapata refers to the above-analysed judgment of the Constitutional Tribunal of 2008, and discusses a situation in which a patient was disconnected from a respirator. The author believes that, due to the judgment of the Constitutional Tribunal, a medic should not have deprived the patient of the respirator.[33] It is difficult to disagree with this thesis but for other reasons than the judgment issued. A medic taking away assistance provided earlier (connection to a respirator) in fact causes a patient's death or poses this threat.[34] Causing death by itself does not automatically mean the infringement of human dignity of the person involved. If it were so, all cases of causing death would be classified as deprivation of human dignity.[35] However, in case of a potential act of taking away a respirator from a sick person, there is a possibility of infringing human dignity because the patient involved is treated as a temporary inconvenience in the application of the equipment. A person connected to medical equipment would not be treated differently than a temporary technical defect or the necessity for moving the equipment, which can

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31 Zontek, W., *Modele wyłączania odpowiedzialności karnej*, 2017, pp. 297–298.

32 Shortages in hospital equipment are discussed in the earlier part of the paper.

33 Tarapata, S., 'Problem rozstrzygania prawnokarnej kolizji…', op. cit., p. 188.

34 Ibidem, pp. 188–189. A situation in which patient gives or refuses to give consent to be disconnected from a respirator in order to provide assistance to another person should be assessed differently. In such a case, the issue concerning consent to expose patient to risk should be analysed, and this is not the subject matter of this paper.

35 This does not mean that causing death cannot also constitute the infringement of dignity, but it is not equivalent in meaning. The judgment of Bundesverfassungsgericht of 28 May 1993 – 2 BvF 2/90 und 4, 5/92 Rn. 158, Kirchhof, P., 'Genforschung und die Freiheit der Wissenschaft', in: *Gentechnik und Menschenwurde an den Grenzen von Ethik und Recht*, Köln, 2002, p. 18.

be "eliminated" in a relatively short time. From the point of view of the other patient, eventually classified for treatment with the use of a respirator, the equipment would be completely available provided that "the defect is eliminated", the equipment is transported or the former patient is disconnected. The only inconvenience would be related to the need to wait for the availability of the equipment. It would lead to equalising purely technical activities like the elimination of a defect with the disconnection of a patient from a respirator, which poses a real threat to his health and life. Such an instrumental action would be connected with the infringement of the constitutional obligation to protect life and human dignity.

A similar analysis was carried out under German law during the initial period of the pandemic caused by the SARS-Cov-2 virus. As early as in March 2020, the German Ethics Council (Deutsches Ethikrat) recognised the application of triage *ex post*, i.e. after the treatment of the first patient started, as inadmissible. T. Hörnle states in her analysis that acting against this directive might result in a criminal proceeding against the decision-maker because the conduct matches the features of the crime of murder.[36] Various proposals for excluding criminal liability due to the collision of obligations occurred in the German doctrine but, as it should be expected, a medic would have to fulfil all the conditions laid down in law.[37]

R. Poscher compares various situations in which the protection of one person's life was weighed and chosen at a cost to someone else's protection of life. As in the Polish legal system, in accordance with the values adopted in the German system, it is inadmissible to sacrifice one person's life in order to protect the other (as confirmed by the judgment of the Federal Constitutional Court on an act of shooting down an airplane). However, the author draws attention to the fact that the Court limits the weighing of the value of life and does not ban such activities completely.[38] It is possible to determine certain criteria for admitting a sacrifice of one person's life in order to protect the other.[39] According to the author, it is not possible, however, to state that the conflict of interests in the form of life and health of two patients infringes human dignity.[40] The infringement of human dignity must show other characteristic aspects than only the choice of a patient who is going to be provided with assistance; the infringement of dignity takes place when an individual's subjectivity is negated, and this depends on many factors.[41]

The development of the criteria for the choice of a patient to be provided with medical assistance as such should not be recognised as the infringement of human dignity. It constitutes a general directive, which not only facilitates activities of decision-makers but also, by establishing similar criteria, enables the state to indirectly supervise particular resolutions. Of course, the influence will be general

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36 Hörnle, T., 'Ex-Post-Triage – strafbar als Totungsdelikt?', in: Hörnle, T. (ed.), *Triage und die Pandemie*, 2021, p. 152.

37 Ibidem, p. 165.

38 Poscher, R., 'Die Abwägung von Leben gegen Leben. Triage und Menschenwurdegarantie', in: Hörnle, T. (ed.), *Triage und die Pandemie*, 2021, p. 51.

39 Ibidem, p. 60.

40 Ibidem, p. 81.

41 Ibidem, p. 67.

in nature because it is not possible to predict every situation. Thus, determining the criteria should be negative in nature, i.e. excluding the criteria for infringing human dignity, which would constitute a form of legal protection of this value.

PROPOSED CRITERIA FOR CHOOSING PATIENTS

A greater interpretational problem occurs in relation to the type of the criterion applied. As it was mentioned above, there are groups of criteria concerning patient's health condition and social position related aspects as well as actual circumstances.

First of all, it is necessary to definitely exclude the criteria concerning patients' personal characteristics such as their financial status, a position held or profession studied. None of these characteristics bears real relation to the provision of medical assistance. In addition, distinguishing some social groups this way leads to unjustified discrimination against others, thus, is in conflict with the constitutional principle of equality.[42] It cannot be justified by the usefulness of one individual for the society, because it is not a strict condition and subject to change due to the current demand in the state. Moreover, it is practically unrelated to the assistance provided. For various reasons, different social groups are recognised as inevitable for the functioning of the state. During the pandemic, the most appreciated professions included not only representatives of medical personnel but also scientists working on the development of new vaccines, employees of hygiene protection services, and even security services.[43] However, is the work of IT personnel and biologists not equally useful for the state? Creating a hierarchy of usefulness for the state among people holding various posts may lead to unjustified discrimination and result in taking away subjectivity from people holding "lower" positions: uneducated, unemployed and poor or homeless people. Such a criterion would infringe the constitutional principle of equality by differentiating people based on an inadequate criterion.[44] When it is necessary to choose a person to be provided with medical assistance, the criterion may infringe the principle of human dignity by assuming that less appreciated people do not deserve protection. Such an opinion negates not only an individual's subjectivity but also an assumption that every person deserves protection.

Specific opinions concern representatives of medical professions, who after their successful treatment might rescue other people. Thus, it might seem that they should be entitled to priority assistance due to the fact that they are potentially able to rescue other people and this way contribute to improving of the entire situation. It is very easy to

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[42] Judgment of the Constitutional Tribunal of 9 March 1988, U 7/87, OTK 1988, No. 1, item 1, should be recognised as important in this matter.

[43] Tarapata, S., 'Problem rozstrzygania prawnokarnej kolizji…', op. cit., p. 184.

[44] In accordance with a commonly adopted opinion, the principle of equality means equal treatment of people in comparable situations. Groups of entities may be differentiated based on "significant features", thus, the differentiation of the legal situation is admitted but not every type of differentiation is justified. Garlicki, L., Zubik, M., in: Derlatka, M., Działocha, K., Jarosz-Żukowska, S., Łukaszczuk, A., Sarnecki, P., Sokolewicz, W., Trzciński, J., Wiącek, M., Wojtyczek, K., Garlicki, L., Zubik, M., *Konstytucja Rzeczypospolitej Polskiej. Komentarz. Tom II, wyd. II*, Warszawa, 2016, Article 32.

refer such reasoning to the situation of an epidemic threat, although in case of the lack of medical resources, it seems to be rather inadequate. On the other hand, even at the time of an epidemic threat, priority assistance to people with medical qualifications would be unjustified in relation to other patients. It would be necessary to substantiate which group of medics should be given the right to priority assistance and what is the link between their qualifications and providing assistance to a larger number of patients, since not every person with medical qualifications can actively combat a pandemic. The reasoning would be unjustified also because of the fact that various professional groups are involved in health protection activities. In case of a pandemic, one can mention scientists developing vaccines, who do not always have medical education. Granting priority assistance to all professional groups that could potentially contribute to combating a pandemic would raise doubts. Moreover, such reasoning cannot be referred to a non-pandemic scenario, in which the limitation of access to medical treatment results from other factors (e.g. insufficient amount of equipment).

Privileges aimed at compensating the additional risk to some social groups seems to be something different. During pandemic, this concerns, first of all, representatives of medical professions: physicians, nurses or rescuers but also employees of healthcare institutions, including administrative staff. They have everyday contact with infected people, thus, they are more at risk others. In addition, these are medics who have real influence on the reduction of negative effects of an epidemic, because they can rescue many people's health and life. Due to a considerably increased risk of being infected during a pandemic, the differentiation of the situation of those people in comparison with other patients-representatives of other professions should be recognised as justified, especially if other people are able to minimise the risk of infection (at least by avoiding social contacts). However, it is necessary to emphasise the extraordinary character of such a privilege. In non-pandemic scenarios in which an issue with insufficient availability of medical resources or assistance provided by medical personnel may occur, one group's privileges raise justified doubts. In spite of the fact that medics rescue people, under "normal" circumstances they should not have more privileges of access to medical services than other representatives of professions who carry the same risk (fire fighters, police officers or representatives of other services). On the other hand, in a global pandemic scenario, the employees of healthcare institutions constitute a group that is exposed to risk most of all. That is why the choice of a medic as a person entitled to priority assistance should not be treated as the infringement of the principle of human dignity protection. The choice is first of all justified by the reality at the time of a pandemic. In this case differentiating between patients' situation is admissible due to extraordinary circumstances and the necessity of carrying additional risks.

When access to medical services is most difficult, an age criterion is taken into account. Under this criterion people exceeding a certain age limit are not going to be treated.[45] The underlying assumption is that older people are usually in poorer

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[45] The criterion was taken into account unofficially, and some physicians' statements suggested that patients aged 80+ should not be provided with assistance. https://www.corriere.it/cronache/20_marzo_09/coronavirus-scegliamo-chi-curare-chi-no-come-ogni-guerra-196f7d34-617d-11ea-8f33-90c941af0f23.shtml (accessed on 9.08.2022), and offi-

health than younger people, and the frequency of chronic diseases occurrence increases with age. This assumption, although true, is not always legitimate. Nobody knows what age limit should be taken into account. Also, it cannot be excluded that an older person may have more chances for recovery than a young one.

The other group of criteria proposed also raises certain doubts. Based on them, a medic should provide assistance to patients on a first come, first served basis. The group of criteria concerning objective circumstances may include not only the order of reported cases but also other formal requirements for the provision of assistance, e.g. health insurance. The criteria within this group also seem to be inadequate. It is emphasised that earlier arrival at hospital does not mean that a given patient requires more attention; it can simply result from a shorter way to that facility. Adopting such a criterion would mean that patients residing closer to hospitals or being able to get to hospital faster (e.g. by their car or taxi without the need to wait for an ambulance) are in privileged situation.[46]

There is one more issue to be considered: obligation to rescue a person with a better prognosis. If this is a patient admitted to hospital later, and a patient connected to a respirator earlier is in a worse condition, the establishment of such a strict obligation would mean that the first patient would have to be disconnected and deprived of appropriate medical assistance. Such an obligation would mean the necessity of posing a threat to the disconnected patient and a medic's potential liability for negative effects of their decision, which can be excluded in case a legal obligation of such conduct is stipulated. There are various opinions on the issue in the doctrine; inter alia, disconnection of a patient is admissible if there are inherent reasons for disconnection (continued therapy is not going to succeed).[47] S. Tarapata states that such an obligation would be inadmissible due to the above-mentioned judgment of the Constitutional Tribunal of 2008.[48] However, as it was mentioned earlier, this judgment does not concern the situation directly under analysis, because a patient connected to a respirator does not pose a threat to another patient. Nevertheless, it is rightly pointed out that law should not legitimise posing a threat to citizens. Such an assumption would mean that only the life of a patient in better health is worth rescuing while a more sick person should be deprived of assistance. At first glance it is evident that such a regulation may infringe the rights of a weaker patient. In particular, the life of one patient is in a top-down way recognised to be of lesser value than the life of the other, which may infringe the principle of equality and human

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cial directives suggest taking a patient's age into account but in conjunction with other features. Faggioni, M.P., González-Melado, F.J., Pietro, M.L.D., 'National health system cuts and triage decisions during the COVID-19 pandemic in Italy and Spain: ethical implications', *Journal of Medical Ethics*, 2021, Vol. 47, No. 5, DOI: 10.1136/medethics-2020-106898, p. 303; Monahan, C. et al., 'COVID-19 and ageism: How positive and negative responses impact older adults and society', *The American Psychologist*, 2020, Vol. 75, No. 7, DOI: 10.1037/amp0000699, p. 5; Riccioni, L. et al., 'The Italian document: decisions for intensive care when there is an imbalance between care needs and resources during the COVID-19 pandemic', *Annals of Intensive Care*, 2021, Vol. 11, DOI: 10.1186/s13613-021-00888-4, pp. 3–4.

[46] Tarapata, S., 'Problem rozstrzygania prawnokarnej kolizji…', op. cit., p. 188.

[47] Kulesza, J., 'Kolizja obowiązków pomocy…', op. cit., p. 33.

[48] Tarapata, S., 'Problem rozstrzygania prawnokarnej kolizji…', op. cit., p. 188.

dignity protection. The first patient, the moment the second one appears, becomes an unnecessary "burden", hampering medical personnel's work.

Thus, a medic is not obliged to provide assistance to a patient at a cost to the one for whom he has already provided assistance, and should not become subject to such an obligation. Quite conversely, there are grounds for stating that a medic is obliged to protect the life of "his" patient, i.e. a person for whom he was first to provide assistance.

The problem resulting from insufficient amount of equipment and human resources in fact translates into doubts whether certain particular criteria are admissible. Compliance with the principle of human dignity protection requires that the choice of order for providing assistance to patients should not negate the individuality of particular people. Human dignity may be infringed if one person is deprived of subjectivity. In this approach, the "withdrawal" or giving up the already made attempts to provide medical assistance may infringe human dignity (especially in case of the connection to medical equipment), because a patient is treated like a temporary technical defect. The issue of the choice based on a characteristics that has no medical justification is another matter. In this approach, it is clear that the profession and social position of a patient should not affect the order of providing medical assistance, but it is rather due to the possibility of discrimination and the infringement of the principle of equality and not dignity protection. The choice of a younger person or a person holding a higher social position does not have to mean the infringement of another person's dignity, provided that a sick person is treated with respect and offered another type of available assistance.

Undoubtedly, priority assistance should depend on medical factors, including the current health condition and a prognosis. As a rule, these factors are changeable to such an extent that they should be assessed by a medic on a case-by-case basis. Although, sometimes, medical assistance is provided first of all for patients who urgently need it, it concerns only simple cases in which the order of assistance provision does not pose a fatal risk. In the analysed case, during a pandemic, only one person can be chosen and provided with assistance, leaving the other one without care. From a medic's perspective it seems that providing assistance to a person in a better health condition is a more rational choice, because they are sure to save at least one person (provided that both patients are in a very serious condition endangering life). This does not exclude the provision of assistance to another person, although it may take place later or with the use of different measures.

Due to the spectre of possible actual situations, definite directives cannot be formulated *in abstracto*, but must be adjusted to particular circumstances. Therefore, it is a supervising physician who should assess a patient's health condition (on his own or together with other medical personnel). One can allege that the solution duplicates issues connected with the lack of any criterion, because it is again a medic who must take a critical decision. That is why, it is advisable to develop a legal state minimising the risk of criminal and civil liability of medics for their choice. In addition, one can call for the issue of guidelines for medics or provide training in the subject matter in order to facilitate the provision of medical assistance in critical situations. Co-decisions made in specific circumstances by a few medics

of various specialisations would also be a practical solution. On the other hand, imposing strict legal criteria will not fulfil its task, because they surely will not cover all possible situations.

It seems that, among all proposed criteria for determining priority assistance provision, a patient's health condition is the most appropriate one. The criterion is objective enough and it does not differentiate people based on factors independent of them (objective circumstances) or potentially humiliating ones (a social status criterion). On the other hand, it is a criterion that is closely related to assistance provision and although it is independent of patient's actions, it does not diminish the importance of an individual. A similar approach appears in the German doctrine, where it is also emphasised that the adoption of non-medical criteria may be connected with the risk of discrimination and nepotism.[49] In the Polish doctrine, the adoption of non-medical criteria is admitted in case of the same health condition of both patients; however, it raises doubts (J. Kulesza gives an example of choice between a young person starting a career and an older one with acclaimed input into the development of society).[50]

Apart from the above-described criteria, it is necessary to indicate one possibility that the legislator has at their disposal. A regulation might explicitly ban criteria based on age or social position, which would considerably reduce the risk of human dignity infringement. A regulation might be in the form of a ban on non-medical criteria, which would be the simplest solution, although, in essence, the same as an obligation to apply medical criteria.

CONCLUSIONS

Extraordinary, crisis-related circumstances often force choices that are ethically difficult and this way show what systemic solutions are necessary for appropriate functioning of the state. The pandemic highlighted the need for directives on acting in critical situations. It is especially important in case of medics who have to take decisions quickly and without access to complete data that they could need.

The establishment of a criterion alone does not determine its non-compliance with the constitutional principle of human dignity protection. Only particular specification of a criterion that leads to objectifying a given person may be recognised as being in conflict with the principle of human dignity protection. Each criterion humiliating a given social group or an individual to some extent may cause forbidden objectification. That is why similar criteria should be expressly excluded. The choice based on utilitarian criteria will infringe human dignity.

A criterion should also be related to the nature of assistance provided. Within this sense, patient's financial status or profession should not affect the provision of

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49 Hörnle, T., 'Ex-Post-Triage – strafbar als Totungsdelikt?…', op. cit., p. 179; Poscher, R., 'Die Abwägung von Leben gegen Leben…', op. cit., pp. 74 and 81.

50 Kulesza, J., 'Kolizja obowiązków pomocy…', op. cit., p. 31.

assistance. Similarly, patient's age does not indicate how efficient assistance can be and if it is necessary.

In crises, it is not possible to fully exclude the risk of infringing human dignity or assessing a person through the prism of purely physical aspects of existence. At the level of general regulations, the state cannot approve of this type of assessment and it is obliged to prevent potential irregularities. What can minimise the above-mentioned risk are rules of conduct in particular circumstances, concerning the choice of a patient to be provided with assistance and laid down in regulations. However, they cannot legitimise the infringement of human dignity of any patients by recognising that some social groups do not deserve medical assistance. Departure from classification of patients based on their age or social position is the only way to comply with the principle of patients' dignity protection. That is why, apart from indicating the advantages of applying the criterion of a patient's health condition, introducing ban on the application of non-medical criteria can be recommended. It is necessary to exclude criteria that are only seemingly related to patient's health condition (like age or gender) because these aspects are not always really correlated.

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