

# Guidelines of the Polish Society of Anaesthesiology and Intensive Therapy defining the rules of qualification and criteria for admitting patients to anaesthesiology and intensive care units

Issued based on Art. 3 of the Regulation of the Minister of Health of 16 December 2016 on the organizational standard of health care in the field of anaesthesiology and intensive care (Journal of Laws of 2020, item 940, as amended)

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## PURPOSE OF THE GUIDELINES

The purpose of the guidelines is to define the conditions for employing physicians specialised in the treatment of adult and paediatric patients to work in anaesthesiology and intensive care units, which act in compliance with the priorities of patient treatment benefits and are compatible with the current medical knowledge. The subject of the guidelines is the patient and his/her welfare when in need of medical assistance, and when any delay in providing it could cause a life threat, severe bodily harm or severe health impairment.

## RECIPIENTS OF THE GUIDELINES

The guidelines are intended solely for medical specialists in anaesthesiology and intensive care as well as physicians undergoing specialist training in the field of anaesthesiology and intensive therapy and currently providing health services in anaesthesiology and intensive care units treating adults and children.

## INTRODUCTION

The Polish Society of Anaesthesiology and Intensive Therapy appointed the Working Group of Experts in the field of anaesthesiology and intensive therapy who were assigned to prepare this document. The key principle of the guidelines was based on the criteria of patient health benefits resulting from application of invasive therapeutic interventions conducted in anaesthesiology and intensive care units, starting with the highest level of patient benefits, followed by situation where benefits are less expected, and down to highly doubtful or a lack of benefits (referred to as 'priorities') [1, 2]. Specification of these principles is intended to assist specialists in anaesthesiology and intensive therapy in the qualification of patients who will potentially benefit from receiving intensive therapy in the anaesthesiology and intensive care units or paediatric anaesthesiology and intensive care units in circumstances which require the provision of prompt medical assistance in cases of life-threatening conditions, serious bodily injury or severe health disorders. All such situations demand clear-cut methodological support.

The present guidelines are applicable to management in anaesthesiology and intensive care units or paediatric anaesthesiology and intensive care units.

Qualification for treatment in the anaesthesiology and intensive care unit is always utilitarian yet consistent with the principle of the greatest chance of survival, recovery and return to society. The purpose of the document is to facilitate risk management in compliance with the risk management doctrine.

Due to limited access to reliable, evidence-based data, the guidelines are a result of the consensus of the Working Group. Additionally, the most common clinical conditions and situations that could qualify a patient for, or disqualify a patient from, treatment in the intensive care unit have been verified by the appointed Group of Experts. The members of the Board of the Polish Society of Anaesthesiology and Intensive Therapy, the chairman or delegated members of sections and branches of the Polish Society of Anaes-

thesthesiology and Intensive Therapy, and regional consultants in the field of anaesthesiology and intensive therapy were invited to express their opinions. Each of the experts assessed the correctness of decisions in individual clinical scenarios on a scale of 0–100, where 0 meant "I completely disagree with admitting the patient to the anaesthesiology and intensive care unit or paediatric anaesthesiology and intensive care unit", and 100 meant "I completely agree with admitting the patient to the anaesthesiology and intensive care unit or paediatric anaesthesiology and intensive care unit". The score to each answer was averaged. The analysis was the experts' subjective assessment, and therefore it should only play an additional, advisory role in making clinical decisions.

## DISCUSSION OF RECOMMENDATIONS

The task of intensive therapy is the application of advanced, highly specialized therapeutic methods and techniques by highly qualified medical personnel to save lives and restore or improve the health of the most seriously ill patients. When taking qualification-related decisions, the following should be considered: directness and degree of threat to life and health (i.e., failure or dysfunction, degree of severity or progression and organ damage), reversibility of the disease process, comorbidities, and the results of accessory examinations (imaging, laboratory tests, etc.) The results of accessory examinations cannot be an independent criterion; they should be regarded as one of the ways of assessing whether the previously indicated general medical criteria have been met. The main aims of accessory examinations are to determine more conclusively the patient's condition and to establish an appropriate prognosis. The patient's chronological age should not be a criterion; instead, his/her biological and functional status as well as the degree of impairment, disability or frailty should be taken into account. It is not recommended to qualify patients for admis-

### Prioritizing and qualifying patients for treatment in anaesthesiology and intensive care units

Priority	Description	Comments
1	The patient will benefit from treatment in the anaesthesiology and intensive care unit.	Patients in an imminent life-threatening condition, i.e. critically ill, with a previously known and potentially reversible cause of a life-threatening condition; patients requiring continuous, invasive and advanced monitoring of vital signs, procedures and methods normally available in the anaesthesiology and intensive care unit and not available in any other ward (unit) of the hospital [3]; patients requiring permanent presence of anaesthesiology and intensive therapy specialists on the ward as well as nursing staff qualified in intensive care and supervision of intensive care patients. Such admissions and employed human and technological resources are conducive to improving the patient's prognosis and quality of life.
2	The patient is likely to benefit from treatment in the anaesthesiology and intensive care unit.	Patients in an imminent health-threatening condition, unstable, with a diagnosed or suspected but potentially reversible cause of a life-threatening condition; patients requiring procedures and methods available in the anaesthesiology and intensive care unit as standard and not available in any other wards (unit) of the hospital [3]; patients requiring continuous, often invasive and advanced monitoring of life functions; patients requiring intensive and qualified nursing care and treatment by specialists in anaesthesiology and intensive care and their continuous supervision. Such interventions are likely to improve the patients' prognosis and quality of life.
3	It is not known whether the patient will benefit from treatment in the anaesthesiology and intensive care unit.	Patients in an imminent health-threatening condition but stable, previously treated in other hospital wards; patients whose condition may potentially deteriorate or become life-threatening and require the use of medical procedures, methods and techniques available as standard only in the anaesthesiology and intensive care unit [3]. Medical interventions undertaken in such patients may contribute to improvement of their prognosis or there may not be a positive effect improving prognosis. Such patients constitute a group in which, potentially, the policy of not initiating futile therapy will be applied [4, 5].
4	The patient will NOT benefit from treatment in the anaesthesiology and intensive care unit.	Patients who are not in an imminent life-threatening condition, stable, who from a medical and organizational point of view can be treated or monitored in other hospital wards; in whom it is not necessary to implement methods and techniques available as standard in anaesthesiology and intensive care unit; patients requiring only intensive medical care understood as increased supervision and provision of intensive care, i.e. patients who are "too healthy" to benefit from hospitalization in the anaesthesiology and intensive care unit. This does not mean that some patients from this group will not meet the criteria for admission to the anaesthesiology and intensive care unit in the future due to a change in their general condition and becoming unstable. Patients with a potentially irreversible cause of a life- or health-threatening condition, in whom implementation of methods and procedures available as standard in the anaesthesiology and intensive care unit [3] will not improve their prognosis and will not stop the inevitable progression of a fatal disease and prevent death; such patients who will not benefit from intensive care should be provided with palliative care instead of initiating futile therapy in them [4, 5], i.e. patients who are "too ill" to benefit from hospitalization in the anaesthesiology and intensive care since their negative prognosis will not change. Patients who legally objected to admission and treatment in the anaesthesiology and intensive care unit using life support equipment and methods available only in an anaesthesiology and intensive care unit. Organ donors or potential organ donors are excluded from this group.

sion to the anaesthesiology and intensive care unit solely on the basis of numerical data or prognostic scoring scales which are only of advisory nature. The recommended scales include APACHE II, SAPS II and SOFA for adults, and PIM, PRISM and PELOD for children. The activities of emergency response teams, for instance, may also be helpful in observing the trend of changes in those individuals who may require hospitalization in the anaesthesiology and intensive care unit. In order to establish a full clinical picture of a patient's condition, all the obtained information should be put together and analysed as a whole. A patient with a life-threatening condition is a priority before a patient with a health-threatening condition. However, the degree of threat in each of them should also be considered. Therefore, if a patient with a life-threatening condition is not in direct danger of death and his/her condition does

not require immediate interventions, while a patient with a health-threatening condition needs immediate medical assistance, the latter should unusually be admitted to the anaesthesiology and care therapy unit first. The procedures should consider the hospital environment, equipment and working conditions of the personnel, with possible rotation between the existing schemes (rotation of departments, staff, work of treatment teams, the order of admissions and procedures performed, or their temporary suspension). It should be made sure that the hospital care team members in the anaesthesiology and intensive care unit are provided with medical supplies, drugs, personal protective equipment and medical equipment, in accordance with the specified organizational standards of health care that are to be applied if serious damage to a patient's health is likely to occur in the near future. Under such cir-

**Selected clinical situations (defined in accordance with the current national and/or international guidelines) in favour of admitting the patient for treatment in the anaesthesiology and intensive care unit – Expert compliance > 75%**

Clinical scenario
Severe acute pancreatitis
Severe metabolic disorders
Subarachnoid haemorrhage with consciousness disorders
Acute respiratory failure in status asthmaticus
Acute respiratory failure in exacerbation of chronic obstructive pulmonary disease (which has not reached end-stage failure)
Acute respiratory failure of extrapulmonary aetiology
Acute liver failure eligible for liver dialysis
Acute metabolic complications in diabetes mellitus
Postoperative patients requiring special monitoring methods or organ function support
Hypertensive crisis with organ complications
Status epilepticus
Cranio-cerebral trauma with severe disorders of consciousness and/or acute respiratory failure
Multiple organ trauma
Anaphylactic shock
Distributive shock
Cardiogenic shock
Haemorrhagic shock
Septic shock, sepsis
Pulmonary embolism with respiratory and/or circulatory failure
Poisoning with drugs or other agents with severe disorders of consciousness and/or acute respiratory failure
Cardiac arrest in the course of a potentially reversible cause ("4Ts, 4Hs")
Acute respiratory distress syndrome (severe)

**Selected clinical situations (defined in accordance with the current national and/or international guidelines) where the decision to admit a patient to the anaesthesiology and intensive care unit is "DEBATABLE" – Expert compliance 25–75%**

Clinical scenario
Chromosomal aberrations: Edwards' syndrome (trisomy 18), Patau' syndrome (trisomy 13), Down's syndrome (trisomy 21 – with complex defects, especially of the heart)
Cancers depending on the stage and grade
Genetically determined metabolic diseases, disorders of metabolism of amino acids, lipids, purines, carbohydrates, and metals; peroxisomal, lysosomal diseases; mucopolysaccharidoses
Acquired syndromes with end-stage multiple organ failure in children, accompanying other congenital defects
Malnutrition (cachexia)
Surgical complications beyond their treatment
Acute kidney injury eligible for renal replacement therapy
Infectious complications without a possibility of carrying out effective causal treatment
Chronic respiratory failure requiring non-invasive ventilation
Diseases of the peripheral nervous system eligible for therapeutic plasma exchange
Condition after at least two ineffective bone marrow transplants due to onco-haematological disease with advanced graft versus host disease
Stroke requiring management available only in anaesthesiology and intensive care units
Multiple trauma
Injury to the central nervous system in children resulting from perinatal trauma, intrauterine hypoxia, birth asphyxia, encephalopathy
Infections and their critical consequences without a possibility of effective causal treatment
Exacerbation of chronic liver failure
Cardiac arrest due to a cause other than that described in the rule "4Ts, 4Hs"
Acute respiratory distress syndrome (mild)
Acute respiratory distress syndrome (moderate)

**Selected clinical situations (defined in accordance with the current national and/or international guidelines) that favour a decision AGAINST the patient's admission to the anaesthesiology and intensive care unit – Expert compliance < 25%**

Clinical scenario
Postoperative patients requiring standard care and therapy appropriate for postoperative departments
Patients in a vegetative state or with minimal consciousness (Cerebral Performance Category 3–4)
Patients with fatal brain injury (Cerebral Performance Category 5) who are not potential organ donors
Gastrointestinal bleeding, no shock
Irreversible multiple organ failure
Terminal neoplastic disease and/or not eligible for causal treatment
End stage degenerative and demyelinating disease of the nervous system in children
Advanced genetically conditioned neurodegenerative syndromes
Exacerbation of chronic respiratory failure in a child with confirmed irreversible damage to the central nervous system
Syndromes of complex and severe congenital defects in children in the end stage

circumstances, an individual in a state of health emergency should be attended to first. If life-threatening conditions of patients are comparable, rescue activities should be carried out first in the patient whose chances of survival are higher.

If a patient expressed a legally confirmed decision to refuse treatment in the anaesthesiology and intensive care unit, it should not be questioned or undermined. Each patient should be treated individually, and it should be made sure that the patient agreed or refused to undergo intensive therapy procedures (the steps should preferably be taken in advance). Before giving consent or refusing the treatment, the patient should be thoroughly informed about the consequences of his/her decision regarding life and health. Subsequently, if the patient maintains his/her decision, the decision is binding for the physician. It is important to make a record of the fact that detailed information has been provided and to obtain the patient's statement in writing or, if that is not possible, it may be an oral statement in the presence of at least two impartial witnesses who confirm the patient's decision in writing. The above considerations do not apply to unconscious patients. A person known to the patient may be a source of information about the patient's previously expressed decision. However, only the statement of a cognizant patient himself/herself is binding. Nevertheless, respecting the patient's decision does not mean that the patient (and much less people from the patient's environment) can force the physician to use intensive therapy methods and procedures that would be against currently applicable medical standards of treatment (current medical knowledge).

It is unacceptable to enforce a decision on admission to the anaesthesiology and intensive care unit based on grounds other than medical. Any

medical specialist is allowed to refer a patient to intensive care treatment in the anaesthesiology and intensive care unit if, according to the doctor's assessment and current medical knowledge, the patient will benefit from the treatment in the anaesthesiology and intensive care unit. Justification of the doctor's decision about the patient's hospitalization in the anaesthesiology and intensive care unit is verified by an anaesthesiology and intensive care specialist. It is obligatory that a qualification form for treatment in the anaesthesiology and intensive care unit is routinely used (Annex 1A – for adults, Annex 1B – for children), and this form should be included in the patient's medical history (in the original version or as a copy for the admitted patients) or in the medical report book (in the original version or as a copy for non-admitted individuals). It is medically justified to admit adult or paediatric patients defined as Priorities 1 and 2 to the anaesthesiology and intensive care unit. Patients identified as eligible for intensive therapy treatment should be promptly admitted to the anaesthesiology and intensive care unit. If it is impossible to admit a patient to the nearest anaesthesiology and intensive care unit, the physician referring the patient should contact the Crisis Management Centre to secure a place for the patient in another intensive care unit nearby. Then, the doctor's obligation is to make sure that the patient's hospitalization in that other intensive care unit is consistent with the aforementioned principles.

Admitting patients classified as Priority group 4 is generally unjustified. Admitting a Priority 4 patient should always be agreed upon with the physician in charge of the anaesthesiology and intensive care unit, and such information must be included in the patient's medical history. In medically doubtful situations (e.g. individuals from Priority group 3),

it is reasonable to call a medical case conference [6] and assess the patient's prognosis according to the current medical prerogatives; the likelihood of the patient's condition's being reversible should also be assessed. The assessment is based on the knowledge and experience of the conference participants. This assembly of consultants is also a good opportunity to assess potential benefits for the patient from implementation of the therapeutic methods (especially invasive) as well as human resources available in the anaesthesiology and intensive care unit. It is particularly important in the case of patients who are "too healthy" to benefit from treatment in the anaesthesiology and intensive care unit as well as in those patients who are "too sick" to benefit from such treatment, including those suffering from incurable neoplastic disease, end-stage chronic organ disease, patients after extensive surgery with post-operative complications and those with numerous co-morbidities that significantly affect the degree of disability and quality of life. Evidence that futile therapy has been initiated should be a strong prerogative to disqualify a patient from treatment in the anaesthesiology and intensive care unit. For a terminally ill patient, futile therapy means unnecessary suffering, pain, fear and loss of dignity in the face of death. Intensive therapy treatment must not be confused with intensive medical care and palliative care or hospice care. In terminal patients, the physician is not obligated to undertake and conduct futile therapy and apply emergency procedures, including resuscitation. Prolonging the dying process, combined with applying invasive procedures causing suffering for the patient, may be a violation of the patient's dignity. Therefore, the physician has to assess whether such actions are justified, or whether they are in conflict with the subjective treatment of the patient and respect for his/her right to a dignified death.

When determining the criteria for discharging an adult or paediatric patient from the anaesthesiology and intensive care unit, the same factors (priorities) should be taken into account that are assessed when determining their admission criteria. The patient should be discharged from the anaesthesiology and intensive care unit to another ward, care and treatment facility, nursing and care facility, or other therapeutic centres, or sent home immediately after their general condition has stabilized and the clinical criteria that do not qualify them for further treatment in an anaesthesiology and intensive care unit have been met (i.e. the patient is no longer in Priority group 1, 2 or 3); the patient should receive written and oral prescriptions and recommendations. Patients who will not benefit from treatment in the anaesthesiology and intensive care unit and

whose intensive therapy should not be continued due to the irreversibility of the disease process (i.e. Priority 4) should be discharged from hospital and receive palliative, hospice or another type of care to let them die with dignity.

The policy of planning the availability of intensive care units/stations to cover the current needs should be implemented responsibly and the methods of transferring patients between intensive therapy units should be formulated. This task rests with the health care organizer in the entity performing medical activities. From an intensive therapy management perspective, the relationship between the demand for intensive therapy and its supply is the most important aspect of this overall health situation. When the level of resources is sufficient to meet the demand, proper management of intensive therapy consists only in rationing it according to the norms of its practical rationality (i.e. not applying intensive therapy when it is ineffective or unnecessary). When the level of resources is insufficient, ordinary (i.e. when the resources are relatively insufficient) or extraordinary (i.e. when there is an overall shortage of resources), rationing is necessary. In this context, continuing treatment that will no longer be beneficial for the patient (i.e. will not improve the prognosis) is unjustified, and it removes the opportunity for prompt implementation of effective intensive therapy in patients who are in a real life-threatening or health-threatening condition. Decisions about readmission of the patient to the anaesthesiology and intensive care unit are complex and should be made by a team, conciliarly, as in the case of Priority 3 patients.

The medical criteria for admitting adult or paediatric patients for treatment in the anaesthesiology and intensive care unit in the case of catastrophes, mass accidents, natural disasters, epidemics and other emergency situations which will pose a threat to human life or health on a large scale may only exceptionally diverge from the principles described in this document and under such circumstances the criteria should always be consistent with the consensus statement of the Polish Society of Anaesthesiology and Intensive Therapy, independently of this document. The statement should contain medical indications for admitting patients to the anaesthesiology and intensive care unit and describe the algorithm of each medical procedure, thereby ensuring synchronized cooperation of the medical and non-medical personnel, including the hospital administrative personnel, when prompt, targeted actions need to be taken. First of all, in such circumstances, a transparent, fit-for-ability and fair process of qualifying for treatment, regardless of age, sex, religion, origin, etc., should be ensured.

The procedure of such intensive care triage has been described previously [3]. It is impossible to produce uniform recommendations for all emergency situations, and this issue is beyond the scope of the present document.

As of the date of publication of this document, the “Guidelines of the Polish Society of Anaesthesiology and Intensive Therapy defining the rules of qualification and criteria for admitting patients to anaesthesiology and intensive care units – February 2012”, of February 22, 2012, shall become invalid.

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