

Bioethical dilemmas on medical grounds – psychological perspective

Dylematy bioetyczne na gruncie medycyny – perspektywa psychologiczna

Justyna A. Kaczmarczyk¹, Monika Szpringer²

¹Doctoral Studies, Faculty of Medicine and Health Science, Jan Kochanowski University, Kielce, Poland

Head of the Department: Prof. Marianna Janion MD, PhD

²Department of Social Prevention, Institute of Public Health, Faculty of Medicine and Health Science, Jan Kochanowski University, Kielce, Poland

Head of the Department: Prof. JKU Monika Szpringer MD, PhD

Medical Studies/Studia Medyczne 2017; 33 (1): 67–72

DOI: <https://doi.org/10.5114/ms.2017.66961>

Key words: death, consent, patient rights, treatment.

Słowa kluczowe: śmierć, zgoda, prawa pacjenta, leczenie.

Abstract

The rapid development of medicine that has taken place in the last 10 years confronts personnel with new challenges that extend beyond life-saving treatments; they include moral, legal, and deontological dilemmas, which can be recognised as bioethical ones. The new discourse of patient's participation in planning their treatment makes it impossible to remain indifferent to their expectations and will, the patient's approval, and declaration of intent on the healing process, and at the same time not to respect their basic privileges guaranteed by law and those arising from the codes of ethics. Humans are a bio-psycho-physical unity, and therefore should be perceived from a holistic perspective. This article presents the different dilemmas concerning the treatment of patients in the terminal stage of disease, including minors. It indicates the assessment and the prospect of death, from the child and adult perspective. It recognises patient's rights, his/her autonomy, dignity, subjectivity, but also the responsibilities and duties of health care personnel, taking into account respect for the patient, his/her independence, the adequacy of activities, and reference to the principle of double effect.

Streszczenie

Intensywny rozwój medycyny w ciągu ostatnich lat stawia przed personelem medycznym nowe wyzwania dotyczące nie tylko zabiegów ratujących życie, lecz także zagadnień moralnych, prawnych i deontologicznych, które można ująć jako dylematy bioetyczne. Dyskusja o udziale pacjenta w planowaniu jego leczenia powoduje, że nie można pozostać obojętnym na oczekiwania pacjenta co do zgody na proces leczniczy i oświadczenia woli, nie respektując jego podstawowych przywilejów, zagwarantowanych przepisami prawa, a także wynikających z kodeksów etycznych. Człowiek jest jednością biopsychofizyczną i konieczne jest postrzeganie go w perspektywie holistycznej. Artykuł ukazuje różne dylematy dotyczące leczenia osób w terminalnym stadium choroby, w tym niepełnoletnich. Wskazuje na perspektywę śmierci – z pozycji dziecka i dorosłego. Ujmuje prawa pacjenta, jego autonomię, godność, podmiotowość, a także powinności służby zdrowia, uwzględniając poszanowanie i autonomię pacjenta, proporcjonalność działań i odniesienie do zasady podwójnego skutku.

A wise man should know that health is his most precious possession.

Hippocrates

Introduction

Working with other people is associated with constantly having to deal with unpredictable situations that one has never experienced before and therefore has not developed any pattern of reactions. The human being is a bio-psycho-physical unity, a separate being, who has the right to self-determination. He/she is an indivisible whole, and not the sum of its parts. The essence of man is characterised by self-awareness, the ability to manage both development and behaviour. As an individual

living in a society he/she verifies this behaviour on the basis of what is accepted by common standards and principles, which may be either formal or contractual.

Examples include legal acts, specific sets of rules, codes, legal procedures, including the medical and the informal ones such as cultural norms or standard customs. An inseparable aspect of the morality of every human being is his/her personal moral sensitivity.

Each person creates their own system of ethical norms. To put it simply, the science that deals with the fundamental duties of a man towards other people is

called ethics [1]. In medicine, it is bioethics, which regulates the moral standards in relation to the scope and limits of intervention in human life, in its beginning, duration, and death [2]. One cannot treat a person as an object, because this would violate his/her dignity, and dignity and freedom are basic attributes of humanity [3]. Developmental psychology recognises the course of human life by describing its development phases. Ślipko [4] in his work refers to the three-phase rhythm of human life, which, according to him, includes the beginning, duration, and death. Similarly, while referring to these three phases we can speak of biogenesis, biotherapy, and thanatology.

Thanatology, as an independent scientific discipline, has its goal, object, and method, it is an integral part of bioethics, and belongs to the remaining disciplines of normative ethics. According to Adamkiewicz [5], thanatology deals with the so-called borderline situations of human existence, which among many others includes agony states. On its basis, the activities of doctors and medical staff should be recognised as multidimensional and multileveled, as well as being performed from a variety of individual perspectives. It is worth paying attention to the problem of dignified death in terms of bioethics, where on one hand we have the growing technological abilities to prolong life, and on the other it is necessary to respect human dignity in the face of death [6].

Death – conceptual scope

To address the problem of death, it is necessary to define it and to answer the question of when it takes place and what the death of a human being really is? This question is problematic, because depending on the paradigm that we operate in, the answers may be very different. Two aspects of death should be taken into account: the medical and philosophical (existential). Death is an inevitable end of human life. During the course of life we have little influence on it, and little possibility to control it or to create it. Death can be a result of exhaustion of the biological body, and the lack of vigour and stamina, the action of a pathogen (disease), or natural ageing. It can also occur as a result of the causal, direct (intentional or not) action of another person, or self-destructive behaviour. A significant number of medical scientists, specialists in the field, believe that death is a biological fact, a moment in space-time, which we call dying. In science, the term “death of personality”, defined in the context of social relations, that is understanding death as a social contract [7], did not last. The most fundamental characteristic of death is its irreversibility [5].

In our culture the subject of death is not publicly and widely discussed, especially not with children. It should not be marginalised, but should be presented to children, adequately to their comprehensive potential (intellectual and emotional), it ought to build

the appropriate representation of cognitive phenomenon of death. Depending on the phase of a child's mental development, the cognitive representation of death may vary. This is closely related to the way a child thinks. In middle childhood, understanding has a specific, imaginative character. Death imagined by 3 to 5 year-old children is often personalised and has a particular form. Mental processes at this age are devoid of abstract thinking, and children believe that death is a separation, a reversible process, that the deceased lives on. Hence, they easily accept death; it does not generate fear in them [8]. Fear is foremostly caused by the attitude of people from their immediate surroundings.

Older children also do not accept the basic attribute of death, which is a definite end of life. Therefore, they are not afraid of talking about it. If the conversations concerning death are carried out according to children's cognitive abilities, they provide knowledge and build a sense of security, especially in terminally ill youngsters uncertain about their future. Cancer is a critical event in the life of a young patient and his/her family, according to conceptual psychology [9]. Thus, people who directly or indirectly deal with cancer require not only professional medical care, but also the help of psychologists and therapists as the integrated treatment of terminally ill patients [10].

Conversations with minor patients about transience, about the end of life, should not be avoided, especially if they exhibit curiosity and desire to explore the world in this regard. It is a mistake that for the child's own good, one should not discuss death, ought not to name this phenomenon clearly, and use interchangeable terms, such as “going away”, “crossing to the other side”. What is important for building children's cognitive representation of death is a cognitive representation of the death of their parents and their personal attitude towards the process of dying. As Szewczyk [11] highlights, parents have strongly constituted motives for deciding to cure their children beyond fear, hope, and a sense of guilt, they reject the child's death as a natural event. In terms of lifespan psychology (Trempała) the child is in the first stages of life, and his/her death is a non-prescriptive event. From the perspective of an adult it is a destruction of the natural order. Accepting the death of a child is certainly more difficult than accepting the death of someone in old age. Dying is something very personal, individual; however, this process has a broader perspective, partly due to the large number of professionals involved in the difficult situation of the patient, including the circle of medical specialists [12, 13].

Treatment and its negligence

Salus aegroti suprema lex esto, means that the patient's health is his/her supreme right. This saying indicates the basic principle of a doctor's work and

creates the relativism in perception of actions undertaken for the patient. Vagueness of the statement ‘patient’s good’ appears significant especially when the subject of therapeutic activities is a person terminally ill, as well as a minor [14].

In medicine, the accepted rule is that the doctor’s duty is to save the patient’s life “to the end” and “at any price” by all possible means. The Hippocratic oath is often understood this way. Certainly, the basic role of medicine is taking any action to protect the health and life of a patient. However, is such a definition sufficient to resolve ethical dilemmas concerning a dying person? How should a doctor or medical personnel react when the patient, for instance, demands the use of all available therapeutic measures, including the ones that may increase the likelihood of death? Should they respect the patient’s desire to die, without commenting on the chances of curing or prolonging life?

A sick person cannot be treated instrumentally, solely as an object of treatment and medical procedures, devoid of the attribute of subjectivity. With the progress of civilisation and increasingly sophisticated methods of saving and prolonging human life, dilemmas concerning the limits of interference in human life and the natural dying process arise [12, 15].

From a psychological perspective of humanity and subjectivity of the individual, it should be noted that the primary purpose of medical treatment can neither be therapy alone nor its effectiveness. It is vital to remember that while helping one should not undermine important human values, not to deprive a patient of a sense of independence, the possibility to decide for themselves, and autonomy [16]. All somatic illnesses, especially incurable ones, present a patient with a mentally difficult situation, which is often accompanied by lowering of mood, decreasing self-confidence, inefficiency and disability, and above all fear [17, 18].

Defining and describing actions from the perspective of bioethics in thanatology, Ślipko [4] suggests looking at death as an irreversible and invincible phenomenon, especially while pondering the limits of activities that prolong life while suffering from an incurable disease. Despite medical and technical advances, including those in related science, there are critical points – the limits at which medicine does not give you any chance of recovery, and becomes part of the disrupted process of dying, which should run in a natural way. In Ślipko’s view, the physician’s actions in this situation are justified only if they are intended to reduce pain and suffering in dying. The author reminds us that agony and death belong to the category of human individual existence.

Morally unjustified and medically unfounded prolonging of biological life often makes human existence severely hurtful and debilitating, both for the patient and for the environment [19]. At that moment, we do not deal with the process of life, but with the

artificially maintained and prolonged process of dying. Such an existence becomes the source of disproportionate suffering, in which patient is “bestowed” with the possibility of technological immortality. At this point it is worth nothing that every person has the right to die with dignity, and no one has the right to convert his/her existence into a prolonged agony [12, 20, 21].

Today, these dilemmas are explained and regulated by legal documents. In our country it is the Constitution, the Criminal Code, the Code of Civil Procedure (CCP), or corporate codes such as the Code of Medical Ethics (KEL), declarations, regulations, resolutions, and other documents issued by important organisations of international and national range as well as scientific associations and unions. The basis of the procedures performed by medical staff while treating terminally ill people should be the ability to respect the autonomy and dignity of the patient, the adequacy of activities, and reference to the principle of double effect (action). In light of the above, a competent patient or his legal representative may at any stage of the disease report, request, or express consent for emergency treatment and/or even life support.

Patient’s consent for treatment

Independent consent may be given only by a patient with full legal capacity, who is in good psychophysical shape and capable of conscious expression of will. Hence, the patient can give consent only when his/her condition allows him/her to understand the information regarding his/her health and make an independent decision, appropriate to the information obtained, to submit to certain treatments and therapeutic procedures or refuse them. The scope of the consent must be clearly defined [14, 22, 23].

According to the law, a child up to 16 years of age has the right to express a desire for his/her needs in terms of treatment. As far as the right to perform medical procedures on the child is concerned, the consent of parents/guardian is required. Parents are the legal representatives of the child, provided that they are not deprived of parental authority and they are not incapacitated. A legal representative is the only entity that can give consent or object to therapeutic procedures. The decision to treat a minor under 16 years of age can be made independently by each of the parents, unless they relate to important issues for the child. According to art. 97 § 2 of the Family Code, parents decide together about important matters concerning the child. Hence, it is best when both parents make decisions regarding medical procedures that are going to be performed on a child, especially those with increased risk [23].

After becoming legally adult, i.e. – after turning 18 years old, even if the patient remains dependent on his parents, he/she has the right to self-determina-

tion, and is even able to prohibit informing the family about matters regarding his/her health. Between 16 and 18 years of age, in accordance with Article 3, paragraph 1 of the Act on Professions of Physician and Dentist, the patient can co-decide about any medical choices. Then, the consent of a legal representative is also required and in case of disagreement between the two sides, the conflict is settled by the family court. Such situations referred to in Article 17, paragraph 1 of the Act on Patients' Rights and the Commissioner for Patients' Rights: a minor who is 16, has the right to express consent to receive medical examination and/or other medical procedures ordered by a doctor. Likewise, the patient has the right to express objections to any medical procedures, in light of Article 17, paragraph 3 of the Act on Patients' Rights and the Commissioner for Patients' Rights [24].

The level of cognitive development of child's mind does not allow it to adequately assess the situation in the event of a severe, incurable disease. During a child's development, the concept of self becomes more accurate and it includes the concept of disease, while the improvement of mind functions is associated with greater opportunities to evaluate the course of treatment and its effects.

One cannot deny an adolescent whose mental development is normal, the ability to create their own concept of the disease and the possibility of assessing the situation as to the course of treatment (in practice, a minor patient must be 16 years old). Hence, cooperation and the relationship between therapeutic staff and the patient takes place on two levels: the child (patient) – the medical team and the guardians of the child – the medical team.

According to the Working Group on Ethical Issues Concerning End of Life, opposition or lack of consent to therapeutic activities results in a doctor's obligation to neglect the treatment. This obligation does not depend on the doctor's assessment of the usefulness of the therapy. Medical personnel do not need to regard therapy as being persistent or pointless, for the patient to be able to oppose it. According to the decision of the Supreme Court dated 27 October 2005., Ref. III CK 155/05, the principle of respect for patient autonomy requires respect of the patient's will, consequently it should be assumed that the patient's disagreement for surgery is binding for a doctor and therefore eliminates the risk of his/her criminal and civil liability [25].

From a psychological perspective, it is necessary to draw attention to the patient's informed consent in relation to medical services that are performed. The patient must fully understand all circumstances and have knowledge about therapeutic activities that are undertaken for his/her benefit [22, 26]. Obtaining the patient's agreement to the course of treatment makes him/her an active participant in the therapeutic process and gives greater assurance that the patient will

cooperate and comply with the doctor's instructions. Additionally, in modern medicine, the patient's consent must be carefully and precisely defined. It is necessary, for example, before surgery when the area that will be operated on may be difficult to predict and there might be the need to broaden the intraoperative field [22].

Referring to the issue of respect for patient autonomy, Szewczyk [11] points to solutions such as a declaration of intent, also called directives for the future. In Poland there are no legally sanctioned regulations regarding wills, or court orders concerning will of living and patients' counsellors, as is practiced in many countries around the world. Patients' formal written will relating to the way of their treatment, is mainly connected to negligence to take cardiopulmonary resuscitation (DNR). Such decisions and openly, consciously expressed will of the patient to discontinue treatment should be respected by healthcare professionals [27].

Often in medicine and bioethics one faces a difficult situation – when therapy ends, to which the physician and carers should encourage without applying too much pressure, and when treatment that prolongs suffering and does not allow the patient to die with dignity, should be terminated [3, 28].

Patient rights

An important problem in the case of terminally ill patients is their right to get a complete picture of their health condition. This fundamental law of every patient allows them to acquire the necessary knowledge on the diagnostic and therapeutic situation and consequently decide on an appropriate treatment, its form, or its termination [29]. The role of the physician is to provide patient with information in the most clear, comprehensive, and fully understood manner [30]. Polish law says that the patient has a right to complete information about the state of his/her health.

Only in justified cases, dictated by the patient's good, the doctor has the right to censor information, if he/she believes that its disclosure would be harmful for the patient's condition. This privilege is reflected in the Act on Professions of Physician and Dentist, article 31, section 4. The ethical aspect of this principle is sanctioned in article 17 KEL, stating that if the doctor believes that informing the patient about his/her poor health and adverse prognosis may cause him/her suffering or grave consequences for his/her health, he/she may choose not to communicate the information. However, at the patient's request the physician is obliged to provide full information on his/her condition. Under no circumstances can this information be withheld from a patient, including a minor one.

Children are especially sensitive to non-verbal signals and attempts not to provide them with the information directly. Lack of clear information evokes

a child's fear and impairs his/her sense of security, which significantly enhances the psychological discomfort. It is a false assumption that children are unaware of what is happening to them, that they cannot understand it, and the younger they are, the less they know, hence they stress less.

From a psychological perspective, the unethical conduct of not informing patient about the state of his/her health, real threats to his/her life as well as applied medical procedures, obstructs the patient's ability to form the cognitive structure known as the self-image of the disease. According to Heszen-Niejodek [17], the self-image of the disease consists of the following elements: an idea concerning the causes of health loss, essence or nature of the disease, a picture of the current state, views relating the ways of treatment, as well as predictions about the further course of the disease progress and its effects.

A doctor's conduct when informing a patient about an incurable disease and terminal condition requires knowledge of the meaning of various stages of this process, as well as empathy, precision, and attentiveness [31]. A doctor should acquire basic knowledge and skills in the area of psychology and crisis intervention, so that he/she can understand the situation of the patient facing death, not only from a medical perspective.

Another principle – proportionality of means of treatment, often called the principle of ordinary and unusual means of treatment – both regulates the rights and duties of the doctor towards the patient, but also the rights and obligations of the patient, in terms of ethics. Here, the patient is morally obliged to take a proportionate therapy, and medical personnel are not obliged to take up and continue the disproportionate one. This categorisation allows the principles of ethics of concern to be followed, such as rules obliging to minimisation of avoidable suffering.

This proposal of a moral approach to the obligation to use of therapeutic means indicates that the patient's opposition to the disproportionate treatment is not a suicidal act, and respecting the patient's will cannot be assessed as a shared responsibility for his/her death. The patient's will should also be unconditionally accepted by his/her family.

The principle of double effect is a matter of controversy and it is interpreted in a variety of ways. As Szweczyk [11] noted, article 150 of the Penal Code, which speaks of the act commonly called the mercy killing, collides with article 30 KEL, which obligates doctors to relieve the patient's pain and suffering until the end of his/her life. Suffering and physical pain justify the use of such methods and treatments that can help to minimise their source. This is one of the basic moral duties of a doctor towards the patient, whom he/she takes care of. The principle of the double effect relates to the important issue that pain-relief therapy

cannot be conducted at any cost, even at the cost of causing death. Such situations force us to ponder attitudes (as theoretical construct of the three aspects – cognitive, behavioural, and emotional), both of the dying person facing the end of life, but also those directly related to a dying person, family members, friends, and medical staff. The phenomenon of a person is to make informed and free decisions exceeding the limits of social conditions. Discussed issues relate to both the sick person (child) – dying, his/her loved ones, and those providing the assistance. The spiritual structure of a person makes him/her open to endless possibilities of progress and creativity [21].

The latest treatment methods and achievements in medicine are not always beneficial for the patient. Sometimes, instead of prolonging life, they prolong dying, causing disproportionate suffering and pain [32]. Accompanying a dying person one should try to be a careful listener, to be honest, not to give promises impossible to fulfil, not to give false hopes, not to comfort lightly, not to restrict the freedom of the patient limiting his/her choices or dictating what he/she should do [33].

Today, death is not taboo, but it is still a very difficult topic arousing a lot of emotions, especially when it concerns dying children. However, it should be remembered that the child is a separate entity and, depending on his/her level of biological development and psychological maturity, is capable of perceiving the surrounding reality and making decisions.

Conclusions

Medicine and psychology are fields of science that devote a lot of space to a person, albeit in different aspects. Their integration is, however, crucial for the patient. Every human interaction exerts a real influence and does not remain indifferent. It is important for this interaction to be positive, with no negative consequences for the individual psyche. It is worth seeking answers to questions concerning the ways of helping dying people, so as to respect their dignity and guarantee respect for their rights, while complying with one's own ethical system. It is also worth sharing knowledge in this area among health workers as well as the whole of society.

Conflict of interest

The authors declare no conflict of interest.

References

1. Kowalczyk S. Filozoficzne podstawy etyki pielęgniarstwa. In: *Etyka w pracy pielęgniarstwa*. Wrońska I, Mariański J (eds). Czelej, Lublin 2002; 39-60.
2. Muszala A. *Encyklopedia bioetyki*. Polwen, Radom 2005.
3. Kaczkowski J, Żyłka P. *Życie na pełnej petardzie, czyli wiara, połędwica i miłość*. Wydawnictwo WAM, Krakow 2015.

4. Ślipko T. Bioetyka. Najważniejsze problemy. Petrus, Kraków 2009.
5. Adamkiewicz A. Oblicza śmierci. Propedeutyka tanatologii. Europejskie Centrum Edukacyjne, Toruń 2004.
6. Li Y, Li J. Death with dignity from the Confucian perspective. *Theor Med Bioeth* 2017; 38: 63-81.
7. Becler R. Ewolucja operacyjnej definicji śmierci człowieka. *Prawo i Medycyna* 2015; 17: 37-45.
8. Mesjasz J. Kłątwa czy dar przemijania? Studium z tanatopsychologii. Difin S.A., Warszawa 2010.
9. Cieślak M, Bidzan M. Wzrost osobowy u młodzieży zmagającej się z chorobą nowotworową – charakterystyka zjawiska. *Psychoonkologia* 2015; 4: 152-60.
10. Kazak AE, Noll RB. The integration of psychology in pediatric oncology research and practice: collaboration to improve care and outcomes for children and families. *Am Psychol* 2015; 70: 146-58.
11. Szewczyk K. Bioetyka. Vol. 1. Wydawnictwo Naukowe PWN, Warszawa 2009.
12. Hegedus K. Bioethics as a key to well-being in illness. Ethical questions in palliative care. *Psychoonkologia* 2013; 2: 83-9.
13. Pająk K. Bioetyka a wybrane aspekty umierania człowieka. *Piel Zdr Publ* 2011; 1: 77-81.
14. Dąbrowski A. Próba samobójcza jako domniemana zgoda na podjęcie czynności leczniczych w celu ratowania życia. *Prawo i Medycyna* 2012; 3-4: 224-34.
15. Drabik K. Godność umierania jako podstawowy problem etyczny. In: *Etyka wobec sytuacji granicznych*. Probuca D (ed.). Oficyna Wydawnicza Impuls, Kraków 2007; 225-35.
16. Teopltz-Winiewska M. Etyczne aspekty uprawiania zawodu psychologa. In: *Psychologia. Podręcznik akademicki*. Vol. 3. Strelau J (ed.). Gdańskie Wydawnictwo Psychologiczne, Gdańsk 2005; 821-36.
17. Heszen-Niejodek I. Psychologiczne problemy chorych somatycznie. In: *Psychologia. Podręcznik akademicki*. Vol. 3. Strelau J (ed.). Gdańskie Wydawnictwo Psychologiczne, Gdańsk 2005; 513-31.
18. Bilikiewicz A. Zaburzenia psychiczne spowodowane chorobą psychosomatyczną. In: *Psychiatria. Podręcznik dla studentów medycyny*. Bilikiewicz A (ed.). Wydawnictwo Lekarskie PZWL, Warszawa 2011; 223-37.
19. Guevara-López U, Altamirano-Bustamante MM, Viesca-Treviño C. New frontiers in the future of palliative care: real-world bioethical dilemmas and axiology of clinical practice. *BMC Med Ethics* 2015; 16: 11
20. Kohlen H, McCarthy J, SzylitBuosso R, Gallagher A, Andrews T. Decision-making processes in nursing and activities at the end of life in intensive care – an international comparative study. *Pflege* 2015; 28: 329-38.
21. Gajdosz R. Koniec życia – aspekty medyczne, prawne i moralne. *Studia Medyczne* 2011; 24: 73-6.
22. Głuszek S. Problemy etyczne w chirurgii. In: *Przegląd piśmiennictwa chirurgicznego 2008*. Noszczyk W. Fundacja Polski Przegląd Chirurgiczny, Warszawa 2009; 1-9.
23. Hartman J. Bioetyka dla lekarzy. LEX a Wolters Kluwer Business, Warszawa 2012.
24. Augustynowicz A, Wrześniewska-Wal I. Dopuszczalność prowadzenia postępowania diagnostyczno-terapeutycznego na podstawie upoważnienia ustawowego przy sprzeciwie osoby uprawnionej do wyrażenia zgody na świadczenie zdrowotne – analiza wybranych regulacji prawnych. *Prawo i Medycyna* 2014; 1/2014 (54 Vol. 16): 47-60.
25. <http://www.prawapacjenta.eu/?pId=1657> (data dostępu 03.11.2016r.)
26. Stemplewska-Żakowicz K. Diagnoza psychologiczna. Diagnozowanie jako kompetencja profesjonalna. GWP, Gdańsk 2011.
27. Głuszek S, Rębak D, Kozieł D. Wybrane problemy bioetyczne w chirurgii. *Studia Medyczne* 2010; 20: 7-11.
28. Venkat A, Kim D. Ethical tensions in the pain management of an end-stage cancer patient with evidence of opioid medication diversion. *HEC Forum* 2016; 28: 95-101.
29. Kubiak R. Ograniczenie obowiązku informacyjnego ciężącego na lekarzu. *Med Paliat* 2014; 6: 101-10.
30. Głuszek S. Problemy etyczne w chirurgii. In: *Przegląd piśmiennictwa chirurgicznego 2000*. Noszczyk W (ed.). Fundacja Polski Przegląd Chirurgiczny, Warszawa 2001; 1-9.
31. Jankowska AK. Komunikacja medyczna w onkologii dziecięcej. Przekazywanie informacji o rozpoznaniu choroby nowotworowej. *Psychoonkologia* 2014; 4: 123-7.
32. Mariański J. Człowiek jako podmiot moralności – kontekst psychospołeczny. In: *Etyka w pracy pielęgniarskiej*. Wrońska I, Mariański J (eds). Czelej, Lublin 2002; 61-89.
33. Brzeziński J, Chyrowicz B, Poznaniak W, Teopltz-Winiewska M. Etyka zawodu psychologa. Wydawnictwo Naukowe PWN, Warszawa 2009.

Address for correspondence:

Justyna A. Kaczmarczyk

Doctoral Studies, Faculty of Medicine and Health Science
Jan Kochanowski University
al. IX Wieków Kielc 19, 25-317 Kielce, Poland
Phone: +48 600 832 129
E-mail: psycholog77@interia.pl