

Between procedural safeguards and the patient's best interests: physicians' experiences with judicial substitute consent in Poland—a cross-sectional survey

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Abstract

Background

Judicial substitute consent safeguards patients who lack decision-making capacity. However, procedural requirements for obtaining court authorisation may create tension with the need for timely treatment consistent with patients' best interests. This study assessed physicians' experiences with this procedure in adults and identified practical, legal and ethical challenges associated with its use.

Methods

We conducted a cross-sectional, anonymous online survey of physicians working in Polish hospitals with previous clinical experience of judicial substitute consent in adults. Organisational, legal and ethical aspects of the procedure were analysed using descriptive analyses, analyses of associations and multivariable logistic regression.

Results

The study included 159 physicians. Waiting time for a court decision was considered too long by 121 respondents (76.1%), and 107 (67.3%) reported at least one situation in which waiting was associated with the need to perform a procedure without prior substitute consent. Concern about legal liability for acting without substitute consent in an urgent situation was reported by 73 physicians (45.9%). Thirty-six respondents (22.6%) had been unable to obtain a second medical opinion; this was associated with greater concern about legal liability (odds ratio 2.55; 95% confidence interval 1.01–6.45).

Conclusions

Judicial substitute consent is an important safeguard, but its practical operation may create tension between procedural safeguards and timely treatment. The findings suggest a need for more predictable and efficient procedures that protect patients' rights while reducing the risk of delaying treatment consistent with their best interests. These findings may also inform comparable court-based consent systems internationally.

Background

Obtaining a patient's informed consent is a fundamental condition for the ethical and legal permissibility of medical intervention. When an adult patient lacks capacity to make decisions independently, legal systems provide various mechanisms of surrogate decision-making intended to protect the patient's autonomy, rights and best interests [1, 2]. These mechanisms serve an important safeguarding function by reducing the risk of arbitrary decisions made without the patient's involvement [1]. At the same time, their procedural requirements may prolong the decision-making process, potentially creating tension in clinical settings between procedural protection and the need to provide timely treatment consistent with the patient's best interests [3, 4].

In Poland, certain medical procedures involving patients who lack capacity to give informed consent require authorisation from a legal representative or the guardianship court. For adults who had previously made their own treatment decisions and have no appointed legal representative, a sudden loss of capacity may necessitate obtaining guardianship court authorisation [5]. These arrangements are intended to protect particularly vulnerable individuals, but their practical application requires cooperation among physicians, hospital administration and courts [1, 6]. Delays in

obtaining a decision, uncertainty about applicable requirements and physicians' legal liability may have not only organisational and legal but also ethical implications, affecting the ability to provide treatment consistent with the patient's best interests [3, 4]. This is particularly important in urgent situations, when the patient's clinical condition requires action before the formal procedure is completed. In such circumstances, a physician may provide necessary treatment without prior court authorisation, seeking a second physician's opinion where possible [5].

Despite the importance of these issues, empirical evidence on the operation of judicial substitute consent in clinical practice remains limited. A recent retrospective study of 240 court petitions from a Polish tertiary hospital reported a median time to judicial decision of five days but did not examine physicians' experiences of the procedure [7]. Available empirical studies have focused mainly on related problems involving care for patients without an authorised decision-maker and procedures for establishing legal guardianship [3, 4, 8]. In particular, little is known about process organisation, physicians' perceptions of waiting times for court decisions, difficulties in applying legal requirements, concerns about legal liability and the role of a second medical opinion. Although legal arrangements differ between jurisdictions, the underlying tension between procedural protection and timely treatment is not unique to Poland. This study therefore examined the experiences of physicians working in Polish hospitals with judicial substitute consent and identified practical, legal and ethical challenges arising from its use in adult patients.

Methods

Study design and questionnaire development

We conducted a cross-sectional, anonymous online survey of physicians working in Polish hospitals. The questionnaire was administered in Polish via Microsoft Forms from 31 March to 16 July 2026. Participation was voluntary, electronic informed consent was obtained before the survey, and the form collected no data allowing direct identification of respondents.

The questionnaire was developed by the investigators specifically for this study and has not been published previously. It was independently reviewed by an interdisciplinary panel of 11 experts: six legal professionals—four judges, an advocate and a legal counsel—and five physicians with relevant clinical experience. Each question was rated on a five-point scale for relevance, clarity and usefulness; experts could also provide comments and propose changes to the questionnaire's content and structure.

The pilot study was conducted from 19 August to 7 December 2025 and completed by 32 physicians. Based on the pilot findings, physicians in the first year of specialty training were included in the eligible population, selected questions were reordered, and minor wording changes were made without altering their meaning. Pilot data were not included in the main analysis.

The final questionnaire comprised 48 single-choice, multiple-choice and open-ended questions divided into two thematic sections. This analysis included 23 questions addressing physicians' experiences and the practical, legal and ethical aspects of judicial substitute consent. The remaining questions concerned knowledge and educational preparation and were outside the scope of this analysis. Branching logic was used, and all displayed questions were mandatory except the final open-ended question on proposed system changes. Estimated completion time was 6–10 minutes. An English translation of the complete Polish questionnaire is provided in the supplementary materials (**Supplementary Questionnaire**).

Participants and recruitment

Eligible participants were specialists and physicians in specialty training working in Polish hospitals, caring for adult patients, familiar with the concept of judicial substitute consent, and with previous clinical experience of the procedure. Eligibility criteria were assessed using screening questions with branching logic. Psychiatrists were excluded because of distinct legal and clinical considerations concerning consent in psychiatry.

Participants were recruited by convenience sampling through online professional groups, academic and professional networks, medical events and direct professional contacts. Of 199 individuals who opened the survey, 35 were excluded at screening: one did not consent to participate, 10 were unfamiliar with the concept of judicial substitute consent, 21 had never encountered the procedure, and three did not work in a hospital. A further five discontinued the survey, leaving 159 respondents in the final analysis. Because the recruitment channels were open and overlapping, a response rate could not be calculated.

Sample size

The minimum sample size was determined a priori in R version 4.1.2 using the `pwr.chisq.test` function from the `pwr` package. For a χ^2 test with one degree of freedom, assuming a medium Cohen's effect size of $w = 0.30$, a significance level of $\alpha = 0.05$ and statistical power of 0.95, the minimum required sample size was 145 participants. The final sample comprised 159 respondents.

Statistical analysis

Question-specific denominators were used because branching logic meant that not all questions were presented to all respondents. Multiple-choice questions allowed more than one response.

For analyses of associations, respondents' age was grouped into three categories: ≤ 31 , 32–42 and ≥ 43 years, and clinical experience into 1–5, 6–14 and ≥ 15 years. Specialties were grouped into four categories: neurology and neurosurgery, anaesthesiology and intensive care, surgical specialties, and internal medicine and related specialties. Frequency of encountering the need for judicial substitute consent was analysed in five categories: less than once a year, once a year, once every few months, once a month, and more than once a month.

Associations between categorical variables were assessed using Pearson's χ^2 test or Fisher's exact test, and the strength of associations was expressed using Cramér's V. A p value < 0.05 was considered statistically significant.

To identify factors associated with concern about legal liability for performing a procedure without substitute consent in an urgent situation, multivariable logistic regression was performed. The model included knowledge of the judicial substitute consent procedure, frequency of encountering the need to obtain it, perceived complexity of the relevant regulations, perceived difficulty applying them in everyday clinical practice, and previous experience of being unable to obtain a second physician's opinion. Results were reported as odds ratios (ORs) with 95% confidence intervals (CIs).

Numeric responses entered in open-text fields were standardised and grouped into categories. Responses to the final open-ended question on system changes were coded independently by two researchers using an inductive approach. Disagreements were resolved through discussion. A single response could be assigned to more than one thematic category. Non-substantive responses were excluded from the analysis.

Statistical analyses were performed using the R environment and STATISTICA 13.0.

Ethical considerations

The pilot study and main study received separate approvals from the Bioethics Committee of the Medical University of Lublin (KB-0024/88/05/2025 and KB-0024/37/03/2026, respectively). All participants provided electronic informed consent before taking part. The study was conducted in accordance with the principles of the Declaration of Helsinki.

Results

Characteristics of the study population and frequency of encounters with judicial substitute consent

A total of 159 physicians were included in the analysis. The median age was 37 years (interquartile range [IQR] 30–44), and the median duration of clinical practice was 10 years (IQR 4–16). Specialists comprised 57.9% of the study group (92/159), while physicians in specialty training accounted for 42.1% (67/159). The largest group consisted of physicians in neurology and neurosurgery (60/159; 37.7%), followed by internal medicine and related specialties (47/159; 29.6%), surgical specialties (39/159; 24.5%), and anaesthesiology and intensive care (13/159; 8.2%).

More than half of respondents encountered the need to obtain judicial substitute consent once a year or less often (90/159; 56.6%), 43 physicians (27.0%) reported encountering the procedure once every few months, and 26 (16.4%) at least once a month. Frequency of encounters with the procedure was significantly associated with professional status, hospital type, specialty, age and duration of clinical practice (all $p < 0.001$). The strongest association was observed for professional status (Cramér’s $V = 0.41$), followed by hospital type ($V = 0.37$), age ($V = 0.34$), duration of clinical practice ($V = 0.33$), and specialty ($V = 0.30$). Detailed data are presented in Table 1.

Table 1
Participant characteristics by frequency of encounters with judicial substitute consent

Variable	< 1 time/year	1 time/year	Every few months	1 time/month	> 1 time/month	Total	p	Cramér's V
Professional status							< 0.001#	0.41
Specialist physician	36 (73.47%)	31 (75.61%)	13 (30.23%)	7 (58.33%)	5 (35.71%)	92		
Physician in specialty training	13 (26.53%)	10 (24.39%)	30 (69.77%)	5 (41.67%)	9 (64.29%)	67		
Hospital type							< 0.001#	0.37
County hospital	13 (26.53%)	0 (0.00%)	6 (13.95%)	3 (25.00%)	3 (21.43%)	25		
Municipal hospital	9 (18.37%)	1 (2.44%)	2 (4.65%)	1 (8.33%)	1 (7.14%)	14		
Regional hospital	12 (24.49%)	33 (80.49%)	8 (18.60%)	0 (0.00%)	5 (35.71%)	58		
University hospital	15 (30.61%)	7 (17.07%)	27 (62.79%)	8 (66.67%)	5 (35.71%)	62		
Specialty							< 0.001#	0.30
Neurology / neurosurgery	17 (34.69%)	10 (24.39%)	22 (51.16%)	6 (50.00%)	5 (35.71%)	60		
Anaesthesiology and intensive care	0 (0.00%)	3 (7.32%)	3 (6.98%)	1 (8.33%)	6 (42.86%)	13		
Surgical specialties	20 (40.82%)	10 (24.39%)	7 (16.28%)	1 (8.33%)	1 (7.14%)	39		
Internal medicine and related specialties	12 (24.49%)	18 (43.90%)	11 (25.58%)	4 (33.33%)	2 (14.29%)	47		
Age							< 0.001#	0.34
≤ 31 years	12 (24.49%)	7 (17.07%)	28 (65.12%)	6 (50.00%)	8 (57.14%)	61		
32–42 years	18 (36.73%)	10 (24.39%)	9 (20.93%)	4 (33.33%)	5 (35.71%)	46		
≥ 43 years	19 (38.78%)	24 (58.54%)	6 (13.95%)	2 (16.67%)	1 (7.14%)	52		
Duration of clinical practice							< 0.001#	0.33

Variable	< 1 time/year	1 time/year	Every few months	1 time/month	> 1 time/month	Total	p	Cramér's V
Professional status							< 0.001 #	0.41
1–5 years	13 (26.53%)	7 (17.07%)	27 (62.79%)	5 (41.67%)	7 (50.00%)	59		
6–14 years	19 (38.78%)	10 (24.39%)	10 (23.26%)	4 (33.33%)	6 (42.86%)	49		
≥ 15 years	17 (34.69%)	24 (58.54%)	6 (13.95%)	3 (25.00%)	1 (7.14%)	51		
Total	49	41	43	12	14	159		

Data are presented as n (%). Percentages were calculated within categories of frequency of encounters with the procedure. p values refer to the test of association; Cramér's V indicates the strength of association. # Fisher's exact test; no symbol indicates Pearson's χ^2 test.

Organisation of the procedure and assessment of the legal framework

Respondents identified different individuals and organisational units as responsible for preparing and submitting applications for judicial substitute consent. For application preparation (n = 147), the roles most frequently identified were the attending physician (125; 85.0%), the legal department or lawyers (88; 59.9%), and the head of department (55; 37.4%). For formal submission (n = 143), the roles most frequently identified were the legal department or lawyers (104; 72.7%), the attending physician (85; 59.4%), and the head of department (53; 37.1%). Twelve respondents did not know who was responsible for preparing the application in their institution, and 16 did not know who was responsible for submitting it.

Responses concerning responsibility for these tasks differed significantly by hospital type. The strongest association was observed for the attending physician's involvement in submitting the application (Cramér's V = 0.52; p < 0.001) and for the head of department's involvement in both preparing and submitting the application (V = 0.49; p < 0.001 for both analyses). Weaker associations concerned involvement of the legal department or lawyers in preparing (V = 0.35; p < 0.001) and submitting the application (V = 0.27; p = 0.018), and involvement of the attending physician in preparing it (V = 0.28; p = 0.004). Detailed data are presented in Table 2.

Most respondents rated both the complexity of the regulations governing substitute consent and the difficulty of applying them in practice as moderate. The regulations were rated as difficult or very difficult in terms of complexity by 33/159 physicians (20.8%), and their practical application by 35/159 (22.0%). Perceived complexity of the regulations was significantly associated with hospital type (p = 0.009; V = 0.23), while perceived difficulty in applying them in practice was associated with hospital type (p = 0.002; V = 0.25) and specialty (p = 0.042; V = 0.20). No significant associations were found with professional status, age or duration of clinical practice.

Table 2
Responsibility for preparing and submitting applications for judicial substitute consent by
hospital type

Role / hospital type	No	Yes	Total	p	Cramér's V
Application preparation					
Attending physician				0.004 #	0.28
County hospital	7 (31.82%)	15 (12.00%)	22		
Municipal hospital	3 (13.64%)	11 (8.80%)	14		
Regional hospital	2 (9.09%)	54 (43.20%)	56		
University hospital	10 (45.45%)	45 (36.00%)	55		
Total	22	125	147		
Legal department / lawyers				< 0.001	0.35
County hospital	9 (15.25%)	13 (14.77%)	22		
Municipal hospital	7 (11.86%)	7 (7.95%)	14		
Regional hospital	11 (18.64%)	45 (51.14%)	56		
University hospital	32 (54.24%)	23 (26.14%)	55		
Total	59	88	147		
Head of department				< 0.001 #	0.49
County hospital	14 (15.22%)	8 (14.55%)	22		
Municipal hospital	12 (13.04%)	2 (3.64%)	14		
Regional hospital	19 (20.65%)	37 (67.27%)	56		
University hospital	47 (51.09%)	8 (14.55%)	55		
Total	92	55	147		
Application submission					
Attending physician				< 0.001	0.52
County hospital	13 (22.41%)	8 (9.41%)	21		
Municipal hospital	9 (15.52%)	5 (5.88%)	14		
Regional hospital	5 (8.62%)	51 (60.00%)	56		
University hospital	31 (53.45%)	21 (24.71%)	52		
Total	58	85	143		
Legal department / lawyers				0.018 #	0.27
County hospital	4 (10.26%)	17 (16.35%)	21		
Municipal hospital	4 (10.26%)	10 (9.62%)	14		
Regional hospital	9 (23.08%)	47 (45.19%)	56		

Role / hospital type	No	Yes	Total	p	Cramér's V
Application preparation					
Attending physician				0.004 #	0.28
University hospital	22 (56.41%)	30 (28.85%)	52		
Total	39	104	143		
Head of department					
County hospital	15 (16.67%)	6 (11.32%)	21		
Municipal hospital	13 (14.44%)	1 (1.89%)	14		
Regional hospital	19 (21.11%)	37 (69.81%)	56		
University hospital	43 (47.78%)	9 (16.98%)	52		
Total	90	53	143		

Data are presented as n (%). Percentages were calculated within the “No” and “Yes” columns. Multiple responses were permitted. Respondents who did not know who was responsible were excluded from these analyses; denominators were 147 for application preparation and 143 for application submission. # Fisher’s exact test; no symbol indicates Pearson’s χ^2 test.

Waiting time for a court decision and reported clinical consequences

Most respondents (121/159; 76.1%) considered the waiting time for a court decision too long. Of these, 78 physicians (49.1% of the total sample) rated it as somewhat too long and 43 (27.0%) as definitely too long. A total of 38/159 respondents (23.9%) considered it appropriate. Assessment of waiting time was significantly associated with hospital type ($p = 0.026$; Cramér’s $V = 0.21$) and specialty ($p = 0.004$; $V = 0.26$), while no significant associations were found with professional status, age or duration of clinical practice. Detailed data are presented in Table 3.

Respondents also reported clinical situations associated with waiting for a court decision. Overall, 107/159 respondents (67.3%) reported at least one situation in which waiting for the court’s decision was associated with the need to perform a procedure without obtaining prior substitute consent. Among these physicians, 24 (22.4%) reported one such event, 52 (48.6%) two to five, 13 (12.1%) six to ten, and 8 (7.5%) more than ten such situations. Ten respondents (9.3%) confirmed that such events had occurred but did not provide their number.

Table 3
Assessment of waiting time for a court decision by respondent characteristics

Variable	Appropriate	Somewhat too long	Definitely too long	Total	p	Cramér's V
Professional status					0.784	0.06
Specialist physician	23 (60.53%)	46 (58.97%)	23 (53.49%)	92		
Physician in specialty training	15 (39.47%)	32 (41.03%)	20 (46.51%)	67		
Hospital type					0.026 #	0.21
County hospital	5 (13.16%)	12 (15.38%)	8 (18.60%)	25		
Municipal hospital	3 (7.89%)	4 (5.13%)	7 (16.28%)	14		
Regional hospital	19 (50.00%)	32 (41.03%)	7 (16.28%)	58		
University hospital	11 (28.95%)	30 (38.46%)	21 (48.84%)	62		
Specialty					0.004 #	0.26
Neurology / neurosurgery	10 (26.32%)	35 (44.87%)	15 (34.88%)	60		
Anaesthesiology and intensive care	2 (5.26%)	2 (2.56%)	9 (20.93%)	13		
Surgical specialties	8 (21.05%)	23 (29.49%)	8 (18.60%)	39		
Internal medicine and related specialties	18 (47.37%)	18 (23.08%)	11 (25.58%)	47		
Age					0.559	0.10
≤ 31 years	14 (36.84%)	29 (37.18%)	18 (41.86%)	61		
32–42 years	8 (21.05%)	24 (30.77%)	14 (32.56%)	46		
≥ 43 years	16 (42.11%)	25 (32.05%)	11 (25.58%)	52		
Duration of clinical practice					0.543	0.10
1–5 years	15 (39.47%)	28 (35.90%)	16 (37.21%)	59		
6–14 years	8 (21.05%)	25 (32.05%)	16 (37.21%)	49		
≥ 15 years	15 (39.47%)	25 (32.05%)	11 (25.58%)	51		
Total	38	78	43	159		

Data are presented as n (%). Percentages were calculated within categories of waiting-time assessment for the court decision. Cramér's V indicates the strength of association. # Fisher's exact test; no symbol indicates Pearson's χ^2 test.

Legal representative, time limits and proposed system changes

Twenty-nine respondents (18.2%) reported at least one situation in which the legal representative of a legally incapacitated patient refused consent to the proposed medical procedure. These were most often isolated or occasional events: 14 respondents reported one such situation and 13 reported two to five. One respondent reported 10 such cases, and one did not provide the exact number. Among these 29 respondents, 12 did not remember the reason for the refusal, while eight indicated that no reason had been given. The remaining responses included doubts about the necessity or appropriateness of the procedure, limited understanding of medical information or unrealistic expectations regarding prognosis, religious or other beliefs, concerns about pain or the burden of treatment, previous negative experiences, and reluctance to assume responsibility for the risks associated with the decision. No respondent reported a situation in which the court agreed with the legal representative's position and refused consent to the proposed procedure.

Experience of refusal of consent by a legal representative was significantly associated with professional status ($p = 0.047$; Cramér's $V = 0.16$), hospital type ($p = 0.003$; $V = 0.30$) and age ($p = 0.010$; $V = 0.23$), while no significant associations were found with specialty or duration of clinical practice.

Most respondents (116/159; 73.0%) supported introducing a statutory maximum time for attempting to contact a legal representative before applying to the court for substitute consent in situations not requiring immediate action. Fourteen responses did not contain an interpretable time value and were excluded from further quantitative analysis. Among the remaining 102 respondents, the median proposed maximum time was 48 hours. A limit of no more than 48 hours was proposed by 56 respondents (54.9%), 42 (41.2%) indicated a period longer than 48 hours but no more than 7 days, and four (3.9%) a period exceeding 7 days. Support for introducing a statutory time limit was significantly associated with professional status ($p = 0.003$; $V = 0.23$), hospital type ($p < 0.001$; $V = 0.43$), age ($p = 0.001$; $V = 0.31$) and duration of clinical practice ($p = 0.001$; $V = 0.29$), while no significant association was found with specialty. Detailed data are presented in Table 4.

In the open-ended question, 105 respondents provided answers concerning possible system changes, of whom 80 made at least one substantive proposal. The most frequent suggestions were shortening the waiting time for a court decision or introducing clearly defined deadlines ($n = 32$), simplifying and standardising procedures ($n = 20$), improving communication between hospitals and courts, increasing digitalisation and organisational support ($n = 18$), and increasing physicians' autonomy, including allowing a medical team to replace court authorisation in selected situations ($n = 15$). Ten respondents proposed limiting physicians' legal liability or introducing no-fault protection, while nine indicated a need for additional training and education. Less frequently mentioned suggestions included advance directives, appointment of an additional legal representative, adapting the procedure to the patient's clinical condition, and abolishing the requirement for a second medical opinion. Five respondents considered the current arrangements satisfactory or saw no need for change. Twenty non-substantive responses were excluded from the thematic analysis; a single response could be assigned to more than one category.

Table 4
Consent refusal and support for a statutory time limit on contacting legal representatives

Variable	No	Yes	Total	p	Cramér's V
Refusal of consent by a legal representative					
Professional status				0.047	0.16
Specialist physician	80 (61.54%)	12 (41.38%)	92		
Physician in specialty training	50 (38.46%)	17 (58.62%)	67		
Hospital type				0.003 #	0.30
County hospital	22 (16.92%)	3 (10.34%)	25		
Municipal hospital	14 (10.77%)	0 (0.00%)	14		
Regional hospital	52 (40.00%)	6 (20.69%)	58		
University hospital	42 (32.31%)	20 (68.97%)	62		
Specialty				0.162 #	0.18
Neurology / neurosurgery	51 (39.23%)	9 (31.03%)	60		
Anaesthesiology and intensive care	10 (7.69%)	3 (10.34%)	13		
Surgical specialties	35 (26.92%)	4 (13.79%)	39		
Internal medicine and related specialties	34 (26.15%)	13 (44.83%)	47		
Age				0.010 #	0.23
≤ 31 years	47 (36.15%)	14 (48.28%)	61		
32–42 years	34 (26.15%)	12 (41.38%)	46		
≥ 43 years	49 (37.69%)	3 (10.34%)	52		
Duration of clinical practice				0.053 #	0.19
1–5 years	45 (34.62%)	14 (48.28%)	59		
6–14 years	38 (29.23%)	11 (37.93%)	49		
≥ 15 years	47 (36.15%)	4 (13.79%)	51		

Variable	No	Yes	Total	p	Cramér's V
Refusal of consent by a legal representative					
Professional status				0.047	0.16
Total	130	29	159		
Support for a statutory maximum time for attempting to contact a legal representative					
Professional status				0.003	0.23
Specialist physician	33 (76.74%)	59 (50.86%)	92		
Physician in specialty training	10 (23.26%)	57 (49.14%)	67		
Hospital type				< 0.001 #	0.43
County hospital	5 (11.63%)	20 (17.24%)	25		
Municipal hospital	1 (2.33%)	13 (11.21%)	14		
Regional hospital	30 (69.77%)	28 (24.14%)	58		
University hospital	7 (16.28%)	55 (47.41%)	62		
Specialty				0.576 #	0.12
Neurology / neurosurgery	15 (34.88%)	45 (38.79%)	60		
Anaesthesiology and intensive care	2 (4.65%)	11 (9.48%)	13		
Surgical specialties	10 (23.26%)	29 (25.00%)	39		
Internal medicine and related specialties	16 (37.21%)	31 (26.72%)	47		
Age				0.001	0.31
≤ 31 years	9 (20.93%)	52 (44.83%)	61		
32–42 years	10 (23.26%)	36 (31.03%)	46		
≥ 43 years	24 (55.81%)	28 (24.14%)	52		
Duration of clinical practice				0.001	0.29
1–5 years	7 (16.28%)	52 (44.83%)	59		

Variable	No	Yes	Total	p	Cramér's V
Refusal of consent by a legal representative					
Professional status				0.047	0.16
6–14 years	14 (32.56%)	35 (30.17%)	49		
≥ 15 years	22 (51.16%)	29 (25.00%)	51		
Total	43	116	159		

Data are presented as n (%). Percentages were calculated within “yes” and “no” responses for each question analysed. Cramér's V indicates the strength of association. # Fisher's exact test; no symbol indicates Pearson's χ^2 test.

Clinical uncertainty, legal liability and the role of a second medical opinion

Most respondents reported difficulties in determining whether a given medical procedure required substitute consent, although these difficulties most often occurred only occasionally. This response was given by 101/159 physicians (63.5%), while 25 (15.7%) experienced such difficulties sometimes and 8 (5.0%) often; 25 respondents (15.7%) reported never experiencing them. No significant associations were found between the frequency of these difficulties and professional status, hospital type, specialty, age or duration of clinical practice.

Concern about legal liability for performing a procedure without substitute consent in a situation considered urgent was reported by 73/159 respondents (45.9%). This concern was significantly associated with professional status ($p = 0.008$; Cramér's $V = 0.21$), hospital type ($p < 0.001$; $V = 0.39$), age ($p = 0.018$; $V = 0.22$) and duration of clinical practice ($p = 0.001$; $V = 0.30$), while no significant association was found with specialty.

Thirty-six respondents (22.6%) had experienced a situation in which a second physician's opinion could not be obtained before an urgent procedure. In this group, 24/36 physicians (66.7%) had performed a procedure at least once without substitute consent and without obtaining such an opinion, including 13 (36.1%) on multiple occasions. The absence of a second physician's opinion increased or would increase concern about legal liability in 98/159 respondents (61.6%). This association was significant for professional status ($p < 0.001$; $V = 0.42$), hospital type ($p < 0.001$; $V = 0.51$), age ($p < 0.001$; $V = 0.45$) and duration of clinical practice ($p < 0.001$; $V = 0.49$), while no significant association was found with specialty. Most respondents (126/159; 79.2%) considered obtaining a second physician's opinion by telecommunication to be acceptable. This response was significantly associated with professional status ($p = 0.003$; $V = 0.24$), hospital type ($p < 0.001$; $V = 0.33$) and age ($p = 0.001$; $V = 0.29$), but not with specialty or duration of clinical practice. Full results of the univariable analyses concerning difficulties in determining the need for substitute consent, legal liability and second medical opinions are presented in **Supplementary Tables S1 and S2**.

In the multivariable analysis, concern about legal liability was significantly associated with perceived difficulty applying the regulations in everyday clinical practice. The odds of reporting concern were 8.53 (95% CI 1.10–66.30; $p = 0.040$) among respondents rating the difficulty of applying the regulations as moderate and 55.97 (95% CI 3.61–869.08; $p = 0.004$) among those rating it as high or very high, compared with respondents rating the difficulty of applying the regulations as easy or very easy. A significant association was also found for previous experience of being unable to obtain a second physician's opinion (OR = 2.55; 95% CI 1.01–6.45; $p = 0.049$). Encountering the need to obtain judicial substitute consent once a year was associated with lower odds of reporting concern about legal liability compared with

encountering the need to obtain judicial substitute consent less than once a year (OR = 0.33; 95% CI 0.12–0.92; $p = 0.034$). The remaining predictors did not reach statistical significance. Results of the multivariable model are presented in Table 5.

Table 5
Multivariable logistic regression of liability concerns during urgent procedures without substitute consent

Predictor	Level	OR	95% CI for OR	p
Knowledge of the judicial substitute consent procedure	I know that such a procedure exists, but I do not know what it involves	0.80	0.24–2.67	0.721
	Yes, and I know what it involves	1.00	-	-
Frequency of encountering the need to obtain judicial substitute consent	Once a year	0.33	0.12–0.92	0.034
	Once every few months	1.58	0.62–4.06	0.338
	Once a month	2.26	0.50–10.28	0.292
	More than once a month	0.38	0.08–1.75	0.216
	Less than once a year	1.00	-	-
Perceived complexity of regulations concerning substitute consent	Moderate	0.51	0.11–2.33	0.386
	Difficult / very difficult	0.25	0.03–2.52	0.241
	Easy / very easy	1.00	-	-
Perceived difficulty applying regulations concerning substitute consent in everyday clinical practice	Moderate	8.53	1.10–66.30	0.040
	Difficult / very difficult	55.97	3.61–869.08	0.004
	Easy / very easy	1.00	-	-
Inability to obtain a second physician's opinion	Yes	2.55	1.01–6.45	0.049
	No	1.00	-	-

OR – odds ratio; CI – confidence interval. Reference categories are shown as OR = 1.00. Statistically significant results ($p < 0.05$) are shown in bold.

Discussion

Our findings suggest that judicial substitute consent, despite its fundamental protective function, may in practice generate substantial tension between protecting the autonomy, rights and best interests of a patient who lacks decision-making capacity and the need to provide timely and clinically justified treatment. This is not a marginal problem. Sessums et al. found decision-making incapacity in approximately 26% of medical inpatients, compared with 2.8% among healthy older adults [9]. Similarly, in a study of 3,746 individuals aged ≥ 60 years, Silveira et al. found that 42.5%

required treatment decisions near the end of life, and 70.3% of these lacked decision-making capacity [10]. The efficiency and quality of surrogate decision-making mechanisms are therefore important for protecting a substantial group of particularly vulnerable patients.

One of the most striking findings of this study is the scale of the time-related consequences of the procedure. In this study, 76.1% of respondents considered the waiting time for a court decision too long, and 67.3% reported at least one situation in which waiting for a decision was associated with the need to perform a procedure without prior substitute consent. Although a previous Polish retrospective study reported a median time to judicial decision of five days, the present findings suggest that even relatively short procedural delays may be perceived as excessive when clinical decisions are time-sensitive [7]. This reveals a potential ethical paradox: a mechanism established to protect the patient may, if it does not operate sufficiently efficiently, be associated with additional risk arising from delay in a clinically necessary intervention. The problem therefore cannot be reduced to a simple opposition between procedural protection and treatment efficiency. Rather, it concerns maintaining proportionality of safeguards: they should be strong enough to prevent arbitrary decisions made without the patient's involvement, while also being sufficiently efficient to avoid preventable harm.

Direct comparison between Polish judicial substitute consent and guardianship arrangements in other jurisdictions requires caution because they are distinct legal constructs. Available literature nevertheless indicates that the time required to establish a formal mechanism of representation may have measurable clinical and organisational consequences. Moye et al. compared patients hospitalised before appointment of a guardian ($n = 116$) with a control group ($n = 348$) [11]. Mean length of stay was 30.75 and 7.74 days, respectively ($p < 0.001$). After appointment of a guardian, mean length of stay was 11.65 days, while among 35 patients hospitalised both before and after guardianship was established, it decreased from 23 to 10.37 days ($p = 0.045$). Similarly, Ricotta et al. demonstrated a substantial burden associated with the guardianship process: mean length of stay was 31 days, and mean total hospital charges approximately US\$179,243 [12]. Although these data cannot be directly extrapolated to the Polish system, they indicate that delays associated with formalising representation may be linked not only to organisational consequences but also to the patient's clinical situation.

Particularly important evidence comes from the multicentre study by Smeraglio et al., which included 170 patients hospitalised in 14 Veterans Affairs hospitals while awaiting appointment of a guardian [13]. The median length of stay was 38.5 days. As many as 45% of patients experienced at least one event such as involuntary detention, a behavioural intervention, an attempted unauthorised hospital departure or use of restraints, while 28% experienced at least one hospital-acquired infection or fall. A guardian was ultimately appointed for 72% of participants. These findings are not a direct analogue of the Polish procedure, but they highlight an important relationship: a prolonged formal process may be associated not only with administrative burden but also with greater patient exposure to risks related to extended hospitalisation.

Similar consequences have been observed among patients without an available representative. Catlin et al. reported that professionals caring for such patients identified prolonged hospitalisation in 66% of cases, delayed palliative care in 52% and delayed treatment in 49% [14]. In the cohort studied by Bandy et al., which included 79 hospitalised patients awaiting appointment of a guardian, 32 underwent a total of 81 invasive procedures [15]. For 39 of these procedures, consent was not required because of the urgency of the situation or the medical necessity of acting in the absence of an available surrogate. Of 17 new decisions not to attempt resuscitation, eight were made by physicians without surrogate involvement. These observations correspond with one of the key findings of our study: failure to complete the formal procedure does not remove the need to make a clinical decision. It may instead place a greater burden of decision-making responsibility on the physician, who must act with limited procedural and legal certainty.

The consequences of delays also have a distributive justice dimension. Brierley-Bowers et al. analysed data from 31 of 56 acute care hospitals in Massachusetts and estimated that medically unnecessary hospital days associated with waiting for guardianship generated approximately US\$18 million in annual costs, with required revenues estimated at US\$20–24 million [16]. The ethical assessment of substitute consent should not, of course, be reduced to economic considerations. These data nevertheless show that a prolonged formal process may consume resources that could otherwise be used for other patients. The issue therefore concerns not only the best interests of the individual patient, but also the fair allocation of limited healthcare resources.

Against this background, the organisational variation between hospitals observed in our study is particularly important. Responsibility for preparing and submitting applications was assigned to varying degrees to attending physicians, heads of departments and legal departments, while some respondents did not know who was responsible for particular stages of the procedure. This suggests that the practical effectiveness of a formally uniform protective mechanism may depend on local organisational infrastructure and access to legal support. From the perspective of organisational ethics, this is important: the actual level of protection of patients' rights should not depend on the type of hospital in which they are treated or on locally established divisions of responsibility.

This finding should also be interpreted in the context of the fact that 73.0% of respondents supported introducing a statutory maximum time for attempting to contact a legal representative, with a median proposed duration of 48 hours. Open-ended responses were dominated by calls to shorten waiting times, introduce clearly defined deadlines, standardise the procedure and improve communication between hospitals and courts. This finding does not, of course, provide empirical justification for introducing a specific 48-hour limit. Rather, it points to the need for greater procedural predictability and for the intensity of safeguards to be adapted to the urgency of the situation, the level of risk and the reversibility of the clinical decision, so that the protective mechanism remains proportionate to the patient's actual needs.

A study of professional guardians also suggests the possibility of a similar tension. Cohen et al. analysed end-of-life decisions in 33 patients with a professional guardian. In 33% of cases, the guardian sought judicial review, while delays in decision-making were recorded in 42% [17]. Despite the small sample size, this observation is important because it suggests that adding another formal level of oversight may create a situation in which protection against an unauthorised decision begins to compete with the need to make that decision at the clinically appropriate time.

A second major problem identified in our study is legal uncertainty. Difficulties in determining whether a specific procedure required substitute consent were reported at least occasionally by 84.3% of respondents, while 45.9% were concerned about liability for performing an intervention without such consent in an urgent situation. Particularly noteworthy is that, in the multivariable analysis, it was not the perceived complexity of the regulations but the difficulty of applying them in practice that was significant. Compared with the reference category, the OR for concern was 8.53 for moderate difficulty in applying the regulations and 55.97 when their application was rated as difficult or very difficult. The very wide confidence intervals require considerable caution in interpreting the magnitude of these effects. The findings nevertheless suggest that concern may arise less from the complexity of the law itself than from uncertainty about how it should be applied in a specific, often rapidly changing clinical situation. This observation may justify considering clearer rules for applying existing exceptions to the requirement for prior court authorisation and a more efficient pathway for urgent cases, in order to increase legal certainty without weakening patient protection [5].

The broader literature on defensive medicine provides important, although indirect, context for this observation. A meta-analysis by Zheng et al., which included 64 studies and approximately 35,900 physicians from 23 countries, estimated the pooled prevalence of defensive medicine practices at 75.8% [18]. This figure cannot be equated with the concerns reported in our study because we did not directly assess defensive behaviours. However, the literature indicates that perceived exposure to legal liability may influence physicians' decision-making. From an ethical perspective, a

particularly problematic situation would arise when a clinician considers a particular course of action to be in the patient's best interests but refrains from it or chooses an alternative primarily because it is perceived as legally safer for the clinician.

A second medical opinion may be an important safeguard against such a conflict. In our study, 22.6% of respondents had experienced a situation in which a second opinion could not be obtained before an urgent procedure, and this experience remained independently associated with greater concern about legal liability. Moreover, 61.6% of respondents reported that the absence of a second opinion increased or would increase their concern, while 79.2% considered obtaining such an opinion by telecommunication acceptable. A second opinion may therefore be understood more broadly than solely as a form of legal protection for the physician. When a patient cannot express their wishes, involvement of a second clinician may provide an additional safeguard against arbitrary decision-making by enabling an independent assessment of the necessity and proportionality of the proposed intervention. The high level of acceptance of remote consultation may in turn indicate a practical way to preserve the safeguarding function of a second opinion without generating additional delay.

The availability of a surrogate does not eliminate decision-making difficulties. Torke et al. surveyed 281 physicians and found that, although a surrogate was available for approximately 90% of patients, difficulties contacting the surrogate occurred in 21% of cases; conflicts between physicians and surrogates were also reported [19]. In our study, 18.2% of respondents had experienced refusal of consent by a legal representative. Reasons for these refusals included differing beliefs and assessments of the appropriateness of the procedure, difficulties understanding medical information, unrealistic expectations regarding prognosis, concerns about suffering and the burden of treatment, and reluctance to assume responsibility for the potential consequences of the decision.

These observations should be considered in light of the limitations of surrogate decision-making itself. The systematic review by Shalowitz et al. included 16 studies, 2,595 patient–surrogate pairs, 151 hypothetical scenarios and 19,526 paired responses. Surrogates accurately predicted patients' preferences in approximately 68% of cases [20]. Formal authority to make decisions therefore does not guarantee that a decision will faithfully reflect the patient's autonomous preferences. This does not argue against surrogate decision-making or oversight of such decisions; on the contrary, it reinforces the need for appropriate procedural safeguards. The central challenge is to design these safeguards so that they increase the likelihood of a decision consistent with the patient's values or best interests without causing disproportionate delays in care.

The psychological burden of making decisions on behalf of another person should also not be overlooked. In the systematic review by Wendler and Rid, which included 40 studies and 2,854 surrogates, at least one third of participants in quantitative studies experienced negative emotional burden associated with making such decisions [21]. Reported effects included stress, guilt and persistent doubt, with consequences lasting for months and sometimes even years. These findings are complemented by data from Chiarchiaro et al. In a cohort of 471 surrogates for 257 critically ill patients, moderate or high levels of decisional conflict were identified in 48% of participants. Prior advance care planning conversations were associated with a mean score 3.3 points lower on the Decisional Conflict Scale [22]. These findings emphasise that a well-designed surrogate decision-making system should not only protect patients from arbitrary decisions or decisions contrary to their interests, but also provide appropriate support to those who bear the burden of decision-making.

Importantly, improving the decision-making process does not necessarily require weakening patient safety. In the systematic review and meta-analysis by Bibas et al., which included 13 randomised trials and 10,453 critically ill patients, interventions supporting surrogate decision-making were not associated with mortality (RR = 1.03; 95% CI 0.98–1.08). Among patients who died, these interventions were associated with a shorter intensive care unit (ICU) stay (mean difference = – 2.11 days; 95% CI – 4.16 to – 0.07) [23]. Although these interventions are not equivalent to judicial

substitute consent, they provide an important conceptual argument: greater transparency, structure and availability of decision-making support may help reconcile protection of patients' rights with a more efficient process.

Against the background of the available literature, a particular strength of our study is that it captures the perspective of physicians working directly at the intersection of clinical, legal and ethical requirements. To our knowledge, no published study from another jurisdiction would allow direct comparison of our finding that 67.3% of physicians reported the need to perform a procedure before obtaining judicial substitute consent with an analogous figure elsewhere. There is therefore no basis for assuming that the scale of this phenomenon in Poland corresponds to that observed in other systems. However, the available literature points to a broader common mechanism: when the time required to establish a formal mechanism of representation exceeds the time available to the clinical team, procedural safeguards may come into conflict with timely care [11–17]. From an ethical perspective, the aim should therefore not be to weaken oversight of decisions made on behalf of people who lack decision-making capacity, but to design it so that procedural protection and the patient's best interests reinforce rather than compete with each other.

Limitations

The main limitations of this study include convenience sampling and the inability to calculate a response rate; inclusion only of physicians with previous experience of the procedure; the self-reported and partly retrospective nature of the data, with the possibility of recall bias; lack of independent verification of reported events in medical records and court files; the cross-sectional design, which precludes causal inference; limited precision of some regression estimates, reflected in wide confidence intervals; and inclusion of physicians' perspectives only. Future studies should also include patients, legal representatives, family members, judges and lawyers, and prospectively assess the actual duration of proceedings and the clinical consequences of delays.

Conclusions

Judicial substitute consent is an important safeguard for the rights of patients who lack decision-making capacity, but its practical operation may be associated with delays that affect clinical decision-making, including situations in which treatment must proceed before court authorisation is obtained, as well as with legal uncertainty among physicians. The findings indicate a need for more predictable, efficient and standardised procedures that maintain an appropriate level of patient protection while minimising the risk of delaying treatment consistent with the patient's best interests.

Declarations

Ethics approval and consent to participate

The pilot study and main study received separate approvals from the Bioethics Committee of the Medical University of Lublin (KB-0024/88/05/2025 and KB-0024/37/03/2026, respectively). All participants provided electronic informed consent before taking part.

Consent for publication

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Clinical trial number

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Competing interests

The authors declare that they have no competing interests.

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Author Contribution

M.S. contributed to conceptualization, methodology, questionnaire development, literature review and source analysis, data collection and curation, visualization, project administration, and writing – original draft, review and editing. M.D. contributed to literature review and source analysis and writing – original draft, review and editing. M.C. contributed to data curation, formal and statistical analysis, interpretation and presentation of results, visualization, and preparation of tables. A.K.-O. contributed to methodology, questionnaire development, and writing – review and editing. R.P. contributed to conceptualization, questionnaire development, data collection, supervision, and writing – review and editing. All authors reviewed and approved the final manuscript.

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Data Availability

The datasets generated and/or analysed during the current study are available from the corresponding author on reasonable request, subject to applicable ethical and institutional requirements.

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