

## CASE STUDY RESPONSES

### Guiding light at the end of the tunnel

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The most important issue here is obtaining informed consent for any procedure. Informed consent should be patient- and procedure-specific; otherwise there is a gap between what has been explained to the patient and what s/he has understood. A mere signature does not signify full comprehension. The process of informed consent must be one in which the patient and the relatives are taken into confidence and the risks involved in the procedure are explained to them. The process should envisage acute events that might occur and their subsequent treatment. The occurrence of a cardiac arrest was obviously not anticipated in this case, and because it was sudden, resuscitative efforts were attempted without having the time to take the relatives' consent. As the authors themselves state, "...the absence of high-risk consent and preliminary discussion before the procedure increases the gravity of the event and poses a major dilemma regarding resuscitation. The medicolegal implications of such an omission can be severe and this incident emphasises the point." (1)

The second important issue is that of obtaining advance directives for Do Not Resuscitate (DNR) orders when this type of case comes up for any procedure in the operating room (issues related to the autonomy of the patient). An advance directive is a document signed by the patient nominating the spouse, relative or other person who is entrusted to make medical decisions when the patient is unable to do so. In the directive, the choice of treatment in certain situations is given. For example, it might ask that the patient not be resuscitated in the event of a cardiac arrest. Both advance directives and DNR orders are not commonplace in India. Hence it is very difficult for physicians to decide on continuing or withdrawing treatment in many situations, while also respecting the patient's autonomy.

In February 2005, The Indian Society of Critical Care Medicine (ISCCM) (2) published guidelines for limiting life-prolonging interventions and providing palliative care towards the end of life. Guideline 2 states:

"When the fully informed capable patient /family desires to consider comfort care, the physician should explicitly communicate the available modalities of limiting life-prolonging interventions. If the patient or family do not desire the continuation of life-supporting interventions the available options for limiting the supports should be identified as follows: (i) do not resuscitate status (DNR), (ii) withdrawal of life support and (iii) withholding of life support."

What are the legal implications of limiting support? The Indian

judicial system has no clear stand on end-of-life issues except that suicide and abetment to suicide are punishable offences, hence withdrawal of life support even with the expressed consent of the patient or next-of-kin can be misinterpreted as physician-assisted suicide.

However, with the publication of the ISCCM guidelines and constant interaction with the law ministry, some changes are apparent. Justice M Jagannadha Rao, chairperson of the Law Commission of India, states that the commission has recently taken up the study of legal issues relating to "limiting life support" in patients in intensive care units (3).

This is important because until now, the law has been contradictory on such issues. For example: In P Rathinam and another vs Union of India and others JT 1994 (3) SC 392, the Supreme Court held that punishment for attempted suicide is unconstitutional. The Court ruled that an attempt to hasten death may be viewed as a part of a natural process. "A person cannot be forced to enjoy the right to life to his detriment, disadvantage or dislike." The Supreme Court thus recognised "the right to die" in that case. If a person has a right to live, he has a right not to live.

The above judgement of the Supreme Court stands overruled by a Constitution Bench of the Supreme Court in Gian Kaur vs the State of Punjab, in JT 1996 (3) SC 339: The judge ruled that permitting termination of life in the dying or vegetative state is not compatible with Article 21 which states: "No person shall be deprived of his life or personal liberty except according to procedure established by law."

Citing these two judgements, Justice Panachand Jain observes, "The patients who are in a permanent vegetative state may be allowed to die by seeking direction from the Court for the removal of the feeding tube. Law must march, in a changing society, in tune with the changed ideas and ideologies". (4)

There seems to be some light at the end of the tunnel, and fear of litigation should not deter physicians from honestly discussing end of life issues with family members.

The third important issue relates to who is eligible for giving consent (issues of proxy consent). In the case of an advance directive, the living will or durable power of attorney is automatic, and the patient names the surrogate who is eligible to make decisions. In most US states, the surrogates are: spouse, adult child, parent, sibling and nearest relative.

The decision to withhold and withdraw life support in a comatose patient, in the absence of an advance directive, becomes problematic in India, where the term "family" is loosely applied. If the spouse is female, she is rarely allowed to make decisions, while several male members of the extended family can have conflicting opinions.

It is therefore all the more important for the primary physician to have an excellent rapport with all available family members, as effective communication is the key. Even in the US, Puri states, "The families are often hopelessly confused and divided, as the physicians concentrate on the technical aspects of life support devices. Thus, every patient-family faced with withdrawal of treatment goes through a process of making decisions, when least prepared." (5)

Guideline 6 of the ISSCM states, "The overall responsibility for the decision rests with the attending physician/intensivist of the patient, who must ensure that all members of the caregiver team including the medical and nursing staff represent the same approach to the care of the patient."

The fourth important issue is: who is responsible for taking care of the financial aspect of the whole process, the institution or the relative? This is the most contentious issue of all. Unlike the advanced western countries, 82.2 per cent of the total health-care bill in India is paid out-of pocket by the patient or her/his family. Public hospitals, which offer free treatment, have a severe shortage of ICU beds. Socio-economic considerations complicate the delivery of intensive care and especially end of life decisions.

In their study of four hospitals in Mumbai, Kapadia et al (6) showed that limitation of treatment and withdrawal of treatment were at least twice as common in private hospitals than in the public general hospital, which probably reflects the financial constraints of the patients' relatives. Taking into account the financial burden on the patient's relatives, the ISSCM guidelines assume importance:

Guideline 1 states, "The physician has a moral obligation to inform the capable patient/family, with honesty and clarity, the poor prognostic status of the patient when further aggressive support appears to be non-beneficial. The physician is expected to initiate discussions on the treatment options available including the option of no specific treatment." Thus, the relatives are spared the guilt of withdrawing or withholding treatment, when such expensive interventions will not alter the outcome.

I end with a quote from an article (7) in *The Hindu* by the immediate past president of the ISSCM, Dr Ram E Rajagopalan:

"...India stands out as one of the few countries in the world that have no laws on limitation of treatment. It is this issue, not euthanasia, that is being addressed by the Law Commission. As we recognise the burdens imposed by modern medical technology and realise that the constitutional guarantees of individual liberty are being neutralised by an antiquated Penal Code, we come to appreciate the urgent need to formulate new laws. These laws will go a long way in minimising the emotional and financial hardships faced by patients who are condemned to unwarranted therapeutic excesses."

#### References

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