Commentary: taking decisions one can live with

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This dilemma, presented with reference to a case report (1), is frequently seen in various aspects of medical practice. It is also seen in war situations where triage has to be clearly established so that the more deserving get a better chance to survive. The case outlined by Victor Kong is perhaps reflective of certain pre-decided parameters such as: a previous (anecdotal) yardstick of what constitutes salvageable burns and what does not; and a limited budget, covering X number of patients which cannot be augmented on a case- by-case or even a monthly basis.

Analysis of the case

Criteria for admission and active management: I agree that from the records of survival in the same unit, 50% burns have shown consistent mortality. However, that need not be the cut-off point for definitive management. I feel that even if a 55% burns case presents, attempts should be made to aggressively treat these patients. After all we are doctors and are expected to do our best irrespective of the perceived outcome. Thus I feel that an upper limit of 5 to 10 % over and above the 'standard' cut-off point should be treated seriously.

Patient involvement in decisions: This is one of the imponderables. For example, if you are attempting to resuscitate a 55% burns case, it is important not to inform the patient that survival chances are bleak. If at all the decision is taken to try and save the patient, hes/she should be infused with optimism. I believe that the patient's mental strength plays a critical role in borderline cases, and if the patient does not have the will to live, the treatment can be an uphill battle.

Denying full treatment to a current patient for fear of compromising treatment of a potential future patient: This is the situation which makes this case different from other examples of the triage system. I cite an example: in an emergency ward there are only three ventilators, all being used. One of the patients is deeply unconscious and potentially brain dead, and a new patient is brought in, who is young, has a good prognosis and who needs a ventilator. The decision appears easier, as both the protagonists are present at the time. Ethically, transferring the ventilator to the more deserving patient is acceptable.

Reversing the decision, either inadvertently or unknowingly: I feel this is where the doctors' judgement could be a little different. Since the patient had already started deteriorating, we must assume that some irreversible damage had already occurred. Now, within the parameters of survival statistics, funding, etc, I feel that the decision to begin aggressive management should not have been taken lightly. Granted, it was due to miscommunication, but it could still have been reversed when it fully came to light, even after a day. The subsequent treatment, though carried out with the best intentions and energetic effort, was, in my opinion, already too late. As a matter of fact, this is the only real decision I would disagree with. Most of the other decisions seem to have been 'forced', given the existing parameters and preconditions.

Towards developing guidelines

IN an attempt to formulate ethical guidelines for such situations, let us first look at near ideal situations. Budgetary provisions should be made unlimited or at least take into account a 30% surplus, thus allowing the clinical staff to have some decision- making powers in borderline cases. Facilities should be there for the referral of the really deserving cases. This includes some monetary support as well. Granted, these may not be possible in most cases.

Second, the cut-off point should be about 5% more than the 'established' line for survival. Plan for a budgetary allotment must be based on this. The administration should be involved in decisions regarding the management of borderline cases. Why should doctors always have to play God, especially when their commitment is not in question, but the reasons are purely administrative?

One more aspect seems to have been ignored. What are the medico-legal implications of inadequate or incomplete treatment of a patient? Irrespective of the ethical and medical basis of the decision, I believe that this question needs to be answered, or we are laying ourselves open to legal wrangling. My suggestion is therefore, even after a decision has been taken not to aggressively treat such patients, a normal complement of intravenous fluids should be given, in order to forestall any medico-legal allegations. Other burns-related surgical procedures may be deferred, as these are subjective, and one can always argue that there is a risk-benefit ratio.

In summary, a difficult yet common situation has been described. It is difficult to fault the concerned doctors for their course of action. They seem to have taken the most appropriate decisions based on the set of parameters that govern them. What is important is to extrapolate a set of guidelines to take similar decisions in other situations. There are no absolutes in medical practice, especially in ethics. What we need to do is take decisions which we can live with.

Reference

1. Kong V. Ethics in burns surgery: when is enough, enough? *Indian J Med Ethics.* 2012 Apr-Jun; 9(2): 126-8.