CORRESPONDENCE

Intensive care units and ethical issues

The October–December 2003 issue of *IME* carried two interesting articles (1,2) that raise some interesting questions. Prolonging life at any cost in the terminal state is definitely not justified. Medical practioners have subtly practised this art of palliation where prolongation of life is abrogated, with or without legal sanctions. Withholding any supportive treatment, for example, a gastrostomy in oesophageal cancer, needs an explicit consent from the patient. Withholding nourishment in a patient with an obstructed oesophagus due to cancer and who may live for few months even without treatment, is tantamount to starvation and is bound to be construed as cruel, unethical and illegal.

Barreto (1) correctly states, 'It is ethical to withdraw life-sustaining treatments from those unable to decide for themselves, only when the treatment can no longer achieve its intended clinical purpose and cannot provide any benefit.' Indeed it is laudable to help patients live with dignity till the last breath. But does the law of the land permit anyone to be take off the life-supporting system even before the patient is dead? Similarly, in the article, 'The friend', one gets an impression that the patient's relatives took the decision to switch the ventilator off without having the power of attorney to do so (2). The pertinent question is also about switching off the ventilator without any objective evidence of brain death. I wonder what the legal stand is on this issue of switching off ventilators at will. I hope the future issues of the journal will discuss these matters.

References

1. Baretto Z. Ethical issues in palliative care. Issues in Medical Ethics. 2003;**11:**118–19.
2. Shah K. The friend. *Issues in Medical Ethics* 2003;**11:**120–1.

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Informed consent—a view from the trenches

I read with interest the deliberations of two MBBS students on informed consent (1). They state that for a consent to be legally valid, it must be both, informed and intelligent. They further point out many fallacies and loopholes that exist in the process of making the patient understand the implications of a proposed clinical manoeuvre. They state that lack of intelligence, communication barriers, unpredictable course of the illness or 'motivated' interests, all hamper the true spirit of 'informed consent'.

A recent report (2) on the study of patient factors affecting the process of informed consent in a proposed clinical trial reported some interesting results. Only 30% of the subjects gave consent for the trial, irrespective of the quantum of information given (complete or partial). Of those who gave consent, the understanding of the elements of consent was poor, irrespective of the subjects' educational status. Such poor understanding of the information given to subjects of a clinical trial before they consent to participate has been reported in other countries as well (2).

In my own clinical practice, I find that most patients are unable to understand completely, the 'fine print' about a proposed clinical manoeuvre. Indeed, they cannot be expected to do so, as they are completely uninitiated to medical jargon. Why, even doctors when they come as patients, fail to comprehend completely the nuances of their proposed treatment. Hence, often, patients refuse to listen to a detailed description of their planned treatment and prefer to leave the decisions to the physician in good faith. It is, indeed, ultimately a matter of trust and integrity. Patients prefer to be treated by the physicians they trust and it is incumbent upon the physician to prove this faith. As physicians we must be ready to make decisions for patients. Actually, this is something that all of us do every time. For example, we decide which investigation modalities are necessary for a particular patient. We decide on the drugs to give to a particular patient. Several medication alternatives often exist for a given illness but, it is the physician who chooses the drug and not the patient. It would be ridiculous to discuss every drug with the patient and leave him to choose his own medicines. Why, in principle, it would indeed be a breach of the trust the patient has in his doctor.

I agree with the medical students when they say that consent must be individualised in every case. The idea is to make the patient a participant in his treatment and not thrust the treatment upon him. But, the spirit of consent must prevail at all times. The 'fine print' in writing is important in a court of law. But in the court of human mind, it is the benevolent intention that is important. Such intentions must precede and preside over all technicalities.

References

1. Dangayach N, Joshi N. Informed consent: consent with a view. *Issues in Medical Ethics* 2003;**11**:86.
2. Gitanjali B, Raveendran R, Pandian DG, Sujindra S. Recruitment of subjects for clinical trials after informed consent: Does gender and educational status make a difference? *J Postgrad Med* 2003;**49:**110–13.

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