present case seems to be one such situation.

If on the other hand, the old lady is not in a condition to decide for herself during the present illness, then it would be up to the daughter and son-in-law to decide about whether or not to subject the patient to ventilation. They would have to be told about the nature of the chronic disease, the acute problem, the possible outcomes, and the possible risks and benefits of ventilation (the medical aspects of the problem). They would also have to consider the views that the patient may have expressed earlier about not wanting to go on ventilator (the ethical aspects). Their decision should be respected by the treating doctor. Ventilation could be withheld, if so decided, after properly documenting in the patient's case records, the circumstances and reasons for withholding potentially life-saving treatment.

Dilip Karnad

The doctor, the patient and the relative

Providing the medical diagnosis and identifying the drugs in question would have enhanced the case study about the doctor, the patient and the relative (1) without compromising patient confidentiality. Yet, the case study serves to illustrate how patient, "facilitator" and physician interactions can compromise principles of ethical care.

The doctor's behavior as reported by the relative: We agree that the doctor should have given due consideration to the doubts expressed by the relative and should have explained in detail his reasons for suggesting a change. Yes, it does appear that the doctor's ego was bruised: he was quite brusque and rudely bypassed the relative to talk to the patient directly while, earlier, he had been content to deal through the relative. It is often difficult for doctors to accept that people with no medical training can question their judgment. Every doctor knows that no drug is devoid of side effects. It is far better to relate the pros and cons of the options, recommend the best option, and then let the patient make the decision. A patient who is a partner in the decision-making is less likely to blame the doctor if things do not work out.

The appropriateness of changing a drug: In this situation, the opinion of the first doctor, that newer medicines are not necessarily bad because less is known about them, is quite valid. The second doctor confirmed this opinion. However, his statement that the decision to change a drug rests solely on whether the patient is currently experiencing any side effects is partially true. There may be other reasons for changing a drug. Some drugs cause side effects that are apparent only after prolonged exposure such as L-Dopa for Parkinson's disease. Other drugs such as phenytoin for epilepsy cause subtle cognitive dysfunction that becomes apparent only after the drug is withdrawn. Other drugs like coumadin are more prone to drug-drug interaction or drug-food interactions and therefore, if substituted by safer alternatives, would circumvent future side effects. Finally the response to the drug may be less than what the doctor had hoped for and therefore he may suggest a change. Since we do not know why the first doctor suggested a change of drug, to assume that he was wrong or did it only for personal, financial gain is jumping to hasty and possibly erroneous conclusions.

Patient behaviour: The dependent attitude of this educated, English-speaking patient can be frustrating for the physician. She might as well be deaf, dumb, and demented for all the participation that she provides. How does one enfranchise a person who refuses enfranchisement? Is this behavior a reflection of a fear of making a mistake and thus losing face? Does one feel better if some one else makes the decision so that one is then free to blame and criticise? The relative was unable to elicit the patient's participation in her own medical care and it seems that this dependent behaviour was customary as her children expressed no surprise at this and were willing to have the relative continue to be the decision maker. This, indeed, is not unusual in our country where "loving care" translates into family members "shielding" the loved one from the rigours of decision-making.

The doctor's dilemma It is hard to fault only the doctor for not dealing directly with the patient. It appears that he at first, tried to involve the patient. However, he adjusted to the patient's resistance and was accepted the relative as the decision-maker. Later, when he felt that the relative was making the wrong therapeutic choice, he brought his concern directly to the patient, albeit rudely.

The dilemma for the relative was that she was entrusted to make decisions for a person who, though competent, refused to make them for herself. The relative, commendably, obtained a second opinion, read some literature on the subject before expressing her reservations. It is not clear whether the relative's concern was a result of her reaction to the doctor's rudeness, or, a valid clinical concern based on her literature search. Sound, competent, medical opinion is independent of the manner in which it is proffered. Unfortunately, most patients cannot separate one from the other.

Were any principles of ethical care compromised in this case? We feel that at least two of the seven ethical principles (2) proposed by the Tavistock Group were compromised: "Principle 4: Cooperation – health care succeeds only if we cooperate with those we serve, each other, and those in other sectors"; and "principle 7: Openness - being open, honest, and trustworthy is vital in health care". The doctor was not open and cooperative with the relative who was attempting to do her best. The relative should have repeatedly involved the patient in the decision-making process, in the doctor's presence. The patient's refusal to participate in her own care withheld her cooperation and openness from both the relative and the doctor.

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