Chapter
1

Seriously Ill Patients: Medicolegal and Ethical Issues

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INTRODUCTION

The approach to the management of seriously ill patient has been strongly influenced by advances in sciences and technology, ethics, law, recognition of rights of the patients and social changes. At present, decision making is modulated by ethical and legal considerations. We have to consider basic values of autonomy, beneficence, non-maleficence, justice.

During the past few decades seriously ill patients management is strongly influenced by above considerations. At the bed side, ethical and legal considerations make vital role and has become fundamental challenge in the practice of medicine.

Ethical Principles

1. **Principle of double effect:** It is considered when obligations or values conflict and cannot be released simultaneously. According to this there is a moral difference between the intended effects of a person's action and unintentional, but foreseen effects of action. The desirable effect (good) is linked to an undesirable effect (bad). The good effect is direct and intended, whereas the foreseen undesirable effect is indirect and not intended.
2. **Treatment decision:** It is a combination of medical, emotional, aesthetic, religious, philosophical, social, interpersonal and personal judgment.
3. **The cure and care systems** are not mutually exclusive but rather overlap.
4. **Proportionality principle** states that a medical treatment is ethically mandatory to the extent that it is likely to confer greater benefits than burdens upon the patient.

Decision-making Considerations

1. **Futility:** The medical profession has no obligation to provide futile or unnecessary treatment. The futility takes into consideration, the purpose of therapy, its chances of success (quantitative aspect), and balance of burdens and benefits (qualitative aspect). The treatment is probably not futile, if there is a real chance of achieving some desirable end, which is cure of the patient, patient comfort, patient dignity or even comfort to the family. The question about futility may be raised in cardiopulmonary resuscitation (CPR) of terminally ill patients, seriously ill patients, persistent vegetative state patient and use of total parenteral nutrition in seriously ill patients.

2. **Informed consent**.
3. **Decision making for the incompetent:** If the patient lacks capacity someone must be designated to make decisions on the patients behalf. This person may be guardian, health care agent, surrogate.
4. **Advanced directives:** These can be oral or written instructions specifying the wishes of a person concerning medical treatment in anticipation of future in capacity. The most common types of advance directives are—living will and durable power of attorney which can be general or specific.
5. **Withholding and withdrawing therapy:** This is considered when treatment in seriously ill patient is medically futile. Withholding occurs when the treatment is not provided. Withdrawing is defined as ending treatment that has no demonstrated value.
6. **Do not-attempt resuscitation (DNAR) order:** Physicians have the obligation to clarify patient wishes concerning CPR, but there are numerous problems in communication and implementation of DNR. A patient who is for DNR can still continue treatment.

In certain situations, providing CPR is likely to increase suffering of patients who have serious illness and without the prospect of reasonable quality of life even if they are reviewed. DNAR is an option that may be exercised by the treating physician in the best interest of the patient. Whenever a treating physician is in doubt on whether to perform DNAR or not, CPR should be performed as the default option. DNAR would apply to seriously ill patient where CPR would be inappropriate, nonbeneficial and likely to prolong the suffering of the patient in the best judgment of the physician.

Procedure as per ICMR Guidelines

a. Document to facilitate DNAR.
b. Give adequate opportunity, time and space to discuss with the patient and the family in private and facilitate the clear understanding of DNAR and its implications.
c. Team work and good communication are crucial.
d. Combined decision may be taken with the help of another physician or hospital administration.
e. DNAR forms should be available in the language understood by the patient / surrogate and should be signed, timed and dated.
f. Hospital administration should make efforts to sensitize their health care professionals on all issues related to DNAR.
g. In case of conflict of opinion, an independent 2nd opinion from a qualified medical practioner belonging to the relevant specialty may be sought by the treating physician/patient/surrogate in a timely manner.
h. Storage of DNAR forms: Completed, should be easily accessible to all the medical professionals to respond appropriately in the event to cardiorespiratory arrest of the patient concerned. All reports and forms should be archived for future reference.

Sedation in Seriously Ill Patients

When suffering cannot be managed at the end of life, sedation is an option. The literature shows a lack of consensus with regard to medication, doses and routs used

to induce sedation. Because of serious implications of terminal sedation, its implementation should follow guidelines based on compassion, consideration and trust.

Pain and Palliative Care

It should be initiated in seriously ill patients as per the Indian Association of Palliative Care (IAPC) guidelines.

CONCLUSION

A mature society will develop effective means for caring for its seriously ill members. Respect for the unique nature of each patient constitutes the essence of ethics in medicine. The challenge of ethics is to provide an intellectual and pragmatic frame work for pursuing the values of autonomy, beneficence and justice.