

Controversy in biomedicine

Life supports for patients without living will or surrogate decision-maker

Some time ago, one of the editors rounded on a 70 year old patient with advanced acquired immune deficiency syndrome (AIDS) who was in the intensive care unit (ICU). He had been living alone until recently and had no close relatives that could be found. The man had been obtunded for some time, had at least two opportunistic infections and was now found to have a large mass in his right upper thorax. The ICU residents had scheduled bronchoscopic biopsy of the mass. The consultant questioned this procedure at this stage of the patient's illness and advised comfort care only. One of the residents argued that it was his obligation to make a tissue diagnosis as there might still be a chance to prolong life if one could determine the nature of the mass.

This patient was not able to make his own decision or give informed consent for the invasive procedure. There was no surrogate relative or even close friend to make it in his behalf. This is not an uncommon dilemma and was recently addressed in an extensive study by DB White et al [1] in the United States involving nine major medical centers in six American states. This study found that an average of 5.5 % of deaths in ICUs occurred in patients that had made no advance life support decisions and lacked a surrogate decision maker. The percentage varied between hospitals and was as high as one third in some centers, mostly located in inner cities and treating many indigent patients. There was also a distressingly wide variety in hospital policies dealing with this problem. The majority of the life support decisions made were inconsistent with the guidelines published by the American College of Physicians and American Medical Association [2, 3]. More disturbing was that guidelines of major professional societies dealing with critically ill patients as well as laws of individual American states varied a great deal and even conflicted with one another. Major medical centers in America also do not have uniform guidelines on how to deal with life support issues and the manner of how to make decisions on withholding further treatment in terminally ill patients who have no family member or surrogate to help in making such decisions.

The decision not to continue further life support or diagnostic procedures that appear to be of no clear

benefit to the patient whatever the results, is usually made by the attending physician without judicial or institutional backup. What are some of the questions that may arise in this process? Does the attending medical staff or the institution have any conflict of interest in terminating treatment in an apparently hopelessly ill patient? Is the ICU full and free beds are needed to serve patients with a better prognosis or ones that are more likely to pay the hospital bill? Does the staff have an academic or educational interest in performing further invasive procedures and costly tests, instead of instituting comfort care only? Or is it of financial benefit to the attending doctor and the hospital to carry out such procedures and tests that may not prolong the patient's life or alleviate his suffering?

Some guidelines from authoritative sources recommend judicial (legal) action before terminating treatment in a subject without a "living will" and a surrogate person to help make life support terminating decisions [4, 5]. These have been found difficult to implement. Others have recommended institutional committees that must approve such decision making by the attending staff. It has been mentioned that such a committee should include at least one person not connected with the hospital in order to avoid conflicts of interest. It is obvious that this issue has not been resolved in most western countries and is equally unresolved in Southeast Asia including Thailand [6].

References

1. White DB, Curtis R, Curtis JR, Wolf LE, Pendergast TJ, Teichman DB, et al. Life support for patients without a surrogate decision maker: who decides? *Ann Intern Med.* 2007;147:34-40.
2. American College of Physicians. *Physicians guide to end-of life-care.* Ed. Snyder L. Philadelphia:ACP, 1998.
3. Council on Medical Ethics and Judicial Affairs. *Am Med Assoc. Current opinions with annotations.* Chicago: AMA, 2004.
4. Thicus Study Group. End-of life practices in European intensive care units. *JAMA* 2003;290:790-7.
5. Mariner WK. Decision making in the care of the terminally ill incompetent persons: concerns about the role of the courts. *J Am Geriatr Soc.* 1984;32:739-46.
6. Garden D. Advance medical directives (living wills). *J Med Assoc Thai.* 1999;82:414-23.

Comment

Domnern Garden (LLD Harvard)

What legal guidelines do the attending physicians have in Thailand for the situation described: a difference of opinion on what to do with a non-communicating, unrepresented, non-paying, probably terminally ill patient?

There are the Regulations on Medical Ethics, B.E. 2526 (1983) issued by the Medical Council. In Chapter 3, Clause 1, the physician's duty is spelled out. It is to maintain the highest standards of medical practice and try to alleviate the patient's suffering and for that not to ask for more than the normal fee. Section 3 requires the physician to act with good intentions without considering the financial situation, race, nationality, etc. of the patient.

This freedom to decide in good faith what the appropriate treatment should be is further confirmed by Section 315 of the Civil and Commercial Code that says if you manage someone else's affairs, e.g. the care of a non-communicating patient, you must do it "as the interest of the principal requires, having regard to the actual or presumptive wishes of the principal".

Under the Penal Code, Section 374, it is a misdemeanor to refrain from helping a person in danger of his life if there would be no danger to the

person helping. Would a doctor who did not put a hopeless patient on a life-support machine if by doing so he could prolong the life of the patient be guilty of a misdemeanor?

Note there is no rule or regulation that says a physician must prolong the life of a patient if possible to do so.

In practice, there are virtually no legal risks for the physicians in attendance. The invisible legal representatives of the patient will make no complaint. The police will not appear to file charges. Provided there was no conflict of interest, like a desire of the physician to experiment, or a special payment for attending the patient, there would be no liability under the Civil and Commercial Code. The source of criticism, perhaps encouraged by in-house jealousies or particular ethical convictions of a higher-up, would be censure by the hospital board itself.

The case described is one in which different doctors who are dealing with the case have different opinions. The hospital should intervene first deciding whether its equipment and facilities should be used and perhaps wasted and secondly to take the physician whose opinion is not to be followed off the case to relieve him of responsibility or better still, to provide an emergency review procedure that will make the decision on what treatment to give or not give that of the hospital itself.

ศูนย์วิทยทรัพยากร
จุฬาลงกรณ์มหาวิทยาลัย