COMMENTARY

Ethics and Medicolegal Aspects of Withdrawal of Treatment in Critical Care Patients without Advanced Directives in India: Who will Guard the Guardians Themselves?

Mahesh Radhakrishnan Menon

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Abstract

The Supreme Court (SC) verdict of 2023 has been welcomed by the medical community in India by those who treat patients with terminal or advanced illnesses. The earlier verdict of the apex court in 2018 was ground-breaking in allowing for advanced directives (ADs) by patients in terms of their preferences at the end of life. However, it was an impractical and lengthy process in the Indian context. The recent verdict has simplified the process of withdrawal of life support, making it more practical. The authority to withdraw life support in dying patients is now also with the treating physician, the hospital, the primary medical board, and the secondary board. This article examines ethical issues related to the specifics of the judgment with respect to those who do not have ADs in India. The present article emphasizes the need for self-regulation, credentialing, and continuing medical education in critical care and palliative medicine. In the absence of these, who will guard the guardians?

Keywords: End-of-life care foregoing of life support withdrawal and withholding ethics, Law, Terminally ill patient.

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Introduction

All say, "How hard it is that we have to die" – a strange complaint to come from the mouths of people who have had to live.

– Mark Twain

With advances in medical technology, more diseases have become curable, and many conditions have become controllable. One challenge in medicine is to prognosticate with objectivity and accuracy the patient who will inevitably die. The next challenge is more subjective—to judge the point at which medical treatment is becoming simply "too much". This article will explore the Supreme Court (SC) of India's judgment of 2023, in the context of the principles of ethics and practical application. It specifically covers the process prescribed by the court for the patient who does not have an advanced directive (AD).[1]

Mani et al. have described the status of the end-of-life care judgment of the Supreme Court of India very succinctly in a recent article.[2]

Summary of the Legal Process for Withdrawal of Life Support

1. **Who can Do It?**
    a. A healthy adult of sound mind can execute an AD. This flows from the ethical principle of autonomy and the right to refuse life-supporting measures in an adult individual with the ability to provide informed consent.
    b. Previously, the patient proxy was a named guardian or close relative, which has now been replaced by specified names of guardians/ close relatives who will be authorized to execute the AD.
    c. In those who do not have named surrogates, the medical community steps in to safeguard their right.

Department of Palliative Care and Pain, Bahrain Oncology Centre, Busaiteen, Bahrain

Corresponding Author: Mahesh Radhakrishnan Menon, Department of Palliative Care and Pain, Bahrain Oncology Centre, Busaiteen, Bahrain, Phone: +97335359541, e-mail: algosdoctor@gmail.com

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2. **How can It be Done?**
    a. In an amendment to the 2018 judgment, the AD should be signed by the executor in the presence of two attesting (preferably independent) witnesses before a notary/ gazetted officer.
    b. It recommends a two-tier process. It is activated by the treating physician and taken forward by the hospital, which involves a primary medical board and a secondary medical board.
    c. The process has slight variations depending on whether an advanced directive is present or not. For patients who do not have an advanced directive, see Figure 1.
    d. The High Court may be approached for decision-making by the relatives after the above steps in case there is no concurrence between primary and secondary boards.
3. **Who is in the Board?**
    a. *Primary board*: The treating physician and at least two subject experts of the concerned speciality with at least 5 years' experience (previously 20-year experience required was from specified specialties).

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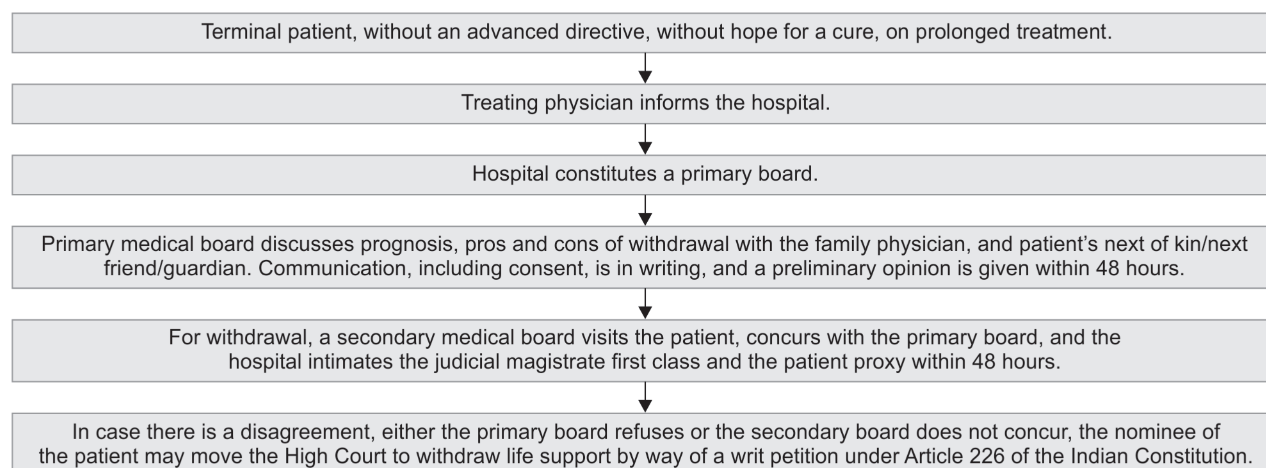

Fig. 1: Algorithm for withdrawal of life-sustaining treatment for a patient without an advanced directive

   b. *Secondary board:* One registered medical practitioner (RMP) nominated by the chief medical officer of the district and at least two subject experts with at least 5 years' experience of the concerned specialty who were not part of the primary medical board (previously 20-year experience required was from specified specialties).

4. **When should They give their Decision?**
   a. The process is time-bound with decisions from the boards expected within 48 hours each.
   b. In case the High Court is approached, the apex court stresses on the need for speed, in such judgments.

A simplified legal process to withdraw life-supporting treatment affords dignity, compassion, and good quality of life to the terminally ill. Advanced directives are an extension of the previous principle of autonomy in a consenting adult with capacity. There are concerns raised about the decision-making abilities of adults with clinical depression in a recent article.[3] This concern was also put forth by the Union of India, who were the respondents in the 2018 Supreme Court hearing on the end-of-life care law.[4]

Issues in Withdrawal of Life Support in a Patient who does not have Advanced Directives

1. **Role of the Treating Physician**
   The trigger for initiating the discussion starts with the treating physician who identifies a terminal patient without hope for a cure, but lacks an advanced directive and decision-making capacity. Two issues raised are:
   a. At what clinical point does a physician decide to act in the best interests of the patient who does not have an AD?
   b. In this age of specialization, with patients having multiple systemic comorbidities, who will be the "primary physician" to initiate the discussion on withdrawal of care? Will this responsibility fall on critical care specialists, who are already stretched thin by the demands of a huge population?[5]
2. **Role of Hospitals**
   a. Will this ruling be used by private hospitals to free up precious beds by prematurely halting treatment, and utilizing them for financially lucrative hospital admissions?
   b. Will the process become a backdoor justification in an abandoned patient who is admitted in an emergency, hospitalized, with no one coming forward to pay the daily, ever-increasing hospital bills?
3. **Role of the Primary Boards**
   a. What should the minimum credentials of a board be? A five-year medical experience in a medical field can be as arbitrary as the erstwhile 20-year experience. A medical board without experience in handling critical patients toward end-of-life may risk either aggressive withdrawal or overtreatment of patients. This violates the principles of beneficence and non-maleficence.
   b. Will there be a direct financial conflict of interest in freeing a bed for a high-revenue-generating event under the physicians in the primary board?
   c. Should the primary board physicians restrict their actions to offering an opinion on withdrawal without placing safeguards for checking "what next" after withdrawal?

Some of the safeguards for the above issues are proposed below:

1. **For the Primary Physician**
   a. *Documentation*: The trigger to initiate the discussion of the dying patient must be objective. It must be supported by the best-available medical evidence of the time and documented in written applications as such. On scientific merit, there must be documented objective evidence that justifies the benefits of withdrawal versus the risks of continued treatment.
   b. *Evidence generation:* Internal regulation by professional medical societies is needed by way of clear-cut guidelines on different conditions encountered in clinical medicine that may warrant discussing poor prognosis. In the absence of solid scientific guidelines and evidence to initiate discussions on terminal prognosis, one will function on clinical heuristics, which may not always represent a sufficient standard of care. It is not an easy task, as a recent review of evidence to identify older people with frailty who were approaching the end-of-life observed the need for more measures for assessment of frailty and noticed the evidence gap on interventions in these patients.[6]
   c. *Improving the art and science of prognostication*: This will help the conscientious clinician in doing the best for a dying patient, while safeguarding patients from potential premature poorly planned withdrawal decisions.

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2. **For the Hospitals**
    a. *Documentation:* Hospitals must receive the proposal for withdrawal of care from treating physicians in a documented, standard-of-care format.
    b. *Credentialing*: Hospital credentialing processes for end-of-life care policies must involve the specific operating protocols in constituting the review boards and acting on the information. When these processes are scrutinized by external accrediting agencies, there may be a greater chance of compliance with protocols and documentation.
    c. *Palliative care provision*: Withdrawal of life-supporting measures without the backup of a symptom control team for patients would be ethically violative of nonmaleficence. The best interests of the patient are not addressed, and the patient will be subject to possible distress. Hospitals must embrace integrated palliative care services as a part of healthcare delivery. This would indicate that the hospital offers continuity of care to dying patients. It shows that the patient who has been withdrawn of life support continues to be managed in a setting where there is provision for pain relief, dyspnea control, nursing, spiritual care, etc. This requires reflection and self-regulation. National medical guidelines must incorporate death education and integrate palliative and end-of-life care across specialties in hospitals to facilitate this environment.
    d. *Transparency*: Documentation of all withdrawal of care must be transparent and meticulous, both by the treating physician and the hospital, and any variance in operational quality is subject to scrutiny by law. At present, both digital formats and hard copies of withdrawal of life-support decisions are to be kept by the registry of the High Court, which shall be destroyed after 3 years from the death of the patient. This is an example of a safeguard suggested in the concurring decision of Hon'ble Justice Sikri in the 2018 judgment.[4] The possibility of misuse of the law should be safeguarded against by robust medicolegal processes.
3. **Role of the Boards**
    a. The state (acting through the nominated RMP for the secondary board), the hospitals, and medical organizations must work together in a systematic way to credential physicians who have the requisite 5-year experience. This could be like the systematic accreditation of life-support providers, for example.
    b. A private institution's primary board will always be open to scrutiny, in terms of the distributive justice principle. How can physicians elevate themselves to be seen as being above this financial conflict of interest in the race for precious resources? This conundrum of "Caesar's wife must be seen to be above suspicion", does not lend itself to easy solving. Declaring conflicts of interest may be one possible option.

Difficult real-world conflicts will eventually make their way to where the law will be called upon to act in the best interests of the individual. These situations will draw public attention. The critical care community must be prepared with processes and protocols to stand up to public scrutiny not just scientifically, but also ethically.

Conclusion

The journey toward providing care, comfort, and dignity to the dying patient has been bolstered by a practical outline laid down by the Supreme Court of India. While the SC ruling must be celebrated, there is a need for self-regulation, credentialing, and continuing medical education rather than relying on the benchmark of 5-year experience or seniority in an institution. It is time to lay down scientific and ethical safeguards that protect the patient and treating teams in their environments while achieving shared goals in the best interest of the patient. Medicine specializes today to deliver better results to patients, the basics of palliative care, prognostication, communication, and understanding end-of-life issues must be integrated early in the medical curriculum to provide continuity of care to patients with advanced diseases. In the absence of criteria, training and retraining, and standard operating processes, discussions around quality-of-life and futile treatment may become ambiguous. Who then, will guard the guardians? Quis custodiet Ipsos custodes?

"*The more privilege you have, the more opportunity you have. The more opportunity you have, the more responsibility you have.*"

– Noam Chomsky

Orcid

Mahesh Radhakrishnan Menon https://orcid.org/0000-0003-0533-5697

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