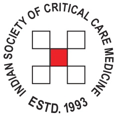

Editorial

End-of-life care

Ram E. Rajagopalan

Critical care medicine has grown rapidly in India. While the short span of just over a decade might have been adequate for the technology of critical care to become widely available in urban India, this interval has been insufficient for both the Indian physician and his patient to develop a mature understanding of the value and limitations of this technology. With expectations that clearly outstrip reality, it is not unusual to see life support being initiated inappropriately in irremediable situations. But, when the family and the physician realize that the therapy is ineffective, the willingness to withdraw is confounded by a lack of clarity on the ethical and legal obligations of the physician.

Amongst doctors, there is often an apprehension that withdrawal of support would be perceived as a criminal act, and the absence of legislation or legal precedents only reinforces their fear of prosecution. The current legal milieu, which is perceived as discouraging an early transition to palliative care, imposes enormous financial burdens on the families of hopelessly ill individuals. Under these circumstances, it is also not unusual to see otherwise well-meaning professionals resorting to acts that could be viewed as dishonest, if not blatantly unethical. The classical example has been the widespread use of LAMA ('leaving against medical advice')[1] to allow discontinuation of therapy on the grounds that the patient requested it. While it is often stated that LAMA is only initiated on the request of the patient or the family (usually on financial grounds), we all recognize that it is used by physicians (often with tacit approval from the hospital administration) to transfer responsibility – and hence culpability – from themselves to the patient or his family. Laws that encourage such a distortion of ethical principles need to be changed.

Though these issues have been discussed extensively in intensive care fora for many years, the ISCCM felt that there was a need to obtain some kind of professional consensus prior to our seeking either public acceptance or legislative change. Under the chairmanship of Dr. R. K. Mani, the Ethics Committee of the ISCCM has labored through the better part of 2004 to produce a document that was presented initially at the Annual Conference of the ISCCM in Nagpur this year. Though a broad consensus was present among the members of the Committee, it was felt that a wider opinion ought to be sought before the document was published. The initial draft recommendations were posted on the ISCCM website inviting comments from members and was also submitted for review by a group of overseas experts.

While the modified document was being prepared, the ISCCM had an excellent opportunity to interact with medical and legal professionals at a meeting organized under the aegis of the Delhi Branch of the Society in April 2005. Though I attended the meeting with preconceptions about the intents of the legal profession, I was pleasantly surprised to find that in this instance the Law was *not*, as Dickens expressed in Mr. Bumble's ineloquent voice, 'a ass.'

Each of the participating legal professionals (the Union Law Minister, the Chairman of the Law Commission and a Supreme Court lawyer) had a sophisticated un-

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derstanding of the law in relation to this issue and agreed that, in the context of currently available critical care technology, there is a need to change Indian laws on withholding and withdrawing of life-support systems from patients who cease to benefit from them. Justice Jagannadha Rao of the Law Commission reviewed the international consensus in favor of limiting life support in irreversibly ill patients[2] and felt that a similar law would ultimately come into existence in India as well.

There exists, at present, discordance between the Fundamental Rights enshrined in Article 21 of the Indian Constitution on the one hand, and the Supreme Court decisions and Indian Penal Code sections related to suicide and abetment of suicide, on the other.[3] However, the opinion expressed by the lawyers was that if a doctor who withdrew or withheld treatments in good faith was subject to criminal prosecution, there was ample room for his defense even under current laws.[3] Mr. S. Balakrishnan, the Supreme Court Lawyer, was emphatic that the best defense for the doctor in a civil suit related to this issue would be to prove that he 'has acted in conformity with the standards prevailing in his profession.' In this context, he felt that a document such as the Position Statement that we are currently publishing would be a good example of the 'professional standard' that the courts are seeking.[3]

While they agreed that new legislation related to informed refusal of treatment, withholding and withdrawal of life-sustaining treatment and palliative care would greatly enhance ethical medical practice, I was also left with the clear impression that even under the current laws, doctors (and the hospital administration) do not have to resort to furtive measures when they limit life-sustaining therapy. The ISCCM document underscores the importance of transparency, communication, careful documentation, and the avoidance of measures that may be construed as being coercive.[4] Prior to publication, the document was sent for approval by the ISCCM Executive Committee which agreed with the overall content of the recommendations, but felt that in the absence of a broader public consensus that these should presented as a 'statement of the ethical position' of the ISCCM and not as definitive 'guidelines' for the present time.

So where do we go from here? It is highly likely that specific aspects of the Position Statement will be debated over the next few years, but a clearer professional consensus will eventually emerge. From our meetings with law professionals and on the basis of the papers published in this issue of the IJCCM, it appears that there also is a legal consensus. However, it appears that the translation of these opinions into new legislation will depend on the persistence of interested parties including the ISCCM, and on a progressive build-up of public opinion. In the meantime, this Position Statement could serve as a model that other interested organizations could either endorse or alter to serve their specific ends and these organizations in turn can assist us in our efforts in petitioning the Government for better laws.

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