The issue of legal protection of the intensive care unit physician within the context of patient consent to treatment. Part II: unconscious patient

Jacek Siewiera¹, ⁴, Andrzej Kübler², Monika Filipowska³, Jakub Trnka¹, Aleksandra Zamaro-Michalska⁵

¹Department of Medical Law, Chair of Forensic Medicine, Piastowie Śląscy Medical University in Wrocław, Poland
²Chair and Department of Anaesthesiology and Intensive Therapy, Piastowie Śląscy Medical University in Wrocław, Poland
³Faculty of Law and Administration, University of Administration and Law in Warsaw, Wrocław branch, Poland
⁴Department of Anaesthesiology and Intensive Therapy, Health Care Centre in Bolesławiec, Poland
⁵1st Department of Anaesthesiology and Intensive Therapy, Medical University of Warsaw, Poland

Abstract
Cultural changes in Western societies, as well as the rapid development of medical technology during the last quarter of a century, have led to many changes in the relationship between a physician and a patient. During this period, the patient’s consent to treatment has proven to be an essential component of any decision relating to the patient’s health. The patient’s will component, as an essential element of the legality of the treatment process, is also reflected in the Polish legislation. The correct interpretation of the legal regulations and the role that the patient’s will plays in the therapeutic decision-making process within the Intensive Care Unit (ICU) requires the consideration of both the good of the patient and the physician’s safety in terms of his criminal responsibility. Clinical experience indicates that the physicians’ decisions result in the choice of the best treatment strategy for a patient only if they are based on current medical knowledge and an assessment of therapeutic opportunities. The good of the patient must be the sole objective of the physician’s actions, and as a result of the current state of medical knowledge and the medical prognosis, all the conditions of the legal safety of a physician taking decisions must be met.

In this paper, the authors have set out how to obtain consent (substantive consent) to treat an unconscious patient in the ICU in light of the current Polish law, as well as a physician’s daily practice. The solutions proposed in the text of the publication are aimed at increasing the legal safety of the ICU physicians when making key decisions relating to the strategy of the treatment of ICU patients.

Key words: intensive care unit, patient, consent to treatment, proxy consent
to be the sole aim of physician’s actions, and for it to result from the current state of medical knowledge and prognosis, the legal safety of the physician has to be complete. In the case of physicians working in intensive care units, the legal safety, as a factor directly affecting the quality of therapeutic decisions, must be indisputable even if providing it would require an obligatory application to the court in each case of a potential conflict of interest.

The aim of this paper was to determine the way to obtain consent (proxy consent) to ICU treatment of an unconscious patient in accordance with the Polish law and everyday medical practice. The legal solutions proposed herein aim at the improvement of legal safety of ICU physicians during the process of taking key decisions as to the treatment of ICU patients.

This II part of the paper is based on the legal acts mentioned in the I part.

SPECIFICITY OF ANAESTHESIOLOGY AND INTENSIVE CARE DEPARTMENT

The treatment of patients in intensive care units differs to a large extent from the one they receive in other branches of medicine, whether surgical or non-surgical. These differences may be divided depending on their medical and legal character.

From the medical point of view, the essence of treatment in the anaesthesiology and intensive care department (ICU) is the fact that patients are unable to survive without the use of technologically advanced and invasive medical procedures. The basic indication for ICU treatment is potentially reversible failure of one or multiple organs causing immediate threat to life and health of the patient.

The first and the essential difference in actions taken by the ICU personnel compared to those performed in other medical fields is the extent of threat to life. Due to the specificity of intensive care, each therapeutic decision directly affects the patient’s survival and his subsequent return to the environment in which he had functioned.

The second extremely important characteristic of intensive therapy is the extensive use of advanced medical technology to maintain basic vital functions until the patient’s clinical condition improves and there is no longer a threat to his life. Medical technology used in ICUs allows not only to sustain the patient’s life until recovery but also to unnaturally and harmfully prolong the dying of the affected.

Thirdly, the nature of ICU therapy is different compared to other branches of medicine as the majority of ICU patients remain unconscious due to the course of the underlying disease, damage to the central nervous system, or necessary pharmacological treatment.

Apart from obvious medical consequences, both the extent of threat to a patient’s life and the inability to make a declaration of will entail significant legal effects in terms of the physician-patient relationship.

The fact that the patient is unconscious makes him, in the legal sense, a person unable to make declarations of will concerning the consent to medical treatment. The provisions of law that apply to such a patient describe in detail the manner and situations in which the medical personnel is obliged to immediately save his life as well as the ones in which the medical personnel should obtain appropriate consent to treatment in another way. Meanwhile, in everyday ICU work, the medical personnel lacks conviction that the appropriate consent to treatment is also necessary in the case of unconscious patients. Such a situation is likely to be rooted in the belief that since the ICU treatment is to eliminate the immediate threat to life, and thus to protect one of the most important constitutional legal interests, then in terms of criminal liability the state necessity applies here[2], which excludes illegality of treatment without the required consent. Inadmissibility of application of the state of necessity to the general rules of medical law is rejected by some in legal circles, as was proven by Prof. Andrzej Zoll[3]. The opposite view is represented by Prof. Barbara Świątek, who claims that duty to save life expressed in Article 30 of the Act on Medical and Dental Professions is of an absolute character even when the patient’s formal consent is lacking[4]. According to Eleonora Zielińska, the application of the state of necessity to all cases would in reality make the patient’s right to autonomous decision illusory and fictitious[5]. In the face of strong criticism based on everyday clinical practice, even Prof. Zoll called the absolute duty to obtain consent to treatment provided for in Article 192 “an unpleasant legal loophole”. ICU physicians while taking therapeutic decisions in the face of these imperfections of the legal system should assume that the duty to obtain the patient’s consent in accordance with the rules provided by the Act on Medical and Dental Professions is of an absolute character, especially in the case of patients with poor prognosis, undergoing prolonged treatment. This constitutes not only protection of the patient’s good, but also protects the physician taking key decisions as to the treatment strategy.

OBLIGATORY CONSENT TO TREATMENT

In the Polish common law system, the obligation to obtain a consent to any medical treatment comes from the Act on Medical and Dental Professions and failure to comply is sanctioned in accordance with Article 192 (1) of the Criminal Code which reads: “Anyone who performs a medical procedure without the consent of the patient is liable to a fine, the restriction of liberty or imprisonment for up to two years”[6]. Opinions in legal circles as to the evaluation of the arbitrary character of Article 192 of the Criminal Code vary. It is pointed out that Article 41 (1) of the Polish Constitution is not of unconditional character and reads: “Any deprivation or limitation of liberty may
be imposed only in accordance with principles and under procedures specified by statute". Apart from Article 192 of the Criminal Code, the consent as a requisite component of medical and diagnostic procedures is also mentioned in Article 32 (1) of the Act on Medical and Dental Professions [7] and Article 18 of the Act on Patient Rights and Ombudsman for Patient Rights [8] which reads: “a physician may conduct examination and provide other medical services, subject to exceptions provisioned by the law, only following the patient’s consent”. Furthermore, Article 34 (1) provides that for surgical and high-risk procedures, written consent has to be obtained.

In both the abovementioned acts, the legislator stipulated different forms of consent, that is the oral and the written one, depending on the degree of risk that a given method of treatment involves. Notwithstanding the qualification of ICU procedures, in each case their legality depends according to the legislator on obtaining the consent. Maria Boratyńska believes that it is not necessary to differentiate different procedures. She claims that “it can be any necessary medical procedure both ordinary and high-risk” [9, 10]. It should also be stressed that obtaining the consent concerns medical procedures (both diagnostic and therapeutic) in every medical discipline regardless of the type of ward where they are performed (including the intensive care unit). The pivotal issue with the discussed consent to ICU treatment is not the type of procedure, but the mere act of obtaining legally-effective consent from the patient able to express it [11].

Professor Marek Sałaj believes that regardless of the scope of procedures performed by the physician “the condition of almost complete lack of consciousness, and not the hindered contact with the outside world or obstructed perception” [12] undoubtedly excludes the patient’s ability to give autonomous consent to treatment, and thus entails the necessity of obtaining proxy consent. It should be added that the prevailing view of legal doctrine is that even “a minor consciousness disorder” influences the patient’s ability to make declarations of will [13], although this fact has little effect on the process of obtaining the consent from unconscious patients.

The legislation indicates that as far as patients hospitalised in ICUs are concerned, the person authorised to make a declaration of will in place of the patient is the guardianship court. ICU patients do not usually possess a statutory representative entitled to give consent on their behalf, which results in an obligatory necessity to apply the general rules for its obtaining detailed in the Family and Guardianship Code [14]. The legal basis for the duty to obtain a proxy consent constitutes Article 32 (2) of the Act on Medical and Dental Professions, which reads: “If a patient is a minor or is unable to give informed consent, the consent of his or her statutory representative is required, and in the event of its absence or when it is impossible to communicate with him or her – a permission granted by the guardianship code is necessary”. Duty to obtain the proxy consent for the performance of intensive care medical procedures in the case of unconscious patients is thus obligatory and rests on the physician undertaking the performance of medical procedures.

Some of the medical procedures performed by physicians, anaesthesiology and intensive therapy specialists, are undertaken as emergencies, which very often are difficult to anticipate. Hence, it is difficult to obtain the consent of the patient pro futuro. This concerns usually resuscitation procedures and cardiac interventions such as cardioversion, heart stimulation or intensive therapy in the first hours following the ICU admission. All the emergency procedures conducted to save the patient’s life may be performed without the consent under Article 33 (1) stating: “Examination of a patient or performing other treatment procedures without the patient’s consent is admissible if he or she requires immediate medical assistance and due to the condition of health or age cannot give consent to it and when communication with his or her statutory representative or actual guardian is impossible”. The wording of this article is consistent with the legally accepted interpretation of Article 192 of the Criminal Code from which it results that “if for the sake of saving the patient’s life a therapeutic procedure must be performed and it is not possible to obtain the immediate consent of the patient or his or her statutory representative or the guardianship court, the physician has a right to perform such a procedure under the provisions of the Act on Medical and Dental Professions” [15, 16]. The analogous right of the physician to carry out high-risk procedures is included in Article 34 (7) of the Act on Medical and Dental Professions, reading: “A physician may conduct procedures described in par. 1 without the consent of the patient’s statutory representative or the competent guardianship court when the delay caused by it would constitute a threat to the patient’s life, could result in damage to his or her body or a serious health disorder. In such a case, the physician is obliged, if possible, to consult with another physician, preferably of the same specialisation. The physician should immediately notify the statutory representative, actual guardian or guardianship court of the conducted procedures”. As results from the quoted provisions, the right to carry out therapeutic procedures without the patient’s consent expires when the performance of these procedures is no longer emergent or urgent. That being the case, it can be reasoned that once the immediate threat to life and health of the patient is averted, if he or she is hospitalised in the ICU, a competent guardianship court should be informed of the conducted procedures and it should consent to subsequent treatment in accordance with the prognosis. This act, although tro-
ublesome from the practical point of view, in the light of formal requirements allows to legalise the entirety of procedures undertaken during further hospitalisation, and thus to ensure the legal comfort of the physician taking crucial therapeutic decisions only on the basis of medical reasons and assessment of prognosis, and not as a result of fear of legal evaluation of his actions.

PROPOSED FORM OF A REQUEST TO GUARDIANSHIP COURT

In the light of the quoted legal acts, as well as in the face of increasing controversies as to the limits of intensive therapy, it is in the authors’ view essential for medical circles to work out a simple and at the same time uniform way of obtaining proxy consent in the case of unconscious patients with poor prognosis, especially those undergoing long-term treatment. This can be achieved using a model form of request sent by the hospital secretariat to the competent guardianship court, the contents of which the authors propose in the Annex. The common law system does not specify one concrete form of such a document, and the proposed form may be modified in any medical entity by its head or a physician authorised, depending on the circumstances and the type of the requisite consent.

While filling out the above request form, both in electronic and paper form (as in the case of an anaesthetic questionnaire), it is possible to include the patient’s personal details, information important from the clinical condition point of view, as well as the planned range of therapy with details concerning intensive and non-invasive therapy and diagnostic procedures. The request sent by facsimile or by mail together with appropriate information on patient medical records is the basis for the guardianship court to grant the proxy consent to proposed therapy, ensuring legal safety of the ICU personnel and legalisation of further medical management.

It should also be firmly stressed that in the opinion of the authors the current provisions of the Act on Medical and Dental Professions as well as the Act on Patient Rights and Ombudsman for Patient Rights are not suitable for the conditions of ICU treatment. This pertains to both inadequacy of formalised court procedures involved in obtaining the proxy consent as well as the complete exclusion of the role of the family (even advisory) in relation to the selection of therapy or its limitation (which is the source of conflicts between the family and the physician). Scrupulous carrying out by the ICU physician of all the duties required by law would lead not only to substantially increased administrative procedure costs of both the hospital and guardianship court, but would also prolong the time necessary to take appropriate therapeutic decisions, which would have detrimental effects on the patient’s health. The proposed request form may only help the physician in obeying the restrictive and inadequate to the specificity of intensive care units law, which in the opinion of the authors requires changes.

CONCLUSIONS

1. Obtaining the consent of the guardianship court to ICU treatment of an unconscious patient guarantees protection of the patient’s autonomy, not only in the face of immediate threat to life, but also of the irreversible process of dying. Moreover, it proves the selected method of management is optimal in the light of possible recovery chances and guarantees the legal safety of the physician in the face of, often divergent, therapeutic expectations of the family.

2. Obtaining the proxy consent of the guardianship court, although troublesome in clinical practice, in the current legal situation guarantees the legal safety of physicians taking key decisions concerning the strategy of management of ICU patients, especially those with poor prognosis, undergoing long-term treatment.

References:

1. „Kwalifikacja i kryteria przyjęcia chorych do Oddziału Anestezjologii i Intensive Therapie”WytyczneKonsultanta Krajowego w Dziedzinie Anestezjologii i Intensive Therapie dir hab. med. Krzysztofa Kuszy prof. UMK.

Corresponding author:
Jacek Siewiera, MD
Department of Medical Law, Chair of Forensic Medicine
Piotrowie Strażnicy Medical University in Wrocław
ul. J. Mikułasza-Radeckiego 4, 50–345 Wrocław, Poland
tel.: +48 71 784 14 58
e-mail: jacek.siewiera@gmail.com

Received: 20.1.2013
Accepted: 23.12.2013
REQUEST FOR PROXY CONSENT TO HOSPITALISATION AND TREATMENT IN THE INTENSIVE CARE UNIT SETTING

Under Article 32 (2) and Article 34 (3) of the Act on Medical and Dental Professions of December 5, 1996 I hereby request the proxy consent of the guardianship court for hospitalisation and treatment in the intensive care unit setting of a patient in a condition preventing personal declaration of will concerning consent to a medical procedure (Annex).

Annex

Patient’s personal details:
Name: ........................................................................ Surname: ......................................................................................................................
Address:
Personal Identification Number (PESEL): ..............................................................................................................................
Medical case record number: ..............................................................................................................................................

Pursuant to Article 32 (10) of the Act on Medical and Dental Professions the guardianship court of competent territorial jurisdiction to grant the consent to medical procedures is the court in which district the procedures are to be conducted.

Description of the patient’s condition and possible directions of treatment:

______-year-old patient was admitted .................................................................
on ...........................................................................................................................................................................................................................
with a life-threatening condition due to:

..................................................................................................................................................................................................................................

Currently the patient remains unconscious, with a life-threatening condition resulting from multi-organ/system failure:

..................................................................................................................................................................................................................................

The request concerns granting the proxy consent to treatment depending on the clinical condition of the patient, therapeutic chances and current test results and includes the following:
— Intensive care procedures: supply of catecholamines, supply of anaesthetics, supply of analgesics and muscle relaxants, antibiotic therapy, dialysis therapy, haemodialfiltration, central venous cannulation, arterial cannulation, parenteral nutrition, intracranial pressure monitoring, performing tracheostomy, transfusions of packed red blood cells and blood derivatives, resuscitation and cardiac procedures,
— Non-invasive therapy procedures: ventilation therapy, supply of anaesthetics and analgesics, pain management, parenteral nutrition, catheterisation of blood vessels, urinary catheterisation,
— Imaging and invasive diagnostic procedures: CT scans, magnetic resonance, X-ray of the head, chest and other organs, ultrasonography, bronchoscopy, gastroscopy.

Pursuant to Article 34 (7) of the Act on Medical and Dental Professions of December 5, 1996 the following high-risk procedures have been performed so far:..........................

..................................................................................................................................................................................................................................

COMMENTS:
..............................................................................................................................................................................................................
..............................................................................................................................................................................................................

Data and time of the request submission: .................................................................

Signature of the head of medical entity

ANNEX