LETTERS

Catch-22 for the radiologist

Here is a scenario not very uncommon for radiologists in day–to-day practice.

A pregnant woman, who has symptoms such as pain or bleeding per vaginam, comes to a stand-alone ultrasound clinic for an obstetric ultrasound examination in what is apparently an emergency. She does not have a prescription for ultrasound examination from her obstetrician, either because the obstetrician is not reachable for some reason or there is a technical difficulty in obtaining a prescription at that time. What should a radiologist do in such a case?

As per the format of form F under the Pre-conception and Pre-natal Diagnostic Techniques (PCPNDT) Act, a prescription is a must for obstetric ultrasonography. However, there are other questions which have not been clarified in the Act,. These are as follows.

1. Is it essential to have a prescription from a referring physician (third party) or can a radiologist self-refer an obstetric ultrasound study? The question of self-referral becomes pertinent because unlike a gynaecologist, a radiologist does not actually counsel a patient on antenatal care.
2. Can a request for obstetric ultrasound made by the referring physician verbally over the phone, via short messaging service (SMS) or e-mail be considered a valid prescription?

One finds that the answers to these questions depend on how the local authorities interpret the law, and are subjective and variable to the point of contradiction.

In such situations, common sense is supposed to guide the radiologist in taking the best decision. Logically, a radiologist, by virtue of being a doctor, should be able to self-refer a patient for obstetric ultrasound. Logically, in an emergency situation, a request from the referring physician, whether it takes the form of a prescription, an SMS or an e-mail, should suffice. However, the radiologist's problem is that self-referring a patient or accepting informal requests would raise suspicion in the minds of the PCPNDT officials when they visit the clinic later to inspect the documents. Moreover, there is no way that a radiologist can be sure that a patient who has come for an apparently urgent obstetric scan without a prescription does not have malicious intent. With so many radiologists having suffered grave consequences for errors in documentation, it is not surprising if a radiologist is extremely reluctant to entertain such a request and refuses to perform an ultrasound scan. However, there is another angle to this situation that radiologists need to be careful about.

Emphasising the compulsion on doctors to provide emergency medical services, the Supreme Court of India, in the *Parmanand Katara v. Union of India and Others* case, stated that "Every doctor, whether at a government hospital or otherwise, has the professional obligation to extend his services with due expertise for protecting life. The obligation being total, absolute and paramount, laws of procedure, whether in statutes or otherwise, which would interfere with the discharge of this obligation cannot be sustained and must, therefore, give way" (1). Guided by this verdict, the District Consumer Forum and State Commission penalised a private doctor with a sum of Rs 3 lakh for having made no attempt to save an adult victim of a stab injury who was incidentally found lying bleeding on the road outside his clinic (2). The doctor apparently had no doctor–patient relationship/service contract with the victim. The argument that he was a private doctor and a paediatrician, and had no obligation to treat a patient lying on the road did not sustain. In short, what such cases tell us is that all doctors have a compulsion to serve society in case of medical emergencies, and that compulsion overrides the professional freedom of a doctor to refuse a patient.

If the pregnant woman whom the radiologist refuses to scan in an emergency situation suffers an adverse outcome, her case is likely to be viewed with sympathy by the legal system. The radiologist's plea that he/she was following the PCPNDT protocol is not likely to suffice in such a case. So, whether a radiologist agrees or refuses to perform a scan, he/she is likely to breach one of the legal protocols – either PCPNDT Act or the absolute legal obligation to attend to a medical emergency. This is a radiologist's Catch-22.

In the absence of clear guidelines from an appropriate authority on how to handle such situations, radiologists are well advised to consider all aspects of the case before refusing or accepting a request for emergency obstetric ultrasound without a valid prescription. A possible solution could be to make adequate written documentation of the circumstances, specifying in precise terms the nature of the emergency and the reason for the non-availability of a prescription, and asking the patient to sign this before performing the scan. One copy of this document could be sent to the appropriate authority at the earliest and another could be attached to form F. Such clear communication may help the radiologist to carry out his/her ethical responsibility while safeguarding him against legal

complications. However, the best way of avoiding confusion and uncertainty among radiologists would be if such a protocol were officially incorporated in the PCPNDT Act.

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Advance directives, palliative care and clinical bioethics committees

Concerns relating to end-of-life decisions

The topic under discussion at the 10th Brazilian Congress on Bioethics was "Advance directives, palliative care, and clinical bioethics committees," among the most important end-of-life issues. Other than the psychosocial, medical, and ethical aspects of making an end-of-life decision, juridical concerns need to be considered as well. From the point of view of physicians, one of the main difficulties faced by them while making such decisions is determining the appropriate time for the suspension of medical procedures in patients with incurable diseases.

What is right and what is wrong?

In ethical terms, the discussion of the end of life with patients is rooted in the four bioethical principles of autonomy, beneficence, non-maleficence, and justice (1).

In countries that uphold the right to orthothanasia, designed protocols are followed for this purpose and it is ensured that the practice is backed by complete legal certainty. Hence, the patient's wishes are fulfilled and at the same time, the medical and health institutions participating in the process are protected from any kind of liability (2).

This, however, is not the scenario in Brazil. Although a resolution by the Federal Council of Medicine in 2006 (3) and the revised 2010 Brazilian Code of Medical Ethics (4)lay down guidelines for end-of-life decisions for terminally ill patients or those who are not competent to take a decision, as you stated in your article (5), there is no federal law regulating these matters.

When should doctors stop trying to treat patients? Our current technological skills and biological knowledge have served to make dilemmas regarding death more problematic and have made the choices more difficult (2). More than ever, health actions are ruled by an inclination towards critical care and high-tech medicine.

Once the occurrence of death is deemed irreversible, who is responsible for taking a decision in the case of an unconscious patient? How would familial ties and economic realities influence this decision? How could such a medical decision be questioned? Each situation is unique, and people have different emotions, reactions and expectations. Even when the informed consent of a family member has been obtained, other family members may have different perceptions and may later argue that they were not consulted. The readiness to have the treatment stopped depends on the relative's personal acceptance of the end of life. As for the patient, he/she has the right not to receive futile treatment. Physicians should respect the wishes of the patient, but not necessarily those of the patient's family.

A document that could help avoid several dilemmas is the "living will" This is like a clinical record that is prepared by patients as proof of their willingness to undergo invasive or painful procedures to prolong their lives in terminal states. The concept of a living will was recognised by the Brazilian Federal Council of Medicine in 2012. The living will is acknowledged in countries such as Spain, Japan, the United States, Portugal, and Uruguay (6).

Medicine today offers a wide range of possibilities by which life can be extended and this raises the question of how to determine the limits to which life should be extended. Protocols for end-of-life issues should be developed and validated, and laws must be framed and enacted. Without clear rules, decision-making becomes more difficult and tends to be coloured by personal views. Consequently, cultural, psychosocial, and religious influences seep in. By helping in the identification of goals and establishment of procedures, laws and protocols help make end-of-life decisions less emotive and more technical. The emphasis of medicine should be concern for the patient with the disease, and not the disease itself. Medicine should be oriented to relieving the suffering of the patient. To fulfil this ideal, legal support is needed.

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