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Law and medical ethics in geriatric patient: Current perspectives and a literature review



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ABSTRACT

Background: In the field of geriatrics, ethical issues (including the law) are very important, even among various branches of medicine, possibly in this branch that ethics and law have the most crucial role. Those several issues need special attention in Indonesia, in which geriatrics is a field of science which was just starting to develop. Therefore, some of the following ethical principles which will be put forward have often not yet present/executed in Indonesia. Meaning and knowledge regarding this matter will give a picture concerning how ethical and legal issues on the elderly patient should be enforced.

Objective: This review aims to explore further about the law and medical ethics in geriatric patient.

Method: A review of relevant literature was performed to elaborate the law and medical ethics in geriatric patient. A total of 12 qualified published literature of all years until 2019 were collected from several electronic database and manual search and included in this review.

Result: According to the law and medical ethics in geriatric patient, there were several considerations that need to be carried out in the service of the elderly patient, those are ethical principles, directives of patient's wish, administration of life sustaining device, condition of geriatric in unconscious/deep coma, approach to the patient, and religious and ethical aspects.

Conclusion: In the practice of geriatric services in our country, several aspects should be a consideration by following the law and medical ethics.

Keywords: Law, medical, ethics, geriatric, perspectives

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INTRODUCTION

In the field of geriatrics, ethical issues (including the law) are very important, even among various branches of medicine, possibly in this branch that ethics and law have the most important role. Kane et al. were stating, "ethic is a fundamental part of geriatrics. While it is central to the practice of medicine itself, the dependent nature of geriatric patients makes it a special concern."¹

Various things that are required to be noticed are, among others, a decision regarding the life and death of the patient. Is the treatment should be continued or to be ceased? Is it necessary for resuscitation treatment? Whether supplemental food per infuse is still given in condition of the patient who clearly will pass away? In geriatrics, this ethical aspect is closely related to the legal aspect, so that discussion concerning these both aspects is often put together in one discussion. The legal aspect of the patient with a very low cognitive ability, such as in dementia patients, is closely related to the ethical aspect. Among others, it regards the property management of an elderly patient who has no children and so forth.^{1,2}

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ETHICAL PRINCIPLES OF HEALTH SERVICE ON ELDERLY

Several ethical principles which must be carried out in the service of the elderly patient are:^{3,4}

A. Empathy: the term empathy related to the meaning of: "sympathy on the basis of deep understanding." In this term, it is expected that the effort of geriatrics service must view a sick elderly with understanding, affection, and understand the pain experienced by that patient. This act of empathy must be carried out naturally, not excessively, so that not giving the impression of overprotective and merciful. Therefore all of the geriatric officers must understand the physiology and pathologic process of the elderly patient.

B. The do's and the "don'ts": this principle is often put forward as **non-maleficence** and **beneficence**. Geriatrics service always based

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on requirements to do the good for the patient and must avoid activities that do more harm to the patient. There is an adage “primum non nocere” (“the important thing is not to make someone suffers”). In this meaning, an effort to make a proper reclining position to avoid pain, administration of analgesic (if necessary with morphine derivative), which is sufficient, expression of comforting words, are examples of various things which may be easy and practical to be done.

- C. Autonomy:** namely, a principle that an individual has the right to determine his/her fate, and express his/her wish. Sure this right has a limitation; however, in the field of geriatrics, it will be based on circumstance, whether the patient can make a decision independently and freely. In eastern ethics, often, this is assisted (or become more complicated?) by the opinion of close relatives. So basically, the autonomy principle tries to protect the patient who **functionally** he/she is **still capable** (whereas non-maleficence and beneficence are more to **protect incapable** patients). In various ways, this ethical aspect is as if using the paternalism principle, in which someone becomes a surrogate of another person to make any decision (for example, a father makes a decision for his child who is not mature yet).
- D. Justice:** namely, a geriatrics service principle that officers must give equal treatment for all patients—the obligation to treat a patient properly and do not discriminate based on the irrelevant characteristic.
- E. Sincerity:** namely a principle to always fulfill all promises given to a patient.

Beneficence

1. All For The Good Of The Patient.
2. Adjusts To The Patient's Economic Conditions.
3. Reflecting the adverse effects that will occur.

Non-maleficence

Prioritizing patient interests.

Autonomy

Give priority to the patient's rights doctors must be forthright.

Justice

1. Consider the patient's economic status.
2. See the adverse effects of patients and their families in the future.

If the person is too ill to choose freely and if other persons in similar circumstances would likely choose the same intervention.^{4,5}

By looking at the principles mentioned above, the ethical aspect of geriatrics service is based on the autonomy principle and later emphasized on various things as follows:

1. The patient should join to participate in the process of decision taking and decision making. Eventually, decision taking **must be voluntary**.
2. The patient must be getting sufficient explanation regarding treatment or decision to be taken completely and clearly.
3. The decision to be made only considered legitimate if patient is considered capable mentally.

Based on the aforementioned things, then ethical aspect regarding autonomy later is written in the form of law as **the consent of medical treatment or informed consent**.⁶ On the things aforementioned, so patient is entitled to reject medical treatment suggested by the physician, but it doesn't mean they can choose the treatment if, based on doctor's observation, the treatment being chosen is useless or even harmful.

The capacity to make a decision is a very complicated ethical and legal aspect.^{3,4} The basis of a capacity assessment of decision making by the patient should be from the patient's functional capacity and not based on diagnosis label, among others can be seen from:

- Whether the patient should make/show the wish correctly?
- Can the patient give reasons regarding the choice that he/she made?
- Whether the reasons by the patient are rational? (after patient getting complete and correct explanation?)
- Whether the patient understands the implication to himself/herself? (for instance, regarding the advantage and disadvantages of the treatment? And also understand various existing choices?)

This functional approach is indeed difficult since, frequently, there is still a proper function from one aspect, but other functions are not so good anymore, so that it requires consideration from several factors. In the elderly also frequently, there is an obstruction in communication due to the loss of hearing so that it needs more time, effort, and patience to find out the functional capacity of the patient.

This ethical principle states that the patient's capacity to take/make a decision (autonomy principle) is limited by:

- **Clinical reality of the obstruction of the decision-making process** (for example, in the condition of severe depression, unconscious or dementia). If the disorder is so severe, meanwhile decision must be made soon, then the decision can be transferred to the legal representative of the family surrogate (wife/husband/children or lawyer). This condition is referred to as **a surrogate decision-maker**. If the decision expecting for its assistance not only in the medical aspect but concerning all life aspects (legal, property, etc.), then there should be a government agency that protects the patient's interest, which is referred to as legal protection body/guardianship board.

In reality, this decision-making is often carried out based on de-facto state, that is by husband/wife/family member, compared to the de-jure state by a lawyer, since the latter often unpractical, takes longer time, and often tiresome both physically and emotionally.

Due to some reasons, for instance, communication disorder, misunderstanding, patient's faith, or cultural background can lead to the patient making the wrong decision (among others rejecting transfusion/life-saving surgery). In this case, the physician is facing a difficult situation in which the autonomy principle of the patient must still be appreciated).

The important thing is that the physician is willing to hear all the patient's complaints or reasons and, if possible, to correct the patient's decision by providing education. Often it requires the act of "compromise" between what is good according to the physician's consideration and what the patient wants.

DIRECTIVES OF PATIENT'S WISH (ADVANCE DIRECTIVES)

In the case of appreciating the autonomy rights of the patient, it is known what is called directives of the patient's wish, that is, expression or wish of the patient that is being spoken when the patient still in a good functional capacity state.⁷ Directives of the wish which being spoken are better noted down/recorded to be used later as a guideline if needed for decision making when the functional capacity of the patient is decreased or hampered. Even if the directive is not noted down/recorded, it still has legal force, provided that there are sufficient witnesses when the directive is spoken.

What is more powerful than directives of a patient's wish is what referred to as a testament of death/living will, namely a statement from the patient when he/she is still capable functionally to face a legal officer (lawyer/notary). This living will provide a legal force over the physician's treatment to give, cease, or release all treatment with the life-sustaining device.^{3,7,8}

ADMINISTRATION OF LIFE SUSTAINING DEVICE

One of the ethical aspects which are essential and still controversial in geriatrics service is the utilization of the life-sustaining device, among others are ventilator and other life-sustaining efforts (cardiopulmonary resuscitation, etc.).^{3,8} In a young adult patient, it is often not an issue, since it is expected that patient can live longer if he/she can survive. But in the elderly, especially if the disease is in an advanced stage, the administration of this device often debated as exactly is a cruel/futile treatment.^{3,8}

It is said as "physiologic cruelty" if the given therapy/treatment will not bring improvement at all (plausible effect) on the patient's health. It is called "quantitative cruelty" if the treatment or therapy apparently is useless. It is called "qualitative cruelty" if therapy or treatment to sustain life does not show improvement or exactly even reducing the life quality of the patient.^{3,8}

Although it is often raising emotional responses from the family, the cessation of the life-sustaining device (ventilator, etc.) should be given equal consideration as to whether the device should be installed or not. Installation of this device is not by itself hinder it if at one time to be discontinued if deemed useless.

The physician must explain this matter to the patient's family and give an explanation that the evaluation showed that administering the device needs to be stopped.

Regulation of Minister of health republic of Indonesia number 76 year 2016, regarding guideline of Indonesian case base groups (ina-cbg) in implementation of national health insurance by the blessing of the almighty god minister of health republic of Indonesia for Indonesia people including elderly person.⁹

Considering: a. whereas in implementation of Health Insurance in National Social Healthcare System, healthcare service tariff has been set on the first level of health facilities and advanced level health facilities;

- b. whereas the Regulation of Minister of Health Number 27 the year 2014 regarding Technical Instruction of Indonesian Case Base Groups System (INA-BG's) needs to be adjusted with development and requirement of healthcare service at Advanced Level Health Facilities, so that it needs to be refined;
- c. whereas by virtue of consideration as referred to in letter a and letter b, it needs to set the Regulation of Minister of Health regarding the Guideline of Indonesian Case Base Groups (INA-CBG) in the Implementation of National Health Insurance;

- In view, of:
1. The Law Number 40 year 2004 regarding National Social Insurance System (Gazette of Republic of Indonesia year 2004 Number 150, Addendum of Gazette of Republic of Indonesia Number 4456);
 2. The Law Number 36 year 2009 regarding Healthcare (Gazette of Republic of Indonesia year 2009 Number 144, Addendum of Gazette of Republic of Indonesia Number 5063);
 3. The Law Number 24 year 2011 regarding Social Insurance Administration Organization (Gazette of Republic of Indonesia year 2011 Number 116, Addendum of Gazette of Republic of Indonesia Number 5256);
 4. Regulation of President Number 12 year 2013 regarding Health Insurance (Gazette of Republic of Indonesia year 2013 Number 29) as has been amended several times, the last time with Regulation of President Number 28 year 2016 regarding the Third Amendment over the Regulation of President Number 12 year 2013 regarding Health Insurance (Gazette of Republic of Indonesia year 2016 Number 62);
 5. Regulation of Minister of Health Number 52 year 2016 regarding the Standard of Healthcare Service Tariff in Management of Health Insurance Program (Gazette of Republic of Indonesia year 2016

Number 1601) as has been amended with Regulation of Minister of Health Number 64 year 2016 regarding the Amendment over the Regulation of Minister of Health Number 52 year 2016 regarding the Standard of Healthcare Service Tariff in the Management of Health Insurance Program (Gazette of Republic of Indonesia year 2016 Number 1790);

To decide: Stipulating: Regulation of minister of health regarding the guideline of Indonesian case base groups (ina-cbg) in the implementation of national health insurance.

Article 1

Guideline of Indonesian Case Base Groups (INA-CBG) in the Implementation of National Health Insurance is a reference for advanced-level health facilities, Social Insurance Administration Organization (Healthcare BPJS), and other related parties regarding payment method of INA-CBG in the implementation of Health Insurance.

Article 2

Guideline of Indonesian Case Base Groups (INA-CBG) in the Implementation of National Health Insurance, as referred in Article 1, is contained in the Appendix, which is inseparable part from this Minister's Regulation.

Article 3

At the time, this Minister's Regulation is put into effect, Regulation of Minister of Health Number 27 year 2014 regarding Technical Instruction of Indonesian Case Base Groups System (INA-BG's) (Gazette of Republic of Indonesia year 2014 Number 795), is revoked and declared invalid.

Article 4

This Minister's Regulation is put into effect on the date of promulgation and is retroactive since the date of October 26th, 2016.

GENERAL RULE

In the implementation of JKN, INA-CBG system is one of the important instruments in the submission and payment of healthcare service's payment claim which has been implemented by FKRTL that has collaborated with Healthcare BPJS, then management or functional party in each FKRTL needs to understand the implementation concept of INA-CBG within JKN program.⁹⁻¹¹

INA-CBG system consists of several components that are related to each other. The component which has a direct connection to service output is a clinical pathway, coding, and information technology, meanwhile separately, there is a costing component that indirectly influences the tariff setting process of INA-CBG for each case group.⁹

CODE STRUCTURE OF INA-CBG

Basis of classification in INA-CBG is using the codification system from final diagnosis and treatment/procedure, which becomes service output, with reference to ICD-10 Revision of 2010 for diagnosis and ICD-9-CM Revision of 2010 for treatment/procedure. Classification using an information technology system in the form of INA-CBG Application, so that result in 1075 groups/case groups consist of 786 case group of inpatient and 289 case groups of outpatient.^{9,10}

FOR PATIENT WHO IS IN CONDITION OF UNCONSCIOUS/DEEP COMA

All organ functions definitely cannot improve with various drugs/treatment being given, agonal breathing, and “condition which is clearly hopeless” or “failure to thrive,” the issue is not too difficult.^{11,12} However, for the patient who is fully aware, often still mobile, with various organ functions still in good condition, ethical and legal issues become more complicated. In this condition, several things must be considered:

- Whether the patient needs to be informed.
- If all the treatments/medical actions.

Of the former above, the problem for medical practice in Indonesia (and Eastern countries) is to notify the actual condition to the patient often leads to a massive psychological outcome. So those families often prevent the physician from informing the exact condition to the patient, even though from autonomy principle as described regarding ethical of elderly care, it should be the patient who the first ought to know of his/her disease state and then decide what is allowed to do by the medical team.^{11,12}

Elizabeth Kubler Ross, a psychiatrist who studied the psychological aspect of the patient who was informed regarding his/her upcoming death, and usually responded in several ways: (a) avoid/denial and isolate him-/herself. “No, not me. It can't be true!”; (b) Anger. “Why me?”; (c) Bargaining; (d) Depression, and finally (e) Acceptance.^{11,12}

From the answers to those questions, the hospice team can prepare so that dignified death can be pursued. Indeed to be able to prepare patient so that he/she can answer those questions required time and effort, which is not easy.^{3,11}

APPROACH TO THE PATIENT

Some of the patient's feelings who is informed about his/her upcoming death, and how should these feelings are confronted by team members.^{3,4,11}

As described above, it is very difficult to determine when exactly the patient will pass away. Therefore the most important is to recognize the aggravating symptoms of the patient:

1. Physical pain and somatic symptoms, for instance, anorexia, nausea, vomit, singultus, constipation, diarrhea, pruritus, cough, breathlessness, asthenia, and cachexia.
2. Psychological pain, for instance, fear, aggressive, desperate, and depression, since the patient has been encountered with a fatal diagnosis.
3. Sociologic pain, among others isolated feeling in the community, resigned from professional position related to the job, feeling separated, and having to stay in the hospital, financial issue.
4. Spiritual pain, among others, fear related to human existence and their relation with God.

RELIGIOUS AND ETHICAL ASPECTS

It is clear that in geriatric service, the ethical aspect has a vital role. In many western countries, the geriatric team is often included a member who is representative of a certain religious body. In the practice of geriatric service in our country, this is may and should be considered as a must, since some religious considerations can help a patient (functionally still capable) to decide his/her life and health. For the incapable patient, religious consideration can help not only family members but also physicians to see life aspects from the spiritual-religious viewpoint.^{3,7,11}

CONFLICT OF INTEREST

There is no competing interest regarding the manuscript.

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AUTHOR CONTRIBUTION

Raden Ayu Tuty Kuswardhani responsible for the study from the conceptual framework.

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