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SPECIAL REPORT

Legal issues encountered in the intensive care: presentation of three cases

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Abstract

Juridical problems can frequently be encountered in the ICU and quick decision-making may be necessary. In case of doubt, it is wise to consult the legal expert of the hospital. However, basic knowledge is required by all physicians. This article addresses three cases comprising different legal issues: professional confidentiality after a patient has died, blood sample collection from an unconscious patient for forensic investigation and disagreement about treatment limitations with a patient's family.

Introduction

In the daily care of patients, not only clinical decision-making, but also balancing psychosocial, social, economic and legal aspects, can be challenging. Juridical issues can be encountered in every field of care for the patient. Legal expertise is available in most hospitals; however, basic knowledge of relevant legislation is required by every physician. It will help to guide decision-making, especially in the event of problems outside office hours, when legal expertise is usually not available. In this article, we will describe three legal problems we encountered on our ICU. We will discuss several important items of each case based on Dutch medical legislation. The relevant legislation used in cases I-III can be found in *table 1*.

Table 1. Relevant legislation of cases I - III

Name of Dutch law	Translation in English	Content
WGBO Dutch Civil Code Book 7, Title 7 Articles 448, 450, 453, 454, 457, 465	Dutch Medical Treatment Act	Act regulating the legal position of patients while taking into account the responsibility of the care provider to provide good care, among which: - The right of patients to be informed and to give consent - How to deal with confidential patient data and providing access to the medical file - Representation of patients who cannot be deemed capable of making a reasonable assessment of his interests - The right of a second opinion - The right of privacy
Wegenverkeerswet Article 8 and 163	Road Traffic Act	Act regulating rules of conduct for all participants in traffic, among which: - Prohibition to drive under influence of alcohol, drugs or medication - Obligation to undergo a breath test or blood investigation in case of suspicion of being under influence
Grondwet Article 11	Dutch Constitutional Law	Article concerning the protection of the physical integrity

Case I: Life insurance

A 36-year-old British male with an unremarkable medical history went to Amsterdam to celebrate his friend's bachelor party. After he had used alcohol and drugs, he fell on his head. This resulted in skull fractures with severe brain contusion. He was admitted to our ICU. Neurological investigations showed severely damaged brain function with infaust neurological prognosis. After three days the patient died. After his death, the life insurance company of our patient contacted the attending intensivist for additional information about the cause of death. The life insurance company intended to use this information to decide about life insurance collection.

Is it allowed to give medical information about the patient to an insurance company after his death?

The relevant Dutch law for this problem is the 'Wet inzake de geneeskundige behandelingsovereenkomst (WGBO)'. The WGBO is part of the Dutch Civil Code (Book 7, Title 7, Article 446 to 468). It addresses professional confidentiality (Article 457), but also other topics such as the right to information of patient/representatives (Article 448) and the consent of the patient for diagnostics and treatment (Article 450). Professional confidentiality remains valid after the patient has died. The right

to confidentiality of medical records is personal, and cannot be transferred to (legal) representatives. This implies that neither family nor other representatives can exempt the physician of his professional confidentiality. It is at the discretion of the physician whether he will breach his professional secrecy. This is only allowed under the following specific circumstances:

- The patient gave permission while he was still alive.
- The consent of the patient can be assumed (according to a reconstruction of the will of the patient).
- Another law imposes provision of medical records, such as the 'Infectieziektenwet' (Infectious Diseases Act)/ 'Wet op de lijkbezorging' (Burial and Cremation Act).
- The physician has a conflict of duties.
- There is an issue of key importance.[1]

In this case assumed consent of the patient and conflict of duties of the physician are relevant. To determine the alleged permission of the patient there are several important factors. Who makes the request, how is this person related to the deceased and what is his interest? What kind of data are needed (how personal are the data) and for what reason are they needed (for example: life insurance collection, contest a will, claims).
A conflict of duties can arise when:

- Everything has been done to obtain permission from the patient (not applicable in this case)
- Not breaking the professional confidentiality causes severe problems for others.
- Maintaining professional secrecy causes a moral conflict.
- There is no other possibility to solve the problem.[1]
- Breaking professional confidentiality almost certainly prevents damage.

In case professional confidentiality is broken, it is very important to provide no more data than is strictly necessary.

This case is about provision of data to a life insurance company. Dutch law also applies to this British patient. Suspicion of insurance fraud is not a good enough reason for the attending physician to break his professional secrecy. Just the cause of death of the insured person will be provided, but only if several conditions have been fulfilled: the request is made by the medical advisor of the insurance company, it is stated that the cause of death will only be used for the medical statistics of the company and that life insurance collection has been paid out or will be paid out later.[2] This implies that medical information concerning the patient may not affect the decision for the payment of the life insurance.

Can or should the physician refuse to give any information to the life insurance company?
In this case it was an unnatural death, because the patient fell. Provision of information about the cause of death should be left to the public prosecutor. Provision of medical data can be refused with referral to the public prosecutor.

What information am I allowed to give?
Provided that the aforementioned conditions have been fulfilled, it is allowed to give information about the cause of death only. Any other information should not be given under any circumstances. It may be wise to consult the legal expert of the hospital before providing any information. In case of suspicion of fraud, the life insurance company can be referred to the Toetsingscommissie Gezondheidsgegevens. The procedure is described in the 'Convenant inzake toetsing mededelingsplicht gezondheidsgegevens' (www.verzekeraars.nl).

Case II: Police requesting for information

A 32-year-old man caused a severe traffic accident under the influence of alcohol. This patient and the driver of the other car were severely injured and admitted to different ICU wards on a Friday evening. Our patient was the causative. The police asked the attending physician to draw blood from the patient immediately for further investigations, such as the measurement of the alcohol level. The patient was unconscious and intubated. The physician refused and was accused of obstruction of justice by the police.

Is the attending physician of the patient allowed to draw blood or any other body material for forensic investigations?
The relevant laws for this situation are: WGBO (Article 450 concerning consent for diagnostics and treatment), Wegenverkeerswet (Article 8 and Article 163), Code of criminal procedure, Code of penalty law, Dutch Constitutional law (Article 11 of the constitution concerning: protection of the physical integrity).
There are parts of the Netherlands with Convenants: commitments between healthcare facilities, police and judicial authorities on rules and codes of practice for provision of data. The basics of these Covenants are respect for each other's field of action and the possibilities and limitations within the legislative framework. The procedures of common situations have been set down. Every covenant partner appoints a contact officer for the mutual contacts between the covenant partners. [3] All communication takes place by these contact officers. In this way all knowledge and experience is pooled and the healthcare workers are not burdened with these problems.
In a case like the above-mentioned, the police should contact the appointed contact officers in the hospital. The police has to ask the forensic physician to draw blood. To draw blood, the forensic physician has to ask the patient's permission. Consent of the (legal) representative is not enough. If the patient refuses the District Attorney can order the patient to cooperate, in case of driving under the influence of alcohol, drugs or medication. If a patient is unconscious blood can be drawn and stored by the forensic physician (not the attending physician). Consent to analyse the blood sample has to be asked when the patient regains consciousness. If the patient is suspected of driving

under influence and not able to express what he wants, blood will not be drawn within one hour after the first direct contact of the patient with the investigating officer. If the patient dies without being able to give consent the blood sample will be destroyed, unless the District Attorney objects.[3]

Was the attending physician obstructing justice in this case?
The attending physician was not obstructing justice. It is only allowed to draw blood under clearly defined circumstances. This is the responsibility of the prosecution service and not of the attending physician. The attending physician did not deliberately hamper the police in their work, but just abided by the law.

Case III: Do not resuscitate

A 47-year-old-man suffered from coronary artery disease. After an out-of-hospital cardiac arrest in 2011 severe post-anoxic brain damage remained, and he was transferred to a nursing home. At that time, the attending intensivist told his wife that he would not be resuscitated or readmitted to the ICU again in the future, because of his severe brain damage. In the nursing home where he lived, his wife told the attending physicians she did not agree with this policy. In the following years the severe brain damage remained unchanged. In 2015, the patient was admitted to our ICU on a Tuesday night after a very long and difficult resuscitation. At the time of admission his previous medical state (severe brain damage) was not known and the nursing home physician could not be reached. In the morning, when this information became available and CT brain showed loss of normal grey-white differentiation, the entire medical team considered further treatment futile after extensive multidisciplinary consultation. The family opposed this decision and demanded continuation of treatment.

Can the family prohibit the instigation of treatment limitations?
This case is about disproportionate medical care, which can be defined as not proper, untimely use of all medical possibilities. Disproportionate care in the ICU is a broad spectrum under which not only excessive care, but also medical futility fall. Inappropriate care can lead to violation of bioethical principles (harm, injury and injustice to the patient) and to prolonged suffering of patients and relatives.[4]
The relevant legislation in case of disproportionate care is again Article 453 of the WGBO: 'In the course of his duties the caregiver must have regard for the standard of care required of a caregiver and must act in accordance with the responsibilities ensuing from the standard of professional care required of caregivers.' The relevant professional standard addressing this issue can be found in the NVIC guideline: 'Withholding and withdrawal of treatment and palliative care after withdrawal of treatment in adult ICU patients'.[5] This guideline states:
'The family of the patient does not have to give their permission to stop futile medical treatment. It is primarily a medical decision by the attending physician. This is in line with previous jurisdiction such as in the Hankes' case in 1999.[6]
In several countries, such as the United States, patients' family members are legally recognised as surrogate decision-makers when patients are incapacitated. In the Netherlands this responsibility has been given to the attending physician and his medical team. They are considered better able to judge the condition of the patient and the consequences and burden of ongoing therapeutic interventions. In addition, families will not feel guilty about 'pulling the plug'. The physician will take into consideration the estimated prognosis and the reconstructed will of the patient. Mostly, treatment limitations will be instigated after multidisciplinary consultation. All considerations have to be documented properly (WGBO, Article 454). The (legal) representative of the patient should be well informed and supported (WGBO Article 448 and 465). If the family of the patient has objections against these decisions, a second opinion can be offered.

Conclusions

Legal issues are frequently encountered in the ICU. In case of doubt, it is wise to consult the legal expert of the hospital. Basic knowledge of relevant legislation is required by all physicians and can help to guide decision-making, especially outside office hours when legal expertise will not usually be available. The legal issues discussed in the three cases are:

- Suspicion of insurance fraud is not a good enough reason to break professional secrecy. Just the cause of death of the insured person will be provided, if several predefined conditions have been fulfilled.
- The police cannot order the attending physician to draw blood. The forensic physician is allowed to draw blood, but only if the patient gives his/her permission.
- A patient's family does not have to give permission to stop futile medical treatment. It is primarily a medical decision of the attending physician.

Disclosures

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