The Urgency of The Existence of Approval of Medical Actions In Palliative Services

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Article History: Received: Agust 12, 2023; Accepted: November 14, 2023

ABSTRACT
Palliative care really helps patients' lives to be more comfortable and of good quality, this is an important need for humanity. All actions of palliative care carried out by the palliative team, really need informed consent, so that they are not subject to administrative, criminal or civil sanctions. So in this study the aims were to analyze the legal ratio of informed consent in palliative care based on the Minister of Health Decree number 812/Menkes/SK/VII/2007 concerning Palliative Care Policy, and analyze legal liability for negligence in making informed consent in palliative care. The research method is normative juridical with a statute approach and conceptual approach. The results of this study are that in the process of palliative care carried out with multidisciplinary knowledge, these actions really require informed consent. And legal responsibility for negligence in making informed consent in palliative care can be in the form of administrative, criminal or civil sanctions.

Keywords: Palliative, Informed Consent, Legal

1. INTRODUCTION

The provisions of Article 28A of the 1945 Constitution read "Everyone has the right to live and the right to defend his life and living." Meanwhile, Article 28I paragraph (1) reads: "The right to life, the right not to be tortured, the right to freedom of thought and conscience, the right to religion, the right not to be enslaved, the right to be recognized as a person before the law, and the right not to be prosecuted on the basis of laws that apply retroactively are human rights that cannot be reduced under any circumstances."

It is clear from the constitution that citizens' rights to life are strictly protected. Protection of citizens' right to life requires the participation of the Indonesian Government in terms of legality in the form of statutory regulations, one of which is the regulation of the health service system. One of the health services that can accommodate a patient's right to life is palliative services for terminal patients, including services for cancer patients.

Based on Riskesdas data, the tumor/cancer morbidity rate in Indonesia has increased from 1.4 per 1000 population in 2013 to 1.79 per 1000 population in 2018. The highest prevalence rate was
achieved by DI Yogyakarta Province, namely 4.86 per 1000 population. then West Sumatra 2.4779 per 1000 population, next Gorontalo 2.44 per 1000 population (kemkes.go.id, 2022). 1 Cancer is a health problem that exists in the global community in Indonesia and the world.

Pain is the most common complaint felt and feared by cancer patients and patients in other terminal phases. Pain that is not treated properly will result in suffering that will greatly impact the patient's quality of life. Patients in terminal conditions who are suffering really need a multidisciplinary integrated approach in order to have a good and dignified quality of life at the end of their lives. Palliative services really help patients' lives to be more comfortable and of better quality, this is an important need for humanity.

In the Decree of the Minister of Health number 812/Menkes/SK/VII/2007 concerning Palliative Care Policy (hereinafter referred to as the Minister of Health's Palliative Decree) it is explained that the increasing number of patients with diseases that are difficult to cure in adults and children such as cancer, degenerative diseases, obstructive pulmonary disease chronic disease, cystic fibrosis, stroke, Parkinson's disease, heart failure, genetic diseases and infectious diseases such as HIV/AIDS which require palliative services, in addition to promotive, preventive, curative and rehabilitative services. However, until now health services in Indonesia have not been able to meet the needs of patients with this difficult-to-cure disease, especially at advanced stages where the main goal of service is not just recovery, but also achieving the best quality of life for patients and their families. One of the medicolegal aspects in palliative care includes approval of medical procedures/approval of medical procedures for palliative patients. Although in general (Law Number 29, 2004) only medical procedures require approval for medical action, in palliative services it is best for every risky action to be approved for medical action.

Article 45 of Law Number 29 of 2004 concerning Medical Practice (hereinafter referred to as the Medical Practice Law) states that as follows:

1. Every medical or dental action that will be carried out by a doctor or dentist on a patient must obtain approval.
2. Consent as intended in paragraph (1) is given after the patient has received a complete explanation.
3. The explanation as intended in paragraph (2) at least includes: a. diagnosis and procedures for medical procedures; b. the purpose of the medical action performed; c. alternative actions and their risks; d. possible risks and complications; and e. prognosis for the actions taken.

4. Approval as intended in paragraph (2) can be given either in writing or orally.

5. Every medical or dental procedure that carries a high risk must be provided with written consent signed by the person entitled to give consent. (bold by author)

6. Provisions regarding procedures for approval of medical or dental procedures as intended in paragraph (1), paragraph (2), paragraph (3), paragraph (4), and paragraph (5) are regulated by Ministerial Regulations.

The explanation contained in Article 45 paragraph (5) of the Medical Practice Law states that what is meant by "high risk medical procedures" are surgical procedures or other invasive procedures. In palliative care, all medical actions carried out are risky actions, whether they are planned or carried out in an emergency to save lives and prevent disability. This also includes the decision to carry out euthanasia, where the patient is unconscious or unable to sign his own consent to medical treatment and must be represented by his closest family.

Minister of Health Regulation number 290/Menkes/Per/III/2008 concerning Approval of Medical Procedures (hereinafter referred to as Minister of Health Regulation on Approval of Medical Procedures) Article 1 number 1 states that "Consent to medical procedures is approval given by the patient or closest family after receiving a complete explanation regarding medical or dental procedures to be performed on the patient.” In number 3 of the Minister of Health's Decree, it is stated that "Medical or dental procedures, hereinafter referred to as medical procedures, are medical actions in the form of preventive, diagnostic, therapeutic or rehabilitative carried out by a doctor or dentist on a patient.” The provisions of the Minister of Health Regulation do not include the need for approval of medical procedures for palliative medical procedures.

In Material Criminal Law, written approval for medical procedures is something that must be fulfilled in Article 351 of the Criminal Code (KUHP) concerning Persecution. For invasive procedures (for example surgery, invasive radiological procedures) carried out by health workers without the patient's consent, the health worker can be prosecuted for an offence, namely violating Article 351 of the Criminal Code which reads (Tapada, 2018):
1. Persecution is punishable by imprisonment for a maximum of two years and eight months or a fine of up to four thousand five hundred rupiah.

2. If the act results in serious injury, the guilty party will be punished with imprisonment for a maximum of five years.

3. If the act results in the death of a person, then the guilty person is punished with imprisonment for a maximum of seven years.

4. Persecution is equated with intentionally damaging someone's health. (bold by author).

Looking at Article 351 of the Criminal Code paragraph (4), this includes abuse when health workers carry out medical procedures intentionally. With an agreement for medical treatment, there is an agreement between both parties, in accordance with Article 1320 of the Civil Code (hereinafter referred to as the Civil Code) where one of the conditions for the validity of an agreement is the agreement of those who are binding themselves. From these two legal sources there is a connection related to the existence of approval for medical action in health services, especially in palliative services. With the approval of medical action for every palliative care activity, there is an agreement between the palliative care team and the patient and his family. So that all actions that will be taken by the team, the patient and family have the right to know and understand, and will not cause disputes between the team and the patient and their family. With approval for medical procedures, you can comply with Article 1320 of the Civil Code, as well as avoid criminal prosecution in accordance with Article 351 of the Criminal Code.

2. RESEARCH METHOD

This type of research is normative juridical research. The normative juridical approach is an approach that uses primary legal materials as a basis, studying theories, concepts, principles in legal science, as well as statutory regulations related to the research being conducted by seeking solutions to legal issues to identify the basic basic meanings of rights and obligations, legal events, legal relationships, and legal objects. This approach is also called the bibliographic approach, namely by reviewing books, laws and regulations, and other documents related to this research in a written and systematic way (Efendi, 2018).

This approach to legal research uses a statutory approach (Marzuki, 2005), namely an approach that provides a study of legal principles, legal norms and statutory regulations. Also uses a conceptual
approach, namely identifying the meaning of basic legal principles, legal subjects, rights and obligations, legal events, legal relationships, and legal objects.

This research has legal materials consisting of primary legal materials, secondary legal materials and tertiary legal materials. Primary legal materials are legal materials that have binding properties and include legislation, official records or minutes in the making of legislation and judges' decisions. Primary legal materials in the form of laws and regulations related to this research:

a. The 1945 Constitution of the Republic of Indonesia,
b. Law of the Republic of Indonesia Number 29 of 2004 concerning Medical Practice
c. Law of the Republic of Indonesia Number 36 of 2009 concerning Health
d. Law of the Republic of Indonesia Number 44 of 2009 concerning Hospitals
e. Law of the Republic of Indonesia Number 36 of 2014 concerning Health Workers
f. Criminal Code
g. Code of Civil law
h. Regulation of the Minister of Health of the Republic of Indonesia Number 290/MENKES/PER/III/2008 concerning Approval of Medical Procedures.
i. Decree of the Minister of Health of the Republic of Indonesia Number 812/Menkes/SK/VII/2007 concerning Palliative Care Policy

Secondary legal materials consist of all publications about law other than official documents. Legal publications include textbooks, legal dictionaries, legal journals, and court commentaries or decisions. The main secondary legal materials are textbooks because textbooks contain the basic principles of legal science and the classical views of scholars of high quality.

Tertiary legal materials are legal materials to help explain things related to the materials to be studied. Tertiary legal materials include non-legal materials that can help and are complementary, not the main ones, for example: dictionaries, encyclopedias, and others that are relevant to this research.

Collecting legal materials includes the following steps: reading, studying, quoting, comparing and connecting legal materials from legislation and literature so that they become a unity so that processing is easier. Processing of legal materials is carried out by carrying out the following stages:

a. Editing, namely the action of checking legal materials carefully so that there are no errors in the data that has been collected.
b. Classification, namely the act of classifying data that has been collected based on each subject, this processing is carried out so that there are no errors in grouping the data.

c. Organizing, namely the act of sorting legal materials that have been collected in order to avoid significant errors in accordance with the systematization of the materials.

After all the data has been collected and processed systematically, it is then analyzed systematically. The analytical method of legal materials used in this research is the normative descriptive method, namely analysis that does not use models that are measured/expressed with numbers or statistics and econometrics or other specific models. So the analysis of legal materials is guided by legal norms/rules, legal concepts or legal doctrines contained in the framework or literature review used to answer the problems in this research. The legal materials that have been collected and obtained for research are then processed systematically and consistently, then analyzed in a series of statements that describe the research results based on the problem being studied. The next step is to carry out a theoretical analysis of these legal materials in order to find, understand and explain the urgency of the existence of approval for medical action in palliative services.

3. RESULTS AND DISCUSSION

Palliative care is multidisciplinary because palliative care is a service to improve the quality of life of patients (adults and children) and their families to face problems related to life-threatening illnesses. Palliative care is to avoid and alleviate suffering through early detection, appropriate assessment, treatment of pain and physical conditions, psychosocial and spiritual (palliative care, 2022). The multidisciplinary palliative team consists of (Ministry of Health, 2015): doctors, nurses, pharmacists, social workers and psychologists, clergy, physiotherapists and volunteers. The team of doctors consists of: general practitioners, palliative doctors and specialist doctors.

Palliative care is explicitly recognized as a human right in terms of health. This should be provided through person-centred and integrated health services that take into account the individual's specific needs and preferences. Palliative care is a comprehensive and multidisciplinary service, a service provided by a multidisciplinary team that works together in determining, achieving and evaluating the goals of the palliative care program. General practitioners play a major role in the team of palliative doctors, especially in treating end-stage patients in primary care facilities (in community health centers or hospitals) with the aim of ensuring that physical, psychosocial and spiritual
complaints can be managed well. The general practitioner's duties are a) coordinating with the palliative care team in primary care facilities, b) anticipating and preventing the emergence of symptoms through medication and other methods, c) early detection of psychological and social and spiritual complaints and problems, d) maintaining regular medication use, so that patients comply, e) using non-pharmacological methods, f) creating a palliative care program structure, g) building working relationships with palliative care teams in advanced facilities and providing consultations to patients who need them, h) building cooperation and optimizing the availability of resources in primary care so that palliative care programs develop. Palliative doctors in secondary and tertiary care facilities: a) Responsible for patients with palliative care; b) Carry out management of pain and other symptoms if causative therapy has not been or is not carried out; c) Coordinate with other pain and symptom management teams requiring other skills; d) Symptom management for end-of-life patients; e) Coordinate existing case issues with primary care physicians; f) Facilitate guidance originating from primary services. Specialist Doctors: a) Specialist doctors from various disciplines identify end-stage patients and consult patients to palliative care doctors; b) Carrying out complaint management according to consultation from a palliative care doctor if a procedure is needed (such as radiotherapy for pain and bleeding management, surgery, mental disorders, lung function and ascites, etc.); c) Doctors play an important role in the multidisciplinary palliative care team, where doctors must have knowledge and mastery of knowledge in accordance with the principles of palliative care. Doctors are responsible for the assessment, monitoring and management of palliative patients.

Palliative Nurses are required to have skills and knowledge that are in accordance with the principles of palliative care. A palliative care nurse is responsible for assessing, supervising, and managing the nursing care of patients with palliative care. Pharmacist: as many people know, medication use is an important part of complaint management in palliative care. Pharmacists must be able to ensure that patients and their families have important access to palliative care therapy. The capacity and capability of a pharmacist is needed to be able to provide accurate knowledge about doses, administration methods, side effects and interactions of anti-cancer drugs, morphine and other pain relievers prescribed to patients in palliative care. Social workers and psychologists: Their mission is to help patients and their families deal with the personal and social problems caused by cancer and disability, and to provide them with psychological support. Clergy are competent to help in solving problems related to the meaning of life. Chaplains, together with other members of the palliative care
team, are expected to be able to analyze the spiritual needs of patients and families, support religious traditions, and organize religious services needed by cancer patients and their families. Physiotherapists are tasked with carrying out medical rehabilitation activities as recommended by medical rehabilitation specialist doctors and coordinating medical rehabilitation activities with specialist doctors and other team members. Volunteers have many roles. The roles of volunteers in the palliative care team vary according to needs. Volunteers can participate in therapy in the hospital, or at the patient's residence. Volunteers come from various levels of society and aim to accommodate the gap between health facilities and patients. Supported by increasing appropriate competency, volunteers are able to provide services directly to patients and families, help resolve administrative problems, or act as advisors. Apart from that, this can help increase awareness, teach health knowledge, collect donations, assist with the rehabilitation process, and even carry out certain medical therapies.

The scope of palliative service activities consists of: a) pain management, b) physical complaint management, c) nursing care, d) psychological assistance, e) social assistance, f) cultural assistance, and g) assistance in preparing for and during a time of mourning. Apart from inpatient hospital care, palliative services can be in the form of outpatient care or home visits/treatment. The principles in the medical scope that are agreed upon and need to be understood in palliative care in general are: a) Palliative Ethics which consists of autonomy, benefisentia, non-malefisentia, and justice; b) Appropriateness of Therapy; c) Allow Natural Death; d) Stopping and withholding Medical Therapy; e) Disclosure of information data (Ministry of Health, 2015).

The palliative care team is determined based on the suitability of the resources available at the palliative care site. Achieving the goals of the palliative care program to alleviate patient suffering, reduce the burden on families and improve quality of life requires a holistic team, which involves the family (Ministry of Health, 2015). Applying interdisciplinary principles (coordination of disciplines in determining achievable goals and means to achieve goals), the palliative care team conducts routine interviews to make assessments and diagnoses with patients and families to determine goals and plans and manage palliative care programs, as well as carry out monitoring and evaluation. The palliative care team, which in accordance with the Decree of the Minister of Health for Palliative Care has the criteria of having attended palliative care education/training and has a certificate, works holistically and integratedly to achieve literal palliative care, namely improving the patient's quality of life until the end of their life. The definition of palliative care can be interpreted as passive euthanasia.
Euthanasia etymologically comes from the Greek words eu and thanatos, meaning "good death" or "death in a calm or happy state".

Approval of medical procedures in palliative care is regulated by the Victorian Medical Treatment Act 1988 which was amended on 1 September 2015 which states that medical procedures include: operations, administration of drugs or other similar substances, medical procedures (including medical procedures are procedures palliative care measures which include: providing medical interventions to relieve pain, discomfort and providing adequate food and water (Legislation, 2022). There are other classifications according to the Occupational Safety of Health Administration by the United States Department of Labor, consultations and diagnostic procedures such as supporting examinations in the form of X-ray photos and blood tests are not included in medical procedures. Although first aid actions such as administering oxygen, suturing wounds, and prostheses used for immobilization can be classified as medical actions, there are 14 categories of first aid actions that are not actions. medical, namely (Medical Treatment, 2022): administering drugs without a prescription, administering anti-tetanus, cleaning wounds, closing wounds with simple wound dressings, hot and cold therapy, installing non-rigid supports, using non-permanent supports for patient transportation, removal procedures fluid from the finger with the aim of reducing pressure, use of eye patches/eye patches, procedure for removing foreign objects from the eye using fluid or a swab, procedure for removing foreign objects from the body in a simple way, use of finger protectors, massage (except chiropractic treatment), giving fluids to overcome heat/heat stress.

There are two competing analyzes of medical consent analysis in history, namely those of Martin S. Pernick and psychiatrist Jay Katz. Pernick concludes that, based on 19th century sources, the process of “truth telling” was an original tradition in medicine in which the knowledge of physicians and the autonomy of patients had a beneficial effect on the health of patients. He also mentioned the difference in views between the content and purpose of consent to medical treatment in the 19th century and the modern view, where consent to medical treatment is not based on the patient's rights, but only on the process of communicating the benefits of therapy (Kuntarjo, 2017; Faden, 1986). Contrary to the analysis that consent to medical treatment only aims to inform the benefits of therapy, Katz said that doctors pay little attention to patients' rights and desires to make their own decisions. In his view, the law has no power in the communication process in clinics between doctors and patients, or he says there is a lack of openness between doctors and patients in communication.
In essence, consent to medical procedures is informed consent which functions as a tool to determine one's own fate in medical practice. Where the determination of one's own fate is the value and target in approval of medical action, which is carried out before carrying out actions both diagnostic and therapeutic in nature. Patient consent can only be given if the patient truly understands the situation he is facing through the information provided by the doctor (Komalawati, 2022). Approval of medical action includes 4 components, namely: 1). The patient must have decision-making capacity; 2). The doctor should provide information on the actions, tests or procedures that will be carried out, including the benefits and risks as well as possible benefits from the risks that may arise; 3). Patients must be able to clearly understand the information provided; 4). The patient must consent freely, not be coerced or pressured.

In palliative care there is palliative ethics which consists of (Ministry of Health, 2015; Komalawati, 2022): 1) Autonomy, namely the individual's right to give consent to things or therapy that should be carried out or not, after being given an explanation from the doctor and understanding the explanation, it well and correctly. Autonomy in pediatric patients is left to the parents or guardians; 2) Beneficence, namely actions that are beneficial to the patient by paying attention to feelings of comfort, feelings of independence, paying attention to the welfare of the patient and family, and also in accordance with their spirituality; 3) non-maleficence, namely carrying out actions with the aim of not hurting or making the current condition worse; 4) Justice, namely providing equal treatment to all patients without discrimination (differentiating between race, ethnicity, religion, gender and economic status). If there has been an agreement from the patient or his family, then the action to be taken or no action must be stated in the approval for medical action and signed by the patient, family and health worker.

Based on literature published by the Judicial Council of the American Medical Association (AMA) in 1981, consent to medical treatment is the patient's right to make a decision after receiving adequate information. Consent to medical procedures is excluded in cases where the patient is unconscious or incapacitated, in cases where no action is taken that could harm the patient, or in cases where the explanation given to the patient is psychologically harmful to the patient. The paternalistic view that doctors can determine actions for patients even though they are deemed necessary is unacceptable. From a rational point of view, approval for medical procedures cannot be considered the same in all cases or circumstances in terms of patient acceptance or rejection (Komalawati, 2022).
It is clear that consent to a medical procedure can be seen not only as approval, but also as a rejection of a medical procedure, even though the doctor knows best. All of this is related to the patient's right to make decisions for himself (right of self-determination). In addition, consent to medical treatment is not just getting the patient's signature or filling out a form, whether accepting or rejecting a medical action, but rather a series of events or processes through which the patient understands the doctor's information, which has implications for the patient's own decision making (Maclean, 2013).

In the law of engagement, two forms are distinguished (Isfandyarie, 2006): a) Inspanningverbintenis, namely an undertaking agreement, meaning that there is an agreement and agreement between both parties as an effort to fulfill the agreement; b) Resultaatverbintenis, namely an agreement that will produce real results in accordance with the agreement. Therapeutic agreements or therapeutic transactions are included in inspanningverbintenis or effort agreements, because the doctor cannot promise that the patient will in any way recover, but the doctor provides health services to improve the patient's health. In carrying out this effort, doctors must do it seriously, using all their skills and abilities based on professional standards.

4. CONCLUSIONS

The legal ratio for approval of medical action in palliative care is based on Minister of Health Decree Number 812/MENKES/K/VII/2007 concerning palliative care policy is respect for the patient's right to self-determination, where the patient no longer has the possibility of recovering from their illness (the terminal phase of a disease)—Legal liability for negligence in making approval for medical procedures in palliative care can take the form of administrative, criminal or civil sanctions, such as for patients who are not in palliative care.

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