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The Ethical and Legal Challenges Related to CBR (Complete Bed Rest) Patients

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ABSTRACT

CBR is occasionally prescribed for conditions like preterm labor, pregnancy-induced hypertension, and low back pain. However, recent research questions the medical efficacy of extended CBR. Moreover, enforced immobilization may infringe upon patient autonomy, dignity, and quality of life. Legal issues also arise if adequate informed consent is not obtained before prescribing severe activity limitations. To explore the ethical and legal challenges of prescribing prolonged complete bed rest (CBR) for patients. CBR is a treatment that severely restricts patient mobility and autonomy, which necessitates careful consideration of ethical implications. A comprehensive literature review was conducted in medical ethics, legal journals, and general databases. Cases involving CBR were analyzed to identify common ethical dilemmas and areas of legal ambiguity. International guidelines on restricting patient mobility were also incorporated. Key ethical challenges identified include insufficiently informed consent procedures, failure to consider less restrictive alternatives, and disregard for patient preferences. Legally, CBR may constitute unlawful imprisonment if not medically justified or if consent is invalid. International disability rights were also shown to apply. Complete bed rest raises profound medical ethics and legal concerns that warrant careful consideration and additional safeguards whenever used. More research is needed to balance treatment efficacy with respect for patient autonomy and well-being.

Keywords: Medical ethics, patients, Ethics

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Introduction

Contemporary medical science presents complex challenges such as medical ethics and law that require healthcare professionals to manage these dilemmas and often face conflicting patient perspectives (1). Patient and societal expectations require informed decision-making (2).

Healthcare professionals often face complex ethical dilemmas throughout their careers (3). Healthcare teams encounter challenges that may compel them to act against the beliefs of patients, families, or even their values, while ethics committees provide guidance for correct decision-making and help maintain the doctor-patient relationship (4). Bed rest is prescribed for critically ill patients to conserve scarce metabolic resources, for instance, in cases of acute exacerbation of rheumatoid arthritis, cavity tuberculosis, acute myocardial infarction, and acute back pain. However, bed rest has complications that can delay or hinder recovery, such as muscle atrophy and joint contractures (5). Prolonged bed rest increases urination, particularly in patients with hypoalbuminemia, leading to heightened excretion of calcium, oxalate, and phosphate. These substances are primarily sourced from bones and are linked to the formation of kidney stones, especially calcium oxalate and phosphate stones. This condition can also exacerbate proteinuria, potentially aggravating acute kidney injury (6). Individual health is contingent on one's abilities and is influenced by the medical team's performance, impacting personal and social well-being (7). Medical students and physicians must enhance their clinical skills with patients to increase their competencies (8). Limited studies have explored the ethical and legal challenges concerning patients on CBR (Complete Bed Rest). Nonetheless, understanding these experiences is crucial for effectively addressing these challenges. Consequently, this study aims to identify the ethical and legal challenges associated with patients undergoing CBR.

In the 2003 study by Ben-Haroush et al. the potential benefits of bed rest in women with threatened miscarriage and sub chorionic hematoma, as confirmed by ultrasound, were evaluated, along with the potential correlation between the duration of vaginal bleeding, hematoma size, and gestational age at diagnosis with pregnancy outcomes. Women who adhered to bed rest had fewer spontaneous abortions and higher-term pregnancy rates compared to those who did not. Lower spontaneous abortion rates and higher term pregnancy rates were observed in the bed rest group (9).

In 2013, McCall et al. reviewed "Therapeutic Bed Rest in Pregnancy: Unethical and Unsupported by Data." This study summarized Cochrane reviews on bed rest and presented an ethical argument for discontinuing the practice. The researchers concluded that prescribing bed rest contradicts the ethical principles of autonomy, beneficence, and justice. Therefore, if bed rest is to be used, it should only be within a formal clinical trial (10).

In 2006, Dunn et al. conducted a study titled "Antenatal Bed Rest: Conflicts, Costs, Controversies, and Ethical Considerations." They stated that over 90% of obstetricians currently prescribe bed rest for women with complications during pregnancy. However, researchers found that bed rest is not effective in reducing preterm birth. Antenatal bed rest imposes physical, emotional, and financial costs on patients, families, and third-party payers. The researchers concluded that treatment decisions, instead of being made based on ethical considerations regarding fetal/neonatal life, are often driven by emotions or medico-legal issues (11). Allen et al. conducted a study aiming to evaluate the evidence of the benefits or harms of strict bed

rest. According to the findings, 39 trials of bed rest were found for 15 different conditions (total patients 5,777). In 24 trials that assessed bed rest following a medical procedure, no outcomes were significantly improved, and 8 trials reported significant worsening in certain procedures (lumbar puncture, spinal anesthesia, radiculography, and cardiac catheterization). In 15 trials that examined bed rest as a primary treatment, no outcomes were significantly improved, and 9 trials reported significant worsening in certain conditions (acute back pain, childbirth, protein uric hypertension in pregnancy, myocardial infarction, and acute infectious hepatitis). The researchers concluded that further studies are needed to prove the benefits or harms of bed rest as a treatment (12).

Materials and methods

This descriptive-qualitative study was conducted to examine the experiences and ethical considerations of patients undergoing complete bed rest. The research subjects included healthcare providers caring for patients in hospitals affiliated with Guilan University of Medical Sciences in 2023. Entry criteria include willingness to participate in an interview, while the exclusion criteria include an unwillingness to participate.

Initially, keywords were systematically searched in credible electronic databases, and relevant sources were extracted. The study was conducted in a semi-structured manner, continuing until data saturation was reached in the target groups. Data collection appeared based on mutual agreement, with participants and the researcher agreeing on a time and place for the interview. Interviews continued until the interviewee had no additional information to provide and the interviewer had no questions related to the research objectives Semi-structured interviews, based on content extracted from the Interviews were conducted with two anesthesiologists, three emergency medicine specialists, two forensic medicine specialists, four medical ethics specialists and two surgeons. experts until information saturation was achieved. The findings were analyzed using MAXQDA software, and common data were used as output.

Results

Based on the conducted interviews, the following guide can be useful

One of the challenges in providing medical services is the issue of personal consent in patients on complete bed rest. Unfortunately, there is no ethical and legal guideline that can be generalized to all cases, and each individual case must be decided on a case-by-case basis.

Suggested Guide:

Overview:

First, we must have a comprehensive view of the patient's condition

and examine the following eight processes:

A- Part 1 of the assessment

1- Reason for hospitalization or medication:

What is the reason why we considered CBR for the patient? In fact, the treatment and condition of the patient must be assessed.

For example, did the patient have MI or multiple trauma or, for example, DVT? Let's see what the cause of this was. Sometimes this order is so scientifically strong that it is impossible to reject it. Another important point that the therapist should pay attention to is the patient's general condition.

2- Age:

How old is the patient?

Can he consider his own interests or does he need help and advice from someone as a substitute decision maker or guardian?

3- State of consciousness:

What is the patient's level of consciousness? What is the patient's mental status?

Is the patient able to understand his own condition and situation or is he able to communicate correctly and logically

4- Vital signs:

Are the patient's vital signs stable or not?

If the symptoms are not stable, this person should not be discharged under any circumstances

5- Patient's companions:

The patient has or does not have a companion

Using the patient's companions to convince the patient to continue treatment can be very helpful.

6- Patient's competence or capacity:

The patient's capacity, whether the patient has the competence to give personal consent, in other words, we need a higher capacity for discharge consent than informed consent to perform the procedure.

7- Patient's clinical condition:

The patient's clinical condition is the next thing we need to consider. The patient's consent or lack of consent is valid to the extent that his life or that of another is not at risk. However, when the patient's life is at risk, his lack of consent is not a condition. But in the situation where our CBR patient wants to be discharged with personal consent and leaving the hospital is not incompatible with life and the equipment and preparations for it are ready, for example, he can be moved with a stretcher or wheelchair or a patient who is hospitalized in the ICU and is under a ventilator can be removed with an ambo bag and then connected to the ventilator, we can conditionally agree to his request.

8- Patient autonomy:

In general, when the patient's autonomy is in conflict with other conditions and principles, we may put autonomy in second place, that is, if the health of this patient, even if we think that it is in the decision-making situation, but there is a risk to his life, until we can convince him and explain the risks and benefits to him, it is not possible to consider autonomy superior. Therefore, we must be aware of this issue, even in a situation where, suppose a pregnant mother is told that if there is no CBR, her baby will be aborted, then this person, even if we want us to Considering her autonomy and if she wants to move and there is a risk to her life and that of her child, we practically cannot give her this permission.

B- Start making decisions using existing capacities

If the patient meets the eight conditions above, we move on to the next stage:

After considering the above and gaining an overall view of the situation, we take the following steps:

1- Pay attention to the patient's privacy

First, we listen to the patient to find out why he/she wants to be discharged, and whether he/she is concerned about the confidentiality of his/her medical information.

2- Help meet the patient's basic needs:

Or, for example, there may be a patient who is an elderly woman or man who says that he/she has a CBR and has difficulty going to the bathroom and does not like to be given a basin, so the problem can be solved in some way. Another patient may say that he/she wants to pray, so we can help him/her and provide the conditions as much as possible.

3- Social support measures:

Or someone else says they don't like the hospital environment, or someone may have a child at home, or there may be a cost issue.

All of these should be discussed to understand what the circumstances are. Basically, the reason why a patient wants to do something against the best interests of their health must have a reason and it must be found. This reason may be defensible or it may be a reason that is not complete.

4- Involving influential people

We call the patient's nurse to inform him of the situation, we ask all decision-makers, especially influential family members, to explain the situation and get help.

5- Making maximum efforts to gain the patient's satisfaction

We explain the conditions and risks to the patient while maintaining the level of anxiety control and facing the serious condition of the disease. The explanations will naturally be more complete for the patient's relatives, especially when the patient is not conscious enough to make a decision. We tell the patient about the treatment process and the consequences of leaving the hospital. We ask the patient's relatives to help satisfy the patient and control the patient's mental state. We clearly say that we cannot agree to the patient's death. Our openness is always necessary to gain the trust of the patient and his companions. We must use all the communication channels we need and know. We must convince the patient with basic skills why this order has been registered for him.

6- Using psychiatric counseling:

Psychiatric counseling is very often helpful in controlling the situation.

And it can prepare the patient for these conditions.

7- Considering legal considerations

Legal advice is also inevitable in these circumstances. We also inform the hospital supervisor about the situation so that we can perhaps attract the support of the hospital as a larger organization to talk to the patient and his companions.

8- Considering the medical mission

In general, the ethical considerations we have in this regard are very serious and we need to be comprehensive and, as we mentioned at the beginning, the principle of treatment and the patient's condition must be considered. In relation to Iranian laws, we must consider the patient's best interests and we must pay attention to it. Sometimes the patient's best interests may not be in line with the patient's autonomy, so our priority is to make the best decision for the

patient. If this is mandatory in terms of medication, we must be able to convince the patient. If we consider leaving the hospital to be incompatible with life for the patient, our agreement to discharge the patient is against ethical rules, whether it is in the context of our inner conscience.

9- Documentation

In cases of medical situations that are incompatible with life, even with the lack of consent of the companions and the conduct of forensic medical consultations and the rest, it is possible to proceed with the treatment. And in fact, we are forced to proceed with the treatment due to legal consequences, and all these cases and stories must inevitably be documented due to legal consequences. We inform the hospital mortality committee, and if the patient leaves the hospital and we have implemented all the aforementioned ethical and legal considerations, then we will probably face fewer legal and ethical consequences.

In general, in relation to legal issues, given the existing complexities and since obtaining consent from a legal perspective can be problematic in the future, it is better to inform the patient and disclose his condition as much as we can and involve him in the decision made.

Conclusion

The responsibility that therapists have is a collective responsibility. Each member of the treatment team, including the treating physician, assistant, nurse, and technical officer, must weigh the consequences of the patient's discharge; because there is only a personal consent and a patient's desire to go on the one hand, and on the other hand, there are risks that have not been fully explained to the patient. If we have not justified or explained to the patient methods that have no alternative, we will definitely be prosecuted legally and ethically; because in this case, our knowledge is more important than the patient and relatives, and the patient's well-being and saving his life are more important, the patient's personal consent and the patient's discharge from the hospital will never absolve the treating physician from possible complications that may occur to the patient after discharge, in terms of medical law.

In fact, the possibility of discharging such patients is scientifically prohibited and is not possible until the vital signs are stable and the patient is stable.

Regarding the competence and competence of the consenting person to perform discharge or surgery in cases where there is a strong suspicion of the presence of stone in the person in question; there are many challenges and problems that affect it. The existing legal gaps, lack of ethical information, lack of specialized personnel familiar with health rights, lack of practical training, failure to update information and lack of benefit from existing judicial capacities in this regard are clearly visible.

The health system should have close cooperation with regional prosecutors and departments of guardianship of incapacitated persons in this regard.

The most important function of any health system is to maintain the safety of the patient and support him in returning to his pre-illness conditions.

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