

CLINICAL ETHICS DILEMMA

DARING TO DISCHARGE^{1,2}

ROBERT D. ORR, MD, CM; FERDINAND D. YATES, JR, MD, MA (BIOETHICS)

Editor's Note: *This column presents a problematic case, one that poses a medical-ethical dilemma for patients, families, and healthcare professionals. As this case is based on a real medical situation, identifying features and facts have been altered in this scenario to preserve anonymity and to conform to professional medical standards. In this case, discharge planning becomes problematic because of the patient's reluctance to adhere to medical recommendations.*

Column Editor: Ferdinand D. Yates Jr, MD, MA (Bioethics) is a medical staff member at Children's Healthcare of Atlanta and has a private pediatric practice in the Atlanta area.

Question

"My patient is refusing some appropriate medical care and services. How do I transition her to the next level of care?"

Story

Margine is a seventy-three-year-old woman with a history of breast cancer, which was known to have spread to her bones and thus be incurable when she received treatment five years ago. This resulted in a fracture of her left hip last year, requiring short-term nursing home placement. She has been living at home. She began intermittent vomiting a few weeks ago, and an outpatient upper gastrointestinal series showed gastritis and a mass outside the stomach, suspicious for malignancy. She refused CT scanning at that time, saying she was "too sick."

She was admitted to the hospital seven days ago with dehydration, and she requested a Do Not Resuscitate order on admission. She has accepted IV fluids but has intermittently refused both further testing and medications. Her caregivers feel that she needs more treatment and that she clearly needs nursing home care. They predict she will have recurrent and worsening stomach symptoms. She refused to talk with the psychiatry consultant (two tries) yesterday.

She is divorced, has no children and no guardian. Her primary physician, oncologist, and a social worker report she has a long history of intermittent confusion, paranoia, erratic and irrational behavior, including refusal of help from visiting nurses, no-shows for scheduled physician appointments and lab tests, etc.

I spoke with the patient. She says she wants treatment, is willing to accept whatever is needed except nursing home care ("they nearly killed me last time"), and says she will be going home when she is strong enough. She says she will have help from visiting nurses, as well as friends and neighbors, though she was unwilling to give names and seemed paranoid when asked.

Discussion

A patient with decision-making capacity has the right to make her own treatment decisions, even decisions that will compromise her health or lead to avoidable death, as long as she understands the consequences and alternatives. This “rule” becomes problematic, however, if the patient is inconsistent in her decisions or is making irrational decisions. An “irrational decision” is one that is not consistent with her own values (e.g., “I want to live, but I don’t want you to amputate my septic gangrenous leg”). In such cases, it is occasionally ethically justifiable to over-ride decisions with life-threatening consequences.

In this case, the patient is frequently inconsistent in her decisions (refusal of labs, later consent) and occasionally irrational (says she wants to survive, but refuses testing or treatment that would enhance that goal). Over-riding a patient’s right to refuse treatment is a serious ethical breach and should only be considered if that decision would lead to imminent death or disability and there is no alternative acceptable to the patient.

Recommendations

1. It is ethically permissible to continue to try to persuade this patient that she needs more treatment and nursing home care. It might be helpful to have a meeting of three or four professional caregivers (including someone from the Visiting Nurse Association) along with the patient and those she expects to provide home care to present a united front to her of the need for nursing home care. Care must be exercised that persuasion doesn’t become coercive.
2. If there is even a small possibility of successful management at home, it would be ethically permissible to discharge her home with as many services in place as possible to allow her to prove herself. If it should not work, this would force the issue of a long-term care placement.
3. If neither of these situations comes to pass, and she remains in the hospital, it may be necessary to seek a court-appointed guardian with authority to impose involuntary nursing home admission.

Follow-up

She was discharged home three days later with her ex-husband agreeing to help her. She had to be re-admitted two days later with diarrhea. When this was under control, she agreed (very reluctantly) to temporary nursing home placement.

Editor’s Comments

Sometimes the patient needs to be saved from the doctor, or by the doctor, but, on occasion, the patient needs to be saved from herself. As in this situation, even refusing to make a healthcare decision is to make a decision. Choices, or lack thereof, have consequences. Occasionally, a patient is so blinded by a past experience or a misunderstanding of information that she obstinately refuses to go forward with appropriate medical care.

So, in the effort to act with care and compassion, the physician facilitates the making of a choice. Sometimes, the judicial system is necessary to advance care through an appointed guardian, but, sometimes, care comes from an unexpected source.

The goal is to provide proper medical care, but this laudable goal is not always easy to accomplish,

Endnotes

1. The article, as originally published, was untitled.
2. Reprinted by permission of the publisher. "Medical Ethics and the Faith Factor," William B, Eerdmans Publishing Company. Grand Rapids, Michigan, 2009, 206-208

Robert D. Orr, MD, CM, practiced family medicine in Vermont for eighteen years before receiving a post-doctoral fellowship to study clinical ethics at the University of Chicago. Thereafter, he served as consultant and Professor of Medical Ethics at Loma Linda University (CA), Trinity International University (IL), the Graduate College of Union University (NY), and the University of Vermont. He is now retired and currently resides in Vermont, USA.

Ferdinand D. Yates, Jr, MD, MA (Bioethics), is a medical staff member at Children's Healthcare of Atlanta and has a private pediatric practice in the Atlanta area.