

CASE #2

TREATMENT LIMITATION OF AN INCOMPETENT ELDERLY WOMAN AGAINST THE PREFERENCES OF THE PATIENT'S FAMILY

CASE PRESENTATION

Complaint

A physician requests consultation to limit treatment of an incompetent elderly woman against the preferences of the patient's family. Prompted by this and similar cases, the hospital administration requests examination of the significant increase in uncompensated resource intensive care.

Medical History

The patient is an 80 year old woman with chronic medical problems including atherosclerotic cardiovascular disease, atrial fibrillation, cerebrovascular accident with residual dysphasia and right hemiparesis, severe osteoarthritis with joint contractures, seizure disorder controlled with therapeutic phenobarbital who has had a slow two-year decline in functional status admitted for evaluation and treatment of obtundation, seizures and profound hyponatremia.

Six weeks prior, the patient was hospitalized for chest pain. At that time she was not able to understand or communicate information, was bed-fast and was having difficulty with adequate oral fluids and nutrition. She was discharged home to the care of her youngest daughter.

Three weeks prior a nasogastric (NG) tube was placed to supplement inadequate oral fluids and nutrition. Feedings were prescribed by the patient's eldest daughter, a nonpracticing pediatric oncologist residing in California. The patient pulled out the feeding tube on two occasions, each time replaced in the emergency department.

Progressive obtundation and focal seizures prompted this hospital admission. Physical examination was significant for mild volume depletion and worsened mental status. She opened her eyes, had nonpurposeful movements of her left upper and lower extremities but was not responsive to verbal or tactile stimuli. Laboratory testing showed a serum sodium of 106 mg/dl with an appropriately low urine sodium. Computed tomography of the brain was negative.

Mental status improved to near baseline with correction of serum sodium to her chronic value of 120 mg/dl using intravenous (IV) saline. Focal seizures resolved with low dose IV phenobarbital.

On the third hospital day, the patient had a grand mal seizure and respiratory arrest. Bag-mask ventilation was performed for thirty minutes to obtain treatment preferences from the eldest daughter who directed endotracheal tube placement and ongoing intensive care. The patient remained stable from hospital day four to ten: comatose, ventilator-dependent, with NG fluids and nutrition. Laboratory studies were

stable also. Electroencephalography showed slow-wave activity and PLEDS consistent with severe diffuse injury and a predictor of poor outcome.

The entire health care team including consultants in neurology (two), pulmonary medicine and the primary care internist believed chances for survival were nil, the patient remaining "noncommunicative, ventilator-dependent until her expected death". No reversible causes for her neurologic impairment were found.

Social History

The patient is the elderly Protestant mother of four children. She has lived in the home of her youngest daughter and her only son for the last two years. This daughter is the primary caregiver and the son provides funding to support the care of his mother. The middle daughter lives 100 miles away and is involved in some of the decision making. The eldest daughter, a California physician, has directed daily treatment using the local help of the attending physician for the last two years. At times this has been an awkward care arrangement for the attending physician.

During the present admission, communication has been difficult with each family member. Attempts to arrange family conferences to discuss the patient's prognosis and treatment have been unsuccessful. Instead, each of the local children has demonstrated untrusting behavior, such as maintaining constant in-room vigilance and documenting and relaying any treatment changes to the physician-daughter in California. This eldest daughter has refused to travel to the hospital or consider discussion of withdrawal of life-sustaining treatments. She has expressed her desire for a specific diagnosis and has retained an attorney because of concerns about malpractice and to prevent unauthorized therapy withholding or withdrawal. The relationship between the attending physician and the family reflects mutual lack of trust and confidence.

The patient has not knowingly expressed her treatment preferences for this situation and has no advance directive.