

CASE #7

A PATIENT'S RIGHT TO CHOOSE: A QUESTION OF CAPACITY

Abstract

Patients sometimes choose a diagnostic, treatment or social plan that is contrary to their provider's recommendations or that even places the patient at significant risk. This case explores the determination of capacity and its role in creating tension between preserving patient autonomy and providing beneficent cost-effective care.

Query

Because of medical dangers and inability to care for himself at home, should an elderly man with questionable capacity be forced to accept nursing home care against his wishes?

CASE PRESENTATION

Medical History

Mr. M is a 75 year old blind Caucasian man brought to the Emergency Department by paramedics because of agitation and inability to care for himself.

The patient was found to have numerous medical problems including pseudomembranous colitis from *Clostridium difficile*, recurrent urinary tract infections presumed secondary to bladder stones, chronic bilateral lower extremity edema, history of congestive heart failure, history of chronic obstructive pulmonary disease and history of peripheral vascular disease. He improved with IV fluids and trimethoprim/sulfa for a urinary tract infection.

Mr. M was well known to hospital staff from numerous previous admissions, including five within the preceding nine months for similar problems, in addition to gastric ulcers, vertebral compression fractures, cholelithiasis, bursitis of the elbow, anemia and malnutrition. During a hospitalization for severe obstipation two months prior to the current one, Mr. M demonstrated delirium and was evaluated by psychiatry. Guardianship was considered for him, due to his "incompetency" to make medical care decisions and inability to care for himself. The patient's mental status cleared, though, prior to discharge, and the psychiatrist noted that, despite the fact that all the health care professionals involved in his case disagreed with his decision to return home, he was, at that time, "competent to make the decision about his current living situation". The health care team explicitly listed the safety/health concerns inherent in his plan to return to independent/self-care (risk of injury from falling, poor hygiene, incontinence of stool, medication mismanagement, nutrition and hydration imbalance, possible death, etc.) for him, but Mr. M refused to listen, instead saying that he wanted a month at home to prove that he could care for himself. Approximately one month then passed between that discharge and the Emergency Department admission described above.

During the hospitalization, Mr. M appeared alert and oriented and adamantly refused to consider nursing home placement, stating that he would starve himself to death if put in a nursing home against his will. He denied any problem in self-care and, in fact, maintained that he was eating and able to do his own activities of daily living. Physical and occupational therapy evaluations documented that Mr. M could ambulate with minimal assistance with a walker but required help with meals, bathing and dressing and needed maximum assistance for lower extremity and toileting hygiene.

He was evaluated by psychiatry and medical psychology services and determined to be medically competent to make his own decisions. The patient has been marginally functioning in the community for years, demonstrates minor memory impairment, but otherwise is cognitively intact and competent. The medical psychologist indicated that the patient tends to minimize his physical and cognitive problems but was alert, fully oriented, moderately depressed, but did not wish to die. The psychologist also noted that the patient had poor judgment in care and life decisions. He recommended that Mr. M definitely needs close supervision, nursing visits and more than one meal delivery per day.

Social History

Mr. M was not a candidate for home health services because he refused services in a "threatening" manner in the past and was terminated by the last agency due to safety concerns for the patient in his home. Two home health agencies declined to provide services to him after this discharge. The patient's homemaker, his primary source of support at home, is about to quit due to her concerns about his condition at home. Senior services has no further community resources to offer him.