**TITLE: Case study of an elderly patient in an acute setting**

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**Introduction:**

There is much to be desired when defining good care in dealing with elderly and frail patients in the acute setting. Much of literature has focused on end of life care or demands for non- indicated, non- beneficial medical care, as described by *Ho etal,* (1) in the ED and ICU for such patients, however, there are several other angles which remain frequently encountered and not part of the discourse. I wish to present a fictional case of an elderly patient that represents ethical and clinical issues which arise in many similar patients who I come across in my practice in Singapore. I will then analyze these ethical, moral and clinical points which may highlight frequent conundrums and hopefully provide a guideline to improve acute care for such patients.

**Case:**

It is Dr. Omar’s first day on service. He has just returned from completing a surgical fellowship in Boston and is eager to do difficult cases. “Hope I get an epic case today,” he eagerly tells his Consultant when the team met for breakfast at the canteen earlier. He had first seen Mrs. Seah in the Emergency room two days ago when she was admitted with severe abdominal pain and vomiting. Mrs. Seah is an 89 year old lady who has ischemic heart disease and diabetes. She lives with her daughter Alice and had two sons Peter and Thomas who live separately with their families. Her provisional diagnosis is intestinal obstruction. On admission she was advised 24-36 hours of bowel rest with intravenous fluids and a nasogastric tube. However, now her symptoms had worsened and she is acidotic probably from intestinal perforation. She has not made an Advanced Care Plan or Advanced Medical Directive[[1]](#footnote-1), however had stated in a past admission that she doesn’t want any ‘suffering’. Due to her deteriorating condition she is now offered surgery by the doctors.

Dr. Omar discusses the results of the fresh blood tests and clinical exam findings with the three children advising an urgent operation. They agree without discussing the risks and benefits with her. They feel it was too stressful for her to go over the choices and request the doctors not to mention anything ‘serious’ to her. Dr. Omar arranges an urgent laparotomy with a ‘green consent form’(when patient does not have mental capacity) with signatures of two consultants, as the patient is now delirious due to sepsis and lacks mental capacity to sign an informed consent. After the operation she is admitted to the ICU and continues to deteriorate. She is on full ventilator support and her blood pressure is supported with vasopressors. The seriousness of her condition is conveyed to her children.

After 48 hours without improvement Dr. Omar is approached by the ICU physician, Sam, who feels that further aggressive life support would be non-beneficial due her age and poor baseline co- morbids. “Hey Omar, have you seen Mrs. Seah today, her condition is much worse. Her ABG sucks and she’s on two ‘pressors’ now. I’ll have to start dialysis soon if I am to sustain her. But she said she doesn’t want to ‘suffer’. What do you think? Should we ‘DNR’ (Do not resuscitate) her? I doubt the family will agree, they already insisted on all guns ahead last night when she went south”. Dr. Omar replies, “I know, I know Sam, but listen, she’s someone I worked on very hard. We can’t give up so soon. The family is opposed to it too. You just have to press on.”

The doctors conveyed her grave situation to the family. Alice is in tears but Peter and Thomas were more composed. Peter the elder son speaks up. “Just do your best doctor, we want our mother to live, she’s a fighter and she’s not ready to leave. Please, just do everything”. Thomas keeps silent. He isn’t sure what to think. He can’t speak against Peter but he feels his mother had been through enough and the doctors are telling them that things are touch –and- go right now. He wants to tell them not to push her any further and let her die peacefully. Thomas realizes that Peter lives far away and even though he financially supported his mother and Alice, he may be feeling guilt as he had not visited Mother for quite some time.

Mrs. Seah suffers a cardiac arrest that night. The family is not there. The Registrar on call had been instructed to commence CPR and electrical shock if this happened on evening exit rounds, as the family had wanted the patient to be ‘full code’ (requiring resuscitation). Despite this the Consultant and Dr. Omar were called when the arrest happened in between shocks. Both instructed the Registrar to carry on. But despite all efforts Mrs. Seah didn’t recover spontaneous circulation and passed away due to severe sepsis. Her family had arrived and watched the efforts made for her resuscitation.

**Commentary:**

Jonsen etal, have described a structured ethical approach to such cases. Using this so called ‘4 box mode’l of structured ethical consideration, points that emerge in this case scenario will be analyzed to reflect on a patient centered approach. (Fig 1)

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| **Medical Indications**  What are Mrs. Seah’s medical history, diagnosis, co- morbids and prognosis?  What is her chance of survival with or without surgery?  What can happen after surgery?  What are her chances of organ failure?  Can organ failure result in need for dialysis, mechanical ventilation, vasopressors?  What are the risks of ICU care for the elderly?  Can ICU care result in good outcomes for her postoperatively? | **Patient Preferences**  Are Mrs Seah’s wishes known? Is there an advanced directive? If not who is the best person to be a surrogate decision maker? Is there a legal power of attorney?  What are her hopes, values, goals and preferences?  What is her mental capacity now and when she presented to ED?  What were her expectations regarding an operation and ICU care?  What is her preferred quality of life post discharge? |
| **Quality of Life**  What was Mrs. Seah’s functional capacity prior to her illness?  What aspects of her life did she enjoy?  What are the goals of care for her?  What are the chances of returning to her prior QOL? Can surgery and possible deterioration in ICU sustain or improve her prior QOL? | **Contextual Issues**  What are Mrs. Seah’s familial and relational  considerations?  What is the overall situation in the family? What  are their hopes and expectations with Mrs. Seah’s  clinical situation?  What types of support does Mrs. Seah have in  undergoing various treatment options  Are there cultural, religious, or financial  considerations for Mrs. Seah related to treatment  options? Are there resource constraints? |

Figure 1. Four box approach to clinical and ethical decision making –Jonsen, etal (2)

**1. Medical Indications**

Mrs. Seah had presented with multiple co- morbids and an acute illness. Her chances of perforation of the gut were high. A discussion at that point with her about her preferences as well as her chances of recovery should a perforation occur was indicated. Some features of this case are discussed below:

**a) Risk assessment in the elderly**

Elderly patients are high risk due to frailty as well as coexistent diseases. When elderly patients present for emergency surgery they often have poorer outcomes than their younger counterparts. It is a known fact that the most important factors independently associated with the highest risk of death in the very elderly (above 85 years) are: the severity of illness, impaired level of consciousness and infection, as is seen in Mrs. Seah’s case. Risk assessment and clinical decision making is based on chances of survival and patient preferences.(3) A recent literature review found the overall evidence base informing perioperative acute care for the elderly to be limited. (4) Frail and elderly individuals admitted for emergency surgery to the ICU are likely to need life support in terms of dialysis and mechanical ventilation. (5)

**b) Integrated Care for the elderly**

Mrs. Seah’s advanced age and presence of co-morbids predispose her to multiple complications of ICU care. Without her present acute predicament her chances of a long and healthy life are also severely limited. It is unknown whether she has been regularly followed by a General Practitioner (GP) or Primary care physician who in this case could have optimized her medically. She suffers from debilitating chronic diseases which can affect the present prognosis if not controlled. Good integrated care as rendered by a Primary care physician who knows the patient well over the years and perhaps has also discussed with the patient her long and short term health preferences can be invaluable in such cases. (6) These physicians can also be a bridge to acute care when such patients suffer an acute decompensation requiring the help of other disciplines. Had Mrs. Seah seen such a doctor previously, he or she could have liaised with the surgery team to guide them regarding her prior health status, her medical condition as well as the extent of care she would have desired.

**2.** **Patient Preferences and Autonomy**

A recent survey in Singapore showed that “caregivers were far more aggressive in their willingness to pursue treatments with only moderate survival benefits. As a result, patients who do not have a say in their treatment are likely to be over treated compared to what they would receive if actively involved in the treatment decisions.” (7)

1. **When patient’s wishes are unknown and they are ignored in decision making**

All elderly patients should be assumed to have capacity to make decisions regarding their health and treatment. Surrogate decision making is also at times biased due to personal feelings of guilt. Respecting patient wishes, either when expressed at the time of presentation or in the form of an advanced decision to avoid suffering in the past must be at the forefront of the clinician’s mind when deciding on a treatment. In line with several developed countries Singapore offers elderly and chronically diseased patients an opportunity to make such provisions with their doctors in the form of an ACP and AMD. The vague language of many such documents is also subject of criticism as they may not guide clinicians in specific acute scenarios. (8) There is also the opportunity to nominate a legal power of attorney (LPA) who is the designated surrogate. In this case her daughter Alice who was the main caregiver should have had a stronger voice as she was the one looking after her mother; however, her opinion was not explicitly obtained.

1. **Engaging the Elderly in Care decisions**

There seems to be no indication that the patient’s wishes were explored regarding her preferences in her medical records even though she has had a long history of chronic illness. The rights to accept or refuse treatment and have one’s privacy protected are important to everyone but older people are more likely to have those rights ignored. The British Medical Association has recommended that “If they become mentally incompetent, their former wishes must feature as part of any judgment about their ‘best interests’. (9) Older people are often marginalized in discussions if their hearing or mental capacity are impaired or if they lack confidence in voicing their opinions. They may not understand technical details and often the communication does not address their needs. *Atul Gawande* in his book *‘Being Mortal’ (Metropolitan, 2014)* illustrates how after careful discussion with his patient he was able to paraphrase her values into practical choices by simply understanding well what was important to her in life and in death. (10)

1. **Quality of life**

The goals of care of the ICU remain twofold: 1. Restoring health and, 2. Relieving suffering (including suffering of death by prolonging treatment). (11) Distinctions based on the course of a disease can be technical but also takes into account a patients premorbid quality of life as well as their age. Clearly a patient who is younger will have a better quality of life score and fewer chances of mortality in the ICU, however, countless studies show that decisions made solely on the basis of age or perceived quality of life assessment (which is subjective) can prove erroneous.

1. **Whose point of view is important and who decides**

Mrs. Seah is elderly with various illnesses. She is dependent on her daughter for her care. She has presented with an emergent illness which will impair her QOL. Given the risks of surgery and ICU care in such a patient her chances of returning or improving her QOL after surgery and a stormy ICU course are very few. The argument about performing surgery for symptom relief from a possible bowel perforation and the associated pain and septicemia can be made, however, palliation has been done in such scenarios in the past with satisfactory results.(12) A frank discussion by Dr. Omar about alternatives to surgery with Mrs. Seah and her children was warranted at the outset. This could include a palliative care team as well for an opinion. Such discussions provide elderly patients and their families with an option other than risky surgery and maintain the goals and dignity of end of life care. Mitigating distressing symptoms of acute disease as offered by palliative care physicians can help in families choosing a less aggressive course.(13)

The determination that an intervention is futile is based on objective data or judgments within the expertise of physicians. *Lo,* in his book *‘Resolving Ethical Dilemmas: A guide for Clinicians’ (Lippincott 2013*) points out that “Physicians have no ethical duty to provide interventions that are futile in these strict senses:” yet he also cautions that because these judgments can be contentious, “physicians cannot define goals of care unilaterally, but should be guided by the patient’s values”.(14)

1. **When high risk surgery is undertaken for the elderly**

Committing to high risk surgery in an elderly patient must be done after robust risk assessment and on the basis of a carefully balanced risk benefit ratio.(15) As opposed to the US where surrogates make a decision shared with the physician, Singapore Law mandates two physicians to consider and decide best interest for a patient without mental capacity. Physicians must ensure their patient’s world view as well as their dignity is protected by involving the patient as well as close caregivers and family early in dialogue about their wishes, expectations and hopes.

The literature points to surrogates very often not being able to correctly decide what the patient would have wanted.(16) Despite this, it is also well known that such decisions must come with the involvement of close relatives as they intimately influence such decisions and these decisions impact the lives of the relatives. Once these decisions are made a fair chance must be given for the desired results. Futility assessments are based on physicians’ assessment of organ failure as well as extent of life sustaining support and probability of returning to baseline QOL. Mrs. Seah was subjected to risky surgery with a high chance of a stormy post -operative course. Considering withdrawal of life sustaining measures too early would be confusing and counterproductive.(17) A usual practice in our ICU is to allow the patient to be on life sustaining support for a certain amount of time whilst evaluating the extent of support needed. After this, if further care is non-indicated due to futility a shared decision with the family is made to limit the escalation of further support or support is withdrawn.

This time can also be taken to ensure constant detailed status sharing and communication in a realistic manner with the family, whilst preparing them for a negative outcome. Many ICUs routinely engage in Palliative care teams as well as medical social workers in a timely manner to engage in end of life conversations early and to palliate suffering when futility is established. Disability counseling of the patient and family if they were to survive also is often neglected and needs a focus in dialogue with the family. Transition care teams could be alerted to the patient’s disposition and long term needs were they to survive a critical illness in the ICU.

1. **Contextual Issues**

Mrs. Seah’s family dynamics are complex and skewed in a way that favors the oldest son who pays the bills. Such balances often exist in families where an elderly patient’s true choices are influenced heavily by a sense of being a burden to their children. Here we also see the ‘absent child syndrome’ where a relative who is absent from a patient’s life will assume a decision making role out of feelings of guilt rather than the care giver who bears the emotional and physical burden of daily care.(18)

1. **Surrogate decision making and conflicts within them?**

Here we see a difference in opinion between the 2 sons. Also Alice the main caregiver’s opinion was not sought out. This is very often the case in Asian families where the eldest son makes all decisions regarding the health of the parent especially if he is the financial benefactor. The decision seems to be stemming from guilt as well as a sense of filial piety. Doctors must ensure that the decisions made are not overshadowed by the payer’s demands. The second son has a more realistic and humane response but he does not share this from deference to his older brother. Acting in the best interest of the patient is essential whilst taking care that the decisions made are not for the benefit of the family or physician but directly benefits the patient. Doctors must mediate between family members to ensure the long term well-being of their patients in conflicted situations. Often respectfully focusing on the immediate caregivers rather than the louder ones is a means of achieving this goal of care. They can also be instrumental in families coming to terms with end of life decisions. (19)

Dr. Omar must consider this clinical as well as familial quagmire and using the four box approach helps in evaluating the multifaceted components in depth. Families may request aggressive non beneficial care for frail elderly patients based on contextual issues. However, these requests must be balanced against the best interest of the patient and it is important to address filial piety in ways other than aggressive care. Here Thomas respectfully defers to his older brother Peter’s opinion although his own judgment is different. Exploring and affirming a family’s role as not just being obstructive improves communication and patient care. A family centered care approach forms the basis of evolving practices in Singapore Law as evident in the Mental capacity act (Sg Statues 2008) where decisions about patient’s who lack capacity must be made with the involvement of care givers. (20)

1. **Bias towards non- indicated procedures**

With or without Dr. Omar’s explicit acknowledgement he was already biased towards performing technically challenging surgeries to advance his skills. Often, this leads to non- beneficial care being offered to vulnerable patients. In one recent study, one-third of elderly patients have surgery in the last 12 months of their lives, most within the last month. But, three-quarters of seriously ill patients say they would not choose surgery if they knew they are likely to have severe cognitive or functional complications afterward.(21)

1. **Differences of opinion within the medical team**

Mrs. Seah’s ICU physician and surgeon did not agree on the post- operative management and extent of care for the patient. This is also a commonplace occurrence amongst multiple clinicians caring for one patient. ICU care calls for a multifaceted coordinated care however differences in clinical judgment often arise. (22) Probably the ICU physician’s assessment of futility was correct but came too late as the therapeutic course had been set out much earlier and expectations had been raised. (23) Although traditionally, hospital ethics committees (HEC) do not mediate between clinicians in conflict situations, when an ethical decision regarding a patient is to be made and there is difference of opinion, an ethics ‘consult’ can be made.(24)

**Conclusion:**

Four main issues are highlighted in this case which illustrates common scenarios encountered in elderly critical care. 1) Mrs. Seah’s personal world view and wishes were not known. There is a need for ACP implementation among elderly patients and whether there is a formal document filled or a discussion is had with a physician on admission, such values must be explored before the patient loses capacity. 2) Communication and coordination of care seems to be lacking. Regular updates, family discussions, preferably involving the patient and team meetings with short term goals of care laid out are helpful. 3) Family conflicts and disharmony can be assuaged by timely involvement of medical social workers and they should always be referred when conflicts arise. 4) The role for palliative care teams is neglected in this scenario where an alternative clinical course could have been introduced early in the case. This can provide families with a humane end of life pathway which can help ease their decision making burden as well.

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| **Chronic Period** | **Acute Event in ED** | **Admission to Ward** | **Admission to ICU** |
| Integrated care by GP, ACP AMD and LPA determination.  Patient/ Family agreement sought regarding goals of care.  Optimising chronic disease, liaising with acute care physicians when needed. | Risk assessment done early by experienced physicians.  Goals of care defined after detailed discussion with patient and family.  Information regarding preferences obtained from GP.  Timeline set for aggressive care if chosen.  Palliation started if futility established.  Patient’s priorities established and respected.    Continuity of care maintained strictly by personal handover between senior doctors in ED, OT and ICU. | Frequent updates on patient condition to patient and family.  Goals of care maintained.  Changing situation according to pathology relayed 2-3 times a day.    Multidisciplinary team coordination needed.  Involve MSW, nursing or Palliative physicians.  Honest and detailed informed consent process undertaken by senior physicians if high risk surgery is to be undertaken.  Thorough documentation of all communication in records. | Continue detailed and frequent updates.  If patient loses capacity the physicians must ensure best interest of the patient by limiting non beneficial care.  Sufficient time needed to determine outcome of risky intervention.  Palliative physicians to be involved if futility established after such a time when no benefit is obtained from aggressive care.  Family mediation and counseling by senior ICU physicians.  Consider CEC in cases of dispute early. |
| **High Risk Surgery** | **Rehabilitation** | **Demise** | **Family** |
| This is a period of high stress and uncertainty for the patient and family. Expectations and risks must be aligned with goals of care after a detailed discussion.  Timelines of expected results must be elaborated.  Surgeon and anaesthetist as well as ICU consultant must be involved.  Alternatives to surgery or type of surgery must be tailored according to patient’s values and desires. | After ICU discharge when stabilized disability and rehabilitation must be explained and chronic health status, life expectancy, QOL and burden of care must be discussed in detail with patient and family prior to discharge from ICU.  Financial burden must be preempted and efforts made to help families and patients find solutions. | In case of mortality or withdrawal of life sustaining care (LST), detailed, frank and empathetic dialogue with surgeon, intensivist and palliative care specialist if indicated must occur.  Pain and suffering must be dealt with.  Artificial nutrition and hydration can continue.  In general withdrawal of LST must occur completely there must be clear documentation of what has been discussed and agreed upon. | Conflicts and miscommunication can often arise. Families are surrogate decision makers and must be part of the shared decision making.  MSW, counselors and CEC can be asked for support in cases of difference of opinion.  Senior doctors must conduct end of life or other complex discussions with families and clear documentation must be maintained.  Honesty and clarity will gain the family’s respect and trust. |

Table 1. Ethical Care Pathway for Elderly patients in the Acute Scenario

When dealing with elderly and frail patients a spectrum of care evolves with a different focus at different timelines. Table 1. describes the goals of care which should be accomplished in each part of the spectrum starting from the chronic pre admission care of the elderly patient through an acute admission to either demise or rehabilitation.(25) I hope to provide a framework by means of this case and the resultant care pathway to illustrate good ethical care for elderly patients in the acute scenario.

**Word count: 3400**

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1. Advance Care Planning (ACP) is the process of planning for your future health and personal care. An Advance Medical Directive (AMD) is a legal document that you sign in advance to inform the doctor treating you (in the event you become terminally ill and unconscious) that you may or may not want any extraordinary life-sustaining treatment to be used to prolong your life. [↑](#footnote-ref-1)