~~Medical Leader~~	
Medical Expert	•
Communicator	•
Advocate	
Scholar	
Professional	☐
Collaborator	
Manager	

Refusal of Ulcer Care

2013 Q4a

You are a medical manager in a regional acute hospital of 240 beds. An 83-year old man is admitted primarily for social reasons after sustaining a number of small strokes (CVAs) and being referred by his general practitioner to the hospital because he was unable to cope at home. The man is a decorated Korean War veteran, well known for writing articulate letters to the local newspaper about a variety of social and political issues. His strokes, remarkably, do not appear to have significantly impaired his cognitive functions but he is physically frail. Following admission and assessment he is advised that his only option is to move into a long-term care facility.

Two weeks after his admission, to your hospital, the Director of Nursing and the Nurse Unit Manager of the ward in which the man has been admitted comes to you because the patient is adamantly refusing to allow nursing staff to turn him in bed as part of routine pressure ulcer prevention, a situation they have never encountered before. The man has developed significant pressure ulcers that are already infected and smelly. There is evidence that the situation has affected staff morale on the ward and Nurses have been complaining that they did not want to provide care for this man in this situation. The nursing policies of the hospital dictate that all immobilised patients must be turned frequently as pressure areas cause significant morbidity. You are also aware that the rates of pressure ulcer are being used as an indicator of the quality of hospital care (tied to hospital funding) by your jurisdiction.

However, when you speak with him, the patient remains adamant that he will not allow staff to turn him, even though he acknowledges that he already has developed ulcers that will most likely become painful and eventually cause his death.

How do you manage this situation?

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(NZ elements in italics)

Three (3) core requirements for this question

1. Clinical ethics and legality – the candidate must identify this as an issue of patient autonomy and clinical ethics and perhaps explore the boundary between honouring individual patient autonomy and maintaining a good standard of broader patient care (e.g. although an act of autonomy by an individual, is this causing problems with providing good care to other patients).
2. Clinical management – ensuring the correct specialist advice is sought (rehabilitation, psychiatry or geriatric specialist). Management of reluctant staff.
3. Other management issues – How would the candidate address the issue of potential penalties under the funding model for a patient exceeding length of stay parameters or who develops a significant complication (i.e. the pressure sores) that is specifically subject to finance sanctions.

Clinical ethics
Issues of supporting patient autonomy? Are there limits to patient autonomy if it is adversely affecting care for other patients? From where would the candidate seek ethical advice (e.g. is there access to a clinical ethics committee?)
Every NZ candidate MUST be conversant with the NZ Health and Disability Code of Consumers' Rights: Section 3. Provider Compliance (text below)*
Legal and competence
Seeking legal/Coronial advice: is there any legal ability to enforce treatment, particularly if there has been an adverse effect on other patient care.
Assessment of competence by a gerontologist or psycho-geriatrician (or psychiatrist if psycho-geriatrician not available)
Involvement of carers and relatives, assessing and treating for depression if present, continuing to talk to the patient about reasons for decision, advanced care directives
General management
Possibility of transferring care e.g. to a palliative care unit
Reporting of indicators of poor health care - Is it possible to report the specific issue back to the 'funder' to negotiate waiving of financial penalties if transfer is not possible and patient is likely to die of the complications arising from his decision?
Management of hospital staff who have been affected and who are refusing, or are reluctant, to care for the individual.

I'd put an assessment of competence by a gerontologist of psychogeriatrician pretty high up on the list. An NZ answer in relation to competence should include reference to the 3PR Act (The Protection of Personal and Property Rights Act 1988, a compassionate piece of legislation which allows for "welfare guardians" to be appointed to assist people whose competence may be variable or impaired but that leaves the really difficult ones who are assessed as being competent. We also have an archaic but useful piece of legislation in our Health Act 1956, s126, which allows for a court ordered committal process for a person who is "aged, infirm or in need of care and attention" to be cared for in an appropriate location.

More practical stuff (which others should do) is identify the key people in this determined gentleman's life – relatives, neighbours, fellow veterans – maybe RSL/RSA? Does he have a lawyer (if they do, it's always a very useful lever with these stubborn old troopers in my experience).If no-one, whether or not he is competent, we'd get Age Concern to find him some support to help him through this impasse. Why has his previously compelling existence ceased to be attractive to him? How can he find other outlets for his active brain, consistent with his reduced physical abilities?

The NZ Health and Disability Code of Consumers' Rights

3. Provider Compliance

A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.
The onus is on the provider to prove it took reasonable actions.
For the purposes of this clause, "the circumstances" means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.
"All relevant circumstances" here would need to include the issues his refusal creates for staff and other clients. He may well be reassured that basic care such as turns is not done to prevent him dying but to maximise his quality of life in this late phase in his life. He can still decline antibiotics which would be the most likely life-saving intervention as it will be sepsis from necrosis +/- cachexia that will get him in the end if his vascular pathology doesn't get there first.