Mrs. A., a 74 year-old female presented to the Emergency Department after a friend noticed a foul odor in her home and found the odor to be coming from Janet’s leg. Janet states that she is in no pain and was brought to the emergency department against her wishes by her friend. The friend states that Mrs A’s foot is “rotting off” and she refused to just leave her at home at her age and in her health condition. Just the smell filling the room alarmed the ED physician and he persuaded Mrs. A to let him examine her foot even though she persistently stated that “nothing is wrong with me and I just want to go back home.” The physician found a large diabetic ulcer on Mrs. A’s left heel and a significant portion of the lateral aspect of her foot was eaten by dry gangrene. Three of Mrs. A’s toes were black in color and her small toe was on the verge of actually falling off. Another large diabetic ulcer was also found on Mrs. A’s right foot. Mrs. A’s friend was horrified at the site but Mrs. A seemed to not be surprised in the least bit and even told the doctor she wanted no treatment after he explained the severity of her situation.

Mrs. A told the physician that almost a year ago her husband passed after a return of his prostate cancer, and since that time she decided she no longer wanted to “finish out the rest of (her) life like (her) husband, always at the doctor’s office and taking so many medicines.” She had simply decided to stop taking her medicine and no longer kept her doctor’s appointments. Determined to bring the patient to her senses and get her the appropriate help, the ED physician consulted both the internal medicine and surgical services, inquired about contacting Mrs. A’s son, and he pulled her old medical records to
gain a better understanding of her medical condition and past medical history. The physician knew that Mrs. A had requested to go home and nothing be done, but he began to question whether she was mentally competent enough to make such a decision at her age and in her emotional state after the death of her husband. He was determined to find out and to do what he could to save her life. He knew that without medical intervention, Mrs. A’s uncontrolled hypertension, uncontrolled diabetes, and the even more concerning gangrene and infection in her feet would likely lead to an overwhelming infection that could take her life. He returned to her room and pleaded with her to see the doctors he had consulted so they could further explain her condition while he tried to contact her son. She agreed to see them but continued to insist that she was no longer going to take any medicine. She told him, “I’m old and I just want to live out the rest of my life at home.”

The internists and surgeons both came to see Mrs. A and explained to her again that with her uncontrolled diabetes and the gangrene in her foot she could die without treatment. The ulcers needed extensive wound care, the dead tissue on her foot needed to be excised, and her diabetes and blood pressure needed to be under control for her to fight off the bacteria that had invaded her feet. She told them she understood but wanted no intervention and was ready to die, “if that’s what God had in store for (her).”

It was found that her son was a busy banker in New York, hadn’t seen his mother in eight months, and was shocked at what he was told. He said he talked with her weekly had she told him that she had been keeping her appointments and that she had been doing fine. The son felt she was competent but was in disagreement with her decisions and said he would fly home immediately to make sure she got the full care she needed.
Ethical Conflict:

Mrs. A is a 74 year-old female with uncontrolled hypertension, diabetes, bilateral diabetic foot ulcers, and gangrene of her left foot. Her physicians are convinced that she must be treated for her diabetic wounds, her dead tissue removed, antibiotics given to fight her infection, and medications given to control her hypertension and diabetes in order that she not die from complications of her current medical condition. Mrs. A has made it clear that she wishes for no medical or surgical intervention for her wounds and infection and wishes to “let nature take its course.” Her son, and closest of kin, who flew in from New York wishes that she have full medical treatment and although he originally stated on the phone he that she was mentally competent, now wishes that she be evaluated by a psychiatrist to determine whether she is fit to make such decisions regarding her care. The issue at hand is whether the patient is capable of informed consent and if so, is she mentally competent enough to make such a decision.

Issues of the Case:

According to Humayun A. et al, “Reports on issues of patient consent can be traced in the US to the early 18th century. These issues were centered on simple rights of the patients in giving approval of their treatment. Further development of this concept has produced the term 'informed consent' which recognizes not only the patients' autonomy in decision but also the right to complete information. The informed consent process requires the physician to explain in sufficient detail, the diagnostic, therapeutic and prognostic reasoning that leads to his expert decision on what is in the best interest of the patient. Paternalism and coercion are antithetical to the concept of informed consent [1].”

The ED physician consulted with a team of experts regarding Mrs. A’s condition, made a
call to her son to determine his thoughts on the situation, and did what he could to make sure Mrs. A fully understood the consequences of the decision she was making. As for whether Mrs. A was truly competent to make such a decision regarding care of her feet was yet to be determined by the physicians in charge of her care. If Mrs. A was found to not be competent the decision would go to a surrogate decision maker, and her closet of kin was her son.

Two important questions must be asked by physicians when encountering patients with whom they have never had contact and when the physician is uncertain of the patient’s decision making capacity. The physician must determine whether the patient has the capacity to refuse treatment and whether the patient’s refusal is informed [2]. One of the hardest ethical decisions that physicians must make occurs when a patient who does not have a terminal illness refuses life-saving treatment for what appears to be a very treatable and reversible condition. The typical physician’s reaction is to intervene to preserve life, but life saving treatment against a competent patient’s wishes could result in legal action against a physician. Therefore the physician must do his/her best to assess the patient’s decision-making capacity.

An assessment of decision-making capacity must assess the patient’s ability to (a) understand, including comprehending information and appreciating consequences; (b) evaluate, comparing risks and benefits, and to make a rational and consistent choice; and (c) communicate that choice [2]. A common misconception is that patients who refuse to follow medical advice obviously do not have decision-making capacity. On the contrary, patients who possess decision-making capacity have the ethical and legal right to refuse even life-sustaining medical treatment.
What Actually Happened:

In the end, Mrs. A ultimately decided to let the physicians admit her to the hospital after her friend pleaded with her to get medical treatment. At first she still refused to have any surgical procedure to her foot, but later also gave in after her son arrived from New York the following day. Informed consent was obtained, she was found to be competent to make medical decisions, and what could have potentially been a worrisome ethical conflict between Mrs. A, her son, and the physicians involved in her care, all turned out for the best.

References:
