CLINICAL COMMENTARY

What Do We Do? A Clinical and Ethical Conundrum

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Case

A 65-year-old female nursing home resident, presented to the emergency room with 3 days of worsening dyspnea. She was originally from Cambodia with hepatitis C cirrhosis, schizophrenia, with no family, under the care of state appointed conservator. In the emergency room, she had a blood pressure of 105/70, respirations 26 per minute, heart rate 132 beats per minute, temperature of 100.5F and pulse oximetry 100%. Per nursing home report, she spoke Khmer, but refused to talk since arrival. Fortunately, our admitting physician was fluent in Khmer, but she refused to talk to him and even with a professional phone assisted translator. She did report some abdominal pain. Laboratory data revealed WBC 5800, 73% neutrophils, no bands, platelet count 42,000, hemoglobin 12.4 g/dl, INR 1.8, metabolic panel was insignificant except for mildly elevated alkaline phosphatase at 211 and AST at 73. Procalcitonin was minimally elevated at 0.15, with lactic acid level was elevated at 2.9. Chest x-ray revealed moderate right sided pleural effusion with atelectasis versus consolidation. CT scan of abdomen and pelvis with oral and IV contrast revealed a large right pleural effusion with associated atelectasis, small left pleural effusion, mesenteric edema, splenomegaly and cholelithiasis. Urinalysis revealed mild leucocyte esterase, 2-5 WBCs and RBCs, and 1+ bacteria. Blood and urine cultures were taken, and she was started on empiric antibiotics, vancomycin and cefepime. Blood and urine cultures remained negative. Right sided thoracentesis was delayed due to thrombocytopenia, patient's persistent refusal to talk and inability to contact patient's conservator. Without informed consent, interventional radiology would perform only thoracentesis in an emergency. After multiple attempts, the conservator was reached, who would not consent for non-emergent procedures and asked to submit a 7-point letter to the court in that regarding procedure. (Table 1) Conservator was not able to inform us on the goals of care or code status for the patient. Medical ethics committee was consulted. The committee recommended that we provide medical care consistent with the standard of care and not delay care due to risk of clinical decompensation waiting for court orders.

Discussion

Our case highlights clinical and ethical challenges in our desire to provide optimal medical care to an alert patient who refused to talk, had significant medical comorbidities, some deteriorating to the level of potential clinical emergencies, with inability to obtain informed consent for rendering medical care, and the expectation to provide the same standard of care to her as one would to any other patient. Although we were able to find few answers, we were intrigued by her in several ways.

Additional Background

Cambodia was under Communist rule of Khmer Rouge from April 1975 to early 1979 with the population suffering extraordinary brutality during that period. An estimated 158,000 Cambodians immigrated to the United States between 1975 and 1994. About 5% came in 1975, who were mostly educated and had not experienced the Khmer Rouge rule, and managed to find white collar jobs. About half of the immigrants who came during and after the Khmer Rouge regime found employment in blue collar occupations. A large portion relied on public welfare. A significant number of immigrants that came after 1979, were families headed by women who lost the men in their families to the atrocities of Khmer regime and were struggling to keep themselves and their children alive. Many these immigrants suffered from post-traumatic stress disorder, with prior treatment.[1] The NY Times stated said that no country in the 20th century lost such a sizable proportion of its population in such a short period. Depending on the estimate, between one-eight and one-third of Cambodians vanished.[2] We inquired with the nursing home and the conservator, but were unable to obtain information about our patient's immigration history or her family.

Hepatitis C in Homeland

The World Health Organization estimates 58 million people worldwide live with Hepatitis C. In Southeast Asia and Western Pacific region about 10 million people suffer from chronic hepatitis C. In Cambodia, it is estimated that 257,000 people live with hepatitis C, with prevalence of 1.6%.[3] A epidemiological study of hepatitis C virus in Cambodia, reported two-third of cases were associated with invasive medical procedures and others being related to hepatitis C and blood transfusion.[4] With cirrhosis, it is possible that out patient was exposed to blood product transfusions in the past, although the timeline of her liver disease remained unknown, as was her past procedural history and her family background.

Mental Health Conservatorship in California

Mental health conservatorship in California arises from the Lanterman-Petris-Short (LPS) act of 1967, wherein a conservator oversees the responsibility of comprehensive medical treatment for an adult, a conservatee, with serious mental illness. The purpose of the act was to end inappropriate and indefinite and involuntary commitment of persons with mental health disorders in state hospitals. Conservatorship is granted only to those who are gravely disabled with diagnosis of schizophrenia, bipolar disorder, schizoaffective disorder, clinical depression, obsessive compulsive disorder and chronic alcoholism.[5] Our patient suffered from schizophrenia with mutism. We suspect her mutism was either as a manifestation of catatonic schizophrenia or non-catatonic mutism in schizophrenia. Our hospital did not have adequate psychiatry support for further help.

Our patient's central issue during this admission was diuretic resistant recurrent hepatic hydrothorax with thrombocytopenia and underlying cirrhosis. Because of her refusal to talk and describe any symptoms, we had to carefully monitor her for signs and rely on diagnostic studies. On two occasions during the hospital stay, we found a large right pleural effusion with near complete lung field white, while out on titrated doses of diuretics only after she developed subtle tachypnea. Another challenge was to establish effective communication with her conservator. We left several voicemails only to find out that her conservator was someone else. After several attempts, we were able to establish contact with the right conservator, who was not readily accessible for procedure consents and pre-procedure platelet transfusions for near emergent thoracentesis procedures. She subsequently asked us to submit a 7-point letter for medical treatment to the court to obtain permission for medical care for this patient. We were told that the turnaround time for the court decision was several weeks and was not practical in providing acute medical care to our patient in the hospital. Further, she could not address the patient's code status or wishes for cardiopulmonary resuscitation.

Difficulty with prompt medical care decision making for patients with public conservators in California has been mentioned previously.[6] Similar to our belief, other physicians have felt that conservators refuse to make medical decisions in patient's interest in order to avoid legal liability. As the patient's primary attending physicians, we were in a clinical bind. Our interventional radiology colleagues were willing to perform thoracentesis without informed consent only in an emergency. Ethics consult was obtained, who stated that patient should get the same standard of medical care as any other patient would. In our patient's case, we were able to justify the two thoracenteses and platelet transfusions as emergencies with impending respiratory failure. But the standard of care is not to wait for the clinical situation to deteriorate to an emergency but to prevent emergencies. Understandably, the conservator does not have an existing caring relationship with the patient as a family member or a trusted surrogate would. Nonetheless, this relationship places patients' health in potential jeopardy. Although this may or may not be generalizable, the role of public guardian conservatorship in the acute medical care of our patient left a lot to be desired. More engagement and accessibility of the conservator during conservatee's acute care hospitalization, and a time efficient system for court consent procedures will go a long way in providing desired clinical care to this vulnerable population.

TABLE 1

SUPERIOR COURT OF CALIFORNIA
COUNTY OF LOS ANGELES

CONSERVATORSHIP 7 POINT LETTER FOR MEDICAL TREATMENT

The following questions must be answered when requesting either medical or electric convulsive therapy when a patient is on a Temporary or LPS conservatorship

(i) What is the condition that requires surgery?
(ii) What is the recommended course of treatment?
(iii) What is the predictable results if authority to consent to treatment is denied or delayed by the court?
(iv) What is the predictable or probable result if the recommended treatment is given?
(v) Are there any medical alternatives available?
(vi) What are the attendant risks involved in the procedure recommended by the Doctor?
(vii) What are the reasonable efforts by the physician and /or the facility to obtain informed consent of the conservatee?

Source: https://www.lacourt.org/forms/pdf/MH041.pdf

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