

An Ethical Dilemma Regarding Treatment Escalation in a Patient Lacking Capacity to Consent

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Case study

A 74 year old female with a history of COPD and rapidly progressive Parkinson's disease presented to the Emergency department with shortness of breath. She was diagnosed with infective exacerbation of COPD but despite optimal medical treatment, she deteriorated, becoming drowsy and confused with reduced GCS (Glasgow Coma Scale). Since she developed type 2 respiratory failure, the consultant believed non-invasive ventilation (NIV) was indicated. However, she had an advance directive refusing ventilation and a 'do not attempt cardio-pulmonary resuscitation' (DNACPR) order. She had given lasting power of attorney (LPA) for health and welfare to her husband, son and daughter who were involved in subsequent decisions.

Ethical and legal issues

This case raises the issue of consent in adults without capacity, the role of LPA and challenges associated with implementation of an advance directive.

Historically, Hippocrates and Plato considered humans as autonomous beings with the right and freedom to make decisions about their care [1]. Today, this is the basis of informed consent required for medical examination, investigation or treatment. Consent can be implied or verbal but should ideally be written for procedures with greater risk [2]. Legally under section 39 of the Criminal Justice Act 1988, doctors could be charged with battery or assault for treating patients without their consent, regardless of the outcome [3]. Adherence to this principle is a deontological approach or 'categorical imperative' as described by Kant, overriding teleological concerns [4]. Upholding patient autonomy is every physician's duty and a core principle of medical ethics [5]. GMC states that valid consent requires capacity; allowing patients to voluntarily understand, retain, evaluate and communicate a decision based on information provided by their doctor [2]. In this case, the patient could not give valid consent for NIV due to acute confusion, inability to retain information and difficulty in communication. This prompted the consultant to refer to her advance directive.

Advance Directive

The Mental Capacity Act 2005 allows patients to make an advance directive, addressing specific treatments in the future when they may lose capacity to consent [6]. The patient had capacity at the time and

had voluntarily refused resuscitation and ventilation after discussion of her co-morbidities with her GP, making the advance directive valid. Since it refers to life-sustaining treatment, the document was signed and witnessed by a lawyer [6,7]. However, the decision may not have been applicable to NIV. It was difficult to interpret what the patient meant by 'ventilation' and whether she was aware of invasive (intubation) and non-invasive forms. Furthermore, the discussion with her GP may not have outlined the various implications of this decision as it is impossible to anticipate every medical scenario [5,8]. If the patient only intended to refuse intubation and had not anticipated this situation, NIV would be compliant with her advance directive [6]. It would provide symptomatic relief and prevent deterioration from a reversible cause such as infection [9]. The DNACPR order was not invoked but guided the consultant's understanding of the patient's wishes relating to end of life care. To obtain further clarification of her beliefs, the consultant spoke to the legal attorneys.

Lasting Power of Attorney

LPA for health and welfare allowed the patient's nominated relatives to make decisions regarding her care since she lacked capacity. This document was signed and witnessed by a solicitor and was registered with the 'Office of the Public Guardian'. The patient's attorneys had power for joint and individual decision making alongside a duty to act in her best interest [10]. Although the LPA included decisions relating to life-sustaining treatment, it was made prior to the advance directive. This meant that legally, the advance directive was valid for ventilation [6]. When asked about the patient's views on 'ventilation', the relatives said she was very distressed when a family member was intubated and managed on ITU. She had expressed several times that "she didn't want to be kept alive by tubes and machines". The consultant explained the indications for NIV and how it differs from intubation [9]. Based on this conversation, it was believed the patient was referring to invasive ventilation and since there was no specific refusal of NIV, the advance directive was not deemed to be applicable. After taking a second consultant's opinion, consent was obtained from LPA and NIV was initiated.

Conclusion

This case was dealt with and resolved appropriately as the patient was treated with dignity and involved as far as possible in decisions. Discussing the patient's prior wishes and values with the attorneys

aided decision making. It seemed that the patient may not have been aware of NIV. Hence, she would not have anticipated such a situation where NIV was given for symptomatic relief from a reversible cause. It is possible that she may have specifically refused invasive ventilation in her advance directive, had she been aware of the differences. Therefore, the decision complied with the patient's directive and autonomy was respected.

When there was ambiguity, the doctor acted in accordance with GMC guidance and took steps to clarify [2, 7]. He upheld the core ethical principle of beneficence by informing the LPA regarding the patient's best interests [5]. In terms of patient welfare and safety, it was appropriate to administer NIV as clinically, the benefits outweighed the risks and improved patient outcome [9]. It was important to involve the family early, allowing them to follow the rationale behind medical decisions and give informed consent as LPA. Since they were present during admission, it saved time and allowed the necessary discussions.

For further clarification, the GP could have been contacted to ascertain whether the patient was aware of NIV while making the advance directive by referring to the consultation.

On recovery, the patient agreed with the interventions performed and was discharged. She could have been advised to incorporate these clarifications in her advance directive, giving more clarity to the decision.

Learning

This case outlines the different ways in which a patient's preferences regarding specific treatments can be established. If a patient lacks capacity to consent, advance directive and LPA are considered. Where a valid and applicable advance directive exists, opposing this decision is not appropriate (as with intubation and mechanical ventilation in this case). Challenges in application of an advance directive can be minimised through appropriate counselling. This includes exploring the reasons behind a patient's wishes and tailoring information to maximise understanding in an honest and impartial manner. In patients refusing ventilation, it is important to educate them by making a distinction between the different types. In acute situations, a multi-disciplinary team is essential to effectively evaluate the validity and applicability of advance directives or LPA, communicate with relatives and plan management.

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