Comments on the Case of Mr. N.

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Primary responsibility for managing ethics issues in nursing home residents and patients falls to the attending physician in conjunction with the patients, families, and staff. The medical director is responsible for (a) helping establish and implement appropriate care systems and for (b) helping ensure that physicians and nursing facility staff apply appropriate care processes and practices to the care of individual residents and patients. Therefore, the comments on the cases in this series will consider (a) how the medical director can help nursing facilities develop and implement relevant systems and processes to manage ethics issues in their residents and patients; (b) the attending physician’s role in helping a facility manage individual cases, and (c) potential medical director interventions in individual cases to help the attending physician and facility fulfill their responsibilities more effectively.

OVERVIEW OF ISSUES REPRESENTED BY THIS CASE

This case concerns Mr. N., an 81-year-old nursing home resident with a history of vascular dementia with significantly impaired function and multiple comorbidities. He was fed via a PEG tube, and devices were used to try to limit his ambulation when he was in a chair.

The patient tried frequently to get out of his chair and ambulate. A lap belt had evidently been used for this individual in the facility before the HRCA. After admission to the HRCA, the family requested that a lap belt still be used. The staff felt that the patient’s ambulation unaided was unsafe, and that the lap belt was a fairly effective deterrent.

The patient experienced several significant medical complications and hospital transfers after admission. But after his medical condition stabilized, he was felt to be less of a fall risk. Additionally, his improved strength appeared to increase his risk of injury from continued use of a lap belt. With the Ethics Committee’s input, staff recommended not using the lap belt but also appeared to have some reservations about possible liability if he fell again and sustained significant injury. The patient’s family member agreed reluctantly to allow the staff to not use the lap belt.

This case illustrates several issues relevant to medical directors. First, as the authors note, nursing homes often must address everyday or ordinary ethics issues, not just those related to life-and-death matters. Regardless, ethics decision making should always involve similar steps (Table 1).1 As with end-of-life ethics issues, medical directors can help in several ways: (1) ensure that a relevant care process is followed effectively, in order to optimize decision making in individual cases, (2) intervene effectively in case of disagreements or need for clarification, (3) evaluate the quality of the facility’s decision making by reviewing the performance of those steps.

ESTABLISHING CONDITION AND PROGNOSIS

To make effective ethics decisions, patients and families need information about medical condition and prognosis.2 Although this individual had advanced dementia, his medical condition and his overall function had improved somewhat. His ambulation was impaired somewhat, but his improving strength was a potential factor contributing to his risk of injury from continued use of a restraint. The various parties did not appear to disagree significantly about these relevant factors. Instead, the principal source of disagreement in this case appeared to relate to the appropriateness of using restraints.

A principal role for the medical director as a manager in this case is to ensure that the staff and physician had considered potential underlying causes of the patient’s fall risk. Finding and addressing correctable causes would undoubtedly influence potential treatment options. In this case, identified causes of increased fall risk were impaired visuo-spatial orientation and impaired judgment.

Nursing home staff often attribute falling in individuals with dementia to their poor judgment and uncooperativeness. But many individuals with dementia do not fall. Therefore, it is important to rule out other causes of falling, particularly hypotensive and anticholinergic effects of multiple medications in dementia patients who fall repeatedly or who are deemed to have a high fall risk. For instance, had the patient’s physician reviewed possible causes of impaired mobility or balance, or considered changing medications or medication dosages? Dizziness is a common symptom associated with falls and may be due to medication side effects. So the medical director should check on whether the staff and attending physician had asked the patient (through an interpreter, in this case) whether he was dizzy or lightheaded.

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Table 1. Steps in Making Ethics Decisions

| Establish medical condition and prognosis |
| Identify patient values and wishes |
| Determine decision-making capacity |
| Identify primary decision maker |
| Identify treatment options |
| Present options and obtain decisions |
| Evaluate results of interventions and modify accordingly |

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IDENTIFYING PATIENT WISHES

The medical director should help the facility ensure that patient wishes are determined effectively.1 Where these wishes are not sufficiently clear, the medical director should help the attending physician and facility staff apply a patient’s general wishes to specific circumstances. In this case, the patient had not clearly expressed his wishes before his present incapacity. But these could be inferred to some extent from his reactions to being ambulated and from the general principle of autonomy.

There is often a dilemma in managing fall risk in individuals who cannot discuss the situation, such as this patient. The philosophical dilemma contrasts autonomy with paternalism. The medical issue is one of potential for injury versus potential risks of immobility or patient struggle against confinement, as in this case. Although few people would choose knowingly to be injured seriously by falling, most falls do not result in serious injury. But it is often very hard to predict who will sustain serious injury from falling. Therefore, unless this patient had expressly stated that he wanted to be protected against injury at all cost, the staff and physician should consider the relative risk of injury in the context of the patient’s expressed or implicit wishes.

ESTABLISHING DECISION-MAKING CAPACITY

The medical director should help ensure that decision-making capacity is determined appropriately, and that someone with partial decision-making capacity is allowed to participate in considering treatment options to the extent of their capacity.2 In this case, the patient’s decision-making capacity was undeniably impaired. His participation in any treatment selection was implicit more than explicit, as evidenced by his efforts to get out of the chair and his apparently positive response to being walked.

Thus, the medical director can help by ensuring that the physician and staff recognize the value of assent (acquiescence or resistance) even in cognitively impaired patients. For example, patients who cannot communicate verbally may pull out feeding tubes either because of discomfort or as their way of letting others know that they don’t want them.

PRESENTING AND OBTAINING DECISIONS ABOUT TREATMENT OPTIONS

Presenting treatment options should flow from the appropriate application of the preceding steps.3,4 The medical director should help ensure that the attending physician and staff clarify relevant treatment options for substitute decision makers, including risks and benefits.

This case was referred to the facility Ethics Committee primarily because of the issues surrounding the use of the lap belt. The family was inclined to approve of the use of the device, while the staff believed that the device was not warranted, but were nonetheless ambivalent about its discontinuation.

As always, the medical director can help by ensuring that the staff, physician, and primary decision maker are aware of the evidence regarding various options. In this case, for example, devices may not protect against falls but may be associated with serious injury. And, the liability for nursing facilities is apparently greater in case of an injury associated with the use of devices than in case of a fall associated with not using them.

SUMMARIZING THE ISSUES

The case of Mr. N. exemplifies everyday ethical issues in nursing homes, not necessarily associated with end-of-life situations. It is important to recognize that the same care processes and ethics decision-making steps are involved in all these situations. The medical director should help ensure that the facility follows a systematic approach to decision making.

REFERENCES