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Family and Emergency Decision Making in Noncompetent Very Old Patients

To the Editor:

In the Emergency Department (ED), physicians frequently must make critical medical decisions with close relatives without direct input from the patient.1 The medical, legal, ethical, and psychological issues involved become more and more complex and challenging, in consideration of the increased number of elderly patients with impaired cognitive function admitted to ED.2

We report here 2 cases of 97-year-old men with impaired independent decisional capability, recently admitted to our ED, as an example of the lack of support given from the family in the decision-making process of critical medical conditions.

CASE 1

The patient had a history of congestive heart failure (CHF) owing to ischemic heart disease, hypertension, definitive pacemaker, chronic obstructive pulmonary disease (COPD), mild chronic renal insufficiency, iatrogenic hypothyroidism following use of amiodarone, and prostatic hypertrophy. He reported frequent hospitalizations because of CHF relapse following use of amiodarone, and prostatic hypertrophy. He had a history of congestive heart failure (CHF) owing to valvular disease for severe aortic stenosis, secondary pulmonary hypertension, permanent atrial fibrillation, and symptomatic prostatic hypertrophy. These diagnoses were made 1 month earlier, during the first hospital admission of his life. A partial predmission disability (Barthel index 75/100, IADL function lost 4/5) had been reported. Admission to our hospital ED was related to a coma condition following pneumonia and acute coronary syndrome with subsequent multiorgan failure and altered coagulation. At admission family members were unaware of the patient’s prognosis. No indications suggesting the intensity of care were given to physicians.

We report these 2 cases in order to discuss the role of families in the therapeutic decision-making process when patients are unable to express their choice.

Ethical guidelines suggest that both physicians and surrogates can make decisions in accordance with the patient’s prior wishes, if any, and with the patient’s best interest.3 Using this framework, a surrogate is generally asked to make a decision for the noncompetent patient and to address the patient’s choice. Along this line, it is important to determine the accuracy of the family’s awareness on both the prognosis and the actual medical condition. In the 2 cases reported, family members did not show adequate perception of the actual clinical situation, and they were unable to provide directives. In particular, in Case 1 they have shown a contradictory attitude: the repeated resuscitation maneuvers at home apparently contrasted with their statement against “aggressive therapy” in ED. In Case 2, inability to suggest any behavior according to the patient’s health condition left physicians “alone” in building the complex emotional and clinical process of establishing a plan of care.

In our opinion, many ethical dilemmas arise because of the inadequate patient-clinician communication. General practitioners (GPs) do not commonly make families aware of the possible (“natural”) occurrence of death in a very old relative. Therefore, without adequate counseling, families are unlikely to realize evolution of diseases and the patient’s risk of death at this stage of life. Effective communication is an important feature in the art of medicine and is a clinician’s duty. GPs have peculiar responsibilities toward very old patients and their families given the high probability of encountering difficult decisions during emergencies.

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