New Problems in Medical Ethics

What to do with a sick elderly woman who refuses to go to hospital

The problem

Dr S J Harris wrote posing the following problem. An 84 year old woman lives alone and, with support from relations who live nearby, apparently copes. She has always rejected help from the professionals—that is, such services as home help, meals on wheels, day centre attendance. Over a period of about a week she becomes increasingly confused. She becomes dehydrated and takes to her bed. The precise cause of the confusional state eludes physical examination, and it is thought appropriate to admit her to an acute bed in a medical unit for expert urgent assessment by a physician who can order immediate investigations as required. Admission is arranged by the general practitioner, but when the ambulance arrives at the patient's home she refuses, despite persuasion, to get on board. It is thought likely that she will not survive the next two days unless she receives attention in hospital. What appropriate steps can be taken to manage her condition?

A general practitioner, a community physician, a professor of psychogeriatrics, and a consultant in geriatric medicine each offered a solution.

The general practitioner's response

A chess player plans his next move and overall strategy in the light of his present position, the relative strength of his pieces, and the weakness of his opponent's defence. The scenario gives us little such information. We simply know the Queen is in mortal danger and will not move.

In practice I will have overall knowledge of this lady's medical, mental, and social background and will have established some sort of relationship with her, however tenuous. With the advantage of such information I would be most surprised if I could not cajole or coerce her into hospital, though I might enlist additional support from a relative or confidant in my attempts at persuasion. In many years of practice, with an above average elderly list, I have yet to resort to compulsory admission in similar circumstances and have encountered only one such case in my role as a hospital practitioner in geriatrics.

Let us assume, however, that she remains adamant and resolute. The inference is that she is suffering from an acute confusional state, and I would question the absolute necessity for admission on the grounds of investigative procedures as most of these could be carried out at home. Infection of the urinary or respiratory system is high on the list of probabilities, and I would consider prescribing a suitable antibiotic. A list of the causes of acute confusion is not appropriate here, but obviously drug toxicity and depression would have to be excluded. Domiciliary consultant advice might be necessary.

Clearly dehydration is the chief concern. Intravenous treatment is impractical, and an adequate oral fluid intake, monitored by her nursing attendants, is essential. Round the clock supervision is necessary. I would make a complete reappraisal of the situation within 12 hours. If fluid was being refused and she still would not reconsider admission I would regretfully bring this about under the proviso of the 1983 Mental Health Act.

A consultant colleague (Dr P Robinson, Shotley Bridge General Hospital) points out that the patient is likely to be admitted to a psychiatric hospital, whereas ideally she should be admitted to an

acute psychogeriatric unit in a district general hospital, which would have the facilities for performing the requisite investigations. As we know, there are few such units.—J A C HEPBURN

The community physician's response

Dr Gray responds as if he were dealing with a real case and was writing to the general practitioner.

Thank you for asking me for my opinion on this lady. As you said she is suffering from a potentially fatal condition and one feature of this is that she has a toxic confusional state and is incompetent to make decisions about her treatment; thus posing a problem. From discussion with her relatives it appears that she gave no clear guidance as to what she would like done were she to become incompetent and seriously ill, and we therefore have to base our decision on what is known about her attitudes to the services she has been offered in the past. On the basis of these attitudes we may infer that she would not wish us to be overenthusiastic in intervening, but this is only inference and is not based on her stated wishes.

I discussed with her relatives the possibility that they take powers of guardianship, but neither they nor the social worker thought that that was an appropriate step to take. The possibility of using section 47 of the National Assistance Act was also raised by the general practitioner, but section 47 allows only removal and not treatment against the patient's wishes, and, if we work on the assumption that this lady is refusing both admission and treatment, we would not be able to start treatment by using section 47 even if we were to remove her from her home and admit her to hospital. I am therefore of the opinion that we should consider that she has a terminal illness and has asked the domiciliary nursing service to provide as much care as they can to allow her to die in comfort in her own home. Her relatives state that they think that this is what she would have wanted and, provided that they can be given adequate help, wish to care for her at home.—J A MUIR GRAY

The psychogeriatrician's response

More often than not the combined persuasive powers of the relatives, the general practitioner, and the ambulance men will solve the problem. If not there are legal, quick, and effective ways of ensuring that the patient gets the medical and nursing care she needs. Though the patient has prided herself on doing her own housework and cooking, this does not mean she does not want treatment for grave physical illness. Concentrating on the practical rather than the philosophical aspects of the problem I can suggest two options.

Option 1—Acute confusion is a mental illness, and, because of the probability of death without hospital treatment, the patient would satisfy the criteria for compulsory admission under section 2 of the Mental Health Act, 1983. Ideally, the general practitioner should ask his local psychogeriatrician to see the patient for a second medical recommendation. The psychogeriatrician will be approved under section 12 of the Act as having "special experience in the diagnosis and treatment of mental disorder." If such a person cannot be found, however, an emergency admission under section 4 is appropriate. In this case only one medical recommendation is

necessary—that of the general practitioner—and the application should be made by an approved social worker or the nearest relative. In other words, if an approved psychiatrist cannot be found, the general practitioner should admit the patient under section 4 using the social worker or nearest relative to fill in the application on his recommendation. Note, however, that: (1) Patients admitted under section 4 can be treated in general hospitals in medical beds; this patient would clearly be inappropriate for psychiatric care. (2) An emergency admission expires after 72 hours unless an approved psychiatrist has seen the patient and given a second medical recommendation within that period. (3) In practice a patient rarely asks to leave hospital if treated with kindness and care.

Option 2—Section 47 of the 1948 National Assistance Act allows the compulsory removal to hospital of physically ill persons who are unable to receive proper care at home. Local practice is often determined by the attitude of the community physician (the “proper officer”) as it is on his opinion that the section is followed. An emergency removal for three weeks is made by the community physician, the general practitioner, and a magistrate. The British Geriatrics Society guidelines specifically include acute confusional states secondary to physical illness as being within the province of section 47 but recommend that all patients should be seen by a geriatrician.

In my experience it is difficult to invoke section 47 and attempt to muster help quickly from the community physician and a magistrate when a patient needs immediate attention. Section 4 is quicker, easier, and safeguards the patient’s right of appeal. Let us hope that the patient has pneumonia and that after 48 hours of amoxycillin she will be on the way to recovery—home again next week and probably still refusing home help.—ELAINE MURPHY

The geriatrician’s response

An old lady who lives alone and has become confused and unwell and refuses to go into hospital needs to be assessed in detail by a geriatrician who is prepared to go to see her at home. He should take with him a nurse from his assessment unit as this is reassuring for the patient, useful in practical terms (help with examination and simple supportive nursing to establish goodwill), and may even pave the way for eventual admission (“If you come into the ward, we will look after you”).

Specialist domiciliary assessment may uncover one or more diagnoses not picked up by the presumably non-specialist referring doctor. Clinical assessment can be supplemented by routine investigation (haematological, clinical, chemical, and bacteriological) and also by domiciliary x ray examination—for example, of the chest—and electrocardiography. With such information available, the uncertainties of this difficult and unusual case will have diminished considerably and some sort of link will have been established with the patient in the security of her own home. The commonest causes of such a presentation (respiratory and urinary tract infections and drug effects) can often be managed at home. The efforts of the

family can be supplemented, if the family is willing, and willing for the duration of illness to override the old lady’s previous objections, by the services of the district nurse.

If, as is not unlikely, a firm diagnosis of terminal illness is made there is no reason why this lady should not be allowed to die at home. Again, comfort and dignity could be ensured by the family and the district nurses.

The old lady has every reason to be suspicious about the appropriateness of hospitalisation. Many old people are admitted to hospitals and subsequently do not receive any medical or nursing care that could not reasonably have been delivered at home.¹ Various schemes of intervention to prevent unnecessary hospitalisation in such cases have been reported.^{2,3} In our own series one of the most seriously ill patients was one who had refused hospital admission.² He subsequently did very well.

The case as presented neatly exposes the tendency of hospital based medicine to do either too little for people at home or too much for them in hospital. A flexible and sensitive series of responses, ranging from initial specialist assessment at home in collaboration with the general practitioner to the provision at home of almost all the essentials of hospital care for the elderly, would make life easier both for patients like this and for those who care for them. Unfortunately, non-routine responses demand energy, initiative, and time, much of it spent in communication with the various family members and professionals involved. As this lady’s life is, however, at risk and the standard NHS menu is unacceptable to her a more imaginative *à la carte* alternative can and should be offered.—COLIN T CURRIE

Authors

S J HARRIS, MB, MRCPsych, is a consultant psychiatrist and lecturer in psychiatry of the elderly at High Royds Hospital, Menston.

J A HEPBURN, MSc, MRCP, is a general practitioner in Newcastle upon Tyne.

J A MUIR GRAY, MB, DPH, is a community physician for the Oxfordshire Health Authority, Oxford.

ELAINE MURPHY, MD, MRCPsych, is professor of psychogeriatrics at Guy’s Hospital Medical School, London.

COLIN T CURRIE, MB, MRCP, is a consultant in geriatric medicine at City Hospital, Edinburgh.

References

- Currie CT, Smith RG, Williamson J. Medical and nursing needs of elderly patients admitted to acute medical beds. *Age Ageing* 1979;8:149.
- Currie CT, Burley LE, Doull C, Ravetz C, Smith RG, Williamson J. A scheme of augmented home care for acutely and subacutely ill elderly patients: report on pilot study. *Age Ageing* 1980;9:173-80.
- Gibbens FJ, Lee M, Davison PR, et al. Augmented home nursing as an alternative to hospital care for chronic elderly invalids. *Br Med J* 1982;284:330-3.

WORDS PORTER Everyone knows what a porter is, and every doctor presumably knows what a hospital porter is. But did you know that there are two sorts of porter, not merely etymologically, but also in practice? There is the gate keeper porter (L *porta*, a gate or door) and the load bearing porter (L *portare*, to carry). It is by pure coincidence that these two unrelated roots have joined to give us the same final derived English word. Such is the power of words that, in hospital administration, this unification of terms has enforced a unitary staff structure. Both types of porter come under the single authority of the portering manager; thus the distinction becomes blurred. Yet the functional distinction remains. The duties of the gate porter comprise custody of the keys, dealing with inquiries, directing members of the public, maintaining a patient register, and ordering hire cars for staff and patients. He is sited at or near the public entrance door. In a lower grade (except for x ray and pharmacy porters) they are the load bearers or pushers. They convey patients by wheelchair, stretcher, or bed,

including those on their final journey to the mortuary; they also deliver laundry, stores, meals, furniture, etc. While it is clear beyond doubt that the porter in a railway station (if he is not by now an extinct species) is a load bearer, the porter in a block of flats is by contrast in an ambiguous position. He usually regards himself as a gate keeper and a cut above the load bearer, and much embarrassment could be avoided if the distinction were clarified to visitors. “Oh no, madam, I don’t carry luggage!” In American English he is called a janitor (L from L *janua*, entrance door), but despite the terminological distinction, he is likely to include load bearing among his duties. Hospital administrators will not be troubled by linguistic hair splitting. Yet at King’s College Hospital, London, the “problem” recently ceased to exist. The gate or front hall porters were removed from their location and were replaced by lady receptionists.—B J FREEDMAN.