

MORE COMPLEX CASES FOR ADVANCED DISCUSSION

Case Study 1

Previously, Mr A, a Yugoslav migrant with very little English, had been admitted to a local hospital for investigation of chronic headache. He was still employed and had no other symptoms. Investigation yielded the diagnosis of a malignant brain tumour. Upon surgical examination it was decided that an attempt to remove the tumour should be made and this was done. Following the operation Mr A had lost much of the use of his left side and was virtually immobilized.

At the time of the diagnosis, the existence and malignant nature of the tumour had been explained to Mr A's wife and to his adult children and the family's consent had been obtained to perform the operation after an accurate account of the risks, possible benefits and prognosis had been given to them. Mr A's wife had persuaded the health care team that he should not be told of the cancer. She expressed the opinion that he would lose all hope were he to be told, as a friend of his had died of cancer and he had a great fear of it.

Consequently, in spite of the fact that Mr A was a competent adult, an instruction had been made in the medical notes, "Do not discuss diagnosis or prognosis with this patient." At no time had Mr A's consent been sought, the family had made all decisions concerning his welfare, and his English language difficulties had prevented him from taking control of his own circumstances.

Following the surgery, Mr A was treated with radiotherapy and chemotherapy. The family consented to treatment, at each stage, on his behalf.

Five years later, aged sixty seven, Mr A was admitted to the home for the aged for respite care. He had refused to be re-admitted to the local hospital which had been responsible for his management for that five year period.

On admission his doctor at the hospital had given a written instruction not to discuss diagnosis or prognosis with Mr A. Following his admission, the nurses responsible for his care expressed concern about this restriction.

He was, in fact, a very angry man and deeply distrustful of all health professionals, for, not having been told of the cancer, he believed that he had been operated on originally to "to cure his headache", and the surgeon had made a mistake and "damaged his brain".

Not being permitted to discuss diagnosis and prognosis with him, the nursing staff and other carers tend to avoid communication with him, even though they spend a great deal of time manually feeding him.

His wife now admits that he should have been told in the first place, but continues to refuse to allow matters to be explained to him. In fact, while knowing the truth, the family reinforces Mr A's mistaken belief that his condition was a result of a surgical mistake.

Five years of deception could not easily be undone, for the relationships with his family and the health care teams depended on it.

Discussion Questions

Identify the range of ethical issues involved in this case and the ethical protocols in this Handbook which might be thought to apply.

At the time when the original surgical procedure was carried out what duties did the operating physician have to Mr A?

Given the duty of disclosure what now should be done to inform Mr A of his current condition and prognosis?

What should be done about his relationships to his family and the effect that fully informing him would have?

Does the nurse have a right to override the decision of the resident's family or the decision of the resident's doctor?

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Case Study 2

Mrs B, a seventy year old living alone, was brought to hospital by ambulance in a comatose state. A neighbour, alerted by the uncollected newspaper at her door, found her in bed, an empty bottle of sleeping pills beside her. This is the fourth occasion Mrs B had overdosed in an apparent attempt to end her life since the death of her husband the previous year.

Mrs B is now in intensive care with fairly good prospects of recovery. The health care team has responded to her circumstances by making every attempt to save her life and have succeeded this time.

The hospital is seeking to have Mrs B admitted to the home. On assessment, Mrs B has some urinary incontinence and is suffering from malnutrition.

Discussion Questions

Is Mrs B an appropriate candidate for admission to an aged care home? What factors would apply?

Would it be an issue of disability discrimination for the home to refuse admission on the grounds that she has a psychiatric illness?

If Mrs B is admitted should special arrangements be made to prevent further suicide attempts especially in relation to her having control over her own medication?

What specialised assistance should be arranged for Mrs B?

Given that Mrs B's mental state may be related to her physical condition, what obligations are there to assess and treat her malnutrition and incontinence?

Should treatment of her malnutrition be carried out against her wishes?

What consideration should be given to her grieving state?

If Mrs B attempts suicide again should there be life saving intervention?

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Case Study 3

Mr C, who has been a resident of the home for some months and has problems with alcohol, went missing and was subsequently brought to the casualty department of the local hospital in an intoxicated state and suffering the effects of exposure. He was discovered sleeping under a tree at the roadside by a policeman.

He is washed, bedded and the process of drying out is begun. Predictably, he will voice loud protests about being restrained and denied alcohol. The home expects him to be discharged from the hospital back to the home.

Discussion Questions

Does the fact that Mr C is an alcoholic mean that he is incompetent?

Where could Mr C, an elderly alcoholic, be referred for detoxification under medically supervised conditions?

If there is no place what obligation does the home have to receive him back?

If the home receives him back does it have the right to take steps to prevent him from drinking or leaving?

Should the home seek representation for Mr C?

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Case 4

Mr D is eighty years old and suffers from dementia. He has had a guardian appointed who was his wife at the time and some fifteen years his junior. Mrs D, a former nurse, was appointed guardian at a time when there was some conflict between her and Mr D's adult children by an earlier marriage. Mr D's children had contested her representation of him.

Mrs D has since entered into a new relationship. She and her new partner live in the house that is jointly owned by Mr and Mrs D. Mrs D continues to visit Mr D once a week, or so. He is able to recognise her and they talk, but the conversation is mostly recall of past events. Mr D is quite confused about time and place. Mrs D has given instructions that he is not to be given any medical treatments. In particular, she states that he is not to be treated with anti-biotics, nor to be given the influenza vaccine and the anti-hypertensives that his doctor advises should be administered. In the event of a cardiac or respiratory arrest, he is not to be resuscitated.

Discussion Questions

Identify the range of ethical issues involved.

To what extent are the staff compelled to comply with Mrs D's directions?

Should the staff intervene?

Should they seek to have Mr D's representation reviewed?

Is what is being required by Mrs B euthanasia by neglect of reasonable care?

What is the responsibility of the home with respect to preventing euthanasia?

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Case Study 5

MR E is a retired computer scientist who suffers from Parkinson's disease. By day he relates normally and courteously to staff and residents and spends much of his day playing chess or cards with friends. By day he is slow but not demented, following the daily news and able to discuss present events intelligently. He was admitted for respite and assessment because his wife, who has advanced cardiac disease, could not cope with his care. The main problem is his night time behaviour. He gets out of bed at night and wanders about making loud conversation with himself, opening and shutting windows and invading the rooms of others to do so. Sedation at night has been discussed with him but he refuses, saying that he sleeps quite well. He either has no recall or he is denying the night time behaviours. When he was at home with his wife, she complained about him getting-up in a similar way, attempting to make the bed, with her in it, and vacuuming the carpets and mopping floors in the early hours of the morning.

Discussion Questions

After his assessment would a case conference be warranted?

Would it be permissible to sedate him against his wishes?

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Case Study 6

Mrs F has been a devotee of natural remedies for many years. Recently she was diagnosed with cancer and refused medical treatment and, instead, resorted to very high doses of vitamin C and some other preparations given to her by her naturopath. The disease has progressed and the naturopath has prescribed an infusion of urine from pregnant women, which the naturopath is able to supply. The naturopath administers this intravenously. Undergoing this treatment, Mrs F becomes particularly smelly. The nature of the treatment also makes the nursing and other staff very uncomfortable and concerned for Mrs F's welfare.

Discussion Questions

The staff is not directly involved in Mrs F's treatment. Do they have a right or an obligation not to intervene?

Should the staff ascertain whether Mrs F is aware of the impact on others of this treatment?

Is it reasonable for Mrs F to undertake such treatment in a home?

Does Mrs F have obligations to the staff and other residents in her undertaking such a treatment?

Would the home have an obligation to assess whether the treatment is harmful to Mrs F?

Does the home have an obligation to see that Mrs F is fully informed about the procedure?

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Case Study 7

Ms G, a registered nurse, has recently been employed by a nursing home. The home has a secure wing for residents suffering from psychiatric illnesses. The secure unit has a firm policy that no residents admitted to the unit will be resuscitated in the event of an arrest.

Discussion Questions

Identify the ethical issues involved in this policy.

What ethical obligations does the nurse have to make this policy known to those in authority in the home?

If the home refuses to revise the policy does the nurse have an obligation to seek such a revision beyond the home? If she does, to whom can she turn?

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Case Study 8

Dr H has two long term patients, Mrs J and Mrs K, who have recently been transferred to a new home after the previous home had closed after failing to meet the standards. In the previous home, they had been happy and enjoyed what were pleasant circumstances. Much of their day outside meal-times had been spent in a sun-room overlooking a well-kept garden that received morning sun and attracted many birds which the staff encouraged by filling a bird bath and spreading bread crusts on the lawn. On fine days they would sit outside.

In the new home, both of Dr H's patient have become quite despondent. Their chief complaint is that though the staff is better qualified there are fewer of them. Most of the residents' day is spent sitting at the dinner table inside, with no aspect. After meals the table is cleared for other activities and there is a television. Apart from going to the toilet, or returning to their own beds, it seems that they spend their entire day at the dining table.

Discussion Questions

Does Dr H have obligations to seek to intervene with the provider?

Does he have obligation to go beyond the home in the event of an unsatisfactory response to his intervention with the home?

What ethical responsibilities does the nursing staff have in this situation?

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Case Study 9

Ms Q (a personal carer) appears to pay a great deal of attention and is judged to “flirt” with the son of Mrs T when he visits. Mrs T’s daughter-in-law has mentioned this to other staff in a “joking” way. Staff reports that they are concerned for the good reputation of the home and about the conduct of Ms Q. Staff state they are embarrassed as well as being irritated particularly since Mrs T is unwell and currently quite confused.

Discussion Questions

What should the staff do in the first instance?

How would this situation be investigated?

If the situation exists (as reported by the staff) how would it be resolved?

What information could be provided to staff, residents, and/or their support persons to prevent such a situation arising?