Medico legal problems: Group workshop (tables 7 & 8)

Instructions

Outcome - **Tables 7 & 8 consider what happens when an older person runs into medicolegal issues. What do you do?**

Table 7 – **Mr Jones - relative insists on hospital** (discuss for 15 minutes)

Table 8 – **The demented driver** (discuss for 15 minutes)

The two groups then combine and collaborate to compare notes in order to do a (not longer than) 5-minute presentation at the end on how doctors and patients deal with <u>Medico legal issues in the elderly</u> and what it means to you.
This isn't about right or wrong answers in terms of management, much more about the patient's family's and your attitudes and feelings.

The presentation can involve all or just a few of you – can just be a summary of your discussion or innovative and entertaining. The Aim is to educate the res of the audience quickly

(If you have time to spare and you will have a total of an hour in total – go back into groups and discuss the other cases).

The material is on subsequent pages but don't feel you have to include this, think globally, think about your own families, young and old. Think about your own experiences and stories too.

You are called to a nursing home to see an elderly man, Mr Jones with a chest infection.

In his care plan, it states he would like to be cared for at the home and that he would not like to be transferred to a hospital should he fall ill.

After reviewing him, you note he has severe pneumonia and is at risk of death. His daughter is present and comments on how confused and breathless he is.

You explain that he needs intravenous antibiotics and oxygen in hospital but unfortunately his care plan states that you have to treat him in the nursing home, which does not have the facilities for oxygen or intravenous drugs.

She objects to this and, despite the care plan, insists he is transferred to hospital.

What are your options?

Some answers below (try not to cheat too soon)

Opinion on table 7 – Mr Jones case

GP's view - Dr Dan Bunstone is a GP principal in Cheshire The three key issues for consideration are the clinical need to treat the patient, the patient's wishes and the current wishes of the family. If the patient has made a previous advanced directive while fully competent to do so, then this would be my primary consideration.

I would like to know how and when the directive was made and if the patient had capacity to make the decision at that time. Did they really mean they wanted to be left to deteriorate with a potentially curable illness, or did they perceive this directive to apply for something more serious such as terminal stroke or cancer care? If we believe the directive was made with full understanding and capacity, then the patient's wishes need to be observed. The daughter will be angry, and will instinctively want to do all that she can to keep her father alive. I would invite the daughter to discuss the situation, and where possible to involve other family members. My aim would be to reach a common decision with which everyone is happy.

If there continues to be conflict and no resolution achieved, we could apply to the court for a decision to be made. This is a tricky and not uncommon problem we encounter. It highlights the problems of advanced directives and the importance of next of kin being involved.

A medico-legal opinion - Dr Pallavi Bradshaw is a medico-legal adviser for Medical Protection Society

This scenario is not uncommon and many GPs will find themselves in similar situations. It is important to remember that your primary duty is to your patient.

There are many complex legal and ethical issues related to autonomy, capacity and consent. Case law, statute (Mental Capacity Act 2005 and Adults with Incapacity Act 2000) and GMC guidance are increasingly emphasising a patient's right to determine their treatment.

The patient appears to lack capacity but you should confirm this formally and document your findings. The care plan states the patient's wishes, but it is unclear whether this life-threatening situation was ever contemplated. Further, you should bear in mind how long ago the care plan was made and whether there is any indication that his views may have changed or that he lacked capacity at the time of those discussions.

As you are unsure about these aspects and in the absence of a lasting power of attorney or welfare attorney you should act in the patient's best interests.

You should take into account the clinical aspects, the patient's known views, values and beliefs and indeed the daughter's concerns. If you are uncertain about the clinical assessment you should request a second opinion and ensure you keep detailed records of the decisions taken.

A patient's view - Danny Daniels is an expert patient Personal care plans are packages of care that are personal to the patient.

It involves working with professionals, who understand their needs, to agree goals, the services chosen, and how and where to access them.

There appears to be three main questions that arise:

1. Is the care plan valid and was it arrived at using a designated code of practice and co-signed and witnessed?
2. During the process of completing the plan, were the implications of possible refusal of hospital treatment in the future explored in depth?
3. Does the patient's present capacity to understand override his previously expressed wishes?

The GMC guidelines are comprehensive and give valuable indicators on what actions the clinician should do in such circumstances. Their online guidance sections 75-79 are particularly helpful.

The Mental Capacity Act 2005 section 4 is also an applicable reference, particularly in terms of the patient's capacity to understand in his present condition.

On one hand we have the daughter who would like to see her father's health improve. And, on the other, we have the clinician following the wishes which were previously expressed when the patient was cognisant.

This is a difficult situation for the GP to be in.

Table 8 . material

The Dilemma - You have been the GP to an elderly couple for over 20 years. The wife is disabled by arthritis and the husband has been slowly developing dementia. They never ask for a home visit as he always drives her to the surgery. While giving them the annual flu jab, you realise that his dementia has progressed and he no longer knows your name. As they go to leave the room you realise he is still driving. There is no record of anyone telling him to inform the DVLA.

What will you do?

A GP's view - Dr Barney Tinsley is a GP partner in Yorkshire

Driving ability is very difficult to assess in patients with any degree of memory impairment or dementia. The guidance from the DVLA states that 'Those who have poor short-term memory, disorientation, lack of insight and judgment are almost certainly not fit to drive.'

Firstly, don't let them leave the consultation just yet. It would appear that the husband has not had a formal assessment of the severity of his dementia, although the snapshot of his condition during this consultation shows that his short-term memory might be significantly impaired. It is difficult to make a potentially life-changing judgment based on this alone.

The GP could perform a mini-mental state examination or abbreviated mental test score on the patient. Anecdotal information regarding his memory and day-to-day activity from his wife would also be of use.

It may be useful to take advice from the on-call elderly medicine registrar regarding the patient's driving, which the GP could relay to both the husband and wife during this consultation.

Common sense might dictate that we would strongly recommend he should not drive from then on, until further assessment is performed, and the husband should be given the chance to stop driving voluntarily from that point. This is unrealistic, especially as they need to get home from the surgery.

If the patient does lack insight and short-term memory, he is unlikely to usefully retain this information; a home visit or phone call later in the week to the patient's wife to ask whether he remembers the conversation, or to check whether he has continued to drive is in the best interests of the patient and other members of the community.

The DVLA has a team of experienced medical advisers who can be consulted via telephone to help with the advisory process; it may be that this patient needs its formal intervention with deciding whether he is fit to drive, which would most likely be after he is formally assessed via secondary care. If this patient does continue to drive, it is ultimately the GP's duty to inform the DVLA about this.

In addition to this driving dilemma, is the issue of this couple's continuing ability to cope in their own home, should they be unable to continue using a car. With the couple's agreement, referral to the community matron and/or social services might be useful to explore home care, meals on wheels, access buses, day centres and occupational therapy assessment for the home.

A medico-legal opinion - Dr Angelique Mastihi is a medico-legal adviser at the MPS

The transport secretary acting through the medical advisers at the Drivers Medical Group, DVLA, has the responsibility to ensure that all licence holders are fit to drive.

The regulations apply to all drivers and they have a legal obligation to inform the DVLA if they suffer from one of a specified list of conditions, which may affect their ability to drive. If a doctor suspects that his patient has not informed the DVLA of a medical condition he must inform the patient of their legal duty to do so.

In this case there is no record of the doctor advising his patient to contact the DVLA at an earlier stage of his dementia. What is now paramount is that the doctor advises the patient that he should no longer drive. It appears possible that the gentleman is now no longer in a position to advise the DVLA himself.

Therefore the doctor should inform the patient that he will take steps to notify the DVLA. This conversation should be documented in the record and a letter sent to the patient confirming the action taken.

It may be that the patient is no longer in a position to consent to the disclosure of this information to the DVLA. However, in line with the recent GMC guidance 'Confidentiality', the information can be disclosed in the public interest in order to protect both the patient and public from serious harm. It would also be good practice to involve the patient's wife.

A patient's view - Elizabeth Brain is a member of the RCGP patient partnership group

Firstly, you must inform the husband of what he is legally obliged to do and secondly, for your own integrity, you should record that you have done so. Clearly, a probable cessation of driving will have a major impact on their family life, but the absence of surgery visits can be mitigated by home visits.

It is a legal requirement for a dementia sufferer to advise the DVLA as soon as dementia is diagnosed. In return, it will write to the person and seek their permission to contact their GP and discuss the extent of their condition.

Depending on the information received, the DVLA may allow him to continue to drive or may ask for a driving assessment. The patient, if able, should also advise his insurance company as his policy may become invalid.

The absence of any record of the above advice is unfortunate but does not preclude a record being entered once the advice has been given.