ETHICAL AND DEONTOLOGICAL ASPECTS OF PALLIATIVE CARE IN GERIATRIC PATIENTS IN ROMANIA. CASE REPORT

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ETHICAL AND DEONTOLOGICAL ASPECTS OF PALLIATIVE CARE IN GERIATRIC PATIENTS IN ROMANIA. CASE REPORT (Abstract): We present the case of an 82-year-old female patient with a personal history of hypertension and diabetes, who presented to the emergency room for marked physical asthenia, loss of appetite and diffuse abdominal pain with onset about a week earlier. Recent history showed that she suffered a same-level fall in the past 24 hours, and was unable to get up from the floor where she had laid for several hours. On admission, the patient complained of severe diffuse osteoarticular pain that kept her in bed; she also complained of lower abdominal pain on superficial and deep palpation that proved to be a urinary tract infection. She was dehydrated and anemic (Hb=7.3 g/dL); she was depressed and very anxious to get home as quickly as possible. The therapeutic approach was focused on the prompt correction and the thorough investigation of the severe anemia syndrome, the complex therapy of osteoarticular pain, and prevention of the complications of immobilization syndrome. Despite patient’s wish that multiple and complex investigations not to be conducted and to be discharged from the hospital and go home, the family strongly insisted to continue searching, no matter what, for the causes of anemia with the purpose of prolonging her life, but with very poor outcome on patient’s quality of life. With no specific laws concerning the respect for patient’s wishes, the medical personnel had very little to say in this matter, even if we watched the decline in her quality of life with every day she spent away from home. Keywords: PALLIATIVE CARE, ELDERLY AUTONOMY, FAMILY SUPPORT.

In recent years, the dramatic fall in birth rate, along with the aging of the population and the increasing number of chronic patients has led to an increase in the needs for specific care.

In Romania, isolated initiatives draw attention to the continuous increase in the needs for special care to be provided to elderly patients with severe chronic diseases or disabilities who can no longer take care of themselves (1).

While performing the medical act, the medical team must meet the patients’ needs to be informed, to be understood, to be respected, to be helped to reduce anxiety, to feel safe, to be independent, to preserve their dignity and finally to help relieve their pain (2).
Autonomy is a person’s right to self-determination, independence and freedom. It is not just the right to self-determination and treatment of the body; it also implies the right to receive any information regarding himself/herself, his/her way of life and health, the right to decide to whom some of his/her personal, sacred data can be entrusted; these are an integral part of the meaning of self and identity. Knowing personal information about someone can play an important role in procuring the sense of security, freedom and self-esteem (3).

When the patient refuses treatment or any investigation, it is considered that his will prevails over his health.

The legal framework in Romania (Law No. 46/2003 on the Patient’s Right, updated in 2017, Article 13) grants the patients the right to refuse or discontinue medical treatment, assuming responsibility for their decision, in writing, as long as they are well aware and show no loss of judgement (4). In practice, the conduct in such cases is slightly different. Often the caregivers are the ones informed and involved in treatment decisions making in an attempt of either to protect the patient emotionally or due to the pressure (often becoming threats) exerted by caregivers.

CASE REPORT

We present the case of an 82-year-old female patient, living in an urban area with her husband whom she cared for as he was suffering from a major cognitive impairment (vascular dementia), she herself finding it difficult to move around and receiving help from a nurse with some daily activities. She was known to have a history of cardiovascular (hypertension, angina, and degenerative aortic stenosis) and metabolic (type 2 diabetes treated with medication and complicated by peripheral sensory polyneuropathy) diseases, and recurrent urinary tract infections.

She was hospitalized for significant physical asthenia, loss of appetite, diffuse abdominal pain going on for about a week and severe polyarticular pain which did not allow her to move. From her family’s (her sister) statements it came out that the patient had suffered a same-level fall 24 hours previously, without the possibility to get up from the floor, where she was found the next day by her caregiver.

At the time of admission, the patient was in altered general condition, conscious, cooperative, with difficulty in moving around due to the post-traumatic pain, dehydrated, with pale skin and multiple bruises on the upper extremities. Cardiovascular examination revealed rhythmic heart sounds, systolic murmur in the aortic outbreak radiating to the carotids, normal blood pressure. Also noted was the abdomen increased in volume due to panniculus adiposus, with lower abdominal pain on superficial and deep palpation.

**Biochemical findings showed multiple concomitant medical conditions:**

a. Severe anemia syndrome, normochromic, normocytic (Hb = 7.3 g/dL), non-regenerative (reticulocytes = 11,377/mm³), with low serum iron and increased ferritin levels. Considering that in evolution we recorded a drop-in hemoglobin of 1.0 g and the presence of blood in her stools, we interpreted it as an episode of melena, possibly due to a digestive cancer. We explained to the patient and her family that an endoscopy (upper and lower) would be required, investigation refused by the patient, but her family strongly pressed for it. Given the mixed nature of the anemia
(malnutrition + inflammatory syndrome), the therapeutic management was complex, targeting the correction of Hb by administering blood transfusion, iron based medication and dietary supplements.

b. **Urinary tract infection** with *Klebsiella pneumoniae, Candida spp.*, with multi-resistant germs and unfavorable progression towards sepsis despite the complex antibiotic treatment. During hospital stay, probably due to bed immobilization and diabetic neuropathy, she developed acute urinary retention which required urinary catheterization and highly contributed to the negative development of sepsis and decline in her quality of life and self-esteem.

c. **Fluctuating blood glucose levels** that required the introduction of low doses of insulin with daily adjustments depending on the glucose profile; the inflammatory syndrome and the depressive syndrome of the patient made her refuse food.

d. **Geriatric evaluation** showed that she was at risk of malnutrition (MNA= 23.5/30), with a minor cognitive impairment (MMSE= 25/30), depressed (GDS= 6/16) and highly dependent on the help of a caregiver.

During hospital stay, she remained confined to bed, resisting all attempts to mobilization, even for personal hygiene. However, with patience and persuasion, we managed to prevent the complications of bed immobilization (daily tapotement, permanent linen change, feeding and hydration with the help of medical staff, regular changes of patient position in bed, etc.); however, due to the increased resistance of the patient to any medical care, after approximately two weeks her general condition deteriorated, she became hemodynamically unstable and was admitted to the ICU department, where she required IOT and mechanical ventilation with positive inotropic support. The invasive maneuvers for endotracheal intubation and urethrov-vesical catheterization led to sepsis with multiple starting points (urinary tract, lungs, skin) and with multi-resistant bacteria. At that point, the medical geriatric team considered that it was time to consider palliation versus extensive medication. The possibility to choose home care, in her familiar environment might have improved communication and patient compliance with the hygienic, dietary and drug treatment (5). However, due to lack of qualified personnel for home care in Romania and patient’s financial limitations, this approach was not an option.

**DISCUSSION**

Given that autonomy is one of the ethical principles involving the respect for the right of every individual to make their own decisions, the patients’ wishes must be complied with if they are of sound mind and they can decide perfectly regarding their last wishes (6).

Thus, the medical staff had to provide the patient with all necessary information for her to make the right decision, to help her understand and apply the decision, in this case being necessary to stop the aggressive investigations and to conduct invasive treatments only with the patient’s approval. In our case, the patient had given her consent to continue invasive investigations because of the pressure exerted by her family, but despite her own wishes. The creed of the medical profession is to ensure the highest possible level of quality of life, especially in the case of terminal patients for which medical interventions have no longer a curative purpose.
The decision made freely by the patient should be checked to determine whether it was imposed by another person, especially by the family, who, besides being a support, must also respect his/her wishes.

In the here reported case, the family permanently refused the patient to be discharged from hospital and cared at home and requested, even claimed sometimes, the continuation of all investigations (including CT with contrast substance) and maneuvers (including admission to the intensive care unit where she was intubated and mechanically ventilated), thus negatively influencing her evolution. In addition, the stress placed on the medical team was significant, caused by confrontations with the patient’s family on the provision of complex care, without respecting her wish and her privacy (7, 8).

Finally, respecting the patient’s autonomy goes hand in hand with human dignity. The law and the society are pro patient autonomy as a human right and as a basic principle in the doctor-patient relationship.

**CONCLUSIONS**

Regardless of the medical decision, the last word belongs to the patient. In our case, despite all efforts to investigate and treat her, the patient wanted to go home, in her familiar environment, to be with her loved ones in the last moments of her life.

The lack of methodology for the enforcement of the laws on patient rights, but also not knowing the components of such laws, makes such situations difficult to manage by the medical staff, situations in which the emotional elements dominate the legal framework, generating the overstepping of attributions and the involuntary exit from this framework.

The fight is between the slogan: “We did everything humanly possible”, a slogan the family relies on, and the motto “Respect the wishes of the loved one and who is ready to leave from amongst us”.

**REFERENCES**