

Ethical Considerations of Withdrawal of Care Due to Altered Mental Status in the Setting of Treatable Organic Cause: A Case Report

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Background: Altered mental status (AMS) in elderly patients is a common but nonspecific presentation, frequently associated with failure to thrive (FTT). AMS may stem from organic causes, such as infection, or from nonorganic factors, including psychosocial stressors. When patients with AMS present conflicting code status preferences compared to surrogate decision-makers, clinicians must balance patient autonomy with nonmaleficence when assessing decision-making capacity.

Case and Course: A 77-year-old man presented with generalized weakness and poor oral intake. His wife reported that the patient would elect a do not resuscitate/do not intubate status as he wishes to die peacefully, while the patient stated a desire for full code status. On arrival, he was somnolent, oriented only to person and place. Workup incidentally revealed a small bowel obstruction (SBO). With the patient's and family's consent, nonsurgical management was initiated using nasogastric decompression and intravenous hydration. Within four days, bowel function and oral intake normalized, and the patient regained full orientation and memory. Upon recovery, he reaffirmed his preference for full code status.

Discussion: This case illustrates the importance of identifying reversible causes of AMS even when the family states the patient's desire to die. Acute illnesses such as SBO can transiently impair capacity, and surrogate reports of prior wishes may not reflect the patient's true preferences. Clinicians should avoid assuming chronic incapacity based solely on baseline cognitive decline and should instead perform a targeted diagnostic workup to exclude acute causes of cognitive decline. Emotional factors, such as a perceived burden on family, may also influence expressed wishes. We recommend integrating the patient's expressed wishes and underlying emotional state into capacity assessment, and, if capacity is lacking, deferring to family preferences while ensuring they align with the patient's known values.

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Background

Altered mental status (AMS) in the elderly is a common chief complaint in the emergency department (ED). Often vaguely defined, AMS encompasses confusion, lethargy, agitation, forgetfulness, misbehavior, and inattention, and with varying chronicity, resulting in a broad differential diagnosis.¹ AMS in the elderly is frequently associated with failure to thrive (FTT), a syndrome that often presents as malnutrition and sarcopenia and may have organic etiologies (e.g., medical disease), or nonorganic causes (e.g., psychosocial challenges or voluntarily stopping eating and drinking).² In some instances, elderly patients with AMS may express a desire to avoid aggressive (or even non-aggressive) interventions, underscoring the importance of engaging in shared decision-making with the patient and their healthcare proxies in order to propose a treatment plan that is aligned with the patient's priorities of care.

Four ethical principles guide modern medicine: beneficence, nonmaleficence, autonomy, and justice. In situations in which patients make decisions that may lead to clinical decline, the principles of patient autonomy and clinician nonmaleficence may seemingly conflict. In reconciling these apparent differences, clinicians must first assess a patient's capacity to make medical decisions congruent with available resources and their current state of health.

Assessment of a patient's capacity to make one decision is separate from their capacity to make other decisions, and each decision should be followed per the principle of autonomy.³

Case and Course

The patient was a 77-year-old man with a past medical history of type 2 diabetes, coronary artery disease status post three-vessel coronary artery bypass surgery, hypertension, myocardial infarction, and urothelial carcinoma of the bladder status post cystectomy and ileal conduit formation, who presented to the ED with generalized weakness and one-week of poor oral hydration and nutritional intake. As the patient was unable to provide a complete history, information was obtained from his wife at bedside, who shared that the patient had experienced progressive decline over several months, with worsening memory, inability to drive or manage finances, and loss of orientation when outside the home. He frequently would forget his earlier meals and friends' names, and in the past week, he had developed fatigue and emesis and was only able to tolerate water orally. He was ultimately unable to shower or dress himself and had stopped taking medications.

His wife could no longer care for him at home, and she subsequently brought him to the emergency department. His orientation was reportedly consistent with his baseline mental status. From the chart, the patient had expressed a desire for a "Do not resuscitate/Do not intubate" (DNR/DNI) status, which his wife reaffirmed. At this time, paperwork showed the wife as the designated power of attorney, empowering her to make all medical decisions if the patient were incapacitated. However, the patient himself stated that he would like to be full code, explaining that he would want all resuscitative interventions performed (ACLS, intubation) if he were to suffer from cardiac arrest. However, his wife stated that the patient would not want *any* significant interventions and rather would like to die peacefully, as per prior conversations between the patient and his wife. She also stated that this patient was currently unable to consent to a code status. On initial evaluation, he was somnolent and oriented only to person and place.

On evaluation for acute etiologies for his mental status changes, he had unremarkable laboratory studies and infectious workup. A small bowel dilation was incidentally noted on chest x-ray, which was followed up with an abdominal x-ray that confirmed the presence of a small bowel obstruction (SBO).

With the consent of the patient and his family, and per recommendations of the general surgery team, nonsurgical management of the SBO with nasogastric (NG) and colorectal decompression was pursued. At this time, his code status was revisited, and due to identification of a reversible cause of SBO, his family changed their wishes to align with what he originally stated: full code. After one day of NG tube decompression and intravenous fluid resuscitation, the patient became more alert. By day four of his hospitalization, his SBO cleared, and he was able to tolerate oral intake again. His mental status continued to improve—he was remaining alert and oriented to person, place, and time, reciting his friends' names and the directions to his grocery store from his home and even devising new tools to help him around the farm.

Discussion

This case provides an example of a patient whose family believed he was actively dying, only to be found to have a reversible and treatable cause of his AMS and poor nutritional intake, both of which improved once the underlying etiology was addressed.

In this scenario, it was unclear whether the patient was capable of deciding that his code status be full code, or if the family's wishes to make him DNR/DNI more accurately represented his wishes. Appropriate paperwork was available to indicate that the family could make this decision in the absence of the patient's capacity. In any case, the SBO was discovered promptly, and thus the patient's capacity was fully restored.

We propose that the best way to handle cases in which a patient with AMS – whose family states that the patient has a desire to die – is to first attempt to determine the patient's understanding of their current condition. Psychiatrists use four criteria to assess capacity: the ability of the patient to 1) understand alternatives, 2) appreciate how these alternatives apply to him or herself, 3) reason regarding these alternatives, and 4) express a choice.^{4,5}

In the setting of chronic AMS (e.g., dementia), this may be easier, as past interactions with healthcare providers will have been documented. In the setting of acute AMS (e.g., stroke), this may prove more challenging, as a patient's wishes to die may change depending on their current medical status, and these wishes may not have been discussed prior, such as in the case of a patient impaired by excessive alcohol intake. It is important to attempt to bring the patient to a mental capacity at which they can make an informed decision—for instance, by waiting until intoxication resolves or treating identifiable organic disorders such as SBO. This case contributes to the literature by highlighting the importance of this practice: one must not assume chronic AMS just because a patient has identifiable risk factors. One should consider pursuing a noninvasive diagnostic workup if acute causes are suspected.⁶

Other considerations include the patient's emotional state: for example, the patient feels he is a burden to his family and therefore wishes to die. Thus, a sliding scale of capacity determination can be used, in which the underlying emotional state can inform whether a patient has capacity, though this runs the risk of being paternalistic.⁷ We recommend utilizing both the patient's stated desires and their underlying emotional state when determining capacity. If the patient does not have capacity, utilizing their family's wishes, while trying to ensure that they are in accordance with those of the patient, should be pursued.

Next steps in this research involve assessing methods to elicit a more nuanced understanding of a patient's and their family's wishes given both the information they currently have and that which may become available in the future.

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