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Treating a Homeless Psychiatric Patient

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CASE STUDIES

Treating a homeless psychiatric patient: ethical challenges

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Introduction

The story of Mr K illustrates how a busy urban health centre working with poor people confronted and dealt with ethical problems arising while treating a homeless and psychiatrically unwell patient. This story has been mentioned in an earlier publication in the context of how psychiatry could be practiced indigenously (1). The present discussion outlines the ethical dilemmas faced by the clinicians who took care of Mr K.

Mr K was found shuffling on his haunches in a busy intersection of Vellore Town; he was fed and tolerated by the local shopkeepers until they noticed him eating maggots from a wound on his leg. They called Mr C who runs a social service organisation, who in turn contacted Dr A, who runs a psychosocial rehabilitation unit in Christian Medical College (CMC). Since K's physical ailments were as urgent as his psychiatric care, Dr A approached the Low Cost Effective Care Unit (LCECU) of CMC to admit him. This unit is run by the family medicine department of CMC. It was agreed that LCECU would provide medical care, Dr A would supervise psychiatric care, and Mr C would organise an attendant for Mr K and make proxy decisions for him. The legal issue of treating a homeless and psychiatrically unwell patient arose, and as Mr C advised, the local district authorities were informed about Mr K.

When Mr K was hospitalised, he exhibited features seen in many destitute, mentally ill persons. He was extremely disheveled, had long, dirty hair, unkempt beard, and soiled clothes. He was uncommunicative, made no eye contact and moved on his haunches. The ward staff bathed and gave him a haircut. On clinical evaluation, he had scars on the forehead, dorsum of the left foot and a huge, unhealthy ulcer on the posterior of the right leg. The scars on the left foot seemed like wounds healed after a surgical intervention, indicating that he had received some form of in-patient care for some earlier illnesses. Formal psychiatric examination revealed signs of chronic psychosis. In addition, he was found to have severe anaemia probably due to poor nutrition, worm infestation and the infected ulcer.

He was given all the necessary medical care including nutritional rehabilitation and blood transfusion, the cost of which was borne by the institution. Gradually he improved and became more communicative and made eye contact with the staff. He even began to sing and was friendly with anyone who gave him food. As he improved, long term care was discussed

with the entire team and Mr C, and it was decided that LCECU would provide medical care until Mr C was able to find him a long stay home.

Soon, Mr K was even able to write down his address. Before it could be traced, however, Mr K became unconscious one night. Investigations revealed hypoglycemia which was corrected. However, it did not change his state of consciousness. The clinical team met to decide on whether active management should be continued. Experts in general medicine, neurology and endocrinology were called in to review Mr K's condition. They felt that for a definitive diagnosis regarding whether the coma was irreversible or not, several tests [most very expensive] would be needed but that would, most likely, not change the clinical management of the patient from what was already being done. The common reversible causes of coma had already been ruled out. Therefore the team decided not to do any of the expensive tests, but to continue with active medical management.

After a couple of days, Mr K's family was traced with the help of an old CMC student. They communicated that they were not in a position to take care of him and requested the team and Mr C to continue medical care as they thought best. Mr K continued to remain unconscious and Ryle's tube feeding was initiated. Occasionally, Mr K would pull out the feeding tube. At that time opinion was divided among the managing team on the need to replace the tube. The team met with a consultant from the department of palliative care and considering Mr K's irreversible brain damage, it was decided to keep him comfortable but not initiate active measures to support him. The four guiding principles of ethics and end-of-life issues were discussed. This would mean that if he pulled out his Ryle's tube again, it would not be replaced; or if he deteriorated owing to his significant brain disease, aggressive resuscitative measures would not be taken.

Mr C agreed to look after the legal aspects of the situation and search for a long stay home for Mr K as he did not require any active medical intervention. Two days later, Mr K passed away. Mr C, after consulting Mr K's relatives, made arrangements for the appropriate legal formalities as well as for his burial. Mr K, when he was initially found, had been living alone in terrible circumstances on the streets, but he died with dignity amidst friends who loved and cared for him.

Discussion

Several ethical issues were encountered during the process of caring for Mr K, pertaining to medical care and rehabilitation of the homeless: Whose responsibility is the provision of inpatient care for mentally challenged individuals, especially when their autonomy is questionable? Who is financially responsible for the care of the homeless mentally challenged? Finally, who should decide on end-of-life interventions?

Social responsibility

Currently in most parts of India, unlike in some developed nations, there are no effective social/health security nets in place for people like Mr K. In the event of an accident or a medical emergency involving homeless, mentally challenged individuals, there is no established protocol on who takes them to a hospital and who is responsible for their care. In the developed countries, the economically and socially disadvantaged are protected by the government. In India, non-governmental organisations (NGOs) and charitable organisations take over this role, usually only when they come across such an individual in need of care. Systems are so stretched that this does not happen in most parts of India.

Across the country some steps have been taken to address some of these issues. For example, The Banyan, an organisation in Tamil Nadu cares for the medical needs and rehabilitation of homeless women with mental illness (2). The Shraddha Rehabilitation Foundation in Mumbai, founded in 1988, rehabilitates mentally ill destitutes living on the streets (3). Similarly in Kolkata, Iswar Sankalpa project for the homeless mentally ill works in the urban streets and involves community participation in caring for these people (4). In the case of Mr K, the local NGO took the responsibility of initiating medical care along with a private medical organisation. The role of the government in caring for such individuals is notable by its absence. The need of the hour is for the government to assume responsibility in providing medical and social rehabilitative care for the homeless, mentally ill.

Autonomy

The professional opinion on Mr K, when he was seen on the streets, was that he needed to be hospitalised for treatment of his medical condition. This intervention was likely to improve his quality of life. A patient like Mr K cannot make a rational decision about his healthcare and he could be admitted without 'informed consent'. His autonomy then may be violated. However the Mental Health Act of India 1987 has a provision for such patients. In Chapter IV, part 2, it states that a mentally ill person who is unable to express his willingness for admission on a voluntary basis may be admitted and kept as inpatient, provided that the medical officer in charge is satisfied that it is proper to do so and has him examined by two other medical practitioners working in the same hospital, who also corroborate the need for admission (5). This statement however is for psychiatric illness and not for physical illness and in this case Mr K suffered both psychiatric and physical illness needing immediate care.

Cost of care

Was the decision of the medical team to withhold expensive investigations which would not change the medical management ethically sound? In resource-constrained situations, a decision to carry out invasive and expensive investigations for a patient should be based on whether they would radically affect the management of the disease. The Medical Council of India in its ethics statement concurs on this (6).

End-of-life decisions

When Mr K slipped into a comatose condition, the option of continuing life-prolonging interventions arose. Normally, in such a situation, a surrogate should be chosen to act on his behalf if the patient is incompetent to choose. In this situation, Mr C and the patient's relative were informed about the choices available and given the right to choose the manner of treatment. The medical team involved in Mr K's care met periodically to discuss the ethics of this situation. The general principle of non-maleficence or doing no harm, and avoiding the imposition of invasive support, most likely only leading to prolongation of his suffering, was considered and implemented.

The order 'do not resuscitate' (DNR) is not a documented legal practice in India unlike in some developed countries (7). The right to live a dignified life or die a dignified death has not been extensively discussed. Recently, guidelines were proposed for limiting life-prolonging interventions in end-of-life situations in the Indian intensive care unit (8). These guidelines are part of the ethical position of the Indian Society of Critical Care Medicine and suggest informed decision making with a conscious patient/concerned relative about the disease process. The physician should offer the available modalities of limiting life-prolonging interventions like DNR, withholding of life support, withdrawal of life support and palliative care. There is definitely a deficiency in applying these ethical concepts and principles of decision making to terminally-ill persons in day-to-day clinical practice. It would be useful in the Indian context to discuss the need for standard guidelines in the institutional ethics committee and arrive at a common ethics position at a national level. This could trigger action towards a bill regarding end-of-life issues and 'do not resuscitate' orders. In the absence of such guidelines what is happening is that many decisions are made based on the ability of the patient to pay for life support. Informed and shared decision making is often not even considered.

The ethical dilemmas which the medical team taking care of Mr K faced in treating a socially abandoned, mentally challenged patient, and deciding end-of-life care for him, were managed as a team with discussions and periodic review of his medical situation. The resources available were also taken into consideration. Such situations occur every day in all medical emergency units and wards. As discussed by Adhikary and Raviraj in *IJME*, clear guidelines which take into consideration the financial and social constraints of the patient along with

the underlying medical conditions are essential in deciding life-prolonging interventions (7).

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Ethics in burns surgery: when is enough, enough?

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Abstract

Patients with extensive burns injuries are often given a poor prognosis. Those who survive after an initial early resuscitation phase often require extensive operative and critical care input, a prolonged hospital stay, and associated significant complications. The overwhelmingly high volume of patients already using the resource-stricken burns care service places extreme pressure on clinicians in respect of decisions they make about who should and should not be resuscitated. In this paper, we present the case of a young woman who sustained significant burn injuries, and discuss the ethical dilemmas encountered during the subsequent management of her care.

Case

A 20-year-old woman was brought into the emergency department having sustained a significant flame burn to her body. She had been assaulted by her partner, who had deliberately poured petrol onto her body and then ignited it. She was an aspiring model who had recently been offered a contract with a prestigious fashion company. A total of 60% full thickness burns were noted on her face, neck, trunk and thighs. Initial resuscitation was commenced in the emergency department using humidified oxygen, fluid therapy, analgesia and a topical dressing. Subsequently, she was transferred to the burns unit for further treatment. Anecdotally, there is a 100% mortality rate for patients admitted to the burns unit who have sustained burns to over 50% of their total body surface. Intensive care specialists were consulted immediately, but, unfortunately, the patient did not fulfil the criteria for intensive care admission, primarily due to her low likelihood of survival.

An assessment of this information, coupled with a severe constraint on resources within the burns unit, led to a decision being made by medical staff to consider active palliation.

Consequently, the patient was provided with supportive care using a slow intravenous fluid and an opiate infusion. Also, she became the subject of a documented DNAR Order (Do Not Attempt Resuscitation). It was anticipated that she was unlikely to survive beyond the first 48 hours of care. Overnight she became progressively hypotensive and restless, and was seen to be in extremis. The junior intern assigned on duty was summoned, but was unaware of the documented DNAR plan. Therefore, he proceeded to instruct that the patient be resuscitated aggressively with high flow oxygen, a large amount of intravenous fluid (required for continued resuscitation of initial burns patients who are critically ill) and nasogastric feeding. Also, a central venous line was placed (after several attempts) for haemodynamic monitoring.

On review of the patient the following morning, it was noted that her condition had much improved. Now she was alert, able to converse and comfortable. Therefore, after extensive discussion with the burns team, the decision relating to palliation was reconsidered. A new decision was then made to perform multiple staged burns wound debridements, and this required a substantial amount of blood products and significant operative time. However, subsequent to this treatment she developed burn wound sepsis, multiple drug resistant nosocomial pneumonia, limb cellulitis, central line related sepsis and renal failure. Eventually, she developed refractory septic shock from pneumonia, and went into cardiac arrest 14 days after her admission to hospital.