Turf Wars and Interspecialty Conflict:
Navigating Ethical Conundrums on a Psychiatric Consult Service

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A patient that lacks decision-making capacity is considered unrepresented when an important medical decision must be made, and they have no advance directive, suitable surrogate decision-maker, or historical evidence for preference.[1] The present case considers the impact of psychosocial factors, interspecialty disagreement, and conflict of ethical principles on patient care in unrepresented patients.

Case Report

Mr A was a 38-year-old Black man experiencing homelessness with a past medical history of schizoaffective disorder, bipolar type, who presented with sepsis secondary to necrotizing fasciitis and extensive osteomyelitis. Despite consultations agreeing on necessary life-saving surgery, the patient was reactive with decision-making, oscillating between wanting immediate surgery and being resistant within the same conversation. On examination, the psychiatry team opined that the patient lacked sufficient decision-making capacity. Efforts were made unsuccessfully to identify or contact family members or potential medical surrogates, as the patient's sister could not be located. Thus, the patient was placed on emergency legal guardianship after a 9-day period and in the meantime was started on an antipsychotic for his untreated psychiatric disorder. After a week, the patient's paranoia and agitation began to mildly decrease but still favored social isolation.

Given the marked level of agitation in this case before the first attempt at surgery and due to the patient saying he did not want the procedure, the surgical team decided to suspend the case, despite the legal guardian giving consent for surgical intervention. A bioethics consult was placed to represent the patient's best interest with insufficient decision-making capacity countered with the interspecialty conflicts that had arisen over this emotional case. Despite some psychiatric improvement with antipsychotic medication and willingness to listen to the reasoning behind the surgery, upon the second attempt at surgery, the surgical and internal medicine teams suspended the case again, as the patient became increasingly agitated before the surgery, "begging" the surgeon to not perform the surgery. The surgeon then decided to suspend the surgery, as he did not feel it was ethical. A bioethics consult was placed again, determining to ultimately appoint a new surgery team. Members of the team who did not wish to proceed forward recused themselves from the case, and the patient was able to receive bilateral lower extremity amputations followed by discharge in stable condition to a long-term care facility.

Discussion

Mr A, an uninsured Black man experiencing homelessness with a past psychiatric history, is an important representative of unrepresented patients.[2] Bandy et al[2] found that in a sample of patients that lacked decision-making capacity and filed for legal guardianship, 68.4% were male, 56.2% were Black, 16.9% were homeless, and 19.7% were admitted for a psychiatric disorder. Studies have shown that health care workers can have negative biases toward people of color,[3] mental illness,[4] and homelessness.[5,6] Furthermore, there is a presumption that patients who are unrepresented have no family or loved ones.[7] Mr A and patients with similar situations and characteristics are at risk for being perceived negatively by health care workers, which can impact clinical judgment.[8] In Mr A's case, it is unclear if or how such biases impacted his care or influenced the decision-making process.

Mr A's case was complicated by continued interspecialty disagreement over whether the surgery should be considered lifesaving and the value of Mr A's autonomy given his lack of decision-making capacity. Moreover, it is well known that emotions can influence physician decision-making,[9] and the emotionality of Mr A's case likely further complicated the disagreements. Disagreements are not unusual in complicated medical cases and can even assist in identifying different treatment options and points of view.[10] However, in Mr A's case prolonged disagreement was concerning because necrotizing fasciitis is a rapidly progressive infection,[11] and delaying surgery more than 24 hours has been found to significantly increase risk of mortality.[12]

The American Medical Association (AMA)[13] code of ethics recommends that decision-making for unrepresented patients should reflect their best interest, which is based on (1) potential pain and suffering, (2) impact on quality of life, (3) risks, and (4) benefits of the treatment. The mortality rate of necrotizing fasciitis ranges from 20%–80%,

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and early surgical intervention increases the chance of survival.[11] However, amputations can cause pain that is difficult to treat that can be chronic,[14,15] increase risk for psychiatric disorders,[16] result in physical limitations,[17] and hinder social abilities.[18] Moreover, homelessness and lack of health insurance can limit access to important postoperative technologies and therapies.[19] Ultimately, without knowing Mr A's wishes or values, it was difficult to know how he might prioritize the risks and benefits of the surgery.

In the case of ongoing disagreement that cannot be resolved, the AMA code of ethics recommends consulting an ethics committee.[13] Mr A's ethics committee recommended that bilateral lower extremity amputations be performed upon informed consent from Mr A's court-appointed guardian. This decision was based on the best interest standard, which is often used to guide decision-making for incapacitated or incompetent patients.[20] It considers the benefits and burdens of different treatment options and what a reasonable person would choose in a similar situation.[20] Ultimately, Mr A's health care team and court-appointed guardian agreed with the ethics committee's recommendations, and he was discharged to a long-term care facility post amputation.

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