Cross Cultural Newsletter

27 February 2013

Dear Members

Firstly I wish you all a happy Western and Lunar New Year! We met last Tuesday, 19th February and as if to celebrate the New Year, we had a turnout of more than 40 members, making the first meeting a memorable one.

The topic was on **"Psychosocial Management and protection of a Chinese patient with Dementia"** The speaker was Dr Gary Cheung.

Gary stated at the beginning that the case was presented to illustrate the dire dilemma, ethical, cultural and legal that he and his team had encountered. Having successfully managed the patient, he wanted to share with the audience what he has learnt from his experience. As the case is a genuine one, he asked the audience to keep the strictest of confidentiality.

Gary first painted the background clinical, ethical and legal principles that posed difficulties in management. With this, he gave a brief description of the case, highlighted how the various principles were in conflict with each other, and presented him and his team's astute deliberation which finally led to a successful management outcome.
The various background issues are as follows:

Clinically, dementia is an irreversible process in cognitive decline that would ultimately, like cancer, lead to an individual's demise. However, before this stage is reached, he would become incompetent in managing life and making decisions, necessitating external control and protection.

Ethical-legally, a clinician is guided by two sets of principles which could lead to dilemma viz the principle of palliative care and the duty to treat (against will if necessary). The first principle applies to irreversible and ultimately demising conditions in which the clinician's ethical responsibility is to provide the best quality of life for the individual, including the acceptance of patient and his family's decision on treatment options such as non-interference. In the latter condition, especially in cases where treatment would prevent harm or lead to improvement and sometimes even life, the clinician has a duty to intervene , against the patient's will if necessary when the patient is deemed incompetent. In these situations, the clinician is empowered by legal legislations: viz the Health / Disabilities code (HDC right 7(4)) , the Mental Health Act and the 3 PR acts in which an external welfare guardian is appointed to protect the patient's social and financial situation. Decisions in intervention could also be made easier if the incompetent patient has left an enduring power of attorney prior to losing the capacity, expressing clearly about how he wishes to be managed.

Having thus expounded on the various ethical-legal issues, Gary presented his case of an 85 year old Chinese who suffers from dementia with an MMSE of only 11/30, and deemed by clinicians as incompetent to make decisions. He has a wife, a son and two daughters. Unfortunately, apart from the serious demising condition, he has dire behavioural and medical condition that would pose a serious physical risk to self and a burden to his family as he was found wandering, losing his way and having a poorly controlled diabetes further complicating his dementia (including confusion which aggravates his wandering), and quality of life . As if this was not enough, he had refused any intervention, including going to hospital for stabilisation of his diabetes and behaviour. Discussions with the family-especially the son, considered culturally to be the heir, did not empower the team to act. The son had vehemently refused to allow his father to go to hospital as it would upset the father greatly. The patient had unfortunately left no previous enduring power of attorney for his future care.

The dilemma posed to the team was a classical Shakespearean one: "To be (take action) or not to be." On the one hand, ethical duty to respect the patient's and his family (as represented by the only son), and his demising condition would deem taking action to forcefully take the patient to hospital unbecoming. This is made worse by the cultural shame and the dread of rest homes that the traditional Chinese have. The principle for palliative care would also stress the importance of respecting the decision of the patient and family. On the other hand, the patient has a condition which is partially remediable (diabetes) and that his symptoms, including wandering pose both a safety concern and a heavy burden to the family. Being deemed incompetent, the clinician has a duty to protect and intervene against the family and patient's expressed wishes. At the crossroads of dilemma, the team sought a second opinion from a geriatrician who, on balancing the two sides of the coin, recommended that the palliative approach is reasonable but he also attempted to reduce the risk of not treating the diabetes by advising on the use of

oral anti-diabetes medication at home. This suggestion would provide an option fulfilling the "least overall harm" principle. Whilst the team attempted to follow this recommendation, they consulted the family. To reduce the risk further, they suggested the son to move in to live with the patient to reduce the burden of care and increase the safety of monitoring his behaviour. To the team's surprise, all the female members were supportive of enforced admission. The son had rescinded on his decision as he had refused to move in and be responsible for the control and care of the father. Thus, the equation in the team's initial decision-making had swayed towards active intervention side. It was then decided that the MHA be utilised on a temporary basis as his condition fulfils both arms of the Act to enforce treatment against his expressed will.

Once the major decision had been made, other less serious procedures emerged viz, where to treat and how to get the patient to hospital. The family took him "for a ride" which landed him in the psychogeriatric unit. Strangely, he had no resistance to admission. Whilst in hospital, his diabetes was stabilised and after 6 weeks, he was transferred to a rest home (with medical facilities). This transfer was also facilitated by a change from MHA to HDC rights 7(4) and the application for the 3 PPR Act. Thus, a great dilemma had been resolved. Support to the family, especially the son to reduce his guilt would be the next step to consider.

The presentation was followed by many discussions. The meeting finished at 2015 hours.

Complex ethical dilemmas like the above often perplex the individual clinician. Frequently, changing scenarios like the one presented would add further intricacies serving to confuse the clinician. My humble view is that the confusion could be eased by the establishment of guidelines to help the clinician to make decisions. This is in the form of an equation with pros and cons on two sides. Changing circumstances could weigh one side more, thus making the shifting of decision to another side understandable and reasonable to all parties. The equation is dynamic and thus allows clinical flexibility to adjust to changing circumstances. When confused by complex situations, there are three stages that the clinician would have to go through: 1. Define and delineate the issues (ethical, clinical, cultural and legal) that are in conflict with each other 2. Deliberation, using an equation weighing the various opposing factors but bearing in mind that the dynamics of the equation might shift and hence for a revision. (This is illustrated nicely by the case under study). 3. Making a decision guided by the weighing of various factors and keeping in mind the principle of "least harm" 4. Attempts to reduce any harm cause by the decision. As decisions like these would not always be palatable to all parties, action to reduce such harm would fulfil the principle of the "least harm". In this case, support to the family, particularly the son is one of these. The above is my own simpleton's guiding principle which could be laughed at by the sophisticated ethicists. But I find this fits in to Gary's presentation well and would wish to share with you.

The above summary is as much as my failing memory could muster. I must apologise for any inaccuracies which are bound to occur with complicated cases like this. Please send for the DVD which would be a more accurate rendition of the presentation. More importantly, as with any case presentation, even though attempts have been made to cover the true identity of the patient, our members are asked to keep the details of the case strictly confidential.

Preview of next session

For the next two sessions, we shall be hosting a series of two workshops on **Family Therapy across the World**: Family therapy has evolved differently across continents. This talk will give a brief presentation of some of the similarities and differences with particular attention to its history in Aotearoa/New Zealand. Modification to cater for the diverse cultural needs would be discussed. More importantly, the second session would be case studies and emphasise on the sharing of the experience of the audience with a panel of speakers. A flyer would be out soon.

Thank you again for your support.
I look forward to seeing you all in our next session.

Yours sincerely,

S Wong

On behalf of the Cross Cultural Group