

# MEDICOLEGAL ISSUES IN CARE OF THE OLDER PERSON

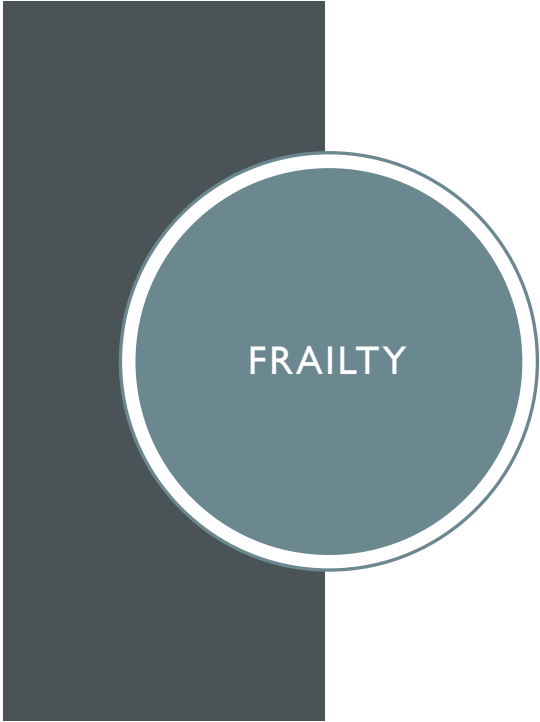
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1

## GERIATRIC MEDICINE

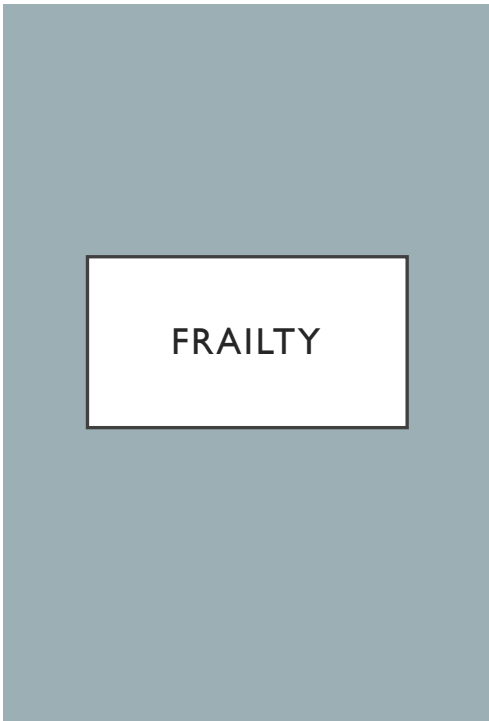
- British Geriatrics Society “*Adding life to years not years to life*”
- Focus on holistic care rather than single organ disease
- Older people have multisystem disease and geriatricians are trained to deal with the competing interactions
- Polypharmacy
- Frailty is current buzz word – has a specific meaning for geriatricians

2












3

- Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves.
- Around 10 per cent of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85.
- Frailty varies in severity (individuals should not be labelled as being frail or not frail but simply that they have frailty).
- The frailty state for an individual is not static; it can be made better and worse.
- Frailty is not an inevitable part of ageing; it is a long term condition in the same sense that diabetes or Alzheimer's disease is.



4

Clinical Frailty Scale\*

-  **1 Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.
-  **2 Well** – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.
-  **3 Managing Well** – People whose medical problems are well controlled, but are not regularly active beyond routine walking.
-  **4 Vulnerable** – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.
-  **5 Mildly Frail** – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.
-  **6 Moderately Frail** – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.
-  **7 Severely Frail – Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).
-  **8 Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.
-  **9 Terminally Ill** - Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

**Scoring frailty in people with dementia**  
 The degree of frailty corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal. In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting. In severe dementia, they cannot do personal care without help.

\* 1. Canadian Study on Health & Aging, Revised 2008.  
 2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.



## MULTISYSTEM DISEASE (CO- MORBIDITIES)

- Ageing brings with it a progressive decline in various organ systems and also in the ability to compensate for fluctuations.
- Small fluctuations can have a devastating impact on an older person
- Presentation of illness in older person is different to that in younger patients
- Falls, confusion delirium, incontinence may be due to a variety of reasons – it is the expertise of a geriatrician to tease out what is relevant and what is not

5



## POLYPHARMACY

- As a consequence of multi-morbidity, older people are often treated with a variety of medications some of which may result in interaction with others
- Older people are at a greater risk of adverse drug reactions (ADR) and the more drugs a person is on the greater the risk
- Around 10 % of hospital admissions in older people are due to ADR

6



POLYPHARMACY

- Patient presents with joint pain - GP starts ibuprofen
- 6 weeks later patient has high BP – amlodipine prescribed
- 2 weeks later patient has indigestion – GP starts omeprazole
- Patient presents with ankle swelling – started on furosemide
- Emergency admission with fall – found to have acute kidney injury and low sodium

7



POLYPHARMACY

- Same patient develops delirium in hospital
- Falls on ward
- Has fracture of hip and undergoes surgery
- Post-operatively more delirious and develops pressure sores
- Review finds incomplete falls risk assessment on admission
- Family consult clinical negligence lawyer
- How would you proceed?

8



## CASE I

Mr LW                      Age 90

- Hypertension age 40
- Panhypopituitarism age 65
- Chronic kidney disease stage 3

At age 89 has NSTEMI and admitted to hospital

Cardiac arrest in hospital – resuscitated and admitted to ITU

According to family looked much younger than 90

Discharged after 8 weeks in hospital

9



## CASE I

After a period of recuperation at home returned to active life

Was driving around London

Returned to preach at Sunday Services

Continued to manage finances and household tasks

10



CASE I

4 months later felt unwell for 48 hours  
Short of breath at rest  
Drowsy  
Admitted to hospital  
Diagnosed with lower respiratory tract infection

11



CASE I

Started on antibiotics.  
Noted to become more unwell with progressively low BP and worsening kidney failure  
Severe metabolic acidosis  
Low BP unresponsive to intravenous fluids  
Admitted to ITU

12



## CASE I

Continued to remain hypotensive despite aggressive management on ITU

After 12 hours on ITU had profuse rectal bleeding

Patient dies a few hours later

Certified cause of death – acute bowel ischaemia

13



## CASE I

All case notes on final admission document patient has panhypopituitarism

**THIS IS A CRUCIAL FACT**

However, the fact needs action which was omitted

Patients with hypopituitarism need cortisol supplements and in acute illness need to increase the replacement dose

None of the numerous medical staff gave this man the cortisol he needed!

14



## CASE I

Trust defence was that the omission of cortisol replacement did not materially impact the cause of death which was bowel ischaemia

Expert reports from a Professor of Intensive Care and Endocrinologist supported this view

Both experts stated that acute bowel ischaemia was the reason for admission and a 90-year-old-man was unlikely to survive such an event

Both stated that administering adequate doses of hydrocortisone would not have prevented the death

15



## CASE I

Geriatrician view

Reason for admission was LRTI – documented by the post take ward round

Chest examination consistent with LRTI

CXR normal – unhelpful

Abdomen described as soft and non tender at time of admission and on post take ward round

BP at time of admission was acceptable

16





## CASE I

Progressive decline in BP documented in first 12-14 hours of admission

Increasing metabolic acidosis over 12 hours

Worsening renal impairment

The persistent and unresponsive low BP was the cause of patient's acute bowel ischaemia.

If he had been treated with cortisol replacement, BP would have responded to IV fluids and prevented the bowel ischaemia.

17



## CASE I

- At joint meeting between endocrine expert, I was able to provide sufficient proof that the chain of events was:

- LRTI
- Lack of cortisol
- Low and unresponsive BP
- Bowel ischaemia, AKI and ischaemic hepatitis
- Death
- Positive outcome for the claimant

18



## CASE 2

- Mrs. GT            Age 82
- 2019 pulmonary TB
- 2019 MI – noted to be sensitive to opiates
- 2019 – Hospital acquired pneumonia post MI
- 2019 - Transferred to rehabilitation unit
- Prior to MI fit and active going on family holidays and cooking meals for family

19



## CASE 2

- 2<sup>nd</sup> March 2020 – fall and hip fracture
- 25<sup>th</sup> March – transferred to rehabilitation unit post surgery
- 3<sup>rd</sup> April – noted to be desaturating at rehabilitation centre
- Admitted to hospital with suspicion of COVID
- Chest X-ray consistent with COVID pneumonitis
- Treated with antibiotics

20



## CASE 2

- Decision was made that she would not be a candidate for CPR
- Continued to decline
- Increasing O<sub>2</sub> requirement
- Respiratory rate around 40-50/min – very breathless
- Treated with morphine to alleviate breathlessness
- Patient died 4<sup>th</sup> April

21



## CASE 2

- Issues raised by family
  - DNAR status – not fully discussed with family
  - Morphine caused death

22



## CASE 2

- DNAR status
  - This was a frail lady at the start of the pandemic
  - Decisions on resuscitation were made on the basis of ensuring ITU availability for those most likely to survive
  - Pressure from DH to make early assessment of resuscitation status
  - Good practice is to discuss DNAR with patient (if has capacity) or relatives **BUT final decision rests with the responsible clinician**
  - The majority of clinicians would have made the same decision at that time

23



## CASE 2

- Opiate sensitivity
  - A lot of misconceptions about allergy and side effect
    - all patients will develop nausea and vomiting a common side effect. It will also result in drowsiness – an intended effect of opiates.
    - Opiates are very useful for the symptomatic relief of respiratory distress
    - In patients who are approaching end of life, opiates are used to alleviate breathlessness with the knowledge that it may accelerate death by a few hours

24





## CASE 3

- Fall in living room at 8.35 am
- Daughter upstairs - called 999 at 08.40 from upstairs
- Ambulance dispatcher called Mrs. DF
- Daughter made her way down to find mother pivoted on the arm of a sofa with face down

27



## CASE 3

- Second call to Ambulance service at 09.19

*“patient condition has got worse, she has managed to get herself halfway up from leaning on the chair. She has injured her stomach and ribs – is also becoming sob” caller aware of high demand”*

28



## CASE 3

- 3<sup>rd</sup> call to ambulance service 09.49

*No worsening however caller concerned that patient was going to fall and hit head as was in precarious position.*

29



## CASE 4

- Final call 11.10

*“my mother had just told me that her temperature was going up. She was still trying to get herself up as she was in pain where the arm of the settee was pressing into her ribs. While I was talking to the dispatcher, my mother was becoming more distressed so I asked for the ambulance to hurry. The dispatcher was still on the phone to me when I realised my mother had stopped breathing”*

30



## CASE 4

- Delay in responding to patient
- Did not recognize the risk of position to patient
- Resulted in cardiac arrest from which patient could not be resuscitated.
- If the Ambulance Service had responded in a timely manner, Mrs. DF would not have died at the time she did.

31



## SUMMARY

- Geriatrics is a complex specialty
- Geriatricians are able to provide a holistic assessment on the patient and provide a comprehensive overview on the clinical negligence issues

32