Management in the best Interests of a Stroke Patient

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Background

Stroke is described as a “rapidly developing clinical signs of focal loss of cerebral function, with symptoms lasting more than 24 hours or leading to death, with no apparent cause other than vascular origin”[1]. It is a leading cause of death and as well as significant disability[2].

Potential impairments in the consent capacity of patients have important medical, legal and ethical implications for healthcare providers. Stroke may affect various areas of the brain and this may include the prefrontal cortex which is involved in decision-making.

Studies of patients who suffered damage to the ventro-medial pre-frontal cortex have shown them to be prone to impulsive decision-making in real life and their ability to balance risks and benefits is impaired[3]. This will have a significant impact on their ability to discuss treatment options and give valid consent.

The mental capacity act is designed for the protection and empowerment of people aged over 16 who may lack the mental capacity to make their own decisions about their care and treatment. It follows five principles:

Principle 1: Capacity must be assumed unless proven otherwise

Principle 2: Individuals must be given all information and practicable help needed to understand them for them to make the decision themselves.

Principle 3: Unwise decisions: patient has the right to make these decisions without rendering them to lack capacity for this reason. Every person has their own beliefs, values and preferences which may not be the same as the clinicians.

Principle 4: Any decision made and action taken on behalf of a person who is deemed to lack capacity must be done so in their best interests.

Principle 5: Principle 4 should be applied in a manner in which it would interfere less with the person’s rights and freedoms of action.

Referral:
67 year old female referred for bleeding inside mouth of unknown cause.

On Examination:
Bleeding caused by a large traumatic ulcer on the upper edentulous ridge caused by the teeth on the lower arch. Teeth remaining LR34 LL45. All four teeth grade II-III mobile, grossly carious and sharp edges.

Medical History:
COPD: not on oxygen
Anticoagulated: Edoxaban – high risk for further thromboembolism therefore not changed.

Capacity:
Under deprivation of liberties (DOLS) therefore decisions made in best interests by clinicians. Patient lives with and supported by son. He does not have Lasting Power of Attorney for Health and Welfare.

Mobility:
Bedbound, would need transport and hoisting for transfer to chair. Not stable on dental chair as complete left sided weakness

Clinical Decision Making

Dental Laboratory	Mouthguard: Few remaining teeth which are mobile, atrophic mandible and lack of muscular control, retention will be significantly compromised.
Speech and Language Therapist	Assessment: Patient has moderate to severe dysphagia and dysarthria, and complete left sided weakness. Drinks fluids and eats only puree diet as high risk of aspiration. Requires prompts to repeat communication. Needs quiet environment and minimal distractions to for any discussions
Medical Doctors	Patient lacks the ability to communicate by speech, writing or typing. Cannot express her decisions. Requires repeated prompts to follow instructions, therefore retention of information may be impaired. Clinical diagnosis in addition to findings resulted in Deprivation of Liberties to be put in place.
Dental treatment	Smoothing teeth off will not remove trauma as still a single point of pressure. Removal of teeth on left will cause new contact with remaining teeth on the opposite side of the arch and likely a new ulcer. No muscular control, and continuous heavy pressure between the jaws
Son	Patient had upper clearance last year and lower teeth only retained for denture stability in the interim. Long-term plan previously when patient had capacity, was for lower clearance in the future.
Nursing Staff	Pt is normally bedbound. Can be hoisted on to a hydro lift chair which can be tilted to aid with treatment. Ward can arrange transport.

Clinical Management

This case involved multiple discussions as demonstrated to make a decision in her best interests. Discussions with teams with made remotely. Telephone conversations with Son on presentation and decision on treatment were made before the treatment appointment.

On the day of treatment, arrangements were made for the son and HCA to be present. Consent form 4 was signed together. Initially extraction of LL34 was completed. The patient was bent forward and required difficult clinician position. Therefore good organisation and prep of instruments as well as a two-clinician and dental nurse set up for the procedure was planned before the administration of LA. With reasonable compliance and ease of extraction of LL45 were extracted, re-discussion with son and the remaining contralateral teeth were extracted.

Conclusion

This case highlights the complexity of MCA, DOLS, best interests, stroke and emergency treatment.

It is important to include teams and family members in the decisions. It is not a one stage process, but one of clear discussion from multiple experts in the care of the individual. Final treatment involves good organization and swift treatment.

References

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