



"I'm making decisions with no medical records, and it isn't just the flickering corridor lightbulb that is leaving me in the dark."

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REFERENCE

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When to safety-net the bad decisions for patients with capacity?

John is 92. I'm visiting him as the out-of-hours GP at 10 pm on a Friday night. The phone triaging doctor has done their best but a home visit is unavoidable as there is no clear solution. He was in hospital for months after a stroke, then a downstream bed. He was advised to move to a nursing home as his swallowing is poor, and, although he can stumble to the toilet, he often falls. He wanted to return to his sheltered accommodation, and I'm told by the exhausted warden of the sheltered housing that he was deemed to have capacity to make this choice. Really? Did he really appreciate, understand, and repeat the inevitable crisis we are now in? If so, how responsible is he versus society for what happens next? How far should professionals go to put a contingency plan in place?

He's been home for less than 24 hours. His own GP this morning felt he didn't have capacity and wanted to move him back to the hospital immediately. Social services 'are aware' apparently, but there is no bed. Too late for advanced planning, and no resuscitation decision yet. He is tired and generally less responsive than usual. *Just not right, doctor.* He wakes briefly when I speak to him, smiles sweetly, and then falls asleep. His physical examination is normal, as so are his observations. The carers are terrified because he keeps choking on food, and worried about their legal stance if he chokes to death. The family are in North America and uncontactable. The warden has been up all day and needs to sleep, and social services have no spare capacity (in August! I'm dreading winter already).

What is there to do? His deterioration is non-specific and he is probably dying. Or maybe he isn't. It's always hard meeting a patient at this stage for the first time, not knowing what their wishes are. But in the absence of specified wishes most people want to die peacefully in their beds. Modern medicine often denies them this. In my experience, often a refusal to engage in advance planning while asking to go home is symbolic of the patient wanting to be freed from medical intervention and allowed to die.

Admitting him poses more risks than

benefits. The lack of emergency carers is out of my control. I resist the urge to prescribe amoxicillin that would only satisfy an urge to do something, anything. I feel sorry for the warden who herself is over 60, going well beyond her role, racked by guilt because she is not able to stay up all night. I try not to be dismissive as I explain the best thing is to leave him for now and check on him once overnight. Yes, he might be dead in the morning, but this is OK. I'm making decisions with no medical records, and it isn't just the flickering corridor lightbulb that is leaving me in the dark. But that is the role of the generalist on a home visit — to make the hard judgement call and unburden the warden and carers from their worries. I write that choking is an acceptable risk, to continue feeding him, and the carers shouldn't be sued.

Nine years ago I worked on a fantastic geriatric unit as a foundation doctor. We had a 'trial of discharge' for when a patient wanted to go home and it was judged to be very risky. Their bed was kept free for 24 hours, in case of problems. Many patients came back overnight. A valuable concrete learning experience to get the wheels of Kolb's learning cycle¹ rotating, helping patients to agree that the nursing home might be better after all. In contrast to acute care, chronic disease patient care is a collaborative working partnership. Informed decisions don't have to be a single point in time, rather a shared process of understanding. Blocking a community bed for 24 hours 'just in case' isn't acceptable any more. Beds are too efficiently used. But tonight, as I practise my trade in a dimly lit bedroom, I wish I had the option to ring a nursing home manager who could say, *'Oh yes, I know about John. We have his bed ready.'*

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The sex and name of the patient described have been altered for anonymity reasons because the patient is unable to provide consent in the usual way to publication.

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