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Authors

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CASE REPORT

A Life-Threatening Emergency Exacerbated by Untreated Mental Illness in a Low-Barrier Health Center

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Introduction: We report on a patient with untreated severe mental illness who presented with a life-threatening emergency: retained products of conception and hemorrhage.

Clinical Findings: A female patient experiencing homelessness developed life-threatening hemorrhage. Her mental illness impaired effective communication and treatment.

Clinical Course: The patient presented with fatigue, vaginal bleeding, and known retained products of conception. Her active mental illness complicated the situation as it limited effective communication and treatment due to delusions. She requested only treatment for an infectious cause of her symptoms. She refused most interventions and had a self-directed discharge from the hospital. Throughout this process, we assessed that she understood the implications of declining care, despite her mental illness. After extensive patient-centered and trauma-informed discussions, she accepted medical treatment.

Conclusions: This case highlights the importance of patient-centered communication and team-based care during emergencies and refusal of care. Shared decision-making and trauma-informed care are appropriate methods for assessing the capacity of patients with severe mental illness in acute and life-threatening conditions.

Keywords: mental disorders, shared decision-making

A female patient who was 38 years old presented to our clinic for adults experiencing homelessness [Preble Street Learning Collaborative (PSLC)]. She had vaginal bleeding and fatigue for 4 weeks after a dilatation and curettage (D&C) for an incomplete miscarriage. She was well-known to the team, as she received regular care for acute concerns or substance use disorder. Her past medical history included polysubstance misuse, unmedicated schizoaffective disorder, physical and sexual trauma, and unsheltered homelessness.

She was seen earlier that day at the emergency department (ED) with the same symptoms. We identified retained products of conception with ultrasound, and she received a blood transfusion. She refused other interventions, including vaginal

exam and D&C, and she left as a self-directed discharge. At PSLC—where her team included a preventive medicine fellow, nurse practitioner, and medical student—she had continued bleeding with mild symptoms but no hemodynamic instability. She showed disordered thinking with delusions, referencing to herself as royalty and to providers as close relations. After hearing detailed explanations of the cause of her bleeding, specifically retained tissue, she persisted in requesting only antibiotic treatment. This method would have been ineffective at that time, though it is often provided in addition to D&C. We recommended urgent hospital evaluation and gynecologic intervention for this reason, but she declined. Her comments in reference to returning to the hospital included a repeated concern that staff were only interested in examining her genitals “for no reason,” and antibiotics were the only cure she needed. She repeated these comments several times during the initial evaluation and grew agitated.

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Initial discussions with the care team reviewed the option of involuntary hospitalization given the inadequate facilities at the clinic, risk of mortality from untreated hemorrhage, and her untreated mental illness. However, she showed capacity of understanding, even with her delusional symptoms. Although she exhibited disorganized thinking, fixations, and delusions during evaluation, she was alert and oriented to person, place, and time; aware of her acute medical condition (hemorrhage); and, importantly, able to “teach back” the implications of declining treatment to the care team.

After 2 hours of discussion, the patient agreed to return to the hospital. The medical student accompanied the patient there. The patient became frustrated within minutes of arrival and left. She returned to the PSLC with the medical student, still bleeding but hemodynamically stable. She left to a local shelter, with plans for follow-up in the morning.

When she presented the next morning, she had persistent hemorrhage and was hypotensive. After repeated discussions for shared decision-making, she was willing to return to the ED. There, she underwent further evaluation and was admitted for a D&C.

DISCUSSION

This case shows the challenges of medical decision-making in emergent situations when mental illness and prior traumatic experiences may influence the patient’s health behaviors. Although her mental illness complicated her decision-making process, she also indicated that she would not want an invasive gynecologic procedure under any circumstances. Meanwhile, she showed capacity and understanding that she would die without taking measures to stop the hemorrhage. As we gained insight into this dynamic, we were confronted with the potential harms of revoking her decision-making capacity and involuntarily hospitalizing her for care, likely damaging her trust in our safety net clinic.

With these risks, our most appropriate efforts were to use shared decision-making and trauma-informed care to guide the patient to the hospital on her own terms. To do this, we had to determine her ability to make the needed decisions in this acute setting. We agree with the definition of decision-making ability by Probst et al.: “a patient’s capacity and willingness to participate in his or her emergency care decisions.”¹ Although we hoped to

avoid involuntary hospitalization, we had to assess her capacity while using trauma-informed care to understand why her history of sexual trauma could have impacted her current refusal of care.² Also, the presence of a trusted ally (the medical student) in the ED encounter gave the patient some support in the context of needing procedures involving her genitals.

Removing a patient’s decision-making autonomy must be a last resort, only after determining whether a patient lacks capacity. Capacity is differentiated from competence in that competence is a legal term determined by a judge, whereas capacity is a dynamic, clinical determination by a provider.¹ It is not binary—it lies on a continuum that depends on the specific situation and choices available.³ The burden lies on medical providers in scenarios like ours to clearly explain information, provide options, and then elucidate capacity.⁴ It is impossible to determine capacity if someone has not been given adequate information or options in understandable language.

Literature concisely states that refusal of care is “a failure not of capacity but of communication.”⁵ Over the 2 days we met with the patient, we were able to establish a shared understanding that retained tissue causes persistent bleeding in addition to being an infection risk. We reconciled the patient’s perspective with the imperative need for operative management. We also educated the patient on the availability of anesthesia during the D&C, addressing her need for psycho-emotional safety during the procedure given her history. The importance of patient-centered communication cannot be understated. Providers must anticipate the gap in medical literacy and avoid jargon to reach consensus with patients.⁶

Though this situation was an iterative, time-consuming process that unfolded over 24 hours, we were able to monitor hemodynamic stability and gradually increase our patient’s ability to comprehend the relevant information. During this time, we clearly believed that it would be unethical to seek involuntary hospitalization due to her active mental illness, as she repeatedly showed capacity. However, if we had not persisted in shared decision-making, then we could have been confronted by very different outcomes resulting from refused care or involuntary hospitalization.

Our case shows how determinations of decision-making capacity should be folded into a trauma-informed approach to care. Although we had the benefit of knowing her medical and trauma history, it is recommended to adapt trauma-informed care for all patients to avoid re-awakening trauma and further delaying care.⁷ Also, we had the benefit of a team-based approach, including a medical student accompanying the patient to the ED. This combination of factors enables providers to humanely navigate the process of determining capacity and medical decision-making in the context of a patient's past experiences.

Conflict of interest: None

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