

Practitioner's blog

Are some of us more equal than others?

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The majority of patients who attend emergency departments do so with a complaint of pain of one kind or another. The description of this pain helps to guide staff in investigating the cause of the problem, formulating a diagnosis and selecting appropriate treatment. However, on the occasion described here, the patient was quadriplegic and therefore, as he had no feeling in his arms or legs, was unable to describe or localise his pain.

Some years earlier this man had been involved in a catastrophic car accident which left him quadriplegic. He had recovered sufficiently to be able to mobilise in a specialised wheelchair, but needed assistance with all of his daily activities, and was constantly accompanied by his carer. He attended the emergency department because his left foot was red and swollen. He was able to clearly describe a history of increasing inflammation, which he thought was possibly due to an ingrowing toenail. He did not think he had injured it in any way, but could not be sure about this, due to the nature of his paralysis. On this occasion he was seen by an emergency doctor who diagnosed an ingrowing toenail and treated the patient accordingly with antibiotics and a referral to a chiropodist.

Seven days later the patient returned because his foot did not appear to be improving despite treatment with antibiotics. This time he saw another doctor who removed part of the nail and advised him to return if there was no improvement. On his third attendance he was seen by a nurse practitioner who noted that his whole lower leg was warm and swollen and, due to his repeated attendances, decided that a duplex scan and an X-ray were indicated to rule out the possibility of a deep vein thrombosis. The senior doctor agreed to review the patient when these investigations were complete. The duplex scan was unremarkable, but the X-ray showed a displaced fracture to the left ankle. How or when this injury had occurred was uncertain, but such an injury required a specialist referral.

The doctor discussed the case with the orthopaedic team, who advised the application of a plaster of Paris and follow-up at the orthopaedic clinic. The nurse

practitioner was very concerned about the reason for this course of action, as such a fracture in any other individual would require reduction. Clarification was sought from the orthopaedic doctor involved, who explained his rationale. The fracture was not considered to be recent, and as the patient involved was not walking, delaying reduction of the fracture would not cause any deterioration or harm to the patient. He had opted to defer a decision about further treatment until more senior doctors could review the patient in the clinic. The nurse practitioner explained the planned management to the patient as best she could.

To some degree the man was relieved that the problem with his foot had been identified, and he expressed his hope that his ankle would soon be healed and back to normal. However, five days later he returned again. He had attended the orthopaedic clinic and was quite upset. Following a brief consultation he had had his plaster of Paris removed and was discharged from the clinic. He was worried that his ankle would not heal without the plaster, and that his paralysis would prevent him from sensing any deterioration. Moreover, he was extremely anxious that he could re-injure his ankle without realising it. Evidently none of these concerns had been addressed with him in the clinic, or if they had, he was not aware of this. The nurse explained that his ankle would heal but that it would form a mal-union, and therefore would always be deformed. A plaster of Paris would not realign his fracture and, because of his immobility, would also predispose him to a greater risk of developing a deep venous thrombosis. This risk outweighed any benefit of a plaster.

At this point the man became very upset that the decision about whether or not to operate on his leg had not been discussed with him. It was clear that he had never fully resigned himself to the reality of never being able to walk again. He lived in hope and perhaps believed that he would be given the opportunity in the future to have a new treatment, maybe stem-cell treatment, that would restore sensation and movement in his legs. He understood only too well that a deformed ankle would compound his disability and limit any future options.

It was difficult to know what had happened in the clinic, but it seemed evident that the patient had not been at the centre of the decision-making process. Little if any consideration had been given to his feelings about his disability or his aspirations for the future. Sadly, it would seem that the doctor in question had seen the disability, but had not seen the person with his hopes and desires like the rest of us. Thus this person was viewed through the prism of a model of disability which relies on a naturalistic conception that biology is at the root of impairment, which in turn causes disability (Bickenbach *et al*, 1999; Imrie, 2004). This approach contrasts with the social model, which sees the problems experienced by people with disabilities as being the direct product of the physical, social and attitudinal environment in which they live (Bickenbach *et al*, 1999; Imrie, 2004). This patient encountered an attitude that perceived his ankle fracture to be incidental and not warranting surgical intervention because he was already severely disabled and unlikely ever to walk again. An assumption was made about the quality of this man's life without reference to or respect for his own hopes and plans for the future.

Whatever was said or not said in this encounter served to diminish this man's sense of autonomy and self-worth. The glimmer of hope that he nurtured and that had kept him motivated over the years had been extinguished by one person's perception and decision making. The prospect of the man ever walking again may have been totally unrealistic in the eyes of the doctor, but without genuine discussion and consideration, the hopes of a man destined to spend the rest of his life in a wheelchair had been summarily dismissed with no apparent right of redress. It was hard to understand why he was not informed about his treatment options. A person who could walk would certainly have been able to have that discussion.

This case raises serious questions about equality and disabled people. Locker (2003) considers that, given the right environment, the quality of life of many people with disabilities would not be very different from that of individuals without a disability. This may well be true, but in the context of healthcare it is dependent on professionals' understanding of the social and psycho-

logical context of disability, which contrasts strongly with the biomechanical view of disability as impairment. Social and psychological conceptualisations of disability encourage a focus on the positive, that is, what the individual can do, whereas the biomechanical view focuses on the diseased body and its inability to function in ways that are considered normal (Nettleton, 1995). Sadly, in this case the focus was on the diseased body, and the person was forgotten.

Although the man was referred for further consultation and, hopefully, for resolution of the problem, this case highlighted to the nurse practitioners concerned the danger of making assumptions about an individual's feelings and expectations. It was also a sad reminder that, in some cases, patriarchal practice prevails, sometimes to the detriment of patient-centred care. The approach to patients with a disability is still not always as equal as it should be. This demonstrates that there is a need for a greater awareness of and advocacy for people who are vulnerable because they are in some way different from the mainstream.

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