CASES

Obtaining consent to a life-sustaining treatment for a patient with a major psychiatric illness

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A 53-year-old woman with a long-standing history of paranoid schizophrenia and advanced chronic kidney disease was brought to the emergency department by police and subsequently admitted involuntarily to the psychiatric service. Because of her mental illness, she had previously transferred power of attorney for medical decisions to her brother, who resided in another city.

The patient had a documented history of nonadherence to medical treatment. On this admission, her renal function had deteriorated substantially, with signs and symptoms compatible with uremia. Treatment with dialysis was discussed with the patient; however, she was deemed incapable of informed consent through a formal capacity assessment performed by the emergency physician and the psychiatrist. Her brother, the substitute decision-maker, subsequently gave consent to proceed with dialysis, stating that the patient had no previously documented wishes against life-sustaining therapy.

A tunnelled hemodialysis catheter was inserted through the patient's internal jugular vein into the right atrium, and dialysis was started. Several days later, the patient forcefully pulled out the catheter. Local pressure was applied until bleeding subsided. A second catheter was inserted to continue the dialysis therapy. Although the patient was agreeable and cooperative with dialysis initially, she consistently and adamantly objected to the treatment after two sessions. She forcefully pulled out the second catheter several days after its insertion. Hemostasis was achieved rapidly, and there was no substantial bleeding.

Joint meetings with the psychiatry and nephrology services ensued. The patient's anticipated clinical course and prognosis were discussed from both the psychiatric and medical perspectives, and the hospital ethics service was consulted. The patient's psychiatric condition was deemed not likely to improve despite pharmacotherapy. Electroconvulsive therapy was considered, but the psychiatry service felt that it would not be of benefit. During the discussions, it was clearly outlined that the patient would likely experience progressive uremic symptoms and eventually die of renal failure without dialysis therapy.

Because of the substantial risk of exsanguination and death if the patient continued to forcefully remove her dialysis catheter or dislodged other blood lines, the medical staff was apprehensive about resuming the dialysis therapy. The patient's brother agreed that her verbalizations and actions constituted evidence that she was unwilling to proceed with the dialysis.

After comprehensive multispecialty meetings that involved the patient's brother, the brother withdrew consent for dialysis because he thought that the associated risks outweighed the benefits. Supportive care and medical therapy were continued.

Discussion

This case illustrates the complexities encountered when a patient's major psychiatric illness is the main factor in the decision not to offer, or to withdraw, dialysis therapy. Although some of the details in our case are specific to the province of Ontario, the concerns are relevant to physicians across Canada and those in other countries.

The Ontario Health Care Consent Act[1] provides health care practitioners in the province with the legal parameters surrounding what constitutes valid consent to treatment from either the

KEY POINTS

- Consent to treatment can be given orally or in writing and may be expressed or implied.
- Every treatment requires informed, capable and voluntary consent.
- If the person is not capable, the decision is made on his or her behalf by a substitute decision-maker.
- A substitute decision-maker must act in the best interests of the patient by considering the patient's previously expressed wishes, values and beliefs, as well as the potential benefits of the proposed treatment.

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