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Case 2: Decisions to Refuse Treatment by Depressed, Medically Ill Patients

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Ethicists, medical associations, and the courts have long accepted that competent patients have the right to decide whether to accept or reject proposed medical treatments. However, patients who lack decisional capacity are denied this right on the basis of preserving their best interest, and others are designated to make their decisions for them.[1] Depressed, medically ill patients may lack insight into their own condition--which could prevent them from making a valid, informed decision about treatment--yet not be so disturbed that care providers can regard them as lacking the capacity to consent or refuse. When caring for a patient who refuses proposed treatments, physicians may be particularly inclined to override that person's wishes if the individual suffers from a mental disorder.[2] The case that follows illustrates prominent ethical and legal concerns that arise when a patient who is both severely medically ill and severely depressed refuses treatment.

R.C. is a 66-year-old, white male who was admitted to a large teaching hospital on an emergency basis after sustaining a self-inflicted shotgun blast to his face as a result of a suicide attempt. The patient incurred extensive damage to his face, including loss of the left orbit and eye, left mandible, left maxilla, as well as most of his oral cavity and nasal bones.

However, a CT [computed tomography] scan revealed no brain damage. The patient was prepped for surgery, which included debridement [removal of dead tissue] and partial reconstruction of his face with skin flaps and a rib graft. At that time, a jejunostomy feeding tube [J tube] was surgically placed into the small intestine to provide artificial nutrition. In addition, a tracheostomy was placed, due to the extensive oral-cavity damage sustained in the suicide attempt. Following surgery, R.C. was transferred to the surgical intensive care unit, where his condition was considered critical, but stable. Approximately one week later, the psychiatry service was consulted to evaluate the patient for demonstrated agitation and suicidal ideation.

Upon initial psychiatric evaluation, R.C. presented as a moderately obese, elderly man lying in bed with four point restraints in place. Although both of the patient's eyes were covered with gauze wrappings, the psychiatrist noted pronounced disfigurement of the face, due to tissue and bone loss and edema. A tracheostomy was in place, and the patient was breathing independently without the aid of mechanical ventilation. Due to the tracheostomy, R.C. was unable to engage in verbal communication. However, he responded to questions in a timely and appropriate manner with head nodding and hand squeezing, and by writing responses on a notepad. He was alert and oriented to person, place, month, and year. When asked about the circumstances that led up to his attempt to take his life, R.C. wrote that he had become depressed several weeks prior to his suicide attempt, when his second wife of nine years left him. He affirmed that he was still depressed and rated his mood as 1, on a scale of 1 to 10 (with 1 equal to the worst his mood had ever been). When

queried about suicidal ideation, R.C. acknowledged that he continued to have thoughts about killing himself. When pressed further, he wrote, "I want to die," and he affirmed that if he had the means to do so, he would try to end his life. R.C. wrote that his desire to end his life was not because of his estrangement from his wife but, rather, a result of his disfigurement and pain. He agreed to begin supportive psychotherapy on a daily basis. The psychiatrist discussed the possibility of initiating antidepressant medication with the patient. However, because R.C. indicated that he wished to "think about it," no pharmacologic intervention was started.

R.C.'s family consisted of his three adult children, who were present with their father on a nearly continuous basis during the first seven days of his hospitalization. Approximately four days after his admission, R.C. signed a durable power of attorney that designated his children, collectively, as surrogate healthcare decision makers in the event that he became incompetent. R.C.'s children related that their father had no history of chronic mental illness, but that he had attempted suicide nearly 12 years earlier with a medication overdose. Again, the precipitating cause appeared to be difficulties in his personal relationships.

Approximately 10 days after admission, R.C. was scheduled for additional reconstructive surgery, consisting primarily of skin-graft replacement. The patient, upon being told of the impending surgery, communicated through head nodding and handwriting that he desired no further surgical interventions. Even though he was informed of the potential risk of infection if the previously placed graft was not debrided and replaced, R.C. persisted in his refusal to undergo further procedures. When asked for reasons, he stated that he believed additional interventions would never fully restore the function and appearance he had lost. During this same period, R.C. also continued to refuse antidepressant medication. During his daily psychotherapy session, he acknowledged that he was depressed and continued to express suicidal ideation. Yet he persisted in his belief that neither surgery nor medication aimed at treating his depression were in his best interest, due to the extensive damage he incurred from his suicide attempt. He communicated that he wished to have his J-tube feedings discontinued, writing, "I don't want to live like this any longer."

R.C.'s children supported their father's refusal of surgery and antidepressant medication. Although they spent many hours over the course of several days trying to persuade him otherwise, they believed he understood his options and was making reasoned choices that reflected his life values and goals. Further, they believed his desire to have food and hydration withdrawn was consistent with his previously expressed values and preferences regarding end-of-life treatment. Citing his strong religious convictions and belief in an afterlife, his children contended that their father did not perceive continued life in his present condition as being his highest value and serving his best interest.

The treatment team, consisting of the hospital social worker, nutritionist, and physicians from the plastic surgery and psychiatry services, requested a hospital ethics committee hearing. R.C.'s family was also in attendance. At the hearing, the ethics committee learned that during the previous night, the patient's requests for discontinuation of the feeding tube had abated and that he was now expressing a wish to begin antidepressant medication. Functioning as an advisory body, the ethics committee determined that the patient had the right to refuse both antidepressant medication and further surgery. Although acknowledging that R.C.'s depression was likely affecting his judgment, the committee determined that the patient's capacity to comprehend information and make choices regarding these specific treatments was not significantly impaired. However, because the withdrawal of food and hydration had irrevocable consequences, the committee determined that a higher standard of decisional capacity had to be met before the treatment team could accede to the patient's wishes in this particular case. Although not precluding the future possibility of withdrawing life-sustaining treatment, the committee did not support the wishes of the patient and his family to discontinue the tube feedings at that time. Subsequent to the hearing, R.C. agreed to reconstructive surgery.

Although the patient's changed views eliminated the need for a direct decision, this case nonetheless raises several concerns. In medicine, seriously ill patients are assumed to be capable of making choices about their desired level of care. In psychiatry, however, seriously ill patients have traditionally been assumed not to be competent to make many choices about their care (for example, suicidal patients are assumed not to be capable of making decisions about their life and death). This case demonstrates the conflict that sometimes arises between the medical and psychiatric traditions.[3] Hence, the following questions warrant attention:

1. In what ways can a medically ill patient with a concurrent mental illness (such as, depression, anxiety, or hypomania) be viewed as a morally autonomous agent capable of expressing legitimate decisions to refuse treatment?
2. How does a psychiatrist preserve a depressed, medically (but not terminally) ill patient's self-determination when the patient's refusal of treatment is accompanied by suicidal ideation? Is there a role for the concept of "limited decisional capacity"? That is, in what ways does the task-specificity of the determination of competency discern morally relevant differences between types of treatment?
3. If R.C. had persisted in his request that food and hydration be withdrawn, and his family had continued to support his choice, on what ethical and legal grounds, if any, could his request be honored?

Clearly, the patient's eventual informed acceptance of the recommended treatments made this case easier for the ethics committee. Nonetheless, R.C. might not have changed his mind. This possibility makes the critical analysis of these questions all the more pressing.

NOTES

1. L. Ganzini *et al*., "Do-Not-Resuscitate Orders for Depressed Psychiatric Inpatients," *Hospital and Community Psychiatry* 42 (1992): 915-19.

2. A.N. Wear and D. Brahms, "To Treat or Not to Treat: The Legal, Ethical and Therapeutic Implications of Treatment Refusal," *Journal of Medical Ethics* 17 (1991): 131-35.

3. M.D. Sullivan, N.G. Ward, and A. Laxton, "The Woman Who Wanted Electroconvulsive Therapy and Do-Not-Resuscitate Status," *General Hospital Psychiatry* 14 (1992): 204-9.