'I Don't Want to Live Like This Anymore': CL Psychiatry and Clinical Ethics' Roles in Withdrawing Life-Sustaining Treatment

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BACKGROUND

- **C-L psychiatrists** often **assess decision making capacity (DMC)** in end-of-life care.
- **Clinical ethics consultants** assist with difficult decisions involving **uncertainty or conflict about values** (Carrese 2012).

CASE

- Ms. A: **27 y.o.** w/ granulomatosis with polyangiitis c/b by **ESRD on HD for 7 years**. Psychiatric hx: MDD; PTSD; tobacco, cannabis, and cocaine use disorders.
- Presented to ED w/ **passive SI** and abdominal pain after 1 week of missed HD.
- **Ms. A repeatedly declined** medications, diagnostics, and dialysis. She consistently stated, **"I do not want to live like this anymore,"** with chronic illness and HD.
- CL psychiatry consulted for concerns about MDD exacerbation. Determined **she had DMC to decline dialysis**. Ms. A's distress stemmed from **demoralization** over 5 years of declining health + psychosocial stressors.
- **Interdisciplinary team** assembled: clinical ethics, palliative care, and CL psychiatry. Code status **switched to DNR** - her values were independence and comfort, not longevity.
- **Discharged to hospice** where she died within two weeks.

DISCUSSION

- **Demoralization is distinct from MDD.** Both are considerations when assessing DMC (Clarke 2002).
- Ms. A's consistent, strong desire for hospice (autonomy, informed consent, and nonmaleficence) outweighed physician obligation to beneficence (Varkey, 2021).
- Other ethical considerations: **act/omission doctrine, doctrine of double effect**, and **active vs. passive euthanasia.**
- **Quadruple aim**: Consider moral distress clinicians experience with necessary respect for patient's autonomy to withdraw dialysis, ending life (Bodenheimer 2014).

Figure. MDD and Demoralization

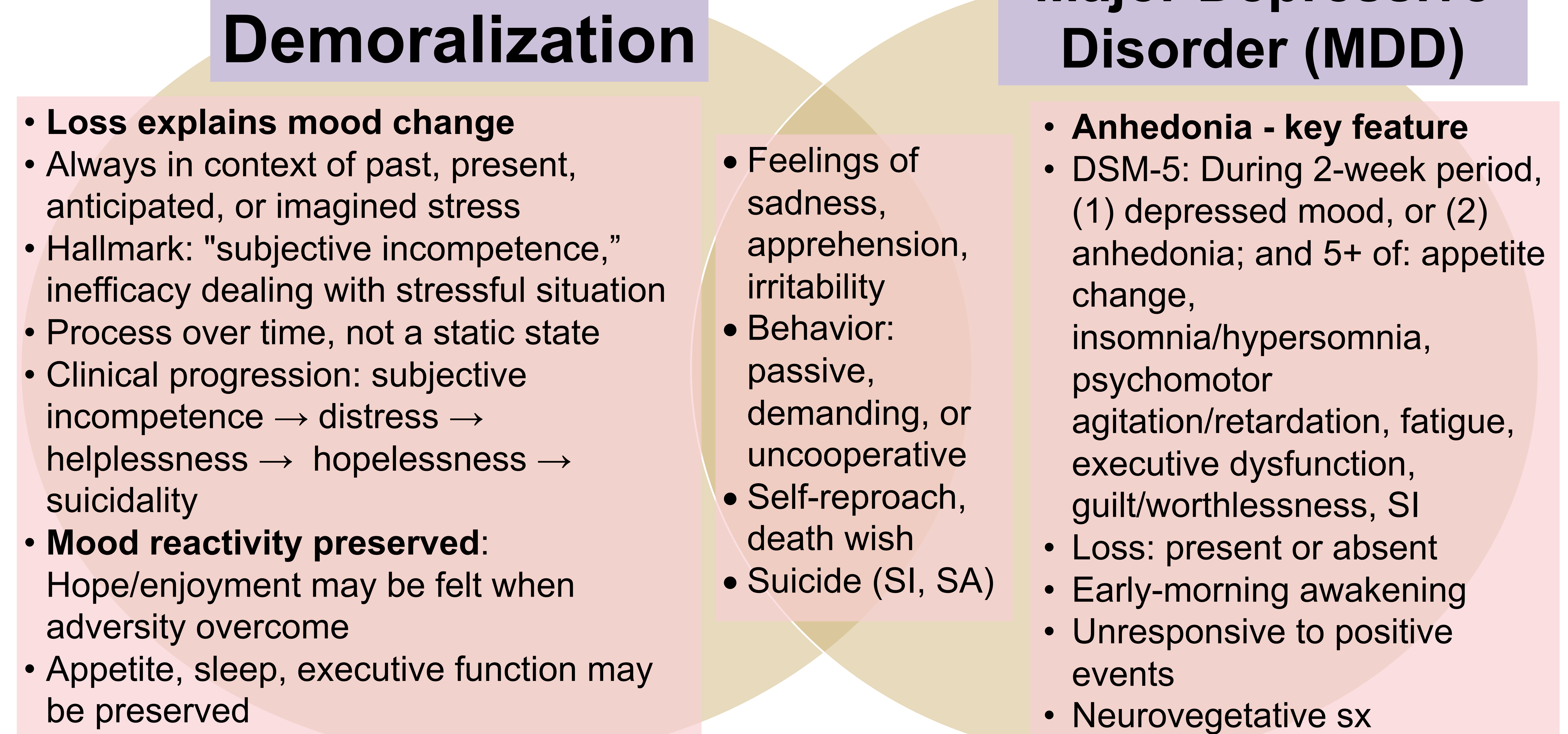

Table. Clinical ethics analysis for Ms. A's case

Ethical Principal	Application to Ms. A's case
Beneficence: Act for patient's benefit and promote welfare	• Metabolic and electrolyte abnormalities 2/2 ESRD treatable with dialysis and medications • Physical pain symptoms treatable with opioid and non-opioid therapies • Emergency hold for SI in ED; Admission to medical-psychiatric unit for 24/7 care • Per rheumatology, patient could live full life on immunosuppressants and against withdrawing care
Nonmaleficence: To not harm patient by avoiding death, pain, suffering, incapacitation, offense, and deprivation	• Withdrawal of dialysis and pharmacologic interventions would inevitably cause death • Release from the hospital could result in SA • Patient was without permanent housing and release from hospital would expose to associated risks • Patient had transportation limitations so hospital release could mean immediate missed dialysis
Autonomy: Respect for person's intrinsic power to make choices for self-determination	• Patient expressed consistent desire for 2+ years to not pursue dialysis; despair with quality of life and wish to not live in this condition; conviction to pursue hospice care and withdrawal life sustaining therapies • Decision to refuse daily medications respected in hospital
Informed consent: DMC + full disclosure (risks, benefits, alternatives) + voluntarily accept/decline	• Patient deemed to have medical capacity to refuse dialysis and pursue hospice care
Truth-telling: The right to know diagnosis + prognosis, with option to forgo disclosure	• Patient expressed desire to know. Team communicated diagnosis of ESRD 2/2 autoimmune pathology and prognosis of lifelong HD given current non-candidacy for kidney transplant
Confidentiality: To not disclose confidential information without patient authorization	• Open dialogue and consent obtained from patient to discuss medical situation with patient's mother
Justice: Fair, equitable, and appropriate treatment of persons; includes distributive justice of scarce resource	• Kidney transplants are a scare resource

REFERENCES