To Dialyze or Not to Dialyze

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Column Editor?s note: This column presents a problematic case that poses a medical-ethical dilemma for patients, families, and healthcare professionals. As it is based on a real case, some details have been changed in the effort to maintain patient confidentiality. The intent of this presentation is to offer ethical analysis and medical recommendations that are consistent with biblical principles. In this case, the second consultant offers further insight into the ethical discussion behind the steps in the recommendation of the ethics consultant.

Column editor: Ferdinand D. Yates, Jr., MD, MA, Acting Consultant in Clinical Ethics, CBHD

Question
Is it mandatory to dialyze a combative patient who is a threat to himself and to others?

Case:
A comatose 64 year-old man was brought to the Emergency Room by ambulance. Someone who remained unidentified had called ?911? only to say that he needed immediate dialysis. There was no family with him, and the patient?s records were retrieved from a nearby hospital. His history included Type 2 Diabetes Mellitus for many years with multiple complications: end stage renal failure (Stage 5 Chronic Kidney Disease), hemodialysis dependence, bilateral above knee amputations (AKA), a previous cardiac arrest with post-resuscitation cerebral anoxia, multiple prior strokes, and heart disease with many admissions for heart failure. He had not dialyzed for nearly one month, and the dialysis unit was also contacted regarding his previous treatments at their facility. Apparently, his course had been complicated by his verbally and physically abusive behavior towards other patients, their families, as well as dialysis center staff. Although he was not disruptive in other environments, when he arrived at the dialysis unit he exhibited multiple dysfunctional and potentially dangerous behaviors. He struck and insulted people in the waiting room, he spit at nurses and dialysis technicians while on the machine, and he pulled out his needles when he was unattended. Occasionally, the
bleeding from this activity was substantial and startled other patients. The unit decided to discharge him from their care and to discontinue dialysis.

After Emergency Department evaluation, he was admitted to the hospital with a critically elevated potassium level. He was dialyzed emergently one time, and his family was contacted by the primary care team and nephrologist for a conference. His divorced wife and a 28 year-old daughter comprised the patient’s entire family, and neither had obtained legal decision making authority through durable power of attorney. As the patient was not competent to make his own decisions regarding his dialysis and other essential care, they were queried as to what statements, if any, the patient had made in the past regarding future medical care. They insisted that he be chronically dialyzed despite the preceding history of abusive behavior. They said that “when he wakes up, he says that he wants to dialyze.” He was temporarily dialyzed three times a week, and an Ethics Consultation was obtained to assist in decision-making.

A review of the past medical history noted that about one year ago, when the patient suffered a heart attack, he also had post-resuscitation anoxic brain injury. Prior to the episode, he did have bizarre behaviors that were primarily self-directed. (He deliberately slammed his below-the-knee amputations into the floor to the extent the bleeding necessitated that AKA be done.) Sometime after the brain injury, he began to exhibit the more violent behaviors that were threatening, dangerous, and abusive to others.

ETHICS CONSULTATION

The Ethics consultants faced a number of challenges. Since the patient could not communicate, were his former wife and his daughter appropriate surrogates? Were they acting in the patient’s best interests or were they motivated by other dynamics in their efforts to continue his dialysis? Was his behavior in the previous dialysis unit appropriately documented and determined to be irreversible? Were there elements of delirium, or had the strokes and anoxic brain injuries made his behavior permanent? Should he be sedated in order to continue chronic dialysis? If not, was discontinuation of dialysis an ethical option?

The consultants decided to obtain the relevant information regarding the patient and his behavior from three sources prior to rendering their opinion: 1) the dialysis unit staff that cared for him during the preceding year, 2) the nurses and staff who cared for him during the present admission, and 3) his family. The family gave permission to review his dialysis unit records. They only cautioned the ethics consultants that one nephrologist at the unit made the decision to discontinue his dialysis because he was frustrated with the family’s behavior and that he had been rude to them.

The staff members at the unit were consistent in describing the patient’s abusive behavior. Whereas it had begun prior to his cardiac arrest, they agreed that it worsened afterwards. The behavior did not seem to “wax and wane,” but was persistent and potentially dangerous to the patient, other patients, and the health care team. In contrast to the family’s contention, four rounding nephrologists were involved in the decision to discontinue his dialysis, not merely the one who may have been biased according to the initial family meeting. One nephrologist admitted that he could only sedate the patient on high dose, parenteral antipsychotic medications and he felt that this option was untenable for a prolonged period of time. Prior to discontinuing the patient’s dialysis, the unit staff and administration held a meeting with the family. They apprised the former wife and daughter that, if a family member sat with the patient on dialysis and helped to relax him, they would try to continue his treatments. However, the family continued to “drop him off” at the unit and leave. The unit documented the meetings in writing and officially discontinued the patient’s access to dialysis at their unit. Some staff members alleged that the family profited from the patient’s Social Security income and therefore desired to have dialysis continued.

The dialysis nurses who had treated the patient at the hospital after his recent admission were asked about his
behavior. Even though he dialyzed enough (four times regularly) to reach a comfortable baseline, he was verbally and physically abusive, and he tried to pull out his needles unless he was restrained and heavily sedated. The behavior had only become worse after he ?woke up? after 1 month without dialysis. No one had been able to hold a meaningful conversation with him regarding his medical treatment plan.

After obtaining this background information, the consultants met with the family and recommended no further dialysis. The consultants, primary care team, nephrologists, and nursing staff of the hospital unit unanimously agreed with that decision. The family disagreed with the decision and requested another attempt with sedation, however they were diplomatically refused.

Commentary by Robert D. Orr, MD, CM

ASSESSMENT:

This patient in chronic renal failure exhibits intolerable behavior during dialysis, and the professionals caring for him are unwilling to continue giving dialysis.

DISCUSSION:

Difficult behavior can be a complicating factor in the care of patients. If the difficult behavior occurs outside of the professional care setting (e.g., failure to follow a diabetic diet, failure to return for needed procedures), caregivers may become frustrated, but it is generally accepted that they have a responsibility to provide ?rescue treatment.?

If the difficult behavior occurs in the care setting, however, obligations and management options are often different. The differences depend on (a) whether the behavior is volitional, (b) the importance of the treatment, and (c) whether the behavior presents a danger to other patients, or even to the professional caregivers.

If the behavior is non-volitional and presents no danger to anyone (i.e., it is merely a matter of inconvenience or extra expense), the professional caregivers have the same obligation to provide treatment as they would for any other patient. If the behavior is volitional in a patient who has capacity, it is ethically permissible to negotiate with the patient regarding terms and limits. If forgoing the treatment presents an imminent danger to the patient, limits should probably be extended as far as possible. If that difficult behavior presents a danger to others, those terms and limits may be more stringent.

If the behavior is non-volitional (or the patient is unable to understand its consequences) and it presents a danger to other patients or to staff, management is even more difficult, especially when forgoing the treatment presents a serious danger to the patient. Efforts should be made to change the environment, to use behavior modification techniques and/or judicious sedation, or to provide close supervision, especially supervision by family or others known to the patient. Rarely, however, if these measures are not effective, it may be ethically justified for those professionals to withhold treatment from a patient in order to protect the well-being of other patients or professional staff. In those situations, especially when the treatment is life-saving, the professional caregivers should try to make alternative arrangements for treatment. If all available treatment sites have attempted treatment (or at least given serious consideration) and all are unwilling to provide the life-saving treatment, it may be ethically justified to accept the fact that the patient is untreatable. Every effort should be made to avoid this tragic outcome.

In this case, it is reported that the patient exhibited difficult behavior only at the dialysis center. Efforts were made to calm him by having family present and by using sedation. His verbal abusiveness and actions that startled other patients are probably not adequate justification for withholding further dialysis. However, physical
abuse and splattering blood might justify such action if they presented uncontrollable dangers, e.g., if he was felt to be capable of serious violence or if he carried blood-borne pathogens. The level of such risk is a judgment call that can only be made by the professionals involved.

RECOMMENDATIONS:

1. It is ethically permissible to negotiate with this patient and his family about management options and the limits of tolerable misbehavior at this dialysis facility.

2. If this fails, efforts should be made to transfer care to a willing facility.

3. If no other treatment facilities are willing to take the patient, and if the patient’s behavior presents unmodifiable dangers to other patients or staff, it is ethically permissible to withhold dialysis and arrange for palliative care for the patient.

Case Denouement: The patient was lost to follow-up and may have expired.

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