CASE REPORT

Can a Depressed Patient Give Consent for Tubal Ligation?

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Abstract

Notion of competence to consent to treatment was originally required to address mainly cognitively impaired or psychotic individuals. According to mental health bill, every person with a mental illness shall be deemed to have capacity to make decisions regarding his mental care or treatment if such person has ability to understand the information relevant to mental health care or treatment, retain the information, use or weigh the information as a part of process of making treatment decision and communicate his decision by any means including talking, using sign language or any other means. We present to you a case of a young woman who had depression and was refused tubal ligation as she was not considered compos mentis to give consent for the same. This case highlights the need to liaison with the medical fraternity and creates awareness about different aspects of mental health for better management of the psychiatric patients.

Keywords: Consent, Depression, Mental Health Bill

Introduction

Depression imposes considerable emotional and financial burdens on families and the society. A depressed patient can refuse psychiatric treatment which should be respected on the basis of widely accepted principle of respect for autonomy. However when the treating doctor other than the psychiatrist refuses treatment to the patient on the basis of depression the question of competence arises. The notion of competence to consent to treatment was originally required to address mainly cognitively impaired or psychotic individuals but today there is a focus on the decision-making capacity required for autonomous treatment choice in the mentally ill patient. The understanding ability is a pre-requisite for a patient’s consent or refusal to be ‘informed’. To assess understanding it is necessary to ensure that information has been given to the patient in a manner clear enough to be understood. We present you a case who had depression due to underlying domestic violence and was refused tubal ligation as she was not considered compos mentis.

Case

A 25 year old woman sought psychiatric referral for symptoms of sadness, headache, giddiness and unresponsive spells. Her history revealed that with loss of her father at 10 years of age, patient was married at 12 and in the 13 years of marriage she suffered harassment for dowry, severe physical and emotional insults of 5 pregnancies, husband’s extramarital affair, lack of support from
her in-laws, domestic violence (DV) in the form of verbal and physical abuse and economic deprivation. Patient also had a miscarriage 6 months ago, when she was pregnant for the 6th time with additional complications of severe blood loss and a hemoglobin of 6gm % for which she required blood transfusions. Patient had not recovered from this bodily insult when she repeatedly faced allegations from her in-laws that she had purposefully had a miscarriage as she did not want to give them a male child. Since 3 months, patient complained of sadness of mood, crying spells, lethargy, disturbed sleep, ideas of hopelessness, helplessness, and worthlessness along with repeated unresponsive spells. It was in this condition that patient was admitted in the psychiatry ward.

She was started on oral escitalopram (10 mg) and haematinics. Patient was examined for bruises and counseled. During one of the sessions patient confided that she wanted a tubal ligation. She also informed that her husband and in-laws had thwarted all earlier attempts from her side for any form of contraception. The patient’s in-laws and husband were then counseled but despite written consent, the gynecologist refused to do tubal ligation as she felt that a depressed patient’s consent was not valid. She instead advised vasectomy to the patient’s husband which he refused. Several talks later the patient’s tubal ligation was done after 2 weeks. During this time some of her depressive features also improved and after an inpatient stay of 1 month with assured support from health care professionals, her mother and in-laws, patient went home physically and emotionally better.

Discussion

This patient had experienced several life events from the tender age of 10. The loss of a father figure, mother who was trying to support the family, child marriage to a person 10 years older, insecure environment at her in-laws house with constant verbal, sexual, emotional, economic and physical abuse, repeated unplanned pregnancies, no contraceptives used by her husband and demand from the in-laws for a male child definitely had a tremendous impact on her mind resulting in depression.

As the patient wanted TL, we were most surprised when the gynaecologist refused surgery as she felt that consent for surgery in depression was invalid. A literature search revealed that the notion of competence to consent to treatment was originally required to address mainly cognitively impaired or psychotic individuals in whom there is poor insight1,2,5. The standard notion of competence to consent for treatment includes four components- ability to express choice, ability to understand information, ability to appreciate the personal relevance of this information and ability to reason logically in decision making2-4. Rudnick has reviewed about depressed patients having the competence to refuse psychiatric treatment and has said that the question of the competence of depressed patients to consent to or refuse treatment for their depression has not been sufficiently addressed to date. However he has not mentioned about competence of depressed patients towards their medical treatment1.

According to mental health care bill of India 20136, “mental illness” means substantial disorder of thinking, mood, perception, orientation, memory to recognize reality or ability to meet ordinary demands of life, mental conditions associated with abuse of alcohol or drugs but does not include mental retardation which is condition of arrested or incomplete development of mind. According to the bill, every person with a mental illness has the capacity to make decisions regarding the mental care
or treatment if such person has ability to understand the information relevant to mental health care or treatment, retain the information, use or weigh the information as a part of process of making treatment decision and communicate his decision by any means including talking, using sign language or any other means.

The patient clearly understood the information about benefits and consequences of the procedure of tubal ligation. She had insight into her mental illness for which she wanted treatment and also was aware that one of the causes for the deterioration in her physical health were her multiple pregnancies, for which she wanted tubal ligation. She had every right to think about her own health and consider TL. The refusal to do TL was happening in an urban tertiary care centre where the awareness among the medical fraternity about mental illnesses is supposed to be better than the doctors doing rural practice. It took several meetings with the gynecologist to create awareness about the mental health bill, competence of the patient and right to consent after which the patient finally got operated after 15 days.

Since she was suffering from depression, her decision of undergoing tubal ligation was challenged without judging her emotional insight. Some researchers have found that psychiatric inpatients have a good understanding but poor appreciation and reasoning in relation to decision making capacity for their treatment, which is contrary to our finding.

This case highlights the need to liaison with the medical fraternity and creates awareness about different aspects of mental health by case conferences, continuing medical education programs. Then only we can hope for better doctor patient communication and doctor patient relationship and implementation of health as a human right to yield better outcomes.

References


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