

# The Acceptability of Discontinuing Treatment After an Unsuccessful Suicide Attempt

Greg Loeben, Ph.D.

Associate Professor

Midwestern University

“Once we recognize that ethics is not best reduced to the search for a universal solvent of moral dilemmas, we are free to explore the varied and rich texture of moral talk and thought.”

- Edmund Pincoff

There is but one truly serious  
philosophical problem  
and that is suicide.

- Albert Camus

# Rule of Rescue

- Generally speaking, when someone is injured or harmed in a way that threatens their life we attempt to save that individual.
- If there are questions about whether saving them is what they wanted or in their best interests, unless we have enough time to sort it out, we save them first and sort it out afterwards.
- Suicide attempts usually require us to save an individual prior to knowing whether death is truly what the individual wanted and/or in her best interests.

# Case

- Patient is a 45 y/o woman, presented through the ER after her husband called 911 because he had found her unconscious on the bathroom floor.
- At the hospital it was determined that she had taken an overdose of Tylenol in an apparent suicide attempt.
- Patient was stabilized and is currently in ICU on hd4. She is unconscious, on a vent, and her liver function is severely compromised.

# Case

- The physicians believe she will survive and that her liver function will recover enough to support her.
- They expect she will need the vent for at least a few more days, maybe longer.
- They think she will return to her baseline, but it is possible the suicide attempt will result in reduced functioning.
- Family (husband and mother) are requesting that patient be withdrawn from vent and allowed to die.

# Case

- Patient has a 17 year history of lupus, which the family (husband, mother, family friend) states has progressed over time to the point where the patient no longer finds her quality of life acceptable. They offered many examples of this.
- They also stated that they have had numerous conversations with the patient over the years in which she has clearly expressed that she would not want to be on life-support.
- This is her second suicide attempt. The first was 2 years ago.

# Case

- They are adamant that a return to her pre-hospitalization condition would be unacceptable to the patient (from the patient's own point of view) and that anything less would be absolutely terrible.
- They are worried that the medical team is not respecting the patient's wishes and choices and that she will be kept alive and returned to a condition she would not want.

# Case

- Physicians expressed the concern that insufficient treatment of the patient's lupus and possible mental health issues (depression for example) that are a consequence of this may have contributed to the patient's perception of her quality of life and her apparent desire to be allowed to die.
- They also expressed a concern that the patient is not actively dying and a worry that withdrawing treatment under the circumstances would amount to a form of facilitating her suicide attempt.

# Case

- Family understands they could continue treatment, possibly get the patient through this event, then secure additional treatment for the lupus and depression.
- They expressed strong doubt that it would be effective or that she would want it. They state they have pursued treatment previously over the years.
- Given their history with the patient they believe her desire to be allowed to die is not a temporary perspective arising out of a treatable depression or problems with her lupus that can be improved.

# Presumption Against Suicide

- There is a strong presumption that suicidal patients are not acting rationally and therefore we are not required to respect their decision to kill themselves.
  - ◆ Product of mental illness
  - ◆ A cry for help from a desperate person
  - ◆ The result of altered neurobiological states
- There is good evidence (both empirical and anecdotal) that most individuals are ultimately appreciative after their suicide attempt is thwarted.

# Rational Suicide

- Does depression always/necessarily entail that the individual lacks decision making capacity?
- Can a person be both depressed and rationally choose suicide?
- Can a person be depressed and rationally choose anything? If so, how is suicide different?

# Rational Suicide

- If suicide can be a rational choice, are we bound by a commitment to respect autonomy or are we allowed to deny it for other reasons?
  - ◆ Slippery slope → to assisted suicide, euthansia, or worse
  - ◆ Medical duty to benefit and prevent harm
  - ◆ Personal (religious) views about the wrongness of suicide
    - Life is a gift from God
    - You are God's property
    - Suicide violates natural law
    - Suffering is valuable
  - ◆ Suicide is selfish and harmful to others
  - ◆ Respect for the value of life

# Self-Determination & DM Capacity

- Given the great value placed on self-determination (autonomy) in our society and contemporary medical ethics, it is hard to see how any of the previous claims can trump the patient's right to refuse unwanted medical treatment when the choice to do so is believed to be rational—realistic, based on adequate info, in line with their values, etc.
- This implies that we need to be able to make reliable judgments about decision making capacity—because this is a central component in understanding whether the choice is rational and therefore whether we are bound by the patient's choices.

# Decision Making Capacity

- Both poor judgment (biased or incomplete reasoning) and weakness of the will (acting on desires that are not one's most valued) are compatible with possessing decision making capacity.
- We generally hold someone to a higher burden of proof that their decision is rational/reasonable when the consequences of their choice are seen as potentially harmful.

# Suicide and Surrogates

- If suicide can be a rational choice under certain circumstances, how should we think of the surrogate/family's role in providing the information upon which we base our decision?
- In the case presented, almost all of the info about the patient's quality of life, values/choices, and previous treatments was provided by her husband, mother and friend. Is this ever sufficient?
- We regularly use surrogates to provide this info when we decide to withhold or withdraw life sustaining treatment in other end-of-life contexts.

# Suicide and Surrogates

- If we cannot be certain, must we err on the side of preventing death or can we rely on surrogates without much additional proof?
- What is the burden of proof? Must the patient/surrogate prove without doubt that the decision was rational or is it sufficient to provide a reasonable explanation?
- How should we judge whether the surrogate/family's explanation of the patient's QoL and wishes is reliable?

# Assisting the Suicide

- How should we understand the physician's role in a suicide when life sustaining treatment is withheld or withdrawn? Imagine:
  - ◆ The patient will never regain consciousness and everyone thinks quality of life will be too low.
  - ◆ The patient has been stabilized for now, but it is expected that the damage done will lead to death in the near future.
  - ◆ The patient will survive but is currently on life sustaining treatment and the family says her QoL will be too low/
    - Physical impairment
    - Mental suffering

# Physician Concern about Assisting

- Is the physician's concern that she is being asked to participate in or facilitate a suicide sufficient grounds for refusing the request to wh/wd?
- It might be sufficient reason for the physician to transfer care to another, but if the request to wh/wd after a suicide attempt is reasonable how could the physician's personal objections to it be grounds to refuse the wh/wd altogether?

# Advance Directives

- Some hospitals have policies that automatically suspend ADs in the context of suicide.
- Given that the suicide attempt itself causes us to question the patient's decision making capacity, it seems reasonable to temporarily suspend the AD in order to collect more info that might support or disprove the reasonableness of the choice.
- In the absence of evidence other than the suicide attempt itself, should the AD be followed?

# Future Treatment

- In the case presented the physicians were concerned that the patient's lupus and depression might improve with additional treatment. They had little evidence for this and it wasn't even clear how they would accomplish it.
- When is it appropriate to refuse wh/wd of LST based on idea that the patient might be able to get better treatment which would change her QoL?
  - ◆ Physicians tend to think that there is something that can be done
  - ◆ They can overestimate what they can do for someone who claims that previous treatment has not been sufficiently helpful

# WH / WD Treatment

- We accept wh/wd of life sustaining treatment in many other circumstances. Many of these are decisions made by the patient or surrogate/family that an earlier death is a good thing.
- These are choices to allow or bring about death—based on judgments of the patient's values and/or best interests.
- Why are these instances of choosing death acceptable when doing so in the context of a suicide attempt is not?

# WH / WD of Treatment

- Imagine the same scenario as the case presented only the patient did not try to commit suicide. She is in the hospital because she was in a car accident.
- Everything else is the same – her medical history, her family's insistence that she would not want this medical treatment, their demand that the vent be withdrawn, the medical team's belief that she is likely to survive if treatment is continued, etc...
- Would you be more likely to agree to the withdrawal?

# Final Thoughts

- Additional comments or issues?
- What have we accomplished?
- Where do we go from here?