

# ETHICS

## ETHICS IN ACTION

### REFUSAL OF TREATMENT AFTER SUICIDE ATTEMPT

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#### CASE PRESENTATIONS

Case 1. A 37-year-old woman with a history of suicide attempts, alcoholism, and depression self-presented to the emergency department of a community hospital after an overdose involving unknown quantities of Vicodin, alcohol, and acetaminophen. Her initial vital signs were stable and her physical exam unremarkable. Laboratory values were significant for an APAP level of 160, ALT and AST to approximately 2,000, and an elevated INR to 1.5. The regional poison control center (PCC) was consulted and recommended intravenous N-acetyl cysteine (NAC). The patient refused NAC treatment, but accepted other medications, phlebotomy, and EKG monitoring. The ED physician documented the patient as “alert and oriented, has a right to refuse treatment.” A psychiatry consult was not immediately available given resource limitations of the hospital. The patient’s transaminitis continued to worsen to the tens of thousands, and her INR was increasing.

Case 2. An 86-year-old man was brought by ambulance to an urban emergency department after being found unconscious next to an empty bottle of cough syrup with codeine. The patient had been discharged three weeks before, after a pneumonia hospitalization during which numerous pulmonary nodules believed to be metastases from an unknown primary cancer had been discovered. The patient was obtunded, rousing only to sternal rub, and showed signs of respiratory depression unresponsive to naloxone. Despite the presence of DNR/DNI status, the senior resident and an attending began preparing materials for intubation. The patient’s wife, his surrogate decision-maker, was present with family. They pleaded with staff not to intubate the patient and to let him “pass away peacefully.”

#### DISCUSSION

In order to safeguard individual autonomy and limit paternalism, patients must provide informed consent or informed refusal before a medical intervention. At times, these decisions may result in the refusal of treatment that may be lifesaving or life-sustaining, provided that a patient is evaluated for and has decision-making capacity. Capacity is evaluated for a specific aspect of medical care, and a patient may have capacity to make some health care decisions but not others. In general, when patients refuse a high-benefit, low-risk intervention, they must meet a higher threshold for capacity. Emergency physicians may not have the luxury of time to perform an extensive evaluation of patient capacity. The extent of patient autonomy becomes further complicated in the case of treatment refusals after suicide attempts.

In case 1, a young woman refuses NAC after polyingestion and acetaminophen overdose. There seems to be misunderstanding about the extent of the patient’s rights after a suicide attempt. While the patient may be awake, alert, communicative, and consistent, the patient’s suicidality implies a lack of rationality. Empirical evidence supports the view that in most suicide attempts, individuals do not have an unambiguous desire for self-destruction.<sup>2</sup> Patients who attempt suicide are generally thought of as incapable of refusing interventions that are meant to mitigate the harms of a suicidal act or gesture, but they may retain the capacity to refuse other interventions, if not motivated by self-harm.

The fact that the woman self-presented to the emergency department and of her acceptance of some, but not all, interventions implies ambivalence about her will to end her life, and subtle manipulation of the providers. Because early administration of NAC, with its limited-side-effect profile, is a well-studied time-dependent therapy to mitigate hepatotoxicity in acetaminophen overdose with few serious side effects, one can argue that the patient should be treated with NAC against her will. However, it is permissible to engage the patient for her buy-in, involve supportive family, and identify staff with whom the patient has good rapport, before acting. If refusal continues, the treating physicians must continue to evaluate the risk-benefit ratio of the therapy, and consider additional risks of continued

*Continued on Page 9*



# ADVANCE HEALTH CARE DIRECTIVE

## INSTRUCTIONS

Part 1 of this form lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions, or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you.

Your agent must be at least 18 years old and a resident of the same state as you. Your agent also may not be an employee of your supervising health care provider. Your agent also may not be an employee of a health care facility or a residential care facility where you are receiving care, or an employee of a long-term care institution where you are receiving care, unless such person is related to you.

Unless you specify otherwise in this form, your agent will have the right to:

1. Consent to or refuse any care, treatment, service, or procedure, including but not limited to, to maintain, diagnose, or cure a physical or mental condition.
2. Select or change health care providers and institutions.
3. Approve or disapprove diagnostic tests, medical procedures, and prescription of medication.
4. Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other health care, including cardiopulmonary resuscitation.

*Continued from Page 8*

therapy such as allergic reaction or the necessity of chemical and physical restraint if present. The goal is not to act on abstract principle, but rather to do what is in the best interest of a patient who temporarily lacks capacity for certain health care decisions.

In case 2, an elderly man has lived a full life, and has recently received demoralizing news from physicians. He attempts suicide. There are multiple reasons for which some physicians may take pause prior to intubating this patient. First, some physicians may feel that this suicide attempt is rational and justified: given the patient's advanced age and poor prognosis, suicide may be a reasonable attempt at avoiding future pain and debilitation. Second, the presence of the patient's family, who can speak to the patient's life goals and values, and who presumably have his best interests in mind, would shed some light on the patient's state of mind when he created the DNR/DNI order and may guide the treating physician's intuition about the right course of action. Third, it is unclear whether the DNR/DNI order is an absolute prohibition that is still valid, or if it has been voided by suicidal intent.

Can the surrogate trump the usual legal support for physician intervention to prevent death and the physician's misgivings about participating in a suicide? After consulting with the emergency physicians and other family members, the patient's wife demonstrated a clear understanding of the risks, benefits, and alternatives of intubation, including supportive care. She felt that it was in her husband's best interests to allow him to die in the ED on the grounds that his underlying prognosis was poor, and with the knowledge that complications from intubation and transfer to the ICU are common. In this case, the surrogate may oppose intubation to spare the patient pain or suffering, and because the

surrogate is not complicit in the patient's suicidal ideation, and is acting in the patient's overall interests and in accordance with his life goals, such a refusal of care may be consistent with the court's ruling.

## CASE OUTCOMES

Case 1. The patient agreed to have IV NAC on the second day of her hospital admission, after frequent conversations with nursing staff and the treating physician. In the meantime, a court order was sought, but proved to be unnecessary. By that time, her transaminitis had peaked and had begun to resolve and her synthetic function improved. She was discharged to an inpatient psychiatry facility once deemed medically stable.

Case 2. Despite the wife's objections, the emergency physician, feeling that he did not have the time for a full analysis of the case, intubated the patient in accordance with his practice in prior cases of attempted suicide.

On hospital day 3, there was evidence of an aspiration event and ARDS on chest x-ray. The patient was hemodynamically unstable, requiring multiple pressors. After consulting with the hospital ethics committee, the ICU team decided that continued treatment would be non-beneficial and was not consistent with the patient's and surrogate's wishes. The patient was extubated and expired shortly thereafter. ▀

## WORKS CITED

1. Appelbaum PS, Grisso T. Assessing patients' capacities to consent to treatment. *N Engl J Med.* 1988;319:1635-1638.
2. Matthews MA. Suicidal competence and the patient's right to refuse lifesaving treatment. *Calif Law Rev.* 1987;75:707-758.
3. Vacco DC. Attorney General of New York, et al. *Petitioners v. Timothy E. Quill et al.* :2298-2301.

