

Saving Life or Respecting Autonomy: The Ethical Dilemma of DNR Orders in Patients Who Attempt Suicide

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Abstract

Extensive bioethics literature discusses DNR orders, but comparatively little has been published on a topic that involves almost every aspect of end-of-life decision making: DNR orders in patients who attempt suicide. Ethics consultants are increasingly confronted with this dilemma in an area where there is little legal guidance or ethical consensus. A case-based analysis of the arguments for and against honoring DNR orders in such patients is presented.

INTRODUCTION AND BACKGROUND

Cardiopulmonary resuscitation was introduced in the 1960s and was intended to reverse cardiac arrests occurring during surgery. By 1974, CPR was so widely applied that the American Medical Association recommended that code status, indicating the patient's preference regarding CPR, be documented in the medical record.² In 1976, hospitals began implementing DNR policies, institutionalizing CPR as the default response to an arrest, unless the patient had previously provided written consent to withhold the procedure.³

The patient Self-Determination Act of 1990, The 1983 report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research,⁴ and the rulings in Cruzan, Quinlan and other landmark cases^{5,6,7} established the right of competent patients, through both advance directives and their surrogates, to refuse life-sustaining treatments, providing the ethical and legal basis of DNR orders. Currently, the Joint Commission standards require all health care institutions to have policies and procedures regarding advance directives and DNR orders. All 50 states have statutory requirements that uphold the autonomy of competent patients to make health care decisions, including those regarding CPR, and to exercise this self-determination through authorized surrogates should they lose decision-making capacity. Few of these statutes, including the New Mexico Uniform Health Care Decisions Act, explicitly mention the dilemma of the suicidal patient who is DNR.⁸

Despite the view of courts, legislatures, and government panels, research over decades has shown that patients' treatment preferences regarding life-sustaining treatment, especially CPR, are often disregarded.^{9,10} A 1997 survey found that most emergency room physicians would resuscitate a patient even when they thought the procedure would not benefit the patient, or the case was futile, primarily out of fear of litigation or criticism. Legal advance directives were generally honored, while other expressions of patient's wishes were not.¹¹ A 2009 study compared emergency room physician practices regarding initiation of CPR from 1995-2007. Advance directives were honored more than 80% of the time, but informal communications of patient wishes were not often followed. Eighty-two percent felt legal concerns should not influence resuscitation decisions, yet 92% believed that their decisions were influenced by such concerns. Because of the current legal climate, more than half of physicians surveyed had performed CPR more than 10 times in the last 3 years in cases where they believed the intervention would be futile.¹²

A voluminous bioethics literature discusses these developments, but comparatively little has been published on a topic that involves almost every aspect of end-of-life decision making: DNR orders in patients who attempt suicide. Most of what has been written on the subject comes from emergency medicine or psychiatry.^{13,14} Beginning in the 1980s, a growing number of states began to implement pre-hospital or out-of-hospital DNR protocols,¹⁵ transferring the ethical and legal dilemmas that had faced emergency room and intensive care physicians to emergency medical

service (EMS) personnel.

These policies increased the likelihood that EMS personnel would encounter individuals with DNR orders who had attempted suicide, and required that ethical and legal guidance be provided on how first responders should manage the ethical dilemma.¹⁶ Most state protocols instruct EMS to provide CPR to patients in the field who attempt suicide, to allow time for them to be transported to hospitals where more highly trained physicians can sort out the ethical and clinical issues. For instance, the New Mexico Administrative Code states that, “if there is any question about the validity of an EMS DNR order, or there is any indication of an attempted homicide or suicide, initiate resuscitation until such time that the questions have been answered; if possible, contact medical control for consultation.”¹⁷

Koenig and Salvucci report one of the only court decisions directly addressing the question. The San Diego County Counsel opined that a valid out-of-hospital DNR should be honored, even if the individual had attempted suicide.¹⁸ These authors also argue for a prospective systems-based approach that removes responsibility from EMS at the scene. They also question the standard practice of default CPR for suicide attempters:

Although we believe, ‘when in doubt, resuscitate,’ initiating truly unwanted invasive interventions can be viewed as just as egregious as

withholding desired resuscitation. We have a responsibility to examine these issues proactively and attempt to preserve patient autonomy to the best of our ability.¹⁹

Research has highlighted the inadequacies of DNR discussions that may contribute to these dilemmas, especially in teaching hospitals, and the need for improved physician education in soliciting patient preferences.²⁰ Sontheimer examined a case analogous to that presented in this paper in an article appositely titled, “Suicide by Advance Directive,”²¹ while Karlinsky, Cook and colleagues analyzed a series of cases from a psychiatric perspective.^{13,22} Physicians from all specialties were faced with a different, yet related problem, of how to handle DNR orders when the arrest was the result of an iatrogenic event.^{23,24}

THE CASE REPORT

Mr. H is an 81-year old veteran with a history of chronic

obstructive pulmonary disease (COPD) and depression. His daughters went to visit their father at 10 AM and found him awake, but unable to communicate or follow commands. Empty morphine bottles were strewn around the room where he was found. Mr. H’s daughters called an ambulance and had their father transported to the emergency department of the local VA hospital. In the emergency department, there was concern for either an accidental or intentional opioid overdose, and the toxicology screen was positive for opioids. Narcan was administered with some modest and brief improvement in mental status, but Mr. H never obtained a level of consciousness that would enable him to express his treatment preferences. Progress notes written during the weeks before the incident indicated that Mr. H had threatened to commit suicide if his respiratory disease progressed to the point that he could not breathe.

Mr. H was admitted to the medical intensive care unit (MICU), where an arterial blood gas showed him to have a respiratory acidosis. Several hours after arrival in the MICU, Mr. H became hypotensive and bradycardic. The intensive care resident on duty advised the daughters of her concern that the patient would develop respiratory failure that was likely to lead to a cardiac arrest, requiring cardiopulmonary resuscitation (CPR). The daughters indicated their father’s longstanding wish to be DNR. A durable power of attorney for health care (DPOA) executed five years before, although not documenting any treatment preferences, did appoint the two daughters as health care agents.

The intensive care resident explained to the daughters that it was standard clinical practice to utilize CPR, even if patients had clearly expressed wishes to be DNR, if the arrest or respiratory compromise was secondary to a suicide attempt. The daughters informed the resident that they had had several extended conversations with their father over the last year, occasioned by his failing health, in which he had communicated to them his wish not to have any aggressive care when his quality of life declined. The daughters both professed to be devout Christians, but said their father had been an inveterate atheist, whose philosophy of life was that when an individual could no longer function at an acceptable level, he had the right to refuse all life-sustaining interventions. The resident and the intensive care attending, who had now arrived, did not feel they could ethically or legally enter a DNR order, precluding the use of a life-saving intervention that could potentially reverse Mr. H’s respiratory failure, because it was secondary to a suicide

attempt. At this juncture, the MICU physicians requested an urgent ethics consultation to resolve the conflict.

THE ETHICAL POSITION AGAINST A DNR ORDER IN THE SETTING OF A SUICIDE ATTEMPT

The decision to override the DNR request of an individual who has attempted suicide is often framed as a clear and classical conflict between the principles of autonomy and beneficence or non-maleficence. Most physicians, when faced with this case, would respond like those caring for Mr. H and give more weight to the *prima facie* duty to preserve life. A good example is found in Hall:

The other situation occurs when an individual, having authorized an EMS DNR order, attempts suicide and is discovered before the attempt becomes successful. Both circumstances provoke the classic dilemma, where the ethical wishes of rescuers to act for the good of their patient i.e., beneficence, run counter to the individual's autonomous wishes expressed in the EMS DNR order. The rescuer cannot satisfy both of these conflicting ethical principles.²⁵

However, when the clinical ethics rationales grounding this conceptualization are closely examined, an inherent contradiction is apparent: the autonomy of the suicide-attempter is not considered legitimate. Opponents of honoring the DNR orders of those who attempt suicide argue that a large percentage of suicide attempts are irrational acts, and that at the time of the attempt the individual does not possess full and free decision-making capacity. The following passage from an article on ethical issues related to treating suicidal patients in the emergency department is illustrative of this argument:

Generally, we intervene with the suicidal patient based on the assumption that the person is suffering from a mental illness that impairs judgment. This assumption is usually correct, with 90% of suicides being found on postmortem psychological review to be associated with mental illness such as depression, substance abuse, or psychosis. The physician assumes that he or she is acting beneficently in preventing harm (in this case self-harm) from coming to the patient, who is incapable of making a rational choice. Most, but not all, physicians would agree that certain mental illnesses so impair the person as to make autonomous decisions impossible.¹⁴

A corollary of these assumptions is that the individual who

attempts suicide is suffering from a treatable mental illness, and that once effective treatment is provided, the individual will no longer wish to commit suicide. This ethical justification is a logical conclusion drawn from the clinical information. The suicide attempt is not an autonomous act, and hence, its intent does not command the same legal or ethical obligation that would be accorded the wishes of a truly competent individual to refuse life-sustaining interventions. Karlinsky presents a case in which an elderly man, "Mr. B," wanting to end his life to avoid further debility, overdoses on his medications. He is brought to the emergency department where both his advance directive and family insist he would not want heroic measures. The author concludes that the patient should be resuscitated because the directive does not apply to the overdose, from which Mr. B can likely recover. Karlinsky at least partially shifts the locus of decision-making from Mr. B to other parties, "Once in the emergency department, the responsibility, judgment and ethical principles of the physicians became operative factors in addition to the wishes of the patient and the family."²²

A 2010 review of the clinical, ethical, and legal dilemmas related to DNR orders in suicidal patients presents a case report of a patient hospitalized for severe depression, who overdoses on the psychiatric unit and is found unresponsive with a recently obtained DNR order in her hands. The authors argue that contemporary law and policy related to DNR orders are not formulated to encompass the situation of an individual with serious mental illness. They recommend that patients be screened for suicidal ideation before a DNR order is entered, and that states and institutions clarify their response to DNR status in the context of attempted suicide.¹³

Impaired decisional capacity is not the only argument presented in the literature in support of overriding DNR in the setting of attempted suicide. A more fundamental claim with a considerable evidence base is that many patients who have requested DNR orders do not really understand the import of the decision.^{26,27} Even those who have an accurate understanding of the request cannot foresee all the circumstances in which an arrest might occur, and therefore are really not consenting to a DNR order for an unforeseeable event, like a suicide attempt or adverse event.

²⁸ Where physicians are not certain that the patient would have refused resuscitation in a specific situation, and when they believe CPR may be successful, then the principle of beneficence requires the overriding of the DNR order in the interest of providing a good outcome for the patient.²²

Lynch and colleagues, in a comprehensive review, persuasively argue that physician non-compliance with advance directives is due to the lack of substantive legal remedies in either torts of battery and negligence or wrongful living suits for patients whose refusal of life-sustaining treatments is not honored.²⁹ Conversely, as Cook has underscored, when the refusal is in the context of a suicide attempt, physicians confront powerful legal incentives in the form of numerous successful malpractice lawsuits for completed suicides that strongly motivate them to disregard a patient's DNR order.¹³

THE ETHICAL POSITION FOR A DNR ORDER IN THE SETTING OF A SUICIDE ATTEMPT

The most cogent ethical arguments offered for honoring a DNR order are found in Casarett's work on the topic of physician overriding of DNR orders when the arrest is an iatrogenic complication. Casarett presented practicing physicians in a teaching hospital with three cases describing arrest due to underlying disease, an unexpected complication of treatment, and physician error. These considerations are relevant to the case of Mr. H, in that worsening of COPD and the prescribing of opioids for pain in a patient with depression were both factors in the respiratory compromise requiring CPR. Eight percent, 29%, and 69% of physicians respectively indicated they would provide CPR in each of the scenarios. Casarett, in an earlier ethical analysis of the predicament, contends that physicians' willingness to override a DNR order due to an adverse event is the result of a conceptual overemphasis on the principle of non-maleficence, leading them to a practical undervaluation of patient or surrogate autonomy.²³ Non-maleficence bears even greater ethical and legal weight, to the point of taking precedence over all other principles, in the resuscitation decisions of physicians confronted with possible suicide attempts like that of Mr. H. The tendency of physicians to overrate the efficacy of CPR and assess the benefits from a purely medical standpoint, while underestimating the burden of the procedure, particularly in patients like Mr. H, for whom quality of life is paramount, amplifies the primacy of the duty to do no harm.³ The American College of Legal Medicine concurs with Cassaret, writing that, "DNR orders are written when there is no medical benefit anticipated, where there is a poor quality of life expected after CPR, or where the quality of life was poor before CPR. The decision to forgo CPR in the latter two instances is based on the patient's individual value system."³⁰

Casarett advises physicians that a more constructive means of addressing these challenging cases is to focus not on the procedures physicians perform, but on the patient's goals for treatment. He claims that the dilemma itself emerges from the systemic failure of physicians to conduct meaningful conversations with patients about their treatment preferences.²³ In both articles, the author acknowledges that a physician's sense of responsibility and the threat of legal action make the decision to override the DNR even more compelling, but still not ethically justified:

As an ethical issue, this problem is in part 'iatrogenic' because it often results from physicians' failure to talk with their patients. This problem is further compounded by physicians' guilt and fear of litigation. However, to let these considerations justify overriding a patient's prior directive is to lose sight of the patient as a person.²³

The National Center for Ethics in Health Care of the Veterans Health Administration has utilized Casarett's work in an examination of the status of DNR orders in adverse events. The broad definition of adverse event used in the report encompasses the situation of Mr. H. "Adverse events are untoward incidents, therapeutic misadventure, iatrogenic injuries, or other adverse consequences directly associated with care or services provided within the jurisdiction of a medical center, outpatient clinic or other VHA facility."³¹ In a 2006 teleconference on the topic, the National Center for Ethics presents the case of a hospice patient with COPD and a DNR order who has attempted suicide and is resuscitated in the field, only to die several days later. The report examines each of the common arguments in favor of overriding the DNR order and finds them ethically unacceptable. While physicians should strive to improve the quality of end-of-life discussions, "at the time of arrest, regardless of cause, the physician should honor the DNR order unless there is clear evidence to suggest that the DNR order is not valid."³² Such clear evidence is provided in the case Cook describes, where a patient who overdosed in the hospital was found holding a copy of a recently completed advance directive requesting that she be DNR.¹³ This patient's request to not be resuscitated in the context of an intentional overdose rendered the DNR order an integral aspect of her suicide plan. The patient's wish to be DNR was thus not an independent and deliberate choice, isolated from her impulsive decision to commit suicide. Implicit in this approach is recognition that several empirical ethics studies, although certainly not all,³³ have found that patients'

preferences regarding DNR status are stable over time, with choices to refuse care more consistent than those to accept it.^{34,35}

Based on this evidence, insisting on the need to question the validity of DNR orders at the time of an adverse event, like a suicide attempt, will not prevent, but will actually cause, more harm than benefit. The National Center for Ethics argues that questioning valid DNR orders fails to honor patient preferences and may lead to patients receiving CPR against their wishes, with the attendant physical and psychological suffering.³² The National Center for Ethics rejects the claim of Karlinsky and many clinicians that the interests of third parties, including physicians, carry moral weight:

Finally, the interests and preferences of persons other than the patient do not in any way justify overriding a DNR order, and providers need to be educated that the concerns of other patients or themselves are not ethically valid reasons to manage DNR orders differently when adverse events cause arrest.”³²

THE ETHICS CONSULTATION ANALYSIS

The consultant assumed that the patient’s current respiratory compromise was likely due to a suicide attempt, resulting from an untreated depression and declining physical health. The claim of the treatment team that these facts legitimated overruling the patient’s preferences was not found to be ethically persuasive. While Mr. H’s treatment preferences were not articulated in his advance directive, they were clearly and convincingly expressed through his surrogates. The surrogates’ decision was particularly persuasive for two reasons: first, the decision was rooted in explicit and repeated conversations with Mr. H, regarding not only his wishes about medical care, but also his philosophy of life; second, the surrogates’ decision was diametrically opposed to the daughters’ own religious beliefs and filial attachment that would have insisted upon resuscitation, and was, thus, an impressive example of substituted judgment.

From the psychiatric perspective, Mr. H’s choice to overdose might not have been an entirely rational act, but ethically the decision to be DNR must be analyzed separately from the decision to attempt suicide. Without persuasive evidence to the contrary, the rationality of a DNR decision is assumed. A defense of the profoundly complex and controversial contention that there are rational suicides was not essential to the ethical reasoning supporting the consultant’s decision.

While that profound question is outside the scope of this paper, there exists legal analysis to support honoring DNR orders in suicide attempts:

“Passive assistance” occurs when a health care provider does nothing to prevent a patient’s suicide. In the health care context, however, passive assistance has been an ethical practice for many years. For example, do-not-resuscitate (DNR) orders have been instrumental in forming the current awareness of rights and responsibilities in the area of death and dying. A physician who refrains from attempting cardiopulmonary resuscitation (CPR) on a patient who has made a rational choice to commit suicide is within the acceptable guidelines of the practice of medicine.⁵

After extended conversations with the daughters and a methodical review of the extensive medical record, the consultant determined that the patient’s wish to not be resuscitated was the result of long and careful deliberation, and consonant with his avowed values and goals. No basis could be identified for the claim that the patient’s desire to be DNR was circumscribed, conditional, or confused, such that overriding the patient’s wish to be DNR was ethically justified in this situation. The consultant’s recommendation to the attending physician that a DNR order be entered on behalf of Mr. H was followed, and several hours later he suffered a respiratory arrest and died with his daughters at his side.

A conventional formulation would contend that the origin of the respiratory depression from a suicide attempt was the ethically determinative factor. This perspective would logically have led to the recommendation to override the surrogates’ request for a DNR order. Yet this attribution gives more ethical weight to a choice the patient appeared to have made impulsively and proximately, with questionable decisional capacity, rather than the distal and deliberate preference of an individual with intact capacity to refuse life-sustaining treatments. It is this crucial difference in the timing of the act and the constancy of the intention, which distinguishes a case like Mr. H from those Cook and others have reported, in which the DNR order is either preparatory to, or part of, the suicide attempt.^{13,21} In these cases, the choice of the patient to obtain a DNR order and to commit suicide were volitionally coterminous, in a way Mr. H’s distinct and separate decisions to refuse life-sustaining treatment and to attempt suicide were not. While it can still be argued that even in Mr. H’s case DNR orders should be overridden, the apposite differences in the two types of

cases warrant further examination.

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