The Journal of Emergency Medicine, Vol. 52, No. 1, pp. 117–120, 2017

0736-4679/$ - see front matter

http://dx.doi.org/10.1016/j.jemermed.2016.09.004

Ethics

SUICIDAL PATIENTS WITH A DO-NOT-RESUSCITATE ORDER

Mary P. Henman, RN, MSN, D. BIOETHICS

Meriter Hospital, Madison, Wisconsin

Reprint Address: Mary P. Henman, RN, MSN, D. BIOETHICS, Meriter Hospital, 202 South Park Street, Madison, WI 53715

□ **Abstract—Background: A suicidal person with a do-not-resuscitate (DNR) order presents an ethical dilemma to the emergency physician. Many believe that suicide is an irrational action, and therefore, all suicide attempts must be treated. Others believe a DNR order should be respected even in the setting of a suicide attempt. Case Report: An elderly woman with a known terminal illness presented to the emergency department after a suspected suicide attempt. She had a DNR order during her previous hospitalization. The emergency physician felt obligated to intubate the woman despite his recognition that she was terminally ill. Discussion: Reasons to both honor and not honor a DNR order after a suicide attempt are reviewed. Conclusion: Not all patients who attempt suicide are necessarily incapable of making a rational decision about their health care. In some cases it may be appropriate to withhold resuscitation attempts in suicidal patients who have a preexisting DNR order. Institutional policies are needed to provide guidance in this situation.** © **2016 Elsevier Inc. All rights reserved.**

□ **Keywords—ethics; prehospital DNR; suicide; hospital policy; DNR order**

INTRODUCTION

Do-not-resuscitate (DNR) orders have existed for 40 years and yet confusion and controversy often arise in their application (1). For example, disagreement still exists about patients having a DNR order while undergoing surgery or other invasive procedures (1). Also, there is frequently confusion as to which treatments are to be given and which should be withheld, as there is a tendency to apply a DNR order to more than just the actual resuscitation of a nonbreathing, pulseless person, as it was originally intended (1). Prehospital DNR orders have added another layer of complexity. Many states limit prehospital DNR orders to patients who are terminal, but the definitions of terminal vary from a life expectancy of <2 weeks to up to 6 months. Other states have no specific timeframe and leave the interpretation to the physician's judgment. Some states extend DNR orders to those with chronic illnesses and others have no specific requirements (2). Even in states that require a terminal diagnosis, physicians may not be aware of this requirement and issue an order to someone who requests it based solely on personal preferences and not on a terminal diagnosis.

Many health care professionals assume all suicide attempts must be treated. This assumption is consistent with the commonly held belief that suicide is an irrational choice and therefore not to be respected (3). But that assumption must be questioned when one considers that five states and several countries have already passed legislation legalizing assisted suicide (4). How one responds to a suicide attempt depends on one's view of the act of suicide. If one sees suicide as an act that is not chosen by the victim, but rather, something that happens to the victim as a result of an illness, then there is a duty to save the person from the evil act they cannot help from inflicting on themselves (5). Others would argue that we have no right to force people to stay alive and people should have the freedom to choose to not live at all (6). Some may have a moralistic perspective about

RECEIVED: 30 April 2016; FINAL SUBMISSION RECEIVED: 24 July 2016;
ACCEPTED: 5 September 2016

suicide and view it as a disgraceful, cowardly act where others view it as a reasonable act to avoid pain or suffering. All major religions condemn suicide, but not all people are religious (7).

Given the divergent opinions about the nature of suicide and the confusion that may arise with any DNR order, it is no surprise that a suicidal person with a DNR order presents a particularly complex dilemma. How should the emergency physician (EP) decide whether or not to honor a DNR order in a suicidal patient? This article will argue that not all patients who attempt suicide are necessarily incapable of making a rational decision about their health care. In some cases it may be appropriate to withhold resuscitation attempts in suicidal patients who have a preexisting DNR order.

CASE REPORT

Mrs. M was an 84-year-old woman with a long history of chronic lung disease and a recent diagnosis of lung cancer with metastases to her bones. She was hospitalized the previous week with pneumonia. At that time, she requested to have a no-code order. Unfortunately, this choice was not addressed on discharge and no community DNR order was written. On the day of her subsequent admission to the emergency department (ED), her son found her in her apartment, barely responsive. He called 911 and informed the paramedics he believed she had attempted suicide based on the number of pills missing from her recently filled prescription of OxyContin (Purdue Pharma LP, Stamford, CT). She was transported to the ED with adequate vital signs and respiratory effort. On admission, her breathing gradually became slower, and despite a dose of naloxone, it seemed she would need intubation and mechanical ventilation. The patient was too groggy to participate in decision-making. The issue was addressed with her son, who was also her power of attorney for health care. Because he had now had some time to reflect on what had happened, he felt he may have made a mistake by calling 911. He requested that his mother's previous wishes to have a no-code order be honored and she not be intubated. The EP was reluctant to follow these wishes because the patient had apparently attempted suicide. The physician's belief was that suicide patients must always be treated. The patient's primary care physician was consulted and the physicians agreed that because the patient did not respond to naloxone, her deterioration was likely due to her underlying disease and not an opioid overdose. Therefore, Mrs. M's previous DNR order should be respected. She was admitted to a general medical unit for comfort care, where she died several hours later.

DISCUSSION

Reasons to Honor a DNR Order Despite a Suicide Attempt

In most circumstances, we presume prehospital DNR orders are valid and should therefore be honored. There is no mechanism in the law to unilaterally void a DNR order without the patient's or a proxy's consent. Overriding a DNR order and imposing treatment without consent makes one vulnerable to claims of battery (8,9). People can legally choose to end their lives. Whereas there are still laws against assisting suicide in most states, there are no laws against committing suicide. Those who complete suicide are usually viewed as victims of their emotional distress, not as criminals, as they once were (5). The cause of the illness should not affect the decisions to withhold life-sustaining treatment when it is otherwise appropriate (10). In the current case, the EP should have foregone the naloxone and allowed the dying process to continue because naloxone is not normally given to dying patients who have received opioids.

Health care providers have a responsibility to respect patient autonomy (11). It is true that an acutely suicidal person may not be thinking clearly and therefore not acting in his or her best interest. But respecting autonomy is more relevant in cases where patients have the ability to consider their decision over time, such as one with a terminal diagnosis who obtains a DNR order (7). Autonomy does not just apply to the ability to determine the course of one's life, but also the course of one's death (5). Suicide may at times be a rational decision. Battin identifies five criteria that may deem a suicide rational. These are 1) the ability to reason: can the person see the consequences of his or her actions and weigh the prospect of dying against existing with a terminal disease?; 2) a realistic world view: does the person have a realistic assessment of the current situation?; 3) adequacy of information: does the person have an accurate diagnosis and prognosis?; 4) avoidance of harm: does the person consider the pain or suffering from the disease to be a greater harm than death from suicide?; 5) accordance with fundamental interests: does the foreseeable loss of independence, mobility, consciousness, etc. make suicide a better option (5)?

Although great advances have been made in treating pain and suffering at the end of life, individuals suffer for different reasons and no one can guarantee that all suffering can be prevented. Suicide may help a person avoid what is feared more than death: a continued existence in a state he or she perceives as worse than death (5).