

Case Study: A Terminally Ill Suicide-Attempt Patient in the ED

A 63-year-old male with metastatic cancer, currently enrolled in hospice but living at home, is brought to the ED by EMS with a gunshot wound to the head that was apparently self-inflicted in a suicide attempt. The family informs ED personnel that the patient has a health care directive stating “no heroic measures.” The Medical Power of Attorney (POA) requests that nothing be done save comfort measures and that the patient should be allowed to die. Despite the wound to the head, the patient is awake and alert.

Legally and ethically could ED personnel at the hospital comply with the patient’s health care directive and the POA’s request? Does the fact that the patient presented to the ED after an attempted suicide factor into the decision?

Commentaries

Editor’s Note: Three persons provided commentaries for this case. Dr. Margaret Barron provided a clinical commentary, Ann Gaylor Rucker provided a legal commentary and Michael Panicola, Ph.D. provided an ethics commentary. We are grateful for their contributions and hope you find these perspectives of interest.

Clinical Commentary

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This case is a tragedy for all involved.

First and foremost, for the patient who was in severe emotional pain and was in such a state of deep despair that he wanted to end his life.

Second, for the family whose last memories of the patient will be tainted by this situation and the guilt they will feel for the rest of their lives.

Third, for the EMS personnel who have to make snap decisions in the field—sometimes without backup from their medical control.

Fourth, for the ED personnel who will also have to make life and death medical and ethical decisions without the benefit of time for critical thinking. Regardless of the final decision, they will second guess themselves and replay the case in their heads for weeks to come.

I assume the patient arrived via ambulance. In situations such as this, the EMS providers would have already established IV access and oxygen per their trauma protocols, regardless of the DNR order. The DNR order does not preclude

“first aid.” Presumably someone gave them permission to transport the patient to the hospital. This also implies permission to treat in this emergency condition—not necessarily definitive treatment, but the “first aid” component. If they were in radio contact with me as their medical control base, I would have told them to initiate the trauma protocols. Since the patient’s airway was not compromised, any decisions about intubation could be delayed until they reached the emergency department. (Most gunshot wounds to the head need to be intubated and taken to the OR for debridement and to control hemorrhage).

The Emergency Medicine physician has the following duties to his patient:

- Take an appropriate history and perform a relevant physical exam or exams;
- Formulate a differential diagnosis based on the chief complaint, the history and the physical exam;
- Order appropriate ancillary studies to refine the differential diagnosis and rule out the most common life threatening causes of the chief complaint;
- Obtain consultation if appropriate;
- Render appropriate treatment;
- Make an appropriate disposition.

In this situation, all of this must be done in a few seconds to minutes. If the patient

did not have a terminal illness the decision would be simple, pull out all the stops and do a full resuscitation. Since the patient arrived awake and alert, the ED physician has the opportunity the talk to the patient. If the family is present, they could (should) be included in these discussions. This is not usually the case in situations such as these.

I discussed this case with my Emergency Medicine colleagues. We all had the same response. We would make the patient comfortable while we tried to sort out the situation. That is, we would supply pain medication, give oxygen if necessary, establish IV access, and obtain initial blood samples to hold in the lab pending final decisions. We would not rush the patient off to the CT scanner or call the neurosurgeon. We would call the hospital chaplain (if there was one) to support the patient, family and us. We would try to call the patient’s primary physician and or specialist or obtain old records to make sure that the “terminal illness” diagnosis is correct.

If the patient still wanted no surgery, I, personally, would honor his wishes. I would make arrangements for in-patient hospice and admit him. A formal ethics consult could be obtained. If he changed his mind and wanted a full evaluation, I would proceed with a CT scan to determine the extent of his injuries. If surgery was indicated, another series of complex decisions has to be made. The patient must understand that in most hospitals any DNR order is void when the patient chooses to have a surgical

procedure. I would call a neurosurgeon. Most community hospitals do not have a neurosurgeon. This would necessitate transfer, which raises other issues.

Let me ask the question; why is the suicide attempt even an issue? How is this different from the situation where the patient has a DNR (even without a terminal illness) and suffers an accidental injury such as a fall with a subdural hematoma? I face this situation frequently. Most times, the patient cannot express his/her wishes. Generally, the outcome is 50/50. Fifty percent of the time the family acquiesces to the patient's previously stated wishes. We admit the patient to our inpatient hospice service and the patient dies in a peaceful, dignified manner. The families of the other fifty percent want "everything done." The DNR order is ignored. The patient is transferred after lengthy discussions with the accepting neurosurgeon. The patient is admitted to the trauma center ICU with or without surgery and dies on a ventilator. I won't even mention the financial implications of the decision to ignore the DNR.

Whatever decision is made in this case, it is imperative that there be some type of critical incident debriefing for all involved. The family will need support and counseling to deal with their grief and guilt. Burnout and post-traumatic stress disorder in EMS and ED personnel are growing concerns. Incidents such as this contribute greatly to the problem. Most of all, if the patient survives mentally intact, he will need intensive psycho/social

support. He will feel guilty for inflicting this suffering on his family. He will be angry that his suicide attempt failed. All of the factors that made him attempt suicide will still be present and are now magnified.

Legal Commentary

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It is not uncommon for a legal analysis to begin with more questions than answers. Such is the case with this scenario. The threshold inquiry, given the facts presented, must be to determine patient competency and decision-making ability. Put differently, can the patient make appropriate choices and understand the consequences of those decisions? The fact that he is awake and alert does not necessarily mean he has decisional capacity, and the knowledge that he tried to take his own life does not mean he does not have decisional capacity, but should be a factor in its determination.

State statutes define requirements for "capacity" and delegate this determination to medical providers. A psychiatric consultation to evaluate the patient's decision-making capability may be required, but even if not, it is still likely in the best interest of all involved. Typically two providers, usually physicians, must certify decision-making capacity in writing. They should be guided by their

medical training and be aware of state laws that are material to the determination. For example, Missouri defines "incapacitated" as "a person who is unable by reason of any physical or mental condition to receive and evaluate information or to communicate decisions to such an extent that he lacks capacity to meet essential requirements...that serious physical injury, illness or disease is likely to occur" RSMo 404.805(2). The language in this statute is demonstrative of other states' statutes.

Even if the patient is found to be competent, there are additional questions that must be answered in order to chart a proper course of treatment. These include:

- What does "no heroic measures" mean;
- What medical care is recommended;
- Are the patient's current thoughts about treatment consistent with his prior goals; and
- What does the Power of Attorney (POA) mean by "nothing be done save comfort measures."

There is no magic order to these inquiries, but all must be answered using whatever means available. An ethics consult is recommended if available and time permits. In-depth conversations with family and providers, memorizations of the patient's thoughts and desired future care, and thorough documentation of answers to the questions posed are paramount to assure appropriate actions are taken.

If the patient is deemed competent to make his own health care decisions, then neither the Advanced Directive (AD) nor the Power of Attorney are in effect and the patient may decide his own course of care and treatment. This may not be true of all presentations for suicidal patients since the attempt to take one's life may be interpreted to mean the patient does not have decisional capacity. Great care should be given to ferreting out whether the suicide attempt was reasonable, given the patient's terminal condition.

If the patient is found not to have decisional capacity, answers to the questions above should be considered along with questions attendant to the sufficiency and priorities of the AD and POA. Advance Directives and/or Powers of Attorney are creatures of state statutes. Providers must be conversant with or have access to legal counsel who is well acquainted with state laws regulating these instruments in order to avoid running afoul of their requirements. For instance, in some states, ADs have restricted purposes and can only be used in limited situations such as for permanently unconscious or terminally ill patients (A.C.A. sections 20-17-201 et seq.). If this patient were in a state with such a law, one might conclude that death from the terminal disease is imminent so the suicide has no effect on the AD. Alternatively, suicide may void an AD in some states.

For purposes of this opinion, I presume the documents are readily available since language from both is quoted. However, in real life, locating these documents may

be a significant challenge. Hospital policy should reference a procedure to obtain such documents including the number of attempts to be made and documentation of the efforts to procure copies. Once found, provisions of the AD and POA must be closely scrutinized by someone trained to do so. If the POA meets statutory requirements, we avoid the costly and time consuming process of a court determination to appoint a guardian.

A Durable Power of Attorney for Health Care grants the Attorney in Fact the legal authority to manage the patient's health affairs during periods of incapacitation or disability. This "authority" normally includes all legal rights and powers the patient could exercise as a competent individual, including the ability to withhold care. One should be cautious in determining which instrument applies and takes precedence. State statutes are instructive in this regard.

Generally speaking, if the patient is found to be competent and still wishes only comfort measures, then legally the ED personnel could withhold lifesaving treatment even in light of the suicide attempt given the patient's terminal status. Similarly, if the patient was found to be incompetent, but the AD and POA along with other extrinsic evidence confirms the patient's wishes to avoid heroic measures, legally treatment could be withheld. The fact the patient tried to commit suicide does factor into decision-making, but must be considered in context.

Ethics Commentary

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This case straddles the line between two situations for which ethics and the law are relatively clear. The first situation involves a previously physically healthy patient who has attempted suicide and presents to the ED. Here both ethical and legal principles require ED personnel to provide medical care necessary to stabilize or resolve the emergency medical condition in question to the full extent of the facility's capabilities according to generally accepted standards of medical care. This would apply even if the patient were awake, alert, and refusing such care or treatment. As the noted medico-legal scholar Arthur Derse states: "[P]atients who attempt suicide cannot refuse life-sustaining measures in the immediate interval when their life is in jeopardy and they are under emergency detention for the suicide attempt. Ethically, this can be justified under the best interest standard to treat patients when they are not capable of decision making because of suicidal ideation" (A. Derse, "Ethics and the Law in Emergency Medicine," *Emerg Med Clin N Am* 24 (2006): 547-55).

The second situation for which ethics and the law are relatively clear involves a terminally ill, non-suicidal patient who presents to the ED. Here both ethical and legal principles require ED personnel to honor the patient's wishes, as expressed by

the patient him/herself if capable, or, by extension, as articulated in a legally valid health care directive or by a legally appointed POA. This would apply even if the patient refuses to consent to certain forms of treatment necessary to stabilize or resolve the emergency medical condition in question or, again by extension, a legally valid health care directive states as such or a legally appointed POA refuses on the patient's behalf.

What complicates this case is that the patient has attempted suicide *and* is terminally ill with a health care directive stating "no heroic measures" and a POA who is requesting that nothing be done save comfort measures. So what ethical and legal principles apply? Do we override the patient's wishes as articulated in the health care directive and by the POA? Or do we honor the patient's autonomy and allow the patient to die without providing necessary treatment to stabilize or resolve the emergency medical condition brought on by the attempted suicide?

As in situation number two above, had this patient been injured or experiencing a complication as a normal part of the disease process, ED personnel, after completing a medical evaluation and verifying the legal validity of the advance directives, could have honored the patient's wishes as articulated in the health care directive and expressed by the POA given the patient's underlying, terminal condition. In such situations, even in an ED setting, patients have the right to refuse treatments that are deemed disproportionate and this right can be

exercised by the patient him/herself if capable, or through a legally valid health care directive and/or legally appointed POA. However, since the patient's emergency medical condition was brought on by an attempted suicide and not by an injury or complication from his terminal illness, the patient's health care directive and POA do not apply because they simply were not created for this situation.

Theodore Bania and colleagues describe this well: "From a legal context, advance directives were designed for patients who become incapacitated from a normal disease process. If this patient presented with a massive pulmonary embolism resulting from immobility or an intracerebral bleed from chronic hypertension, the validity of the health care proxy would not be in question. Similarly, the different forms of advance planning are considered valid in patients who are victims of accidents, violent injuries, and iatrogenic injuries since these, though unfortunate, are expected to occur as part of the risk of living. Suicide is not considered part of the classic normal disease process for which the different forms of advance planning were designed. It was not the intent of these documents to provide guidance regarding medical decisions following a suicide or assist a patient to commit suicide. The different forms of advance planning are usually not considered valid following suicide attempts" (T. Bania et al., "Health Care Proxies and Suicidal Patients," *Acad Emerg Med* 10 (January 2003): 65-68).

An issue not to be lost in this analysis is that of professional responsibility and ethics, including the conscience and integrity of the health care professional. ED personnel might rightly hold back from providing certain treatments to terminally ill patients, advance directives or not. But to ask them to do nothing, to withhold treatments necessary to stabilize an emergency medical condition brought on by an attempted suicide, is contrary to professional ethical principles and could make them, or at least make them feel as though they are, complicit in the suicide itself. Further, attempted suicides can be terribly complicated and all the facts and motivations surrounding them may not be readily available in the ED setting. The time between presentation to the ED and the need to initiate stabilizing treatment is often short and the ED is not the place to work out these issues, especially when a life is hanging in the balance.

From a policy/practice standpoint, in the immediate aftermath of an attempted suicide involving a terminally ill patient who presents to the ED, advance directives should be set aside until the patient is stabilized, which in this context means to intervene in such a way as to minimize the possibility of acute decompensation of vital functions. This definition of “stabilization” does not require that the patient be kept alive at all costs (e.g., invasive surgery), but it does require that basic means be employed to prevent death from occurring as a result of the suicide attempt. As such it strikes a balance between doing nothing and doing everything, neither of which are acceptable

from an ethical or legal standpoint given the circumstances. Once stabilized, the patient’s health care directive and/or POA should then be reinstated and all subsequent treatment decisions should be based on the benefits and burdens of treatment in light of the patient’s overall medical condition.