Robert C. Macauley, "The Role of Substituted Judgment in the Aftermath of a Suicide Attempt," *The Journal of Clinical Ethics* 18, no. 2 (Summer 2007): 111-18.

The Role of Substituted Judgment in the Aftermath of a Suicide Attempt

Robert C. Macauley

Robert C. Macauley, MD, is Clinical Associate Professor of Pediatrics at the University of Vermont College of Medicine and Medical Director of Clinical Ethics at Fletcher Allen Health Care in Burlington, Vermont, *robert.macauley@uvm.edu.*

CASE

A 73-year-old man has, by his own estimation, a poor quality of life. He's retired, recently divorced, and his activity is limited by congestive heart failure (CHF). He spends most of his day watching television. He has completed an advance directive (AD) which stipulates that he does not wish aggressive treatment (such as cardiopulmonary resuscitation — CPR — or intubation), should these ever be required. He named his eldest child as his primary healthcare agent.

He is involved in a car accident, and is now hospitalized with multiple injuries including a collapsed lung and disfiguring facial trauma that will require multiple surgeries . As he is currently intubated and sedated, the medical team turns to his family (especially the eldest child) for guidance. The family is convinced that the patient would not want continued aggressive treatment and requests that mechanical ventilation be stopped and that he be allowed to die in peace.

As far as ethical dilemmas go, this is a fairly mild one. It is well established in ethics and the law that competent patients have the right to refuse any treatment, including those that are life sustaining.[1] Appropriate surrogates may also exercise this right on behalf of patients who lack decision-making capacity (DMC).[2] According to both this patient's autonomous choice and the substituted judgment of his agent, life-sustaining treatment should be withdrawn and the patient should be allowed to die in peace. External assessments of what is in the patient's "best interest" never come into play, they are trumped by the patient's right of autonomy.

Things become much more complicated, though, if two aspects of the case are modified. Take the same patient — same age, social situation, and nature of injuries — but suppose that the patient's activity was limited by *depression* (rather than CHF), and his current injuries are the result of a *self-inflicted gunshot wound* rather than an automobile accident. In cases such as this, physicians commonly bypass both the autonomy and substituted-judgment standards and treat based on the lower "best interest" standard.[3] There are several reasons for this response. First, suicide is considered by many to be irrational (and therefore not a truly autonomous choice), and the overriding ethical duty thus becomes one of beneficence.[4] The patient's lack of DMC at the time of the suicide attempt would also call into question the reliability of the AD, as well as the substituted judgment offered by the family. Was the AD executed at a time of depressive incapacity? And is the family estimating what the *depressed* patient would want (which seems fairly clear from the

suicide attempt), as opposed to the patient's autonomous wishes when he was not clouded by mental illness?[5]

Second, some argue that the high probability of recovery from the underlying illness (that is, depression) justifies aggressive treatment for the sequelae (in this case, the self-inflicted trauma).[6] Third, the patient may not have truly been trying to kill himself, but rather counted on the medical system to "save" him from a suicidal gesture.[7] And finally, there is the concern for professional complicity, for is the medical establishment not abetting the patient's self-destructive behavior by making it "easier" for him to succeed (by virtue of withdrawing supportive measures)? If maximal treatment ceased to be the standard of care, wouldn't we be making suicide more convenient and attainable because suicidal patients would then merely have to render themselves dependent on life support (if only transiently) to achieve their goal? Would suicide thus join the ranks of horseshoes and hand grenades as the only forums where closeness counts as success?

Ironies abound in this instinctual response. A person goes to great lengths to end his or her life, only to have the medical establishment go to even greater lengths to prolong it. Physicians strive to avoid complicity in suicide, even as those in one state (Oregon) are legally permitted to assist patients in actively ending their own lives.[8] And what originally seemed a very reasonable decision (that is, withdrawing life-sustaining treatment) is deemed ethically impermissible due to the mechanism of injury, even though the patient's preceding quality of life, advance directive, current condition, and physical prognosis are unchanged.

In this article I will argue that while maximal treatment following a suicide attempt is a worthy guideline, it should not be an absolute rule. A variety of factors — including overall prognosis, as well as prior psychiatric history and treatment — need to be considered, and, in select situations, a surrogate's request for limitation of treatment following a suicide attempt should be honored.

BACKGROUND

There are approximately 425,000 suicide attempts each year in the United States, leading to over 30,000 deaths. This represents approximately 1 percent of all deaths in the U.S., and constitutes the third most common cause of death in late teenagers, and the eleventh most common cause overall (eighth for men, sixteenth for women). There are also important gender differences: women are more likely to attempt suicide, but men are four times more likely to die from the attempt (largely based on the methods men opt to use).[9]

HIERARCHY OF ETHICAL DECISION MAKING

The traditional hierarchy of ethical decision making emphasizes the patient's autonomous choice, followed by substituted judgment, and finally the patient's best interest. In the immediate aftermath of a suicide attempt, it would seem reasonable to doubt the autonomous nature of a direct patient refusal of treatment, if one grants the inherent irrationality of suicide.[10] This is not to say that all such patients necessarily lack DMC, but rather that there exists strong *a priori* evidence for their incapacity, based on the fact of their suicide attempt. Thus it would be unreasonable to expect that they could fulfill the burden of proof to the contrary, particularly while dependent on life-sustaining treatment.

But what of the patient's AD? Rather than summarily discard it for either legal or ethical reasons, it would seem reasonable to investigate its context and "rationality," if you will. In terms of context, was the AD composed just prior to the suicide attempt, or long before? Are there discernible reasons that the patient communicated those specific treatment directives at the time the AD was executed? An AD composed in the minutes prior to a self-inflicted gunshot wound would certainly be suspect, but one composed years earlier during a happy period of life in a noble attempt to spare one's family from excruciating decisions would not.

In terms of "rationality," one must examine the treatment directive in light of the patient's condition. A request for no aggressive treatment from an otherwise healthy 30-year-old would obviously raise suspicion. By contrast, an older patient with evolving co-morbidities might rationally elect to limit certain life-sustain-

ing treatments in non-terminal situations. For an elderly patient with metastatic cancer to request to be "DNR" (do not resuscitate) seems eminently reasonable; indeed, to perform CPR on such a patient might feel profoundly wrong to the medical team, almost an assault. Yet if that same patient actively attempts to take his or her own life, and the "suicide attempt means full treatment" algorithm were followed, we might find ourselves acting maleficently toward a patient, ostensibly for the sake of his or her "best interest."

Some would also discard the substituted judgment of a healthcare agent in such a situation, arguing that since the patient would not be able to refuse treatment following a suicide attempt (because of presumed depression), neither would the agent. Thus Spike writes, "The agent has authority to make only those decisions the patient would have had the authority to make."[11] Yet this claim does not support his conclusion, for it misconstrues the patient's *authority* with his or her *ability.* As stated above, patients have the authority to offer an informed, autonomous refusal of life-sustaining treatment, but some patients (such as those who do not currently possess DMC) presently lack the *ability* to do so.[12] Thus while it is true that an agent's authority extends only as far as the patient's would have — and thus would exclude, for instance, a request for active euthanasia — the right of the agent to make decisions that the patient currently is unable to make is the very reason for appointing a healthcare agent in the first place.

If one admits that (1) an AD may, in certain cases, be a trustworthy guide to treatment; (2) the "best interest" standard may paradoxically lead to harmful, unwanted treatment; and (3) substituted judgment may indeed have a role in decision making following a suicide attempt; then the rule of maximal intervention in the aftermath of a suicide attempt cannot be universal. Therefore, we must delineate a method to identify the exceptions. The context and "rationality" of the AD have already been mentioned, but further considerations must be applied in the case of "substituted judgment" offered by agents or surrogates: (1) the characteristics of the underlying depression; (2) extrinsic factors influencing probability of improvement; and (3) the level of surrogate certainty as to what the patient would have wanted.

CRITERIA FOR APPLICATION OF SUBSTITUTED JUDGMENT

CHARACTERISTICS OF THE UNDERLYING DEPRESSION

In evaluating a suicide attempt, one must consider the duration and intensity of the underlying depression, as well as the extent of prior treatment, all of which have implications for the patient's prognosis. In terms of duration and intensity of depression, there is a significant difference between a situational sadness (as in the case of a young person responding to the recent breakup of a romantic relationship) and a long-standing major depression that meets *DSM-IV* criteria.[13] It is difficult to imagine honoring an AD or surrogate request for limitation of treatment in the former case.

One might also hypothesize that a patient who has never received treatment for depression is more likely to improve with psychiatric treatment than a patient who had exhausted all known options. This is not to say that the untreated patient would definitely improve, nor that the latter patient might not benefit from new and innovative interventions. In light of the ethical imperative of *primum non nocere* (first, do no harm), physicians are obligated both to give patients an opportunity to benefit from potentially efficacious treatment, as well as to acknowledge the point at which the likely burdens of continued treatment (both somatic and psychiatric) may outweigh the potential benefits.

Ultimately, this criterion focuses on the patient's prognosis. And while the trajectory of depression is more uncertain than somatic ailments such as heart failure (which have quantitative measures such as ejection fractions that can be used to project the future course of the disease), it is no less debilitating. The default response of maximal treatment makes an implicit appeal to either a minimizing bias (which overlooks the profound implications of mental illness) or an optimistic one founded on the claim that "most suicidal patients have a reasonable chance for recovery."[14] If one accepts the intense burden of depression, and acknowledges that refractory cases do exist, then the inherent prognostic uncertainty should not preclude a clinician from making an educated forecast and formulating treatment plans accordingly.

It is worth noting that the best interest standard has traditionally been used to justify withdrawal of life-sustaining treatment for unrelievable *somatic* suffering, but not for psychiatric suffering. There are many possible reasons for this, most notably that many somatic ailments of this severity involve life-sustaining treatments that may themselves be limited. In the absence of unrelievable somatic suffering, though, physicians are reluctant to limit treatment due to the inherent uncertainty as to the "intractability" of psychiatric illness. Mental health advocates, for their part, are rightfully concerned about blanket assertions that it would be in a depressed patient's "best interest" to no longer be alive.

To be clear, I am not arguing that the best interest standard (as determined by an external observer) justifies withdrawal of life-sustaining treatment in the aftermath of a suicide attempt. Rather, I make the much weaker claim that the best interest standard does not automatically mandate *maximal* treatment in *every* such case. The patient's personal values — as expressed prior to decisional incapacity, and applied to both the somatic and psychiatric aspects of the current situation — may trump the presumption of full treatment.

EXTRINSIC FACTORS INFLUENCING PROBABILITY OF IMPROVEMENT

If one views depression from a multifactorial point of view, "extrinsic factors" must also be taken into account when formulating a prognosis. In this case scenario, the patient has multiple risk factors for depression, such as age and marital status. The patient may also have other unspecified co-morbidities and may be responding poorly to retirement. In situations such as this, in which the majority of extrinsic factors that influence (and are influenced by) the patient's depression are irremediable, one should be more likely to take seriously a substituted judgment that requests limitation of treatment.

In addition, various methods and severities of suicide attempts lead to different expected changes in their aftermath. In terms of recovery time and burden, for instance, a failed overdosage would likely have modest long-term consequences (assuming that kidney and liver function were intact). There would be good reason to expect that the patient could return to his or her previous quality of life — however that is defined or quantified — following discharge.

Gunshot wounds are a different story, however. The patient in this scenario is not only facing a protracted, intense, and emotionally and financially draining rehabilitative course, but also long-term social consequences. If he was already depressed, how much worse will his outlook be when he realizes the cosmetic implications of the gunshot wound to his face? Viewed holistically, these concerns represent further irremediable extrinsic factors that influence his probability of improvement.

At the same time, one must be vigilant against potential discrimination. Granted too much importance, this criterion might be used to disproportionately favor limitation of treatment in the aftermath of a suicide attempt by the elderly, divorced, poor, and otherwise infirm. Recognizing that physicians significantly underestimate a patient's quality of life (compared to self-report),[15] extrinsic factors must be considered in light of the other suggested criteria and the overall quality of life of the patient, as defined by the patient himself or herself.

LEVEL OF SURROGATE'S CERTAINTY ON WHAT THE PATIENT WOULD HAVE WANTED

Surrogate decision making is inherently fraught with uncertainty. Studies report that even under the best of circumstances, surrogates frequently advocate a different course of action than the patient would have wanted.[16] Often the medical team has no other choice, though, as the patient may never regain DMC, and a loved one's substituted judgment seems more faithful to the patient than a stranger's sense of the patient's best interest.

In this particular case, the process of substituted judgment is even more complex, as the surrogate must imagine what the patient — *at a time when he still had DMC* — would have wanted. A general policy of full treatment in the aftermath of a suicide attempt may, therefore, be attractive precisely because it eliminates the need for substituted judgment altogether, ultimately deferring critical decisions to the patient himself once he has (hopefully) regained the ability to make them. In yet another instance of irony, one might defend

such a blanket policy of overriding a patient's past statements of refusal, and the surrogate's appropriate request for discontinuation of treatment, in the name of (future) autonomy.

As is often the case, the truth lies somewhere in the middle, between blind trust in a surrogate's substituted judgment and utter reliance on hoped-for restoration of the patient's own DMC. There may be situations in which the surrogate has solid reasons to believe that the patient — at a time of maximal autonomy and DMC — would not have wanted aggressive treatment under *any* circumstances. (The aforementioned hypothetical case of the elderly patient with metastatic cancer might be an example.) On the other hand, a surrogate's vague sense of what the patient probably would have wanted would not be so compelling. And a surrogate's request for withdrawal of life-sustaining treatment would generally be viewed with caution if the patient's level of consciousness were steadily improving and restoration of DMC appeared imminent.

AMOUNT OF PSYCHIC PAIN INVOLVED IN ASKING PATIENTS TO MAKE THE DECISION

These criteria are complex and nuanced, and thus one might be tempted to reject substituted judgment not because it is inapplicable, but simply because it is *impractical.* "Why not simply wait for the patient to regain DMC?" one might ask. Even those who favor mandatory maximal treatment for suicide attempts grant that eventually the patient should be allowed to make his or her own decisions once again, assuming his or her DMC is intact. Thus Bania and colleagues suggest, "Even though the cause of the patient's coma was self-inflicted, it does not invalidate the pre-suicidal wishes of the patient *after he or she is resuscitated from the suicide and is no longer being directly treated for the suicide.*"[17]

Such an approach, however, fails to take into account the psychic pain involved in asking the patient to make such a decision. To state the obvious, the patient wished to end his life.[18] To participate in decision making would require that he acknowledge that this attempt failed, and that he has been "at the mercy" of others — in the ambulance, emergency department (ED), and intensive care unit, unconscious and in various states of undress — for the intervening period of time. In addition, he is facing a future of rehabilitation and disfigurement, as previously noted. Finally, even if he were to subsequently request discontinuation of treatment unrelated to his suicide attempt, it is quite possible that his request would not be honored, out of concern for continuing depression and resulting incapacity.

While it may be noble, therefore, to attempt to involve the patient in decision making, there may be overriding concerns of nonmaleficence to refrain from doing so. Moreover, it is unfair to ostensibly grant the patient the right to make his own treatment decisions, provided he decides in favor of recommended treatment. This makes a sham of the notion of patient autonomy, a noble concept that is better honored and protected through the substituted judgment paradigm suggested in this article, than in a question with only one acceptable answer.

CAVEATS

As stated above, one of the proposed justifications for maximal treatment of all patients following suicide attempts is the concern that the patient may not have intended to actually kill himself or herself. Certainly some methods of suicide are recognized to be much more "effective" than others,[19] with firearms 2.6 times more likely to be lethal than hanging/suffocation, and 270 times more likely to be lethal than intentional ingestion.[20] At first glance, one might tend to treat suffocations or ingestions more aggressively than gunshot wounds, as the latter would be thought to reflect a more "serious" attempt.

There are multiple problems with this interpretation, however. First, the average patient is unlikely to be familiar with epidemiological data regarding the relative lethality of suicide methods, and thus the chosen method may be a matter of convenience. Second, the possibility of gender bias must be considered, for while firearms account for the majority of male suicides, they represent less than one-third of female suicides.[21] It would be profoundly unjust to subject male patients to under treatment (or, conversely, female patients to over treatment) simply because men are roughly four times as likely to own a gun as women.[22]

Context must also be considered in applying the aforementioned criteria. In the ED setting, for instance, many facts are not yet in evidence, and the considerations enumerated here cannot be considered in full.

Initially, then, the *status quo* practice of maximal treatment is reasonable. At the other extreme, well into the patient's course when he or she has been treated for the sequelae of the suicide attempt and his or her DMC has (hopefully) been restored, few would continue to limit the patient's right to make his or her own medical decisions.

The intervening period between initial resuscitation and eventual recovery — the focus of this article — is much more complex. The underlying motivation behind maximal treatment in every such case has been shown to be replete with ironies and given to compelling counter-examples. The consideration of the three proposed criteria — exercised with particular caution so as not to introduce social, health, or gender biases — offers a nuanced approach to surrogate decision making in the aftermath of a suicide attempt. These criteria can be used to identify the select clinical situations in which a surrogate's request for limitation of treatment should be respected.

AKNOWLEGMENT

The author would like to thank Robert Orr and Marcia Bosek for their helpful critiques, and Sanchit Maruti for his invaluable assistance in research and manuscript preparation.

NOTES

1. "The principle of patient autonomy requires that physicians respect the decision to forego life-sustaining treatment of a patient who possesses decision-making capacity." *Code of Medical Ethics of the American Medical Association* (Chicago, Ill.: American Medical Association Press, 2006), 75.

2. Compare with *In re Quinlan,* 355 A.2d 647 (N.J. 1976).

3. T.L. Beauchamp and J.F. Childress, *Principles of Biomedical Ethics,* 5th ed. (New York, N.Y.: Oxford University Press, 2001), 98-104.

4. "There is a prevalent (and probably sound) view that a suicide attempt allows a presumption of psychiatric illness and that intervention over the patient's objection is justified." J. Spike, "Physicians' Responsibilities in the Care of Suicidal Patients: Three Case Studies," *The Journal of Clinical Ethics* 9, no. 3 (Fall 1998): 311.

5. In purely legal terms, there is also the question of whether advance directives apply to situations of self-inflicted injury. One article asserts: "Advance directives . . . are considered to be legally binding when a patient presents with symptoms from a *naturally occurring disease process.* It is not the intent of any state to use these documents to assist a patient who has attempted to commit suicide. . . . Such a view would be considered violative of public policy." W. LeStrange and K. Porter, "Risk Management and Legal Principles," in *Goldfrank's Toxicologic Emergencies,* ed. L.R. Goldfrank et al. (New York, N.Y.: McGraw Hill, 2002), 1776 (italic added). I have not, however, been able to locate statutory evidence of this assertion.

6. "Physicians do not permit suicidal patients to refuse treatment, because most suicide attempts occur when judgment is impaired, and *most suicidal patients have a reasonable chance for recovery.*" R.K. Wagle et al., "An Ethical Dilemma: When the Family Wants the Withdrawal of Care," *Journal of Psychiatric Practice* 10, no. 5 (September 2004): 335 (italic added).

7. A recent study found that only 22 percent of suicide attempters wished that their attempt had succeeded, while 36 percent wished they hadn't made the attempt and were glad to be alive. G. Henriques et al., "Suicide Attempt-ers' Reaction to Survival as a Risk Factor for Eventual Suicide," *American Journal of Psychiatry* 162, no. 11 (November 2005): 2180-2.

8. Albeit under strictly controlled circumstances, including the documented absence of depression. Oregon Death with Dignity Act, Oregon Revised Statute 127.800-127.995, see *http://egov.oregon.gov/DHS/ph/pas/docs/statute.pdf.*

9. WISQARS (Web-based Injury Statistics Query and Reporting System, 2006), Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, *www.cdc.gov/ncipc/wisqars,*

accessed 4 January 2007.

10. The condemnation of suicide can be based on philosophical (e.g., Plato, Aristotle) or theological (e.g., Augustine, Aquinas) grounds. While this is the prevailing viewpoint in our culture, there are well known arguments to the contrary. The Stoics emphasized quality of life over duration. Thus Seneca: "Mere living is not a good, but living well. Accordingly, the wise man will live as long as he ought, not as long as he can." L.A. Seneca, *Moral Epistles,* vol. 2, trans. R.M. Gummere (Cambridge, Mass.: Harvard University Press, 1917-25), 57. Aquinas's condemnation of suicide as a violation of natural, moral, and divine law was answered point by point by Hume. And perhaps most famously, Existentialism stresses the question of continued existence. Thus Camus: "There is but one truly serious philosophical problem, and that is suicide. Judging whether life is or is not worth living amounts to answering the fundamental question of philosophy." A. Camus, "The Myth of Sisyphus," in *The Myth of Sisyphus and Other Essays* (New York, N.Y.: Alfred A. Knopf, 1955), 3.

11. See note 4 above.

12. Or, at the very least, the chance to prove that they possess the ability to make such decisions, all *a priori* evidence to the contrary.

13. *Diagnostic and Statistical Manual of Mental Disorders,* 4th ed. (Washington, D.C.: American Psychiatric Association, 2000).

14. See note 6 above.

15. Compare with K.A. Wilson et al., "Perception of Quality of Life by Patients, Partners and Treating Physicians," *Quality of Life Research* 9, no. 9 (November 2000): 1041-52.

16. D.I. Shalowitz, E. Garrett-Mayer, and D. Wendler, "The Accuracy of Surrogate Decision Makers: A Systematic Review," *Archives of Internal Medicine* 166, no. 5 (March 2006): 493-7.

17. T.C. Bania, R. Lee, and M. Clark, "Ethics Seminars: Health Care Proxies and Suicidal Patients," *Academic Emergency Medicine* 10, no. 1 (January 2003): 65-8 (italic added).

18. Assuming that this was a true suicide attempt rather than merely a suicidal gesture, and granting that this wish may not be deemed truly "autonomous."

19. Both poetically and epidemiologically, as Dorothy Parker wrote in her poem, "Resume,"

> Razors pain you;
> Rivers are damp;
> Acids stain you;
> And drugs cause cramp;
> Guns aren't lawful;
> Nooses give;
> Gas smells awful;
> You might as well live.

D. Parker, "Resume," in *Enough Rope* (New York: Boni and Liveright, 1926).

20. E.D. Shenassa, S.N. Catlin, and S.L. Buka, "Lethality of Firearms Relative to Other Suicide Methods: A Population Based Study," *Journal of Epidemiology and Community Health* 57, no. 2 (February 2003): 120-4.

21. National Center for Injury Prevention and Control, *http://webappa.cdc.gov/sasweb/ncipc/leadcaus.html,* accessed 9 December 2006.

22. G.J. Wintemute et al., "Mortality Among Recent Purchasers of Handguns," *New England Journal of Medicine* 341, no. 21 (November 1999): 1583-9.