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Commentary: Support for Case-Based Analysis in Decision Making after a Suicide Attempt

Tia Powell

Tia Powell, MD, is Executive Director of the New York State Task Force on Life & the Law, New York, *tpp03@health.state.ny.us.*

A curious aspect of healthcare delivery in the United States may be summarized by the following motto: Do everything, but only after all hope is lost. Robert Macauley, MD, presents an interesting article on the subject of providing medical treatment after suicide attempts; the article raises issues related to advance directives, the assessment of capacity, and the limits of surrogate decision making. However, before addressing those topics, we must pause to reflect on the absurd imbalance between the treatment available to the patient after an attempt to die, rather than before. Many insurance plans offer severe limitations on treatment for mental illness; out-patient clinics for the severely mentally ill are closing at a rapid rate, as they do not generate profits.[1] Rates of suicide attempts remain too high; providing access to effective care at a stage before injury is an important goal for mental health policy. Although many have worked to decrease stigma and increase access to mental healthcare, there is still much too much to be done to provide treatment that will prevent suicide.

Nonetheless, we will always be faced with some suicidal patients, and thus with the question of how to determine appropriate medical treatment for a patient after a failed suicide attempt. Decisions in this context are made yet more complex by the aura of grief and anger generated by the patient's act of self-violence. Family members confront their sense of failure in preventing the attempted suicide; physicians battle a sense of futility in trying to preserve a life not valued by the patient. Suicidal patients themselves are most often in the throes of depression, substance abuse, and other significant mental illnesses. Each of these three groups — family, provider, and patient — faces significant challenges as they address their role in making medical decisions. The context of emergency treatment and difficulties in assessing decision-making capacity in the mentally ill add to the complexity of the issues.

Emergency treatment, irrespective of whether a suicide attempt is involved, is often provided without full informed consent either from the patient or a surrogate. Trauma victims are stabilized; in some cases it later turns out that an advance directive prohibited aggressive treatment. As the medical history and options are clarified, life-sustaining treatments or other interventions may be modified or withdrawn based on the fuller information that becomes available with more time. Many post-suicidal patients are trauma victims and thus their treatment follows the same pattern, with aggressive early attempts to preserve the patient's life pursued in the emergent situation, followed by exploration of various treatment options once the patient is

stable. To some extent, aggressive treatment after a suicide attempt is a phenomenon more related to emergency treatment than suicidality *per se*. Acutely ill patients are stabilized if possible, and issues of decision-making capacity and continued treatment are addressed once the emergency is controlled.

Macauley questions whether maximal treatment following a suicide attempt is always appropriate. The suggestion that various factors should influence the choice of treatment is a common sense one, and one that is followed today in many facilities. In all cases, however, it is an emotionally and legally challenging process to weigh and balance factors related to surrogate decision making, mental illness, and prognosis. Not surprisingly, these cases frequently give rise to requests for ethics consultation and assistance from consultation-liaison psychiatry.

One such challenge is to discover who the appropriate decision maker is. A patient is not automatically deprived of decision-making capacity by virtue of a suicide attempt, although clinicians are understandably reluctant to defer to a suicidal patient's wishes to discontinue treatment. Even when denied the right to refuse some treatments, the patient may retain authority to make other decisions. Patients who remain alert enough to communicate require a careful assessment of their mental status, both to support the treatment of the probable underlying mental illness and to assess decision-making capacity. For patients who lack decision-making capacity, designated healthcare agents or other surrogates, when available, must step in to work with the healthcare team in making appropriate choices.

However, even once the correct decision maker is identified, these choices are far from simple. Decisions to withdraw and withhold life-sustaining treatment are often full of conflict, even without the added complication of a suicide attempt. Indeed, third-party requests to forego life-sustaining treatment are a common source of requests for ethics consultation, and appropriately, providers often request additional review of such a request. Bania and colleagues describe the familiar Jonsen-Siegler-Winslade approach to ethics consultation as a useful system for weighing different aspects of one such challenging case.[2] The question of how to separate the impact of suicidal thoughts from long-standing and legitimate beliefs about end-of-life care is exceedingly complex. A useful comparison is found in the work of Ganzini and Lee, who have published a number of studies documenting the relative stability of wishes regarding end-of-life care among elderly patients both when euthymic and depressed.[3] Their work has done much in the last decade and more to promote careful, case-by-case analysis of decision making that involves end-of-life choices, mental illness, and suicidality.

Practical options, too, play a role in decision making after a suicide attempt. For patients with a grim prognosis, either because of the suicide attempt itself or from other pre-existing health issues, physicians and surrogates can, and do, appropriately consider the likely efficacy and physical burden of a proposed medical intervention. Futile or nearly futile invasive treatments need not be imposed on a patient merely because that person has attempted suicide. Karlinsky and colleagues offered a sensitive discussion of these issues almost 20 years ago, which highlights the point that these dilemmas, sadly, are not new.[4]

The treatment of patients after a failed suicide attempt pulls together a number of contentious issues: assessment of capacity, mental illness, surrogate decision making, and the durability of patients' preferences over time and in different states of health. Given the complexity of these issues, healthcare facilities today find that the best practice is to support a careful case-based review of the relevant factors. "Doing everything" for the suicidal patient means thinking carefully about the options, preferences, and best interest of that person, and devising a plan of care that is appropriate to this individual.

DISCLAIMER

The opinions expressed here are those of the author, and do not reflect the views of the New York State Task Force on Life & the Law or of New York State.

NOTES

1. P.S. Appelbaum, "The quiet crisis in mental health services," *Health Affairs* 22, no. 6 (November - December 2003): 281-2.

2. 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.

3. See, for instance: L. Ganzini et al., "The effect of depression treatment on elderly patients' preferences for life-sustaining medical therapy," *American Journal of Psychiatry* 152, no. 12 (December 1995): 1836-7; M. Lee and L. Ganzini, "Depression in the elderly: effect on patient attitudes toward life-sustaining therapy," *Journal of the American Geriatric Society* 40, no. 10 (October 1992): 983-8.

4. H. Karlinsky et al., "Suicide Attempts and Resuscitation Dilemmas," *General Hospital Psychiatry* 10 (1988): 423-7.