A Rational Suicide? Case Consultation and Quiz Commentary

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The author offers a brief commentary in response to feedback from readers of a previously published case.

*The thought of suicide is a great consolation: by means of it one gets successfully through many a bad night.*
—Friedrich Nietzsche, *Beyond Good and Evil*

In the article “A Rational Suicide?” readers were asked to imagine that they were the clinical ethics consultant (CEC) called to the emergency department (ED) to deal with the distressing dilemma summarized below. They were then presented with 4 key questions—each of which is examined in this analysis. Readers were also invited to post their comments.

Case summary
Mrs N is a 65-year-old retired nurse who, driven by seemingly intractable nausea and vomiting, decides to kill herself with an overdose of fentanyl she has stockpiled. She informs her ex-husband, who is also her power of attorney (POA), of her plans and asks that once she is dead he come to her house and take care of her affairs. Unfortunately, her ex-husband arrives while she is still alive and calls 911. When brought to the ED, Mrs N refuses all medical intervention and both she and her ex-husband angrily plead with staff to allow her to die, leading the staff to request an emergency ethics consultation.

Analysis

**Question 1:** The ED nurse asks if she has a legal and ethical duty to report the ex-husband to law enforcement because he knew his ex-wife intended to commit suicide and took no steps to prevent this. **As the ethics consultant, how would you respond?**

In a passive and permissive role, the ex-husband allowed the suicide attempt, but he took no active role, such as obtaining or administering the opioids to assist his ex-wife to kill herself. Since there is no real direct “aiding and abetting” of the suicide attempt, it is not probable—although given the vagaries of the legal system, not impossible—that the husband would be criminally charged. In a morality rooted in deontology or religion, there would likely be an obligation for any individual to intervene to defend the sacredness of life. Remember that anyone can file a report with the police, and the nurse’s claim of conscience that she needs to do so should be respected.

In general, adult protective services do not get involved in cases of elders with intact decision-making capacity. The geriatric consultant’s description of Mrs N as being a “completely cognitively intact woman” with “good coping skills” is not likely to attract the attention of overburdened state social services. The final choice is in part already in motion: in most institutions, the CEC works with, or for, the ethics committee. And once Mrs N became an inpatient, whether
medical or psychiatric, the likelihood is high that clinical staff will query the CEC about visiting privileges for the ex-husband.

**Question 2: Should the ex-husband be allowed to serve as the POA?**

It is easy to envision nursing or social work staff raising the issue of the appropriateness of the ex-husband continuing to serve as POA because it springs from the same well of moral distress as the nurse’s belief that she should report the ex-husband at least for complicity. The CEC must first remind all involved, including the ex-husband, that a POA only goes into effect when a patient loses capacity, and in this case, Mrs N was deemed cognitively intact. Mrs N’s husband voiced his view that his wife should be allowed to die. Since her husband is the POA but did not prevent his wife from trying to kill herself, the staff believe that at the bare minimum, he should be prohibited from making medical decisions on his ex-wife’s behalf—at least until this acute episode resolves.

The devil in the details is “whose best interests?” For Mrs N and the ex-husband who knows her best and cares about her most, the paradoxical truth is that the suicide attempt actualized their shared conception of best interest. Obviously it does not cohere with the ethical schema of most medical professionals in the scenario, although fascinatingly, the majority of readers endorsed this position. The idea of “best interests” as a standard for decision making is actually in many ways far less objective than it appears, and legal rulings and ethical consensus direct that it only comes into play when a patient’s wishes and values are unknown. Research has validated the commonsense intuition that neither decision-making standard is as existentially valid or holistically reliable as the judgment of a trusted surrogate.

This leaves us with the burden of proof lying with the health care team to show clear and convincing evidence that because of his inaction, the ex-husband, who is the patient’s chosen surrogate, cannot ethically remain as POA.

**Question 3: Should the physician honor the patient’s request to be DNR?**

This was the most controversial question. In most EDs and hospitals, any patient who is being treated for the complications of a suicide attempt is prohibited from being DNR. From a risk management perspective, this makes perfect sense and is the reflexive intuition of most health care professionals.

Ethicists and some clinicians, however, challenge the presumption and argue that if the patient previously expressed (eg, in an advance directive) a preference for DNR as a choice separated in space and time from the suicide attempt, it should be honored. The patient’s regaining capacity obviates the need for the POA. However, if she lacked capacity, the same objections examined earlier (that the ex-husband is an unfit POA) as well as that the physician would be an accomplice can again be raised.

**Question 4: Once the patient is medically stabilized, which of the following is the most ethically justifiable option if she continues to state her intention to return home to again attempt suicide?**

The final question brings the case squarely into the realm of psychiatric diagnosis and treatment. Readers’ responses turned on whether they thought suicide and rational are contradictory terms. The majority embraced the last option and believed Mrs N had the right to end her life and that her husband had the responsibility to help her ease her suffering.

In the case of Mrs N, the CEC seeks the expertise of the psychiatric consultant who initially is equally confounded and endorses that the patient does not meet criteria for psychiatric hospitalization, voluntary or involuntary. Fortunately, the two consultants are able to persuade Mrs N to accept admission to the medical unit and to give the medical specialists one more opportunity to control her symptoms. She is admitted, though making her conditions clear: if no sustained and significant relief is obtained, she will return home to commit suicide.

**Response to readers’ comments**

Psychiatrists have done a profound service in critically examining the meaning of the concept of rational suicide for our profession. I would be very foolish to absolutely deny the possibility that there is no problem of human anguish where suicide would not be the most coherent solution. A question mark follows the title of the article “A Rational Suicide?” to underscore that the primary ethics question the case presents is whether in Mrs N’s specific set of contextual features, suicide is rational. The urgency of the circumstances, as it so often is in psychiatry, compels the consultants to make decisions amid the mess of the human condition, often leaving them with haunting loose ends. It is interesting that it was not just readers who identified themselves as mental health professionals, but also relatives of persons who had attempted or completed suicide, who poignantly argued for involuntary hospitalization.

Faced with a woman who has demonstrated the resolve and resourcefulness to take her own life, even without a diagnosable disorder, most psychiatrists would not discharge Mrs N home. Some
would even go so far as to not even consider voluntary hospitalization, believing that the respective mental health laws in their jurisdictions give them the authority and the obligation legally and ethically to hospitalize Mrs N. That authority is politically predicated on the regnant social policy that suicide is always an irrational act and that the lack of reason stems from a mental illness even if not immediately discoverable.9

Other readers suggested what I think is the wisest course—the one ultimately followed—to respect Mrs N’s decision to be admitted to a medical ward with the goal of receiving aggressive treatment of her symptoms in the belief, and yes the hope, that more effective interventions could render Mrs N’s life bearable. The psychiatric consultant with the counsel of the CEC does not threaten Mrs N with an ultimatum if such amelioration is not successful. Rather, the psychiatrist takes advantage of the breathing room the hospitalization affords to ponder Ramsey’s10 wise words, to engage “the patient as a person.”

Part of that engagement is for the psychiatrist and the CEC to accept—without endorsing—Mrs N’s right to determine the conditions of her life and death.9 The psychiatrist will lose any chance to ever get to know Mrs N’s story if he or she does not phenomenologically embrace her self-portrayal as a mentally healthy woman of libertarian philosophical bent. Intellectual sparring or paternalistic insistence on “professional judgment” will only fulfill the prophecy Mrs N has already uttered about the failures of the medical profession to provide a life she feels is livable.

The ethical duty of the psychiatrist and of the CEC is not to unravel the Gordian knot of rational suicide or to change public policy. It is even less to avoid a malpractice suit—although, sadly, more than a few readers and psychiatrists would see this as the over-determining factor in the case. The true duty is articulated in the thinking of my colleague Rebecca W. Brendel, MD, JD11: It is also the role of the psychiatrist to understand the patient’s fears, concerns, life goals, and coping style and how these and other factors may be influencing the patient’s wish to die. Such an enterprise need not lead to the conclusion that there are not rationally motivated desires to hasten death. But the default position of the psychiatrist, given the obligation of physicians to act in the preservation of life, and the fact that most hastened death in the form of suicide is associated with mental illness, must be to err on the side of caution, life, and safety when evaluating and treating patients who wish to hasten their death.

References:


10. Ramsey P. The Patient as Person: Explorations in Medical Ethics. New Haven, CT: Yale University


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[2] [http://www.psychiatrictimes.com/authors/cynthia-m-geppert-md-dps](http://www.psychiatrictimes.com/authors/cynthia-m-geppert-md-dps)