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Case

Suicide and "Do Not Resuscitate": An Ethical Dilemma

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Abstract

Advance directive is a legal document that allows people to accept or decline medical interventions and to appoint surrogate decision makers if they become incapacitated. Advance directives often do not neatly address all the specific medical situations and may require interpretation. There are many limitations of advance directives which can lead to irreversible medical errors. The goal of this article is to share my experience and discuss different scenarios related to the case.

Key Words: Ethical Dilemma; anxiety; depression

Manuscript

This past January, I went to the hospital for my regular morning hospitalist shift and picked up a list of twenty patients. During the morning sign out, one patient caught my attention. She was 49 year old female with past medical history of anxiety and depression, who apparently presented with cardiac arrest and was terminally extubated in emergency department after her boyfriend brought her advance directives which stated "do not resuscitate (DNR)". Patient had been admitted for inpatient hospice care.

On my first encounter I entered in the patient's room and expressed my condolences with the family which included mother, father, two brothers, one sister and a boyfriend. During my conversation I got the impression that some family members (especially the parents) were still hoping that their daughter would come back. Her vitals included a heat rate of 60 beats per minute, respiratory rate of 10 breaths per minute, blood pressure of 63/41 mm Hg and an oxygen saturation of 92% on 2 L/min of oxygen. On my examination the patient was not withdrawing to the painful stimuli, the pupils were slightly constricted but fixed and no corneal reflex was appreciated.

I instantly noticed that the boyfriend was doing most of the talking for the family. While looking at the family the boyfriend said, " Her wishes were not to be resuscitated or intubated and we all want her to depart comfortably, Right ?". The family nodded, yet seemed unsatisfied, almost confused. As soon as I got out of the room, the nurse told me that the boyfriend is requesting opiates and anxiolytics to be administered to the patient every hour, even when not needed. I told the nurse to hold the medications as the patient had a GCS of three. After the morning discharges I started reviewing her chart in detail and started questioning myself about the cause of the cardiac arrest. I was shocked to see that her initial basic laboratory work drawn in emergency department, including complete blood count, complete metabolic profile and cardiac enzymes, was within normal limits. Her EKG, chest X-Rayand CT scan of the head did not show any acute pathology.

I went back to the patient's room to figure out the whole story. The boyfriend reluctantly told me that they were together for 20 years. He came back from work and found the patient in the chair "slamming to the side". He checked her pulses immediately as she was not responding and evidently not breathing either. The boyfriend started the CPR and called 911. Paramedics found the pulses and they intubated the patient for respiratory arrest. Patient was given naloxone on the scene without any response. The patient was brought to the emergency department. The boyfriend claimed that he had the power of attorney. The patient had her advance directives to not to be resuscitated. So the patient was then terminallyextubated.

I asked the family if they knew the cause of her cardiac/respiratory arrest. They all shook their head "no". I explained to the family that most likely the patient did not have a cardiac arrest as her EKG and cardiac enzymes were within normal limits on presentation. It is very possible that she was unresponsive from a drug overdose and she might have made significant recovery if she was not extubated. I told them that she still has a chance if we re-intubate her. The boyfriend panicked immediately. Soon I was bombarded with a lot of questions. Now I ended up in a scenario where the parents wanted to give her a chance and the boyfriend, who was also the power of attorney, wanted her to be on comfort measures only. This further raised my suspicion; I questioned him about the advance directives paper work. He brought the paperwork by the afternoon. The document was apparently signed ten years ago yet the paper looked new to me. There was no witness nor was it notarized. I went to my hospital lawyer who agreed that the paper work is not legally valid. I immediately turned to the parents who agreed on intubating the patient.

It crushed my heart when the mother (with tears rolling down her cheeks) told me," I would not have let anyone extubate my daughter if someone would have told me that there was a chance that she could make a significant recovery". She further said, "It sounded like ER physician was

not sure about her prognosis at all". As a young hospitalist, I will not forget these words for the rest of my life. It haunted me for many days.

The Patient was intubated and transferred to intensive care unit. I will always remember that eureka movement when I gave her flumazenil and she opened her eyes. Her initial lab work showed acute kidney injury and an elevated lactic acid level which improved with aggressive intravenous fluid resuscitation. MRI of the brain was done which was within normal limits. For next 24 hours she was staring continuously, without any other motor response. This haunted me with more fears, as now I was concerned, did I do the right thing? Anyways EEG was done which suggested absence seizure. Patient was started on phenytoin. Soon she started moving her extremities. She was extubated in two days.

On questioning she broke down in tears and said, "I overdosed on xanax to kill myself and he (while pointing finger to the boyfriend) knew that this is coming".

She further confirmed that she signed advance directives paper work a week before the suicide attempt and dated it back to make sure her boyfriend does not get in trouble. She made a full physical recovery and was discharged to psychiatric rehabilitation facility.

Cardiopulmonary resuscitation (CPR) was introduced in the 1960s and was limited to cardiac arrests occurring during surgery. By 1974 the American Medical Association recommended that the code status be documented in the medical records [1]. In 1976 hospitals began implementing DNR policies, institutionalizing CPR as the default response to an arrest, unless the patient had previously provided written consent to withhold the procedure [2]. Congress passed the "Patient Self-Determination Act" in 1990 and since then health care professionals have urged their patients to set up advance directives. The document allows people with terminal illnesses to accept or decline medical interventions and to appoint surrogate decision makers if they become incapacitated [3].

Unfortunately advance directives often do not neatly address all the specific medical situations because the language is too general and overly simplified. Advance directives frequently do not tell physicians exactly how to proceed in certain situations. While there are many limitations of advance directives, two scenarios are quite troublesome.

First, "What to do if a DNR patient is already resuscitated?" Families count on the physician for authentic advice. How many times we have heard this question, "what would you do if this is your loved one". Families don't know what lays ahead and they are haunted with many fears. How much information about the chain of events and prognosis must be obtained before talking to the family before honoring the wishes is debatable. A physician's judgment is the key component and co-morbidities should always factor into our conversations with the families.

Second, "What if a DNR patient comes with a suicide attempt" The decision to override the DNR request of an individual who has attempted suicide is a clear and classical conflict between the principles of autonomy and beneficence. Generally, we intervene with the suicidal patients based on the assumption that the patient is suffering from a mental illness that impairs judgment and once effective treatment is provided, the patient will no longer wish to commit suicide.

Adding even more complexity, "What if a DNR patient presents with a questionable suicide attempt and the family wants to respect his/her wishes". A physician's sense of responsibility and the threat of legal action makes the decision to override the DNR very complicated. Similar scenario has been discussed by Karlinsky et al. The authors concluded that the patient should be resuscitated because the directive does not apply to the overdose and "Once in the emergency department, the responsibility, judgment and ethical principles of the physicians become operative factors in addition to the wishes of the patient and the family". [4] The National Center for Ethics argues that questioning valid DNR status fails to honor patient preferences and may lead to patients receiving CPR against their wishes, with the attendant physical and psychological suffering. [5]

In today's world where we are facing an epidemic of drug abuse/overdose coupled with the limitations of advance directives requires physicians to rule out drug overdose as a possible diagnosis in the unresponsive patients before honoring the wishes. Most of the physicians are not trained enough to translate advance directive documents into appropriate medical decision making at the bedside. In return most of the decisions are based on personal judgment and they may vary widely from physician to physician. Scenarios like this should be discussed as a part of training curriculum.

Competing interests: I, Muhammad Tariq Shakoor, being the first and corresponding author solemnly declare that there is no conflict of interests among authors and no financial interests to disclose.

References

1. American Heart Association. Standards and guidelines for cardiopulmonary resucitation (CPR) and emergency cardiac care (ECC): Medicolegal considerations and recommendations. Journal of the American Medical Association. 1974; 227(Suppl):864-866.
2. Burns JP, Edwards J, Johnson J, Cassem NH, Truog RD. (2003). Do-not-resuscitate order after 25 years. Crit Care Med. 31(5):1543-1550.
3. Leonard Sloane. '91 Law Says Failing Patients Must Be Told of Their Options. The New York Times. December 8, 1990
4. Karlinsky H, Taerk G, Schwartz K, Ennis J, Rodin G. (1988). Suicide attempts and resuscitation dilemmas. Gen Hosp Psychiatry. 10(6):423-430.
5. National Center for Ethics in Health Care. Adverse Events and the Management of DNR Orders: Ethical Considerations: Veterans Health Administration; 2006.

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