
Bioethical Issues

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SHOULD AN ADVANCE CARE DIRECTIVE REFUSING LIFE-SUSTAINING TREATMENT BE RESPECTED AFTER AN ATTEMPTED SUICIDE? DEVELOPMENT OF AN ALGORITHM TO AID HEALTH CARE WORKERS

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An advance care directive (ACD) is a written expression of a person's preferences in relation to health care, which can appoint a trusted substitute decision-maker, describe personal values, and make explicit decisions consenting to, or refusing, certain treatments. When a person with a directive refusing life-sustaining treatments attempts suicide, opinions are divided as to the degree to which health care staff are bound by such a directive. In this section, I will provide an example of a patient who presents to hospital after attempting suicide who has a valid ACD refusing life-sustaining treatment. I will then describe the legislation relevant to ACDs in Victoria, Australia and ethical arguments relating to the application of an ACD in this context. I will present a decision-making algorithm for health care staff faced with the difficult decisions arising from such a presentation.

Keywords: *ethics, suicide, advance care directive, resuscitation, withholding treatment*

CASE PRESENTATION

Robert is an elderly gentleman who lives at home alone. For the last six years, he has had a slowly growing, invasive skin cancer on the bridge of his nose. He has chosen not to have surgery or palliative radiotherapy to treat the cancer, opting instead for a palliative approach to treatment. His other past medical history is depression, for which he takes an antidepressant, and arthritis, predominantly affecting the hips, resulting in declining mobility. He has a combination of paid carers and family members who come to his home every day to assist with cleaning and shopping. He has meals delivered once a week.

In response to his declining health, particularly facial pain from his skin cancer and difficulty mobilising due to his hip arthritis, he took an overdose of unknown quantities of temazepam and sertraline, with the apparent intention of ending his life. Shortly after, Robert was found by one of his carers who rang the paramedics.

He is now in the Emergency Department and is unconscious. He may need to be intubated and placed on a mechanical ventilator while the sedative effects of his overdose wear off. This treatment would have a very high likelihood of being successful. Without this treatment, it is felt likely that he will die.

His son has arrived, bringing with him Robert's advance care directive (ACD). The ACD is dated 2016 but meets the witnessing requirements spelled out in the *Medical Treatment Planning and Decisions Act 2016* (Vic). The ACD describes Robert's frustration with his declining mobility and pain, appoints his son as Medical Enduring Power of Attorney, and has a box ticked to indicate a refusal of cardiopulmonary resuscitation (CPR) and of all life-prolonging treatments. Emergency Department staff are required to decide how to treat Robert.

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RELEVANT ASPECTS OF ADVANCE CARE PLANNING AND THE MEDICAL TREATMENT PLANNING AND DECISIONS ACT 2016 (VIC)

Advance care planning is the process of discussing personal values and preferences in relation to health and health care and can include documenting these in a written document known as an ACD. The directive takes effect only when the person loses decision-making capacity. The recently enacted *Medical Treatment Planning and Decisions Act 2016* (Vic)¹ (*MTPDA*) legislates, for the first time, how ACDs are to be produced, validated and interpreted in this State. Importantly, directives made under this Act must be signed by two witnesses, one of whom is a medical professional, who in witnessing the document declare that they believe the person making the ACD has decision-making capacity at the time of its completion and understands the nature of all statements within the directive.

A key part of an ACD is the opportunity to appoint a surrogate to act on one's behalf in regard to health care decisions, known in Victoria as the Medical Treatment Decision Maker (MTDM). This is a person trusted to make decisions about medical treatment in the event that one is unable to do so oneself. Such an appointed decision-maker is only called upon if the person does not have decision-making capacity, and there are no relevant statements within an ACD to give or refuse consent for a particular treatment. Previously, such surrogate decision-makers were instructed to make decisions based on what they think would be in the person's best interests. However, in a significant change from the language of the *Medical Treatment Act 1988* (Vic),² the *MTPDA* now instructs the MTDM to attempt to make the decision that the person would have made for him or herself if they had decision-making capacity. In order to make such a substituted judgment, they should rely on what is written within the ACD as well as words and actions of the person during their life. Only when there is no basis for them to ascertain what decision the person would have made for him or herself, should they decide based on the best interest test.

In another important change, the *MTPDA* also grants the MTDM the power to refuse treatments as well as provide consent. This is significant because if the person had expressed, either in words or within a written document, that they did not like the idea of receiving life-sustaining treatment, then the MTDM is obliged to refuse such treatments, even if to do so will lead to the death of the person. Health care professionals are bound by this decision, unless they have good reason to believe that the MTDM maker is not acting in accordance with what the person him or herself would have chosen to do. In other words, the MTDM has the same power to refuse treatments as an instructional directive, and indeed as a competent patient him or herself.

An ACD may also contain a description of a person's health care preferences, comprising two types of statements; values directives and instructional directives. Values directives are descriptions of what the person considers important in life, what they value and what they fear. For example, "My independence is the most important thing for me. I want to spend as much time as possible in my own home, and would hate to have to live in a nursing home." These statements are used to guide the MTDM to make decisions on behalf of the person. Instructional directives, on the other hand, are legally binding consents to, or refusals of, specific types of treatment in particular circumstances. For example, "In the event of cardiac arrest, I do not want to have resuscitation attempted", or "in the event of critical illness, I do not want to receive life-prolonging treatment".

Where a relevant instructional directive exists, and the person who wrote it does not have decision-making capacity, it is as if the person has given, or refused, consent to that particular treatment contemporaneously. In this case, there is no decision for the MTDM to make. The Act states that any instructional directive within an ACD which does not meet the witnessing and validity requirements (which will usually include those produced prior to the enactment of the *MTPDA*, although not in Robert's case) is considered only as a values directive. That is to say that the statements in the ACD are used by the MTDM to guide their decisions, but that instructional directives in such an ACD are not binding.

In emergency situations, there is no compulsion for health care staff to search for an ACD. However, if the ACD is immediately available, is valid, and relates to the situation at hand, then it must be followed. The Act allows for health care staff to refuse to comply with an instructional directive only:

¹ *Medical Treatment Planning and Decisions Act 2016* (Vic).

² *Medical Treatment Act 1988* (Vic).

If the health practitioner believes on reasonable grounds that circumstances have changed since the person gave the advance care directive so that the practical effect of the instructional directive would no longer be consistent with the person's preferences and values³

and that delaying treatment to confirm the wishes of the person would result in a significant deterioration of the person's condition.

ETHICAL CONSIDERATIONS IN THE APPLICATION OF AN ACD AFTER ATTEMPTED SUICIDE

Futility

In some situations, after attempted suicide, it will be clear that attempts at resuscitation will not produce a successful outcome, or that the treatment required to attempt resuscitation will be too burdensome for a given situation. In these settings, it is clear that resuscitation should not be attempted, irrespective of the presence of an ACD. For example, CPR should be withheld from people known to be in the advanced stages of a terminal illness. However, in this context, the rationale for withholding such treatments does not relate to the mechanism of illness being suicide, but rather to avoid potentially harmful treatments with little or no hope of benefit. For the remainder of this essay, I will discuss only treatments with the potential to save the life of the patient without an unreasonable burden of treatment, that is, treatment which is not futile.

AUTONOMY, BENEFICENCE, NON-MALEFICENCE AND JUSTICE

Autonomy

The primary reason for following an ACD in any context is to support a person's autonomy. Here, autonomy means the "self-governing ability of a person ... to choose a course of action".⁴ Autonomy is now enshrined in medical decision-making, and it is considered professional misconduct to treat a person contrary to a wish expressed in a valid and applicable ACD unless subject to the exclusions documented in s 51 of the *MTPDA* outlined above.

However, in order to be autonomous, certain conditions must be met, in particular that the person making decisions has enough information to do so, and that they have decision-making capacity. Absence of one or both of these conditions is often invoked as a reason to ignore an ACD in the setting of attempted suicide.

Informed Decision-Making

Autonomous decision-making requires that it is informed. This is challenging when decisions are being made in relation to future illnesses, the implications of which have not been felt first hand, as is the case with ACDs. Several authors have questioned the degree to which ACDs are informed, although these concerns are not unique to the setting of attempted suicide. Specifically, in relation to suicide attempts, several authors have expressed concerns about whether the writer of an ACD refusing life-sustaining treatments would have imagined their instructional directive being applied in such a circumstance.

Geppert suggests that the unforeseeable nature of attempted suicide means that we cannot be certain that the person would have refused resuscitation in such a circumstance.⁵ However, there is no requirement for people to predict the reason why certain treatments might be required in order to refuse them. Furthermore, attempted suicide is no less foreseeable than any other sudden illness. That someone did not expect they would be in a car accident is no reason to treat their resulting injuries contrary to an ACD that refuses such treatments.

Hall contends that the holder of an order refusing resuscitation attempts is not likely to have considered "a sudden catastrophic, yet easily reversible event" and that it is therefore essential to intervene in

³ *Medical Treatment Planning and Decisions Act 2016* (Vic) Pt 4 Div 1 s 51(a).

⁴ M Porta and JM Last, "Autonomy" in *A Dictionary of Public Health* (OUP, 2018) <<http://www.oxfordreference.com/view/10.1093/acref/9780191844386.001.0001/acref-9780191844386-e-309>>.

⁵ C Geppert, "Saving Life or Respecting Autonomy: The Ethical Dilemma of DNR Orders in Patients Who Attempt Suicide" (2010) 7(1) *The Internet Journal of Law, Healthcare and Ethics* <<http://ispub.com/IJLHE/7/1/11437>>.

such a situation contrary to a treatment limiting order by the person.⁶ This assumes that the writer of such a directive did so in fear of receiving treatment for a condition that was not easily reversible, or treatment that might not work. In fact, this may not be the case. As pointed out by Casarett and Ross, people commonly wish to avoid the resuscitative effort itself, with its accompanying discomfort, fear and indignity.⁷ People have a right to refuse treatment without rational explanation, and may refuse even simple, minimally invasive treatment with a high chance of saving life, such as a Jehovah's Witness refusing a life-saving blood transfusion. Notwithstanding that the transfusion is easy to administer and likely to have benefit, we respect their right to refuse it. Similarly, just because there is a higher chance that resuscitation in some settings will be successful does not allow us to administer treatment against the wishes of the patient, whether that be expressed in real time or in an ACD.

Karlinsky discusses a case of a man with a DNR order (do not resuscitate) who attempts suicide, and poses the question "was it certain that he did not have a depressive illness that might have responded to treatment?"⁸ Again, he presumes that if the person writing the ACD had known that their underlying disorder would be treatable, then they would not have refused treatment for it, and that therefore the person's autonomous decision to refuse treatment should be null and void. However, this consideration is not applied to physical illnesses. People who have made an autonomous decision to decline treatment in an Intensive Care Unit (ICU) are not admitted to ICU against their wishes simply because they may have a very treatable condition, such as a urinary tract infection.

Decision-Making Capacity

To make autonomous decisions, one must have decision-making capacity. Some who suggest that an ACD should not be binding after attempted suicide argue that the act of attempting suicide is irrational, and therefore the person does not have capacity. For example, Hall proposes that treatment should be initiated in order to restore decision-making capacity for the person, so we can check that their refusal of treatment was truly autonomous.⁹ Others would argue that suicide is usually an effect of significant mental health illness, such as depression, which would imply a lack of capacity. I reject these concerns about the validity of autonomy based on lack of capacity for several reasons.

First, not all suicide attempts are irrational. Battin has attempted to identify criteria on which a suicide attempt may be considered rational.¹⁰ These include that they are based on stable views rather than impulse, that the decision is informed and made without coercion, and that the person can appreciate the consequences of their actions. Similarly, Werth argued that under certain conditions, suicide could be a rational choice, and showed that most mental health practitioners agreed with the notion.¹¹ While it is clear that many instances of attempted suicide will not meet her definition of rationality, it can be seen that the mere act of attempting suicide is not, in and of itself, proof of a lack of decision-making capacity. The recent passage of legislation for voluntary assisted dying supports the notion that the choice to end one's life can indeed be deliberate and rational. One aspect of rational suicide is that it comports to a stable goal, rather than being an impulsive act. The presence of an ACD written in advance, refusing life-sustaining treatment, lends weight to the suggestion that a given attempt at suicide is part of an enduring preference for death, and it could be argued that a suicide attempt in which such an ACD is present is more likely to be rational than one without it. This concept is explored in more detail below.

⁶ SA Hall, "An Analysis of Dilemmas Posed by Prehospital DNR Orders" (1997) 15(1) *The Journal of Emergency Medicine* 109.

⁷ D Casarett and LF Ross, "Overriding a Patient's Refusal of Treatment after an Iatrogenic Complication" (1997) 336(26) *The New England Journal of Medicine* 1908.

⁸ H Karlinsky et al, "Suicide Attempts and Resuscitation Dilemmas" (1988) 10(6) *General Hospital Psychiatry* 423.

⁹ Hall, n 6.

¹⁰ MP Battin, *Contemporary Perspectives on Rational Suicide* (Taylor and Francis, 1999).

¹¹ JL Werth, *Rational Suicide? Implications for Mental Health Professionals* (Taylor and Francis, 1996); JL Werth and DJ Holdwick, "A Primer on Rational Suicide and Other Forms of Hastened Death" (2000) 28(4) *The Counseling Psychologist* 511.

Concerns about mental state are relevant in the context of suicide attempts, many of which occur in the context of mental illness, most commonly depression. However, the *MTPDA* makes no mention of a person's mood or the presence or absence of a mood disorder, when assessing capacity to make treatment decisions. In order to have capacity, one must be able to understand and retain information relevant to the decision at hand, use that information to make a decision, and communicate that decision. While decisions made are no doubt influenced by mood, and attention to managing a mood disorder is crucial, a mood disorder such as depression does not render someone unable to make decisions. In fact, the decision to forego treatments based on a poor quality of life might be equally rational whether the cause of the impaired quality of life is a mood disorder or a physical illness, particularly if the mood disorder is persistent despite treatment.¹² In other words, a mood disorder does not render someone incapable of making medical treatment decisions, and may in fact be a perfectly reasonable consideration in a person's decision to refuse life-sustaining treatments.

Second, Hall's suggestion to resuscitate in order to assess capacity and only then allow the person to refuse life-sustaining treatment is problematic. It introduces the significant possibility that the person's life is no longer dependent upon life-sustaining treatment by the time such assessment of capacity is made. Therefore, they would never have the opportunity to refuse life-sustaining treatment, giving the same effect as ignoring their ACD altogether. Furthermore, the purpose for many of refusing life-sustaining treatment in an ACD, as mentioned above, is not to prevent survival, but rather to prevent the experience of being resuscitated and maintained on life-sustaining treatment. To resuscitate them in order to assess capacity therefore eliminates the intended purpose of what they had written in their ACD.

Finally, and most importantly, ACDs are, by definition, only in effect when a person does not have decision-making capacity. The purpose of writing an ACD is that it will be invoked at a time when the person cannot speak for themselves. To suggest that the ACD can be ignored because the person attempting suicide does not have capacity, is to subvert the purpose of advance care planning altogether. By this measure, the lack of decision-making capacity could equally be used to ignore the directive in any and all situations in which the directive would have had a role. Hall writes:

Suicide is an affirmative act that requires a decision by the individual to undertake that act. Treatment is necessary because the individual must be returned to a level of functioning where it is possible to demonstrate that the decision to end life is truly an autonomous decision.¹³

This is flawed logic. If someone who refuses resuscitation in an ACD is injured in an accident or suffers an unforeseen and unavoidable illness such as a stroke, then their ACD will be followed, although they have had no choice in bringing illness upon themselves. Being an affirmative act, the person attempting suicide cannot possibly have less control over their illness than the victim of an accident or stroke, even if we cannot be sure that they were acting autonomously at the time of attempting suicide (they may well have more control if their suicide attempt is, even in part, rational). On the grounds of autonomy, then, if we consider an ACD valid after an unsolicited medical illness, then we must also consider it valid after an attempt at suicide.

Retrospective Assessment of Capacity and Knowledge

Following from this argument, what is far more important than the decision-making capacity and knowledge of the person at the time of their attempted suicide is their decision-making capacity and knowledge when they wrote their ACD. Geppert, considering the value of a "do not resuscitate" order in someone attempting suicide, writes that a "suicide attempt is not an autonomous act, therefore does not command the same legal or ethical obligation that would be accorded the wishes of a competent individual to refuse life-sustaining interventions." That might be true in the absence of an ACD, where a person, having attempted suicide, refuses treatment. In this setting, the person's decision-making capacity can confidently be challenged, and their refusal of treatment over-ridden. However, if it can be shown that someone had decision-making capacity when their instructional directive to refuse life-sustaining

¹² JS Dembo, "Are Decisions Made 'In the Throes' of Treatment-Refractory Mental Illness Truly Invalid?" (2013) 13(3) *The American Journal of Bioethics* 16.

¹³ Hall, n 6.

treatment was written, then it does not matter that the illness requiring such life-sustaining treatment was brought about as a result of a suicide attempt in which there was (potentially) a loss of capacity.

The issue then revolves around how we can retrospectively assess the decision-making capacity of the person at the time of writing an ACD, and the degree to which their decisions documented in the directive were adequately informed. This assessment is easier for those ACDs written in Victoria after the 12 March 2018, when the *MTPDA* was enacted, than it is for those written prior to the 12 March 2018.

ACDs Written after 12 March 2018

Importantly, any ACD written after enactment of the *MTPDA* on the 12 March 2018, will satisfy the requirement for both adequate knowledge and decision-making capacity. The Act requires that the written directive is witnessed by two people, one a medical professional, who certify that they believe the person writing the directive is competent to do so. In addition, the medical professional's role is to read the ACD and ensure that "the person giving the advance care directive appeared to understand the nature and effect of each statement in the directive."¹⁴ Therefore, we should assume that decisions made and documented within a valid ACD under the *MTPDA* are informed and were written by someone with decision-making capacity.

ACDs Written before 12 March 2018

In the absence of prospective assessment, there are important considerations for determining the validity of a directive. Importantly, people are assumed to have capacity and there must be good reason to suspect that capacity is lost in order for it to be questioned; a suicide attempt may provide such reason for doubt. In these settings, consideration should be given to the longevity of the ACD, and the opinion of those with knowledge of the patient's capacity at the time of writing the ACD. Concerns about whether instructional directives are adequately informed, as described above, might be addressed by a consideration of values directives. I will describe how these factors can aid clarification of the validity of such an ACD.

Longevity of ACD

Where there is a short-time interval between completion of an unwitnessed ACD and a seemingly irrational suicide attempt, the ACD may take on the form of a suicide note, as seen in a case described by Cook.¹⁵ Here, a voluntary inpatient in a psychiatric ward with diagnoses of severe depression, generalised anxiety disorder, post-traumatic stress disorder and borderline personality disorder, attempted suicide while holding an ACD refusing resuscitation. A decision was made to resuscitate her despite the ACD, and an ethics review led to a decision to refuse her wish to have a "DNR" order placed in her record. It seems possible, if not likely, that the ACD in this case was written when the patient was suffering from an acute psychiatric illness and was potentially therefore part of the suicide attempt.

The fact that an ACD can be changed or annulled at any time means that the longer there is between completion of an ACD and an attempted suicide, the more stable the person's preferences as described in that ACD are, and the less likely it is that the ACD was part of an irrational attempt to commit suicide. In other words, the time between writing an ACD and attempting suicide provides opportunity for the person to change their mind about what they have written in the ACD, and the fact that they have not made changes can reassure us that their decision to forego treatment was durable rather than impulsive. At the time of writing, any ACD written before enactment of the *MTPDA* is more than nine months old, meaning that the writer of the ACD has maintained their wish to refuse life-sustaining treatment for at least that long. Given that these considerations about retrospective assessment of capacity only apply to ACDs written before 12 March 2018, as time passes it becomes increasingly unlikely that such an ACD has been written as part of an irrational and impulsive suicide attempt because of its longevity.

Following the case reported by Cook and discussed above, the hospital involved altered its policy such that DNR orders were routinely ignored following suicide attempts. For the reasons explained above,

¹⁴ *Medical Treatment Planning and Decisions Act 2016* (Vic) Pt 2 s 17(3).

¹⁵ R Cook et al, "Do-Not-Resuscitate Orders in Suicidal Patients: Clinical, Ethical, and Legal Dilemmas" (2010) 51(4) *Psychosomatics* 277.

this was the wrong conclusion for the hospital to reach. I agree that a DNR request should not be supported when requested by a suicidal (or otherwise potentially incompetent) person, and the decision to resuscitate this patient seems like a correct one. However, a DNR that is requested by a person with decision-making capacity who later commits suicide should, in fact, be respected.

The Role of the MTDM

In the rare situation where time permits, as in our case, family members and close contacts of the person should be involved in ascertaining the validity of an ACD. Here, the question for the MTDM is not whether treatment should or should not be offered. Instead, we should ask them whether they can confirm that the person had decision-making capacity and understood the implications of their ACD when they wrote it. If they believe that they did, then the Instructional Directive should be respected. Only if they believe that the person did not have capacity, should the MTDM be asked to make decisions on behalf of the person. As directed by the *MTPDA*, they should then attempt to make the decision that they believe the person would have made for themselves (rather than what is in their best interests), and the Act gives them the power to consent to, and also to refuse, treatment. They should be supported to refuse treatment if they believe that that is the decision that the person would have made for him or herself if they had decision-making capacity.

Values Directives

Values directives are intended to assist the MTDM to make medical decisions in the absence of instructional directives. However, they may also give insight into the reasons behind instructional directives. For example, as described above, if a person has refused life-sustaining treatment, some may wonder whether their refusal would have applied if they had known how readily and successfully treatable their condition would be. This is impossible to ascertain from an instructional directive; however, it might be possible to glean from values directives. If their values directive describes a fear of being in a persistent state of minimal consciousness and of needing full-time nursing care, or of requiring long and drawn out medical therapy, it might indeed be reasonable to suggest that their ACD was not intended to refuse relatively simple, highly effective treatments such as overnight mechanical ventilation with the prospect of full recovery after a drug overdose. If, however, the ACD speaks of a dislike of hospitals, a fear of invasive medical treatment and the experience of pain resulting from treatment, then it becomes apparent that the person is resistant to the treatments themselves, rather than the potential outcomes or duration of treatment. The fact, then, that the treatments are highly likely to work is not relevant.

Furthermore, a values directive may include a description of what the person believes to be an acceptable quality of life. If it is clear from that description that the person's quality of life after receiving treatment (including support and treatment for any mental illness) would not be acceptable to that person, then the MTDM should refuse medical treatment on their behalf.

To summarise, any directive written after the 12 March 2018 fulfils the criteria for decision-making capacity and adequacy of information and should be respected after a suicide attempt. For those written before this date, the decision-making capacity of the person is increasingly likely the longer their ACD has been in existence and can be ascertained through conversations with the person's family, including their MTDM. Finally, values directives can be interpreted to ascertain the degree to which the person intended their instructional directives to be applied in the setting of attempted suicide, and also to determine whether treatment will result in an outcome that is acceptable to them.

Beneficence, Non-maleficence and Best Interests

The decision to treat someone after an attempted suicide is an appeal to beneficence. Although the person has, through their actions, expressed a wish to die, we override their possibly autonomous choice to do so in order to deliver treatment that we feel is in their "best interests". In this way, beneficence is often seen to conflict with autonomy, prompting an ethically difficult choice between the two (and often resolved by calling into question the autonomy of the person who has decided to attempt suicide, as described above). However, when someone with decision-making capacity refuses life-sustaining treatments autonomously (either contemporaneously or in a valid ACD), are we really acting in their

best interests if we treat them contrary to their expressed preferences? Is it actually in the person's best interests to subject them to treatments which they do not want, and/or the prospect of a survival with a quality of life that they do not find acceptable?

First, when we assume that it is in someone's best interests to receive life-sustaining treatments even when they have refused it, we might confuse the person's desire not to be kept alive with the person's desire to avoid the life-sustaining treatments themselves. Even if we believe the former is not in their best interests, the latter may well be, and in order to do no harm to the patient, we must respect their desire to avoid certain treatments. Life-sustaining treatments, including resuscitation, intubation and mechanical ventilation, all have the potential to cause suffering, pain and the possibility of a "bad death". A person's refusal of such treatment may be driven more by their fear of suffering as a result of medical treatment rather than their desire not to die.

Second, the appeal to best interests assumes that it is in everyone's best interests to survive, which may not be the case. Indeed, the situation in which non-futile treatment is withheld or withdrawn is common, preceding most deaths in ICUs.¹⁶ Here, withholding further treatment is thought to be in the best interests of the patient, even though this will lead to their death. Recently passed legislation of voluntary assisted dying also demonstrates that someone's best interests are not always served by being alive. Put another way, sometimes a person's best interests are served by actions (or omissions) which will bring about their death.

Third, surviving with a poor quality of life is considered by many to be a fate worse than death. Indeed, this is a common reason for withdrawal of treatment from critically ill patients. If we provide life-sustaining treatments to someone who has attempted suicide only for them to survive with intolerable sequelae of their suicide attempt (such as neurological injury), then it can be said that we have indeed caused great harm to the person. Caution should be exercised here, however. It is true that many survivors of suicide attempts find value in their lives and are grateful for their life being saved, and few survivors of suicide attempts ultimately die as a result of suicide,¹⁷ suggesting that the perceived intolerability of their life prior to the suicide attempt may be temporary (although this may not be true of those with ACDs refusing life-sustaining treatments). Furthermore, it can be very difficult to predict the quality of life of someone who survives a critical illness, regardless of the cause.

Finally, as indicated in the previous section, the *MTPDA* now directs decisions to be made not based on the person's best interests, but rather based on what the person would have chosen for him or herself if they had decision-making capacity. The Act makes it clear that, despite our best intentions, we should give priority to the person's autonomy over their best interests. This aspect of the *MTPDA* applies to decisions made in the context of ACDs written prior to its enactment and is therefore a highly influential change in the way we might assess someone's treatment options after a suicide attempt.

Justice

Health care resources are finite, and it is important that health care resources are not used for futile endeavours (ie, where treatment is not reasonably likely to produce benefit). The determination of futility of resuscitation after a suicide attempt might be made on the grounds that the person's death is inevitable. In such a case, this decision is not driven by consideration of justice and resources, but rather by good medical practice.

Equally, administering treatment to people who prefer not to receive it is a poor use of resources, even if the treatment is not futile per se. The "Choosing Wisely" campaign which aims to reduce unnecessary health care expenditure has, as one of its key measures for critical care, to identify patients who "value

¹⁶ JL Brieva, P Cooray and M Rowley, "Withholding and Withdrawal of Life-Sustaining Therapies in Intensive Care: An Australian Experience" (2009) 11(4) *Critical Care and Resuscitation: Journal of the Australasian Academy of Critical Care Medicine* 266.

¹⁷ D Tidemalm et al, "Risk of Suicide after Suicide Attempt According to Coexisting Psychiatric Disorder: Swedish Cohort Study with Long Term Follow-Up" (2008) 337 *BMJ* a2205.

the avoidance of prolonged dependence on life support” and to forego life-sustaining treatments in these patients.¹⁸ These campaigns often specify that this applies to patients nearing the end of their life as a result of life-limiting illnesses. However, it is reasonable from the perspective of managing finite resources to apply such concepts to patients who choose to forego treatments even if they are not otherwise nearing death. As described above, the decision to refuse treatment does not need to make sense to the health care provider in order for them to be bound by it. In this context, however, it is reassuring if the refusal of treatment is durable. The presence of an ACD, particularly one with longevity, implies that the decision to refuse treatment is not part of the impulsivity of an irrational suicide attempt, but rather a deeply held personal value which should be respected.

OTHER ETHICAL ARGUMENTS AGAINST RESPECTING AN ACD AFTER A SUICIDE ATTEMPT

Aiding and Abetting Suicide

There is debate over the extent to which we have a right to choose to end our own lives. However, it is the right to refuse treatment, which is widely accepted, that is more relevant to this discussion, as the action to attempt to take one's life has already occurred by the time we confront this ethical challenge. A competent decision to refuse, withhold or withdraw life-sustaining treatment is supported ethically and legally, even if such a decision will inevitably lead to death, and even if such a decision is made in advance and recorded in an ACD.

Nevertheless, some have suggested that honouring an ACD which refuses life-sustaining treatment after a suicide attempt is equivalent to aiding and abetting a suicide, a crime under the *Crimes Act 1958* (Vic).¹⁹ Indeed, the Office of the Public Advocate (OPA) has suggested this as a possible defence for health care staff who administer medical treatment contrary to an ACD after a suicide attempt.²⁰ This position is hard to justify. It would grant health care staff the right to override an ACD on the grounds that their own legal protection takes priority over the values of the patient, who is in fact not committing a crime. Furthermore, the perceived need for legal protection is unfounded given the clarity of the *MTPDA* in supporting, and even requiring, health care staff to abide by a valid ACD. The position of the OPA on this issue would allow health care staff to apply their own values to decision-making in relation to the patient, contrary to the clearly documented values of the patient, and thereby favouring paternalism over patient-centred care.

It is written in the *MTPDA* that an ACD cannot compel health care staff to perform an act which is unlawful or unethical. However, as described above, withholding and withdrawing treatment when it is refused by a patient is considered ethical, and patients lawfully have the right to insist upon it. The idea that health care staff might override a refusal of treatment in this setting, providing treatment that a patient has refused, differs from conscientious objection because of the implications for the patient. Where a conscientious objector refuses to provide a treatment on ethical grounds or personal values, the patient is free to seek such service elsewhere. However, when a health care worker ignores a treatment refusal on the grounds of conscience, the patient is subjected to an unwanted treatment, and the patient has no opportunity to follow an alternate plan which conforms to their own values. Thus, although there may be reasonable arguments for allowing conscientious objection to an act of commission in some situations, allowing health care staff to conscientiously object to an act of omission strips patients of their right to self-determination.

¹⁸ Choosing Wisely Australia, *College of Intensive Care Medicine of Australia and New Zealand: Tests, Treatments and Procedures Clinicians and Consumers Should Question* <<http://www.choosingwisely.org.au/recommendations/cicm>>.

¹⁹ *Crimes Act 1958* (Vic) Pt 1 Div 1 s 6(b)(2)(a).

²⁰ Department of Health and Human Services, *Advance Care Directives and Attempted Suicides; Medical Treatment Planning and Decisions Act 2016* <<https://www2.health.vic.gov.au/acp>>.

Impact on Health Care Staff of Allowing a Preventable Death

That is not to ignore the impact on health care staff of caring for patients who have attempted suicide. Both providing and withholding life-sustaining treatment in this setting carries a significant chance of moral distress for nursing and medical staff. Moral distress can arise either as a result of having to make difficult decisions with significant implications, or from being unable to act in a way that one's personal ethics would see as the right way.²¹ Moral distress in the setting of attempted suicide could equally result from allowing what appears to be an entirely preventable death, and also from treating a person against their wishes. The equal likelihood of burden makes it difficult to imagine that this consideration should be the basis for the decision whether or not to resuscitate a patient. The beliefs of the health care staff are likely to vary from one patient to the next based on clinical details and circumstances. Furthermore, the health care team comprises multiple members, and almost certainly a plurality of views. This is therefore an unsuitable way to determine the correct course of action. Accepting that there is a likelihood of moral distress for staff whatever decision is made, it is of more value to take a policy position rather than allow decision-making in individual cases.

Call for Help Invalidates ACD

Karlinsky suggests that the act of bringing someone to the Emergency Department for treatment after an overdose would contradict a previous advance request for a refusal of treatment. This is not an applicable argument for two reasons; first, it prioritises a decision made in the midst of a crisis and with uncertain decision-making capacity over a considered, rational decision made in writing in an ACD. Second, it assumes that the only way people can be cared for upon presentation to the Emergency Department is to attempt to prolong their life. Health care staff in an Emergency Department are well equipped to deliver end of life care, including when the end of life is precipitated by a suicide attempt.

Involuntary Treatment to Prevent Suicide

As described by Henman,²² suicidal patients are often detained against their will in order to prevent them attempting suicide; we override their autonomy to prevent their premature death resulting from an irrational act. The suggestion is that we should also treat patients against their will after a suicide attempt to prevent their premature death that would otherwise result from the success of such an attempt. The relevant difference here relates to capacity. We are only right to detain a suicidal person against their will because we suspect they do not have decision-making capacity. If we detain a suicidal patient to prevent them injuring themselves, and subsequently find that they have decision-making capacity and are refusing admission, we are not within our rights to force admission and treatment upon them. It follows then that if the ACD refusing treatments was written at a time that the person had decision-making capacity, then it carries the same weight as a competent person refusing treatment and should be followed.

Treatment to Improve Quality of Life in Survivors

Some patients would be expected to survive a suicide attempt even without the provision of life-sustaining treatments. In this situation, it is possible that withholding treatment might lead to injury and subsequent sequelae of the suicide attempt which might otherwise have been prevented. Health care staff would be confronted with the option of following an ACD and having a survivor with an adverse effect of their suicide attempt, or contravening an ACD and having a survivor without injury. An example would be a hypoxic brain injury and subsequent neurological injury resulting from a non-fatal overdose of sedatives, as in Robert's case, that might have been prevented by providing short-term intubation and mechanical ventilation. It could be argued that the person would not have refused treatment in such a situation if they understood the implications of such a refusal.

The most challenging aspect of this approach is the difficulty predicting both survival and the possibility of injury, and so application of this line of reasoning would result in treatment contrary to an ACD in a large number of cases, potentially subverting the purpose of ACDs. Also, as stated earlier, if the patient's

²¹ BM Pauly, C Varcoe and J Storch, "Framing the Issues: Moral Distress in Health Care" (2012) 24(1) *HEC Forum* 1.

²² MP Henman, "Suicidal Patients with a Do-Not-Resuscitate Order" (2017) 52(1) *The Journal of Emergency Medicine* 117.

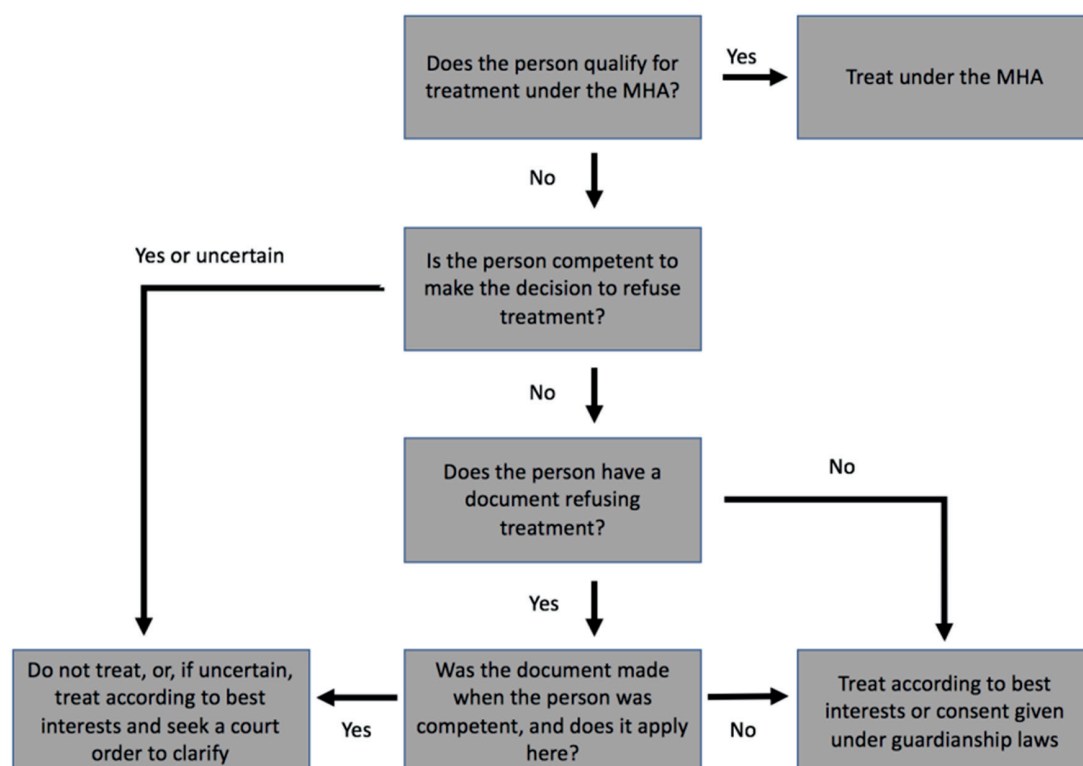
refusal of treatment relates to an aversion to the treatment itself, rather than fear of the possible outcome, then it may still be important to respect the ACD regardless of the potential for a poorer outcome for the patient. Finally, the *MTPDA* only allows health care staff to refuse to comply with an ACD if “they believe on reasonable grounds that the circumstances have changed since the person gave the ACD so that the practical effect of the ACD would no longer be consistent with the person’s preferences and values”.²³ This could be enacted if it was clear that this were the case. For example, if a values directive within the ACD made it clear that the person feared having a poor outcome as a result of illness rather than the life-sustaining treatment itself, health care staff would have reasonable grounds to provide treatment. In this context, the treatment is less “life-sustaining” than “injury preventing”.

DEVELOPMENT OF ALGORITHM

Ryan and Callaghan presented an algorithm to guide health care staff when faced with a person who is refusing treatment contemporaneously after suicide.²⁴

Box 1 presents the Ryan and Callaghan algorithm from 2010. Box 2 presents a new algorithm for making decisions about treatment after a suicide attempt in Victoria, Australia. This algorithm updates that by Ryan and Callaghan to incorporate significant changes resulting from the *MTPDA*, summarising the discussion above. As can be seen, the legislative changes have had a significant impact on how we should make treatment decisions for these patients.

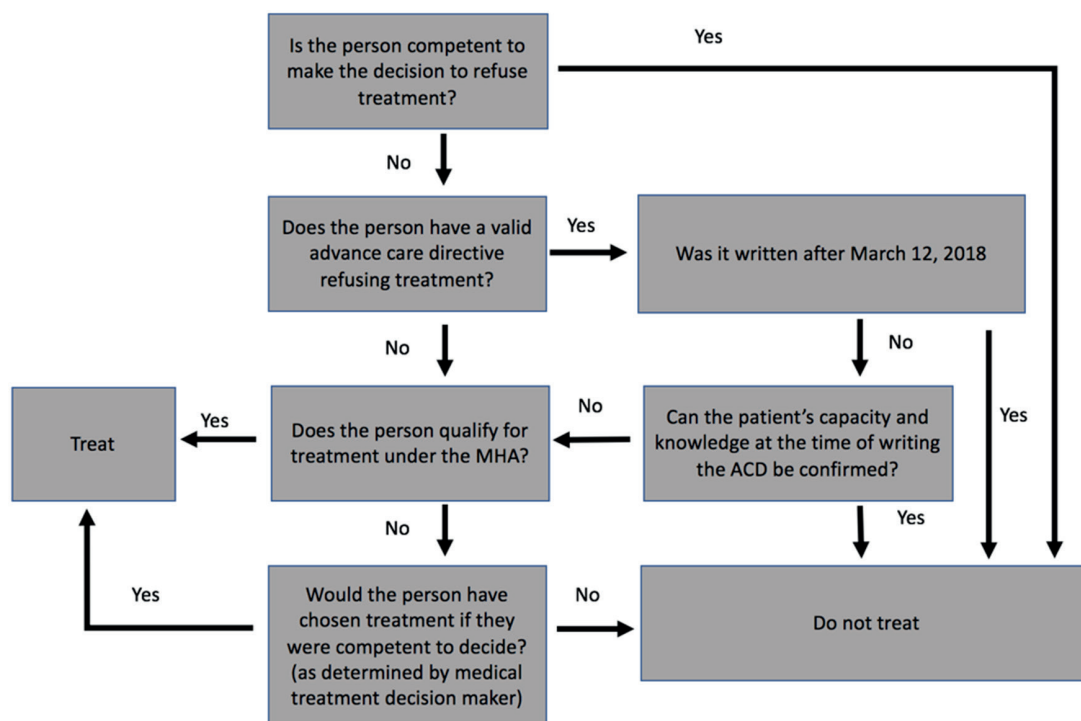
BOX 1. Approach to an apparent treatment refusal after an attempted suicide, from Ryan and Callaghan.



²³ *Medical Treatment Planning and Decisions Act 2016* (Vic) Pt 4 Div 1 s 51(a).

²⁴ CJ Ryan and S Callaghan, “Legal and Ethical Aspects of Refusing Medical Treatment after a Suicide Attempt: The Wooltorton Case in the Australian Context” (2010) 193(4) *The Medical Journal of Australia* 239.

BOX 2. Approach to treatment decision-making after an attempted suicide in Victoria, Australia after 12 March 2018.



If this algorithm was applied to our patient, Robert, his wish for treatment to be withheld would have been respected. Although his ACD was written prior to 12 March 2018, it was signed by his doctor stating that he was “competent and understands the importance and implications of this document”. If it were not witnessed in this way, his son should have been asked to make a retrospective assessment of his capacity on the day that the directive was signed. If there were concerns about his capacity, and he did not qualify for treatment under the *Mental Health Act*, then his son should have been asked what he thought his father would have chosen for himself if he had decision-making capacity.

In fact, the Emergency Department staff decided not to intervene. However, Robert survived his attempted suicide without requiring any specific life-sustaining treatment, and without any adverse effects of the attempt. He subsequently was discharged to a rehabilitation facility.

CONCLUSION

It can be seen from the above arguments that the factor which should determine the validity of an ACD in the setting of attempted suicide is the decision-making capacity of the person at the time of completing the ACD. Any directives written under the *Medical Treatment Planning and Decisions Act 2016* (Vic) will include an assessment of the person’s decision-making capacity and also their ability to understand the nature and effect of statements within the directive, and must therefore be followed. For any other directives, there should be an attempt to retrospectively assess the person’s capacity at the time of writing the directive where possible, including the opinions of the MTDM. In this context, as in others, capacity should be assumed. The longer the duration between writing the directive and the attempt at suicide the more likely it is that the views expressed in the ACD are stable and should be followed. If the person did not have capacity at the time of writing the ACD, then the medical treatment decision-maker should make a decision about treatment based on what they think the person would have chosen for themselves, and they should invoke their right to refuse treatment if appropriate.

Arguments that ACDs should be ignored after a suicide attempt have been discussed. Clearly, the personal values of health care staff should not be the determinants of decisions about withholding treatment in these cases, because of a risk to patient autonomy, and because of the likely variability and plurality of opinion among the health care team. A policy-based approach is preferable, and I have presented an algorithm to help health care staff faced with this situation in Victoria, Australia, in the era of the *Medical Treatment Planning and Decisions Act 2016* (Vic).

APPENDIX 1: JAMES' ADVANCE CARE DIRECTIVE

ADVANCE CARE DIRECTIVE COMPETENT PERSON (Victoria) A record of my future health care wishes		Date: <u>03 OCT 2017</u> Time: <u> </u>
I, <u>[REDACTED]</u> of <u>1212 North Rd. South Oakley</u> declare that:		
1) My current health problems include: <u>Basal Cell Carcinomas and fragile, tremors both hands.</u>		
2) This document has been explained to me and I understand its importance and purpose. I may complete all or part of this document. It is a guide for my future medical treatment. It will only be used if I am unable to make decisions for myself, and will be taken into account when determining my treatment.		
3) I understand that it is important to discuss my wishes with my doctor, and my family, including the 'Person Responsible' or my Medical Enduring Power of Attorney (if appointed).		
4) I request that my wishes, and the beliefs and values on which they are based, are respected. I have written on page 2 of this form the things that I value most in life, and other things that may help my doctors and other decision makers.		
5) I understand that doctors will only provide treatment that might be medically beneficial. I also understand that irrespective of any decisions by the doctor about CPR and life prolonging treatment, I will continue to be cared for, including care to relieve pain and alleviate any suffering.		
A CPR (Cardiopulmonary Resuscitation) Initial appropriate box ☐ It has been explained to me by Dr _____ that I would not benefit from attempted CPR and I understand and accept this. OR ☐ I would like CPR attempted if it might be medically beneficial. OR ☒ I do NOT want CPR, even if the doctors think it could be beneficial.		
AND		
Life Prolonging Treatments Initial appropriate box e.g. breathing machine (ventilator), kidney machine (dialysis), feeding tube, surgery ☐ I would like life prolonging treatment in order to prolong my life as long as possible. OR ☒ I would like life prolonging treatments only if the doctors expect a reasonable outcome. To me, a reasonable out come means: _____ OR ☒ I do NOT want life prolonging treatments at all. If life prolonging treatment has been commenced I request that it be discontinued and that I receive palliative care.		
OR		
C I choose to delegate decisions regarding CPR and life prolonging treatments to my Medical Enduring Power of Attorney or the following person: _____ (insert name of MEPOA and contact number) OR <u>[REDACTED]</u> <u>- NIECE</u> (insert name and relationship)		

* If you have specific health problems you may choose to complete a Refusal of Treatment Certificate. Refer to Advance Care Plan Information Sheet.

Date: _____
Time: _____

The things I most value in my life are: (eg. independence, enjoyable activities, talking to family and friends):

Future situations that I would find unacceptable in relation to my health:

Specific treatments that I would NOT want considered for me :

Other things that I would like known which may help in making decisions about my future medical treatment:

I ask that, if possible, my Medical Enduring Power of Attorney and / or family include the following people in discussions and decisions about my health care: _____

If I am nearing death I would like the following: (eg, music, spiritual care, customs, cultural beliefs met, family members present):

This is a true record of my wishes on this date.

My Signature _____

Date 3/10/17

Witness' signature _____
(preferably Medical Enduring Power of Attorney)

Witness name (Print) _____

I, Dr. _____ believe that _____
(Registered Medical Practitioner) (your name)

is competent and understands the importance and implications of this document.

Doctor's signature _____

Date 3/10/17

The contents of this Advance Care Plan/Directive have also been discussed with:

Name: _____
Relationship: _____
Signature: _____
Date: _____

Name: _____
Relationship: _____
Signature: _____
Date: _____