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Deciding on life-saving treatment after a violent suicide attempt: an ethical case report

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To the editor:

In the USA alone, there were 1.7 million suicide attempts in 2021.[1] Although the majority of suicide attempts are not fatal, immediate medical attention is often necessary, especially when violent methods are used.[2] These methods include jumping from heights, using a firearm, crashing a motor vehicle, and lying down or jumping in front of a moving object.[3]

When a person survives a violent suicide attempt, they may become severely injured and in need of long-lasting rehabilitation with an uncertain outcome.[3] Caring for these patients can be complicated. There is often an underlying psychiatric disorder that interferes with the somatic treatment. Additionally, brain damage is common, and the death wish may persist or even strengthen due to the added burden of physical pain and the fear or prospect of long-lasting disability.[4]

For a number of reasons, clinicians may have doubts about the value of continuing treatment, especially when a patient is unable to make informed treatment choices and clarify their wishes. In this ethical case report, we describe a violent suicide attempt and the subsequent medical discussion that arose about whether to stop life-saving treatment. Our aim is not to defend the decisions that were made but to use this experience to reflect on the complex decisions that occasionally have to be made after a violent suicide attempt and to identify factors that should be considered.

The patient's brother, his legal guardian, read this article and gave signed permission for this publication.

CASE

This case involves a 39-year-old man who was brought to the hospital after attempting suicide by jumping in front of a departing train. He suffered multiple traumata, including skull fractures with diffuse axonal injury, cervical fractures and a left-sided pelvic fracture. He had a history of schizophrenia and had been admitted 12 times to psychiatric wards from 18 years of age. His main symptoms were imperative auditory hallucinations in the form of voices, which he thought originated from satellites. They made him feel anxious, paranoid and unsafe, resulting in a reluctance to leave his house. He was supported by his family and treated by a mental healthcare outreach team. He had been using clozapine and lithium for some time, although with varying adherence due to side effects and limited efficacy. More recently, aripiprazole was added without an apparent effect.

In the months leading up to this suicide attempt, his situation worsened, partly due to the loss of his job in a movie theatre and moving to a supported living arrangement. The increase in his symptoms led to a depressed mood, suicidal thoughts, and finally two suicide attempts by throwing himself in front of a moving train, resulting in minor injuries; these occurred within the same week and 3 months before his hospital admission. On being admitted to a closed psychiatric ward, he increasingly complained about the decline in his autonomy. After staying in the closed ward for some time, he convinced the treatment team to let him go for a walk off the ward. He then again threw himself in front of a moving train, which led to the severe injuries mentioned above.

When questioned, the patient's brother recalled that the patient had not spoken much about his situation prior to the suicide attempts. However, after the third attempt, he apologised to his brother and explained that the attempts had occurred under the influence of the commanding voices he was hearing. His brother further reported other

possible reasons for the attempts, including the coronavirus epidemic and the patient's nearing birthday.

Following his third suicide attempt, the patient was initially admitted to the intensive care unit (ICU). The patient was not paralysed from the cervical fractures. However, he had to wear a neck brace to prevent dislocation and aberrant consolidation. When his condition seemed stabilised after 5 days, he was transferred to a medical psychiatric unit (MPU). The following day, he developed a fever, sputum stasis, increased need for oxygen and disturbances of consciousness, after which he was placed back at the ICU for 18 days, where he was treated with high oxygen supplementation, antibiotics and drainage of the hygromas. He was again transferred to the MPU, where he recovered and started rehabilitation. After 5 weeks, his X-rays showed that the fractures were consolidated, and the brace was removed. He had no hip fracture but suffered from a pelvis fracture, which was treated conservatively. Due to the high intracerebral pressure caused by the hygromas, drainage was performed. Due to the cerebral trauma, causing haematomas, and a mild diffuse axonal injury, the patient suffered from a postconcussive syndrome with cognitive disturbances (eg, disorientation, memory deficits) and restlessness, which gradually subsided. During his recovery on the MPU, the patient was conscious, but his communication ability was severely impaired due to neurological damage. He appeared anxious, spoke dysarthrically, talked incoherently, showed behaviours indicative of hallucinations and did not respond to questions. Moreover, he did not use other ways to communicate. Due to physical restlessness, he had to be restrained to allow the injuries to heal. A possible prognosis included years of rehabilitation and lifelong medical care. It was not possible to obtain informed consent for his treatment at this stage.

Although his somatic symptoms were treated successfully, a discussion arose among the multidisciplinary team about where to draw the line in continuing treatment should his condition deteriorate. On one hand, it was argued there was enough room for physical and mental improvement. On the other hand, the question arose whether the prospect of needing help for the rest of his life, along with the ongoing struggle with the psychotic symptoms that had driven him to three violent suicide attempts in the recent past, would possibly make the rest of his life an agony.

After a moral deliberation, the medical staff concluded that there was enough room for improvement and the patient continued his recovery. During the following 4 weeks on the MPU, the patient improved physically, cognitively and mentally, and was eventually transferred to a neuropsychiatric rehabilitation unit where his progress continued. At the time of this writing, he has been living in a supported accommodation for several years. He is currently struggling with post-traumatic brain damage issues, including memory problems, difficulties with planning and a strong need for structure in his daily life. His brother reported that there are now also positive aspects to the patient's life, including that he found a new job. He has not again attempted suicide since his hospital admission.

DISCUSSION

The main question this case raises is: are there situations where life-saving treatment should be ceased after a violent suicide attempt? Several factors must be considered when answering this question.

The main consideration is whether the patient is able to make an informed decision about life-saving treatment. If this is the case, based on the principle of respecting autonomy, it is widely recognised that the patient has the right to deny treatment, even if the consequence is death.[5] However, as this case illustrates, there are often several factors that hamper the patient's ability to make an informed decision about stopping life-saving treatment directly after a violent suicide attempt. First, life-saving treatment decisions will regularly have to be made during medical crises, often when the patient is unconscious. Second, violent suicide can lead to brain damage, which may further limit the patient's ability to make an informed decision.[6] Last, people who attempt suicide in a violent manner often suffer from a psychiatric disorder, such as psychosis or severe depression, that can unduly influence their decision-making capacity concerning life-saving treatment.[2]

Hence, it will often occur that the patient is unable to make informed choices about treatment after a violent suicide attempt. In these situations, the decision is typically made by the patient's relatives and the team of involved professionals, as occurred in the reported case. It appears to be common practice to 'err on the side of safety', meaning that life-saving treatment is continued, at least until the patient regains the ability to make their own decisions again. This was an important discussion point during the interdisciplinary moral deliberation meeting for the reported patient. The underlying assumption is that life is preferable to death. Still, someone who recently attempted suicide may see this differently, especially taking into consideration that any sustained injuries may further hamper the quality of life.

It would be a mistake to equate a violent suicide attempt to a well-considered death wish. Research shows that people are typically in a state of entrapment when attempting suicide and are not in a position to rationally consider their options.[7] However, a violent suicide attempt can be reasonably interpreted as a sign of severe distress and suffering. Therefore, when weighing the harms and benefits of continuing life-saving treatment, it is important to consider whether there are acceptable options to alleviate the suffering that drove them to suicide in the first place. This appears to be especially relevant when it comes to patients who repeatedly attempt violent suicide. Also, when considering the potential harms and benefits of stopping life-saving treatment, the damage done by the suicide attempt has to be taken into account. If there is a substantial chance of lasting disability, the patient's

suffering may be aggravated. However, seemingly paradoxical, ongoing disability may also improve the patient's situation. For example, the patient with physical needs may gain access to lifelong clinical care that sadly often is not available for severe psychiatric suffering. In the reported case, the patient regained structure, possibly due to his new supported living situation. An additional important factor in regaining autonomy was finding a new job, as previously the loss of his job was associated with his deterioration.

If conclusions are reached that there are no reasonable options to alleviate the patient's suffering in the future, it could be argued that continuing treatment is futile; therefore, discontinuing life-saving treatment may be the more merciful option. Nonetheless, this is a delicate decision that should be taken with utmost care and in consultation with the patient's relatives. In the case described here, the patient attempted suicide three times, suggesting a persistent or at least returning death wish. However, there were still real possibilities for improvement by helping the patient find meaning through a new job and by improving medication adherence or adding electroconvulsive therapy.[8] The fact that the patient has not attempted suicide since can be seen as a sign of relative stability and acceptable quality of life.

This case and the subsequent discussion show the complexity of decision-making after a violent suicide attempt. A possible way to prevent this undesirable situation is to discuss the patient's wishes beforehand, commonly referred to as advance care planning. If there is a clear advance directive, relatives and professionals do not have to speculate about the patient's wishes and what future they deem bearable or not. There are often concerns about whether patients with severe psychiatric illnesses are able to make informed decisions in advance, but research shows that these concerns are often unjustified.[9] Even the majority of patients admitted to an acute psychiatric ward are often able to make informed decisions about future medical care. Even so, it is important that at the time the advance directive is drafted, it is discussed with a mental health professional and decision-making ability is assessed. Advance care planning is an underutilised tool that can help retain the autonomy of patients with a psychiatric disorder in the complex situation that arises after a violent suicide attempt.

Finally, this case report and discussion must be interpreted within a Western/Dutch context and may not be directly generalisable to other (non-Western) cultures.

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