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Article abstract

Do Not Resuscitate (DNR) orders are intended to respect patient autonomy and prevent unnecessary suffering when resuscitative efforts are unlikely to provide meaningful benefit. While their use is well established in end-of-life care, their application becomes ethically and procedurally complex when a patient with an existing DNR order attempts suicide. This paper explores the challenges that arise in such cases, emphasizing the need for a nuanced approach that integrates clinical assessment, considers the temporal context of suicidal intent, and upholds foundational DNR principles.

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TÉMOIGNAGE / PERSPECTIVE

Navigating the Ethical Crossroads of Suicide Attempts and End-of-Life Directives

Elisheva T.A. Nemetz[a], Ryan S. Huang[a]

Résumé

Les injonctions de ne pas réanimer (NPR) visent à respecter l'autonomie du patient et à éviter des souffrances inutiles lorsque les efforts de réanimation ne sont pas susceptibles d'apporter un bénéfice significatif. Bien que leur utilisation soit bien établie dans les soins de fin de vie, leur application devient éthiquement et procéduralement complexe lorsqu'un patient ayant reçu une ordonnance de NPR tente de mourir par suicide. Cet article explore les défis qui se posent dans de tels cas, en soulignant la nécessité d'une approche nuancée qui intègre l'évaluation clinique, prend en compte le contexte temporel de l'intention suicidaire et respecte les principes fondamentaux de l'ordre de NPR.

Abstract

Do Not Resuscitate (DNR) orders are intended to respect patient autonomy and prevent unnecessary suffering when resuscitative efforts are unlikely to provide meaningful benefit. While their use is well established in end-of-life care, their application becomes ethically and procedurally complex when a patient with an existing DNR order attempts suicide. This paper explores the challenges that arise in such cases, emphasizing the need for a nuanced approach that integrates clinical assessment, considers the temporal context of suicidal intent, and upholds foundational DNR principles.

Mots-clés

NPR, ne pas réanimer, éthique médicale, soins de fin de vie, suicide

Keywords

DNR, do not resuscitate, medical ethics, end-of-life care, suicide

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INTRODUCTION

Do Not Resuscitate (DNR) orders emerged in clinical practice following the American Medical Association's 1976 recognition that cardiopulmonary resuscitation (CPR) might not benefit all patients uniformly (1,2). These directives were designed to respect patient autonomy and prevent unnecessary suffering when resuscitative measures would likely prove futile or inconsistent with the patient's acceptable quality of life (3). Despite their widespread implementation in contemporary healthcare settings, DNR orders present significant ethical complexities that challenge clinicians, particularly in non-standard clinical scenarios (4). This paper examines the ethical and procedural implications of upholding DNR orders when a patient with an existing DNR order attempts suicide, exploring whether their implementation aligns with their intended purpose and ethical justification.

MODIFIABLE NATURE OF SUICIDALITY

Suicidality is not a discrete disorder but rather a complex symptom frequently associated with conditions such as depression, which has a higher prevalence among individuals with terminal illness (5). Suicidal ideation often represents a fluctuating state that may respond to appropriate interventions (6). While complete symptom resolution is not universally achievable, evidence suggests that multifaceted approaches — including pharmacological treatment, psychological support, and enhanced palliative care — can significantly ameliorate the psychological distress that underlies suicidal behaviour (7,8). Successful resuscitation following a suicide attempt therefore presents a critical opportunity to address potentially modifiable suffering. Applying DNR directives in the context of suicide attempts may foreclose this opportunity, inadvertently conflating an individual's desire to avoid prolonged suffering from their terminal condition with an acute psychological state that may be amenable to intervention.

In contrast, DNR orders for patients with terminal illness, chronic disease, or severe frailty are based on the recognition that the underlying condition is irreversible or unrelievable and that aggressive interventions are unlikely to improve the patient's long-term prognosis or quality of life (9). While an acute depressive episode may induce profound suffering, it is often responsive to appropriate medical and psychological care, unlike the conditions for which DNR orders are traditionally intended such as a terminal illness. In emergency settings, clinicians often have limited time to assess the intent and applicability of a patient's DNR order. However, the ethical responsibility to respond to reversible suffering, particularly when the underlying cause may be modifiable, provides strong justification for overriding a DNR order in the context of a suicide attempt. Allowing DNR orders to apply in such cases risks creating a dangerous precedent, potentially normalizing their use in contexts far removed from their original intent.

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MORAL INJURY TO PRACTITIONER

The practical implementation of upholding a patient's previously established DNR orders in the case of attempted suicide has profound implications for the healthcare practitioners tasked with making these decisions. Moral injury arises when physicians are forced to act, or refrain from acting, in ways that conflict with their deeply held ethical and professional responsibilities. In the case of a suicide attempt where a previous DNR order is in place, clinicians may wrestle with the immediate and irreversible decision to either override the directive in favour of resuscitation or adhere strictly to the DNR, potentially resulting in a decision that disregards the possibility of recovery (10). This cognitive dissonance is compounded by a lack of clear institutional guidelines for navigating these ethically ambiguous scenarios, leaving practitioners vulnerable to significant emotional strain.

Emergency physicians may face heightened moral injury due to the rapid decision-making required in time-sensitive environments. Unlike other clinical settings, the emergency department offers little opportunity for deliberation, making the burden of responsibility particularly acute. Physicians must simultaneously weigh their duty to honour a patient's autonomy, their capacity to intervene in cases of transient suicidality, and the legal ramifications of their choices. The absence of standardized protocols further exacerbates this tension, forcing clinicians to rely on their own moral compass amid uncertainty.

Ultimately, emergency clinicians bear the immense weight of reconciling their responsibilities to the patient, the family, the institution, and the broader profession of medicine. This burden, in the absence of robust institutional frameworks, increases the risk of moral injury and professional burnout.

PROCEDURAL INTENT

Understanding the procedural intent behind DNR orders is essential to appreciating why their application in the context of suicide attempts presents such profound ethical dilemmas. The application of DNR orders is firmly established within specific clinical contexts, including terminal illness, physiological frailty, advanced age, and severe medical conditions where resuscitative interventions would likely extend suffering without conferring meaningful benefit (11-14). These circumstances exemplify the foundational purpose of DNR directives: to preserve patient autonomy by respecting informed decisions to decline interventions when their anticipated burdens exceed potential benefits. However, the extension of DNR orders to cases of acute suicide attempts constitutes a substantial deviation from this procedural intent.

The validity of a DNR order is contingent upon demonstrated decision-making capacity of either the patient or when the patient lacks capacity, their designated substitute decision-maker (SDM), at the time of its execution (15). These directives are designed to guide care in medically appropriate and ethically justifiable circumstances, not as a blanket refusal of life-saving interventions regardless of context. The well-established precedent for DNR orders in end-of-life care provides sufficient clarity on their intended scope, making it unnecessary to explicitly enumerate each scenario where their use would be inappropriate.

Honouring DNR orders in the context of suicide attempts poses a significant risk to the ethical framework underpinning their application. Such practices may set a problematic precedent, leading to interpretations that deviate from the original intent of these directives (16). This erosion of ethical boundaries could result in the inappropriate application of DNR orders in contexts for which they were never designed, thereby complicating clinical decision-making and undermining the integrity of end-of-life care. Upholding the procedural and ethical foundations of DNR orders is essential to preserving their credibility, ensuring they remain aligned with their intended purpose, and maintaining trust within the healthcare system.

CONCLUSION

In summary, the ethical tensions surrounding DNR orders in suicide attempts reveal a conflict between respecting patient directives and responding to reversible conditions. Our analysis demonstrates that DNR orders must be interpreted within a framework that balances procedural intent, patient autonomy, and clinical responsibility. Clinical decision-making in these cases requires consideration of multiple factors: the context in which the DNRs were established, the state of the patients, the reversibility of their conditions, and their potential for recovery. Healthcare institutions should develop explicit guidelines for these scenarios, informed by ethics committees, mental health professionals, and patient advocates. While beyond the scope of this analysis, legal implications of DNR implementation in suicide attempts warrant further exploration. Future research can provide valuable insight into how legal considerations shape clinical decision-making. Ultimately, preserving the integrity of DNR orders requires a nuanced approach that safeguards patient autonomy while preventing their misapplication in modifiable conditions. Structured frameworks will help clinicians navigate these complex cases and reduce the degree of moral injury faced by practitioners, ensuring that end-of-life directives remain aligned with their original intent and upholding the core ethical principles of medical practice that prioritize patient-centred care.

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