Exploring the Limits of Autonomy

Mr. Galanas, an eighty-six-year-old man, intentionally shot himself in the chest and abdomen. Surprisingly, the bullet damaged only his distal pancreas and part of his colon, requiring a diverting colostomy to prevent leakage of bowel fluids into his abdomen. Mr. Galanas’s only significant past medical history involved severe back pain that, according to his wife, had gone on for years despite treatment from multiple specialists. After being admitted, he lies intubated in the intensive care unit awaiting surgery to repair his colon. He is responsive but does not demonstrate clear decision-making capacity; his doctors can’t tell whether this reflects cognitive deficits or lack of effort. He grudgingly accepts pain medications but refuses antibiotics and antidepressants. When asked if he enjoys his life, he shakes his head no.

Mr. Galanas has a living will from 2007 that gives his wife durable power of attorney. It also explicitly states a desire to refuse all medical interventions if he is permanently unconscious or in an end-stage condition. Mrs. Galanas reports frequent conversations in which her husband said he would not want to be sustained on life support. She also says that he often mentioned he would not want an ostomy bag—a choice to end one’s life in order to avoid additional suffering. During the tragedy of 9/11, some individuals on the upper floors of the World Trade Centers jumped to their death, “choosing” to die sooner (and presumably less painfully) than by incineration in the raging flames. Arguably, they committed suicide and did so based on a reasoned choice when faced with the prospect of prolonged, inescapable suffering followed by death.

To what extent suffering legitimizes the choice of suicide is clearly a contentious issue. So, too, is whether an individual sufficiently appreciates or has explored the options to alleviate the suffering, since a hallmark of severe depression is that individuals cannot perceive or appropriately weigh available alternatives.

Members of Mr. Galanas’s medical team object that the intentionality and self-inflicted nature of his injuries should change how we view a patient’s request to withdraw life-sustaining treatment. There is widespread consensus in bioethics that patients with decision-making capacity have the right to limit life-sustaining medical interventions, even when their doctors disagree or their choices will likely result in harm or death. The current case draws our attention to certain nuances of respect for patient autonomy by asking whether attempted suicide should change how we view a patient’s request to withdraw life-sustaining treatment.

Though it is common to regard suicide as irrational, one can imagine circumstances in which it is reasonable to choose to end one’s life in order to avoid additional suffering. During the tragedy of 9/11, some individuals on the upper floors of the World Trade Centers jumped to their death, “choosing” to die sooner (and presumably less painfully) than by incineration in the raging flames. Arguably, they committed suicide and did so based on a reasoned choice when faced with the prospect of prolonged, inescapable suffering followed by death.

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gun. What is it about the agent of injury that meaningfully differentiates how we should regard an autonomous desire to choose death over a life of suffering?

Understandingly, injuries that are intentionally self-inflicted raise concern that mental illness may be impairing an individual’s decision-making capacity through alterations in attention, perception, cognition, and mood. However, in an examination of the decision-making ability of individuals with mental illness, the MacArthur Treatment Competence Study, published in 2004, found that “most patients hospitalized with serious mental illness have abilities similar to persons without mental illness for making treatment decisions,” and that “taken by itself, mental illness does not invariably impair decision-making capacities.” Even when individuals required hospitalization for depression, they demonstrated intermediate levels of decision-making performance on decisions to receive or refuse medical treatment, with about 75 percent performing well on all measures combined. Moreover, “patients with more severe depression did not necessarily perform more poorly than those with less serious depression.”

Because Mr. Galanas’s decision to refuse life-sustaining treatment is both momentous and irreversible, we must be very careful to ensure it is informed, voluntary, and deliberate—in short, authentic. It is also our responsibility to help Mr. Galanas consider viable alternatives, including options for pain management. However, it is an act of hubris to assume that we can resolve chronic pain that no other provider could ameliorate. Absent any practical means to relieve Mr. Galanas’s suffering, it is not clear how we benefit him by imposing life-sustaining treatments.

Caring for another’s well-being is a good thing, as is support for those who are in distress and vulnerable to imprudent decisions. But we must also be clear that the decision to forego life to avoid further suffering is a legitimate one, and one that belongs to the individual whose life is at stake.

**Commentary**

by George F. Blackall

The Centers for Disease Control and Prevention report that each year, approximately 34,000 people in the United States commit suicide (nearly twice the number of homicides), and for each completed suicide, there are twenty-five nonfatal attempts. Given the frequency with which people survive suicide attempts, a dilemma for health care providers is what to do when these patients arrive at the hospital. A key piece of information at such times—as it is in this case—is what the patient wants. Does he desire medical interventions to preserve life? Or does he wish to be left alone and allowed to die? The argument for allowing Mr. Galanas to die is that the attempted suicide was an outward expression that he wanted to end his life. Should we not respect our patient’s autonomy?

Two important questions that arise are: 1) Is a person rational when he or she attempts suicide? and 2) If we do intervene and save the patient’s life, isn’t the person just going to kill him or herself later anyway? Some interesting research sheds light on these questions.

The rationality question has been studied retrospectively in survivors of suicide attempts. A key finding is that the final decision to commit suicide is not so much an act of psychotic disarray; instead, the person has lost the ability to see more than one way out of the current dilemma. Left with no options, he enacts plan A. It is not that plan A is the best option he could come up with, it is the only option; there is no plan B. This phenomenon draws into question one of the key aspects of rationality and capacity: that is, the ability to think through a variety of options. For the suicidal person, that ability has vanished. Based on the data, the answer to our first question—is a person thinking rationally when he attempts suicide?—appears to be “usually not.”

Data from Thomas Simon, presented on the Harvard School of Public Health Web site, debunked the notion of well thought-out suicides. In a population of survivors of near-lethal attempts between the ages of thirteen and thirty-four, less than 13 percent of survivors had contemplated committing suicide for eight hours or more. An astounding 70 percent had thought about it for one hour or less, and 24 percent had pondered it for only five minutes. One would expect a “rational” person to spend at least a couple of days thinking about whether to go to the grave.

Given that most suicide attempts may not be well thought out, what about the notion of intervention being fruitless because the person will go on to kill himself at a future date? Again, the social science literature offers some insight. As far back as 1972, the British Coal Stove data demonstrated that when Britain phased out coal stoves—a ready source of carbon monoxide poisoning in the home—and replaced them with less toxic gas stoves, the suicides from carbon monoxide poisoning dropped dramatically without a corresponding increase in other forms of suicide. In fact, the suicide rate for the entire country dropped and stayed at that reduced level. Furthermore, a 1978 study by Richard Seiden of jumps from the notorious Golden Gate Bridge examined 515 survivors from 1937 to 1971 and found that only thirty-five—less than 7 percent—went on to successfully commit suicide. Seiden concludes that even if one allows for unaccounted attempts by doubling their frequencies, a full 90 percent of suicide attempts go on to live life and die of other causes.

In 1985, Edwin Shneidman, a suicidology pioneer, wrote that the way to save a suicidal person’s life is to “do something.” Returning to the argument about respecting autonomy, I believe that, given the above data, the medical team’s obligation is to “do something” to sustain Mr. Galanas’s life. This will allow him to be truly autonomous and decide for himself whether to be one of the 10 percent who go on to kill themselves or the 90 percent who do not.
Mr. Galanás's case is particularly challenging, and I confess to feeling ambivalent about how to proceed. On the one hand, surgeons have a responsibility to respect patients' wishes and not do things to them that they do not want done. On the other hand, surgeons have a duty to benefit patients when and if they can be helped. In this case, not fixing the leaking gut because the patient says no is like not sewing up the bleeding wrists of a young woman who slices them with a razor and then demands that the doctors in the emergency department just let her die.

The key question, it seems to me, is not "what would this patient want?"; we already have a good indication of the answer to this—he pulled the trigger in an attempt to die. The more salient question is "how can we best help this suicidal patient?" Others have explored the issue of whether a suicide can ever be rational, and while this is relevant, it is not the main issue here. More to the point is whether this suicide attempt represents an autonomous expression, and what follows from that. I wonder what profound darkness motivated this man to pull the trigger. What was he thinking, and why now? Could adequate treatment of his underlying chronic pain have altered his wish to die? Was he thinking clearly, or was this the impulsive act of a desperate individual? As a general internist who has treated many depressed individuals, I am familiar with depression's black hole, and the way it destroys hope and devours prospects of alternative realities. It is the nature of this disorder that options seem to narrow, and for the most deeply afflicted, death often feels like the only way out.

Now, I am not a psychiatrist, I have never met this patient, and details do matter. That said, it troubles me to simply take his actions and prior words at face value and forego urgent and effective treatment. We simply do not know whether he has an untreated depression or whether his chronic pain has been adequately treated. If his physicians can address the underlying causes that led him to pull the trigger, it seems to me that they have a duty to do so. And if they have such a duty, isn't not treating aiding in his suicide attempt?

Some may object to this line of reasoning on the grounds that overriding his stated wishes demonstrates a paternalistic disregard for his autonomy. But autonomy is a complex notion that involves several components, not least of which are independence of thought and the capacity to rule oneself. It seems to me to be an open question whether a patient with inadequately treated pain and depression can be said to have either independence or capacity, and as such, overriding his stated wishes would not be unwarranted paternalism. Equally important is the question of authenticity. Which is the authentic person—the one who is in pain and suffering, or the (hypothetical) one who (after adequate treatment) no longer wishes to die?

In the end, none of these questions are answerable without the patient being able to speak for himself. My inclination would be to surgically treat Mr. Galanás's urgent problems and give him an opportunity to recover while simultaneously embarking on aggressive treatment of his pain and depression. After giving this strategy a reasonable amount of time to succeed, if Mr. Galanás continues to want to withdraw or withhold treatment and has the capacity to make informed and autonomous decisions, then I would respect those wishes, even if they result in his demise. But this ought to be the last resort, not the first.

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