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Proxy Decision Making in Suicidal Patients

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Abstract

Respecting patient's autonomy and abiding by rules of confidentiality are both important in patient-physician relationships. However, balancing between these rules requires comprehensive assessment of other contextual factors, such as the patient's best interest, his/her real intention, possible harms and suitability of proxy in case of the patient's becoming unconscious. In this case, a 35-year-old female patient who attempted suicide asked the clinicians not to inform her family members, and her boyfriend who is not a legally authorized guardian was to be making proxy decision. Clinicians should judge that her boyfriend to be sufficient to make further medical decision for her or not. To solve these conflicts, possible harms should be identified, weighed and finally judged to be overridden by the rule of confidentiality and autonomy. And we reviewed the Korean legal system about proxy decision making in medical practice.

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BRIEF CASE REPORT

A 35-year-old female visited the emergency department (ED) with her boy friend due to drug intoxication she visited ED one and a half hours after drug ingestion. Her mental status was nearly alert but her breath smelled of alcohol. She had a quarrel with her boyfriend, who lives with her and brought her to the emergency department. She took medicines in a fit of anger, and she was already drunk when she took the medicines. The medicine she took was 25 tablets of benzodiazepine[1] and other medications that she got from the local clinic for her irritable bowel syndrome. She had neither psychiatric history nor the previous suicidal attempt. There was no specific medical history except the irritable bowel syndrome. She complained only nausea and vomiting without headache and dizziness. Initial vital signs were blood pressure was 114/45 mmHg, heart rate was 67 beats/min, respiratory rate was 14 times/min and a body temperature was 36.2 °C. There was no significant finding in laboratory tests, and result of the urine-toxicology examination was negative but benzodiazepine.

She received the conservative treatments including gastric lavage and activated charcoal administration. Consultation to psychiatric department was considered. However, her mental status was deteriorated

1. Benzodiazepines are pharmacologic agents commonly used for the treatment of anxiety, insomnia, and alcohol withdrawal. They also are used in conscious sedation as well as general anesthesia.

as time passed, and she needed to admit to Intensive Care Unit. Since she was not alert enough to decide her treatment strategy by herself, clinicians had to make a decision based on her best interest, her explicit and implicit wishes presumed by proxy. Moreover, the clinicians had to decide who should be the proxy in this situation.

Since she already mentioned explicitly at the beginning of her visit not to contact nor notify her family about her suicidal attempt and her visiting the hospital, it is unclear who should be the proxy in this case. Her family members were against her in marrying him, and she worried about even worse relationship between her family and her boyfriend when the family came to know that she had a suicidal attempt because of the quarrel. Therefore, the boyfriend took the responsibility of guardian until she fell into drowsiness and she did not refuse any treatment.

Discussion

The biggest issue here was whether the clinicians had a duty to abide by the rule of confidentiality even in the situation where the patient became unconscious and needed consent from the proxy to admit her to ICU and to provide other medical treatments. To draw a reasonable conclusion from this issue, we should first make clarify her medical condition whether admitting the patient to ICU is needed and then determine her best interest. This matter would raise the continuous question concerning qualification of proxy in this case, and eventually the duty to follow the rule of confidentiality and respect for patient's autonomy. Finally we also check the Korean legal system about proxy decision and legal duty to treat the patients by the Medical Service Act and the Act on Emergency Medical Service.

Medical decision process on benzodiazepine intoxication patients

Since she fell into drowsy mental status and could not make decision by herself, clinicians and her boyfriend as her guardian had to decide on further treatment plan, especially the issue of admission to ICU. Moreover, the physicians in emergency department had to decide whether her boyfriend could take the responsibility of proxy and judge what her best interest is in this situation. Through these considerations, it seemed to be justifiable and even morally obligatory to admit her to ICU, according to medical condition, patient's implied choice and proxy's decision.

As her medical condition was aggravated and needed a close observation until her level of consciousness would fully recover, the medical needs judged by the physicians were obvious. Indications for observation or hospital admission include significant alterations in mental status, respiratory depression, and hypotension.[2] For her, admission to ICU was absolutely required. Though benzodiazepine overdose is known for the relatively low risk of morbidity, clinicians could not rule out the possible event of neurologic manifestations of drug, such as prolonged coma. If CNS depression persists or is profound, other agents or conditions must be considered. Unfortunately, there is insufficient literature to recommend a specific duration of appropriate observation.

Determining Patient's Best Interest of suicidal attempts patients in Emergency Medical Treatment

However, only the medical needs judged by clinicians cannot be the

2. Judith E. Tintinalli. *Emergency Medicine*. American College of Emergency Physician. McGrawHill, 6th ed. 2004. pp.1055-7.

sufficient reason to decide on the patient's further treatment plan. But suicide is not considered part of the classic normal disease process for which the different forms of advance planning were designed. Usually suicidal patients are not permitted to refuse treatment for a self-inflicted injury. And emergency physicians routinely do not permit suicidal patients to refuse treatment, because most patients who attempts suicide are suffering from substance abuse or mental illness such as depression or psychosis that impairs their ability to make a rational decision. Really there are few cases of suicide that can be supported by patient's autonomy and his best interest argument.[3] Moreover, in Korea by law persons engage in emergency medical service shall, upon receipt of a request for emergency medical service while on duty or when they find any emergency case, immediately render an emergency medical service, and shall not refuse or avoid rendering such service without any justifiable grounds.[4]

In this case, it was reasonable to think that the patient would agree with the admission to ICU, considering the previous behaviors she made when she was still alert. There are several reasons to believe that her intention to die was neither contemplated nor respectable to withhold further treatment. However, this 35-year-old healthy, yet somewhat hot-tempered patient's case cannot be one of the examples of legitimate request for letting die. The judgment about her wish grounded on the medical professionals' observation of her behaviors in ER enabled the clinicians to presume that there was implicit consent for further treatment.

First, she came into ER voluntarily with her partner in her alert mental status. This means that she agreed with the treatment to recover

3. Theodore C. Bania, Richard Lee, Mark Clark. Ethics Seminars: health care proxies and suicidal patients. *Academic Emergency Medicine*. 2003; 10(1): 65-68.

4. EMERGENCY MEDICAL SERVICE ACT Article 6.

from the condition that she brought upon herself. Second, there was no explicit refusal of treatment during the procedures such as application of activated charcoal and bowel irrigation. Based on these, we can assume that there could have been patient's tacit or implicit consent to enter ICU. Tacit consent is an agreement that people express "silently or passively by omissions". On the other hand, implicit or implied consent can be taken in when physicians assume consent to a procedure based on another specific consent to different procedure that they have already received.[5] Her acceptance or absence of refusal can be interpreted as tacit/implicit consent for ICU admission. Third, there was no substantial evidence of her careful deliberation on suicide. She attempted the suicide out of anger toward her partner in the situation where her boyfriend could easily find and rescue her from the risk of death. Also, the method was simple and left the good possibility of recovery compared to other fatal and irrecoverable ways to suicide. She did not leave any last word or other explicit comments that she seriously wanted to die. It was her first attempt and she did it on impulse rather than by design. All the conditions of her suicidal attempt show relatively low risk of suicide[6] and hardly any intention to die. Hence, unlike other justifiable cases of withholding the treatment based on patient's autonomous choice, here we cannot recognize serious conflict between medical need that requires further treatment and autonomy of the patient who conducted suicidal attempt as her expression of anger or reaction to acute stress.

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5. Tom L. Beauchamp, James F. Childress. *Principles of Biomedical Ethics*. 6th ed, New York, Oxford University Press, 2009, p.107.

6. Howard S. Sudak, M.D. Psychiatric emergency. In: Benjamin J. Sadock, Virginia A. Sadock and Pedro Ruiz (eds). In: *Kaplan & Sadock's comprehensive textbook of psychiatry*. 9th ed. Philadelphia, PA: Lippincott Williams and Wilkins, 2009, pp. 2723-2725.

Proxy decision making by guardians

Tricky question here is about proxy judgment. Family members usually take a responsibility of substituted judgment because they are assumed to be the best to know the patient's values and preference. However, because of her expressed wish not to contact her family, clinicians had to decide whether her partner who did not marry her yet but live together could be the proxy in this case and whether his judgment is valid. Substituted judgment requires the surrogates to make a decision that currently incompetent patient would have made if she had been competent'.[7] Therefore, it requires the surrogates to be the one who knows patient's values well and speaks for the patient willingly. In this case, considering their relationship, the state of living together, and their effort to receive the consent on the marriage from her parents, it is plausible to consider him as the appropriate representative for her best interest. Even though she did not explicitly point him as a proxy or surrogate in the same way people do in their advance directives, her decision to accompany him to ER and follow his instruction in there can be valid evidences. However, there were some cultural matters involved as well. Since the patient was not married yet, it is likely that she could be seen as a grown-up daughter who still needs parents' approval rather than as independent woman who can manage her own life, including choosing her surrogate.

But we have to remember that is just cultural matter because 35 year old woman is already majority who has legal capacity. Moreover, unmarried partner might not seem to make the sufficient requirement to be the proxy. He was guaranteed neither by blood relationship nor by legal marriage. Nevertheless, her partner could still be recognized as

7. Tom L. Beauchamp, James F. Childress. Ibid, p.136.

legitimate proxy because of the fact that they lived together. According to civil law which approves common law marriage, it is reasonable to qualify the patient's partner for proxy especially when her express requirement of confidentiality prevents other possible options of proxy.

Of course, there still was a matter that clinicians should be cautious about besides the legal qualification in choosing appropriate surrogate in attempt to protect her best interest. Since her suicidal attempt was triggered by the quarrel with her partner, it was essential for the clinicians to ensure the suitability of proxy. It is true that the quarrel between her and her partner can be interpreted as the evidence of conflict between their interests, which makes him the inadequate proxy. However, it is not necessarily the case when it comes to loving relationship, which is one of the most complex relationships where there is no such thing as 'sides' even in the conflict. Moreover, the fact that he agreed with her admission to ICU, the idea supported by medical need and patient's tacit/implied consent, exempt him from the stricter standard of qualification. If he had been against her admission to ICU, the clinicians should have applied the stricter standard to examine his willingness to protect her best interest, since the risk of the option against the admission would increase. All in all, the patient's partner who knew her values and had the intention to protect her best interest was the appropriate person to be the proxy in the situation where her explicit requirement make this option more desirable. Moreover, the proxy judgment was consistent with the medical need and patient's tacit/implicit choice of admitting to ICU.

And by the Emergency Medical Service act, those engaged in emergency medical service shall explain an emergency medical service to an emergency patient. But in cases where a legal agent accompanies the emergency patient because he/she has no capacity for decision making, those in emergency medical service shall explain to the said agent about

the emergency medical service and secure his/her consent thereto, and where no legal agent accompanies, those engaged in emergency medical service shall render the first-aid treatment after making explanation to the accompanying person, and even may perform emergency medical examinations according to the medical judgment of physician.[8]

Confidentiality in Suicidal Attempt Patient

Rules of confidentiality have a long history along with the Western medicine, and it is also found in various codes of conduct.[9,10] Despite the ethical implications of confidentiality and its practical function that enables medical professionals to access patients' information needed for precise diagnosis and treatment, sometimes breaching confidentiality is inevitable and even obligatory. As in the Tarasoff case,[11] if the predicted harm is grave and likely, medical professionals sometimes have a duty to warn this to the possible victims. In this case, the patient explicitly expressed that she did not want to let her family know about her condition triggered by her suicidal attempt after arguing with her partner. Since the duty of confidentiality is mixed with the patient's explicit choice in this case, we reviewed her request for confidentiality and then measure the possible harm. If our previous judgment of qualification of patient's partner as a proxy was justifiable, if the patient's request is autonomous

8. EMERGENCY MEDICAL SERVICE ACT Article 9.
9. "Whatever I see or hear, professionally or privately, which ought not be divulged, I will keep secret and tell no one." Hippocratic Oath.
10. "I WILL RESPECT the secrets that are confided in me, even after the patient has died;", WMA, Geneva Declaration.
11. Ronald Munson, *Intervention and Reflection*. 8th ed. Belmont, CA: Thomson Higher Education, 2008, p.112.

enough to be respected, and if possible harm is not as grave to notify to family members, complying with her request not to contact the family would be supported both by the rule of confidentiality and the principle of respect for autonomy.

First, it is necessary to examine her capacity for autonomous choice when she made a request of not telling her family. Her initial condition seems to be distinguished from that of other suicidal attempts in incompetent state, such as schizophrenia. She did not have any past history of psychiatric disease or distinctive sign of it. Though these facts could not fully rule out the possibility of her having psychiatric illness which has not been identified, clinicians reached the conclusion that she maintained certain degree of competence when she made her decision. It was not plausible to assume that she overall was incompetent only by the fact that she once attempted suicide which is an irrational behavior. Nevertheless, even if she were competent, the question of whether she was capable of adequate decision making when she was making her request still remains. The concept of competence is usually applied in legal area and it is rather categorical, while the concept of decision making capacity is broadly adopted in health care settings and it is located rather in the continuum.[12,13] The question is whether the patient could demonstrate the requisite level of capacity to assess the risk and benefit of

12. Brock considered competence itself as something that varies as the level of risk changes, while others criticized that this view is perilous and confusing because it 'blend a decision's complexity or difficulty with the risk at stake'. Here, I will use the concept of 'decision making capacity' to mean the required level of capacity which is varied with the specific decision faced. This capacity involves not only the state which is absent from psychologically debilitating disease, but also the state that can demonstrate the requisite skills to assess factors involved and to make decisions.
Dan W. Brock, Decisionmaking Competence and Risk, *Bioethics*. 1991; 5 :105-112.

13. Tom L. Beauchamp, James F. Childress. Ibid, p.117.

the options, to weigh the advantages and disadvantages, and eventually, to make a decision based on the assessment; did she realize the possible risk of actual death? Was she, in a drunken state, alert enough to contemplate on the possible risk and benefit of not telling the truth to her family? However, the very fact that she was the one who tried committing suicide enables the physicians to solve this tricky question. It means that she knew what she was doing and what her action would lead to. Therefore, it is reasonable to consider that she realized the risk of the death to some degree, at least. Moreover, the patient's request not to contact her family had cogent reason and it showed that she carried out the risk and benefit assessment. Overall, it is justifiable to consider that the patient was competent and also had a sufficient level of decision making capacity. Therefore, her choice can be deemed autonomous and ought to be respected unless there are other significant factors related. Finally, we have to balance the respect for autonomy/confidentiality and the possible consequential.

If we can assure her competence and decision making capacity, we are ready to weigh the possible risk when we abide by the rule of confidentiality and respect for autonomy. After measuring the magnitude and possibility of the risk, clinicians could judge whether the risk overrides these duties or is overridden for risk being relatively small and/or unlikely. Regardless of the family's existence in hospital, I already concluded that patient's admission to ICU is sufficiently supported by three different standards: the medical need, patient's tacit/implied consent, and proxy judgment. Therefore, there would be no difference in treatment strategy between the situation where family comes after being notified and another situation where they cannot be notified. Then what is the possible risk then? Here, we can examine two stakeholders, one is the patient and another is family members. The risk to both of them is deeply

related to patient's death.

First of all, the patient herself also can be the victim of the possible harm by her autonomous choice. Though she predicted and accepted the risk of her own autonomous choice, there still is the possibility of harm that was not fully recognized by her, or undesirable event that she would have wanted to avoid if she had been competent. Let us assume that she eventually died without her family by her side in the name of respect for her autonomous request and confidentiality. It might be consistent with her explicit wish, but it might also be against her unspoken idea or changed intention about the circumstances surrounding her death. She asked clinicians for the confidentiality at the beginning of her visit, but her change in condition required an admission to ICU. What if she changed her mind after realizing that she has more possibility of death than the beginning? Since patient's choices can shift over time, physicians are frequently faced with the situation where patient's previous choice contradicts with the present one.[14] This is partially because of the patients' inaccurate perception on the present situation and inadequate prediction of the future. Of course, it would have been best to ask patients multiple times as their conditions changes. Unfortunately, the physician could not figure out whether her mind changed because of her unconsciousness. Dying without family might contradict with her wish that could have changed but which she could not speak. And it is true that this harm could be done to the patient and the magnitude or graveness of the harm is huge. However, not only identifying but also measuring the risk is necessary. Deaths caused by benzodiazepine ingestions are extremely rare[15,16] and the amount of medicine she took was not lethal, even

14. Tom L. Beauchamp, James F. Childress. Ibid, p.110.

15. David C. Lee. Sedative-hypnotic agent. In: Lewis R. Goldfrank, Neal E. Flomenbaum, Neal A. Lewin, Mary Ann Howland, Robert S. Hoffman, and Lewis

though there still is a possibility of death. This low morbidity and mortality enabled clinicians to say that the probability of dying without family, the possible harm we have identified, was not significantly high. Hence, it was justifiable to postpone notifying her family unless she gets worse in her course, and the possibility of dying increases.

Secondly, the possible risk to the family members can be weighed in the same way of assessing magnitude and probability. For the family members, the additional harm that results from the patient's autonomous choice would be losing the chance of deathwatch; as I have already mentioned, the patient's future treatment strategy including admitting to ICU would be the same whether or not the family comes. Clinicians had to decide the magnitude and probability of this harm. The probability of family's losing chance to look the patient's last if she dies would be relatively low, same as that of the patient's losing chance to be with her family in her deathbed. However, the magnitude of harm to each stakeholder, the patient and the family, can be assessed differently. It is because the family's interest to be with dying patient is not as paramount as it needs to be for being recognized as a 'right'. In the Tarasoff case, again, innocent victim's interest of living safe was so important that it was recognized as an individual 'right' to protect. To protect the right, therefore, the medical professionals had a duty to warn the victim who was not even their patients. How about staying by loved one's deathbed? Is it an interest paramount enough to be a right? Most people give significant meaning to staying by the loved one's deathbed, and it is more

S. Nelson (eds). In: *Goldgrank's Toxicologic Emergencies*. 7th ed. New York, McGraw-Hill, 2002, pp.936-937.

16. Raquel M. Schears. Benzodiazepines. In: Judith E. Tintinalli, Gabor D. Kelen, and J. Stephan Stapczynski (eds). In: *Emergency Medicine: A Comprehensive Study Guide*. 6th ed. New York, McGraw-Hill, 2004, pp.1055-1056.

desirable to assist in doing that. However, it is too demanding to suggest these chances be basic human right that medical professional should protect for everyone besides their patients. Therefore, the magnitude of the possible harm to patient's family can be overridden, even though it might involve moral residue. All in all, the risk assessment of the option, resulting from patient's autonomous choice, lead us to abide by the rule of confidentiality and respect for autonomy until the larger, the more probable risk is identified.

Case Resolution and Conclusion

To solve the ethical conflicts in this case, we have to consider several factors such as medical condition, competency of the patient and valid proxy decision.

This case was about patient's explicit claim for keeping her condition confidential from her family. Even though the patient's alert mentality became drowsy, her autonomous request deserved respect especially when there was another option of proxy. Her boyfriend, who was judged to be an appropriate person to protect her best interest, agreed with clinician's decision of her admission. He was not a legally authorized guardian or agent. Further treatment to 35-year-old, healthy woman with recoverable medical condition was obligatory based on medical need, her implied consent and proxy judgment. Since this decision of treatment could be reached even without her family, and possible risk for not telling them was not significant, the options complying with her explicit request of confidentiality was chosen. It was well supported by physician's duty of confidentiality and the principle of respect for autonomy. However, this decision was based on the best interest judgment of only the status quo.

Her best interest should be continuously judged over time, considering her condition, prognosis, future risk of second suicidal attempt and the partner's willingness to take care of her. The balance between the duties could also be changed as the best interest judgment changes. For these judgments, we also consider the Korean legal system such as civil law and emergency medical service act.

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