Do-Not-Resuscitate Orders and Suicide Attempts

What Is the Moral Duty of the Physician?

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Abstract. Elderly persons are living longer with debilitating illnesses and are at risk for suicide. They are also more likely to have a living will with a DNR order. With the medical culture's emphasis on patient autonomy, an ethical approach that respects the dignity of these suffering human persons is needed. Suicide must be viewed as an act against the principle of life and the intrinsic good of the human being. Beneficence outweighs autonomy in such cases. Medical providers are at risk of mediate material cooperation with the evil of such an act if they fail to preserve a life that can be saved. DNR orders should be reversed in these situations until these patients receive psychological treatment and pain relief. *National Catholic Bioethics Quarterly* 14.4 (Winter 2014): 661–671.

In America, someone over sixty-five years of age commits suicide every ninety minutes.[1] There is little discussion in the medical community regarding suicide in the elderly.[2] There is even less discussion regarding the specific situation of resuscitation in suicide attempts by persons with verbal or written do-not-resuscitate (DNR) orders. In a medical practice climate where patient "autonomy trumps all," a conflict

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[1] American Association of Suicidology, "Elderly Suicide Fact Sheet: 2010," accessed October 10, 2014, http://www.suicidology.org/Portals/14/docs/Resources/FactSheets/Elderly2012.pdf.

[2] The term "elderly" refers to persons aged sixty-five years or older.

thus arises between the principles of patient autonomy and physician beneficence.[3] As the overall population of the United States ages, these cases will become more commonplace. Beyond the rising prevalence of physician-assisted suicide, societal views regarding resuscitation of the elderly will bring about increasing external pressure on health care professionals in these particular circumstances. An objective ethical approach to such difficult cases is needed.

The Case

Mrs. M is a seventy-three-year-old Caucasian retired critical care nurse who was brought to the emergency room (ER) after being found unresponsive by a neighbor and friend. Upon arrival at her home, emergency medical service personnel found bottles of extended release morphine capsules. They also found a note to her friend with account numbers and passwords, accompanied by detailed instructions on wrapping up her financial affairs after she was gone. The case was judged to be a suicide attempt by the medical personnel and by her friend and neighbor. Her friend, who she had given power of attorney for health care, was present at the scene and revealed to emergency medical service personnel that she had a living will containing a DNR order. However, the friend did not have a copy of Mrs. M's living will or of the power of attorney for health care form at the time.

On the scene, Mrs. M was initially given a dose of naloxone, which very briefly improved her breathing and mental status.[4] However, when she arrived in the ER, she was again unresponsive and in respiratory failure. By this time, lab work revealed severe acidosis, and her vital signs became unstable. Because of the information that had been presented to emergency medical service personnel that the patient had a DNR order, the ER physician elected not to use any assisted ventilation support for her respiratory failure. Instead, she was placed on a continuous naloxone infusion and moved to a side room in the ER where her friend could be with her.

As the on-call attending physician for the hospital that evening, I was asked to admit her to the hospital. On hearing the story, I immediately proceeded to the ER. At this point, she had been in the ER for nearly four hours. Her vital signs had deteriorated, and arterial blood gases revealed worsening acidosis despite the naloxone infusion, but she had not yet expired. Additionally, chest x-ray also revealed aspiration pneumonia from the overdose. Before going in the room, the nurse reminded me that she had a DNR order.

Her friend with power of attorney was present at her bedside. Further history was gathered. Apparently, her husband had early Alzheimer's type dementia that was rapidly progressive. In the past week, all arrangements had been made for him to live permanently with his daughter and family out of state. The patient also had been dealing with some stable chronic medical issues herself, including severe

[3] Mary Diana Dreger, "Autonomy Trumps All," *National Catholic Bioethics Quarterly* 12.4 (Winter 2012): 653–673.

[4] Naloxone (Narcan) is a medication that temporarily reverses toxicity from the overdose of opiates such as morphine.

chronic back pain. Her friend reported that Mrs. M had mentioned several times in the past six months that once arrangements were made for the care of her husband, she did not want to live in chronic pain and progressively become debilitated. The friend denied that any explicit suicide plans had been discussed.

After gathering a brief history and performing an exam, I felt she had indeed attempted suicide. I explained to her friend that as a physician in the state of Kentucky (the location of the hospital) I have legal authority to place the patient on a seventy-two hour involuntary commitment until she could receive evaluation by a licensed psychiatric professional. I explained that her current condition (respiratory failure) was most likely still reversible by mechanical ventilation, intravenous fluid resuscitation, and hemodynamic support. I explained that I felt I was bound by professional obligations to provide such interventions to stabilize her for evaluation by a psychiatrist. The friend appeared to disagree but said that if I felt duty-bound to compel treatment, she would give me seventy-two hours.

The patient was placed on mechanical ventilation, admitted to the intensive care unit, and successfully resuscitated. She was able to have ventilator support removed by her second day in the hospital. She was diagnosed with depression and placed on appropriate medication. She had a successful medical recovery and was discharged from the hospital a few days later.

Suicide Statistics in Persons above the Age of Seventy-Five

The *Oxford English Dictionary* defines suicide as (1) "the action of killing oneself intentionally" and (2) "a course of action which is disastrously damaging to one's own interests."[5] Although the elderly make up 13 percent of the population, they account for nearly 15.7 percent of all suicides.[6] In 2010, the population group with the highest rates of suicide was males over age seventy-five at 32.3 per 100,000 resident population.[7] For white males over the age of eighty-five, the number is 50.8 per 100,000 population.[8] Older adults also have a higher suicide completion rate than other groups: an estimated one completed suicide per four attempts. Among the young (fifteen to twenty-four years of age), there is one estimated suicide completion for every one hundred to two hundred attempts.[9] These statistics are based on information available from death certificates. The true incidence is likely higher. Because of the stigma still attached to suicide in the United States, and in an attempt to spare the family emotional trauma, it is likely that coroners assign natural causes to deaths in the elderly that are suspected to be intentional overdoses.

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[5] Catherine Soanes and Angus Stevenson, ed., *Concise Oxford English Dictionary*, 11th ed. (New York: Oxford University Press, 2004), s.v. "suicide."

[6] American Association of Suicidology, "Elderly Suicide Fact Sheet: 2010."

[7] Centers for Disease Control and Prevention, "Death Rates for Suicide, by Sex, Race, Hispanic Origin, and Age: United States, Selected Years 1950–2010," accessed October 10, 2014, http://www.cdc.gov/nchs/hus/contents2013.htm#035.

[8] Ibid.

[9] American Association of Suicidology, "Elderly Suicide Fact Sheet: 2010."

Despite some popular notions, depression and mental distress are not normal aspects of aging. In fact, the prevalence of frequent "mental distress" in the elderly is nearly half that of other age groups in the United States.[10] However, possibly as many as one in four elderly people have a mood disorder or some type of mental health problem not associated with normal aging.[11] The Centers for Disease Control and Prevention states, "The notion that most elderly suicides are 'rational' acts in response to irreversible, understandable situations is not supported by available clinical research."[12] Around 90 percent of suicide in all age groups is associated with psychiatric disorder. Depression appears to be the most important predictor of suicide in the elderly population.[13] Chronic medical illness, however, does appear to be a major antecedent in elderly suicide.[14]

Advance Directives and Do-Not-Resuscitate Orders

Cardiopulmonary resuscitation (CPR) as a standardized medical procedure was originally introduced in the 1960s. It was developed to reverse cardiac arrests occurring during surgery. In 1974, the American Medical Association put forth recommendations that a patient's preference for "code status," or whether they wanted to receive CPR or not, be documented in their hospital medical record.[15] By the mid-1970s, hospitals began institutionalizing CPR as the default response to cardiac arrest.[16] Over the next fifteen years, Congressional legislation, presidential ethics commissions, and various judicial rulings established that competent patients have the right to refuse life-sustaining treatment through both advance directives and surrogate decision making. The term "do-not-resuscitate" (DNR) originally applied specifically to a medical order written by a doctor instructing other health care providers not to perform CPR in the event of cardiac arrest. This is how the National Institutes of Health describes DNR orders in their instructional publication for patient advance directive decision making:

> A do-not-resuscitate order, or DNR, is a medical order written by a doctor. It instructs health care providers not to do cardiopulmonary resuscitation (CPR) if breathing stops or if the heart stops beating.

[10] Centers for Disease Control and Prevention and the National Association of Chronic Disease Directors, *The State of Mental Health and Aging in America: Issue Brief #1—What Do the Data Tell Us?* (Atlanta, GA: National Association of Chronic Disease Directors), 2008.

[11] Ibid.

[12] Howard Cattell, "Suicide in the Elderly," *Advances in Psychiatric Treatment* 6 (2000): 102–108.

[13] Ibid.

[14] Ibid.

[15] American Heart Association, "Standards and Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC): Medicolegal Considerations and Recommendations," *Journal of the American Medical Association* 227.Suppl (1974): 864–866.

[16] Jeffrey P. Burns et al., "Do-Not-Resuscitate Order after 25 Years," *Critical Care Medicine* 31.5 (May 2003): 1543–1550.

> A DNR order allows you to choose before an emergency occurs whether you want CPR. It is a decision only about CPR. It does not affect other treatments, such as pain medicine, medicines, or nutrition.
>
> The doctor writes the order only after talking about it with the patient (if possible), the proxy, or family.[17]

Currently, the Joint Commission on Accreditation of Healthcare Organizations requires health care institutions to have policies and procedures in place regarding advance directives and DNR orders on all patients.[18]

It is unknown what the prevalence of advance directives is in the overall US adult population. Estimates vary from 5 percent to 15 percent.[19] Among the elderly in long-term care situations, including home health, nursing homes, and hospice, the prevalence ranges from 28 percent to 88 percent. The most common types of advance directives are living wills and DNR orders. DNR orders are actually more common than living wills themselves among nursing home residents (56 percent compared to 18 percent).[20]

Advance directives in the form of living wills and DNR orders can produce some challenges for family members and health care providers when the patient is either temporarily or permanently unable to articulate specific wishes regarding resuscitation. Living wills are frequently vague and open to interpretation of the original intent in many instances, especially interpretation by a health care professional that has not previously known the patient. Prior established DNR orders sometimes present challenges to decision making in an incapacitated patient. Preexisting medical orders without available in-the-moment patient input to apply context to the unique circumstances of their medical situation may not allow for an accurate interpretation of the patient's wishes. A more optimal form of advance directive is the appointment of a trusted health care proxy, with alternative proxies appointed in case the primary proxy cannot be reached. Open and frank discussions in advance of emergencies can provide trusted proxies with patient intentions and beliefs that can subsequently be more successfully applied to unique medical circumstances.

Demographic Changes

There is currently unprecedented growth in the elderly population of the United States due to an increase in life span and the aging of baby boomers. Over the next twenty-five years, the population of adults aged sixty-five or older will rise to seventy-two million. In 2030, this population will account for 20 percent of the US population.[21] Causes of death have shifted from acute illness and infections to

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[17] National Institutes of Health, "Do Not Resuscitate Orders," *MedlinePlus*, April 7, 2012, www.nlm.nih.gov/medlineplus/ency/patientinstructions/000473.htm.

[18] Patient Self Determination Act. 42 USC §§ 1395 (a)(1)(Q) and SSA §§ 1866 and §§ 4206 (b)(1) of OBRA 90.

[19] Adrienne L. Jones et al., "Use of Advance Directives in Long-Term Care Populations," *National Center for Health Statistics Data Brief* 54 (January 2011).

[20] Ibid.

[21] Centers for Disease Control and Prevention, *The State of Aging and Health in America 2013* (Atlanta, GA: US Department of Health and Human Services, 2013).

more prolonged courses of chronic and degenerative illnesses. Seventy-five percent of all elderly adults live with multiple chronic conditions. Over 75 percent of people aged eighty or older report living with chronic debilitation as defined by an affirmative answer to the question: "Are you limited in any way in any activities because of physical, mental, or emotional problems?"[22] The aging and chronic debilitation of the US population, combined with the increased incidence of suicide and increasing prevalence of living wills, will certainly lead to more cases with the dilemma of resuscitation of patients presenting with suicide attempt in the setting of DNR orders.

Suicide: A Rational Act?

Before analysis of patient autonomy and whether honoring a DNR order in the setting of a suicide attempt can be morally justified, one must explore the act of suicide itself. Can suicide ever be considered a rational act? Some of the most highly regarded philosophical dictionaries generally discuss rationality in the context of epistemology, specifically the acquisition of knowledge by reason alone. Philosophers have generally tried to characterize rationality in such a way as to make it a normative concept that can guide human choice and action. Thus an action should correspond with a reason-based (as opposed to religious belief or emotional response) knowledge of the good to be considered rational.

In our society with its prevailing relativism, the notion of rationality is a person-relative concept that allows for a broad interpretation of the reasonableness of any given action. The words *rational* and *reason* both trace their origins to Latin words meaning "reckon"—*rational* from rat- (meaning "reckoning") and *reason* from reri- (meaning "to reckon").[23] The *Oxford English Dictionary* traces the origin of the word "rational" to its roots in the Latin word rationalis, from ratio. This was an accounting term referring to a quantitative relationship between two amounts showing the number of times one value is contained within another. Therefore, as defined above, the rationality or reasonableness of an act should be understood in terms of proportionality. However, this is still too relativistic, for *ratio*, in accounting contexts, implies a foundational unchangeable quantity (the denominator) against which the second value (or act in this case—the numerator) must be compared.

In the act of suicide, this foundational quantity is the permanent loss of the life of a human being. How is the value of human life quantified? This is the dilemma facing modern medicine and end-of-life decision making. To affirm the rationality of suicide, society (and medicine) must have a universally agreed on and unchangeable quantitative value for a human life. If this value cannot be discovered, an alternative approach to establishing the moral legitimacy of a suicide must be sought. Whatever norm is chosen, it must be exceptionless. Life is not simply an instrumental good; it is a basic human good and one of the intrinsic aspects of a human person's reality and fulfillment.[24]

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[22] Ibid.

[23] Soanes and Stevenson, ed., *Concise Oxford English Dictionary*, s.v. "rational."

[24] Germain Grisez, *The Way of the Lord Jesus*, vol. 2, *Living a Christian Life* (Quincy, IL: Franciscan Press, 1993), 478.

Germain Grisez makes a valid argument regarding a proportionality approach to suicide, euthanasia, or any so-called "mercy killing" of the innocent: "Its central defect is that it assumes what cannot be known: that the repugnant alternative to killing is worse than the killing itself. To the extent examples lend plausibility to the argument, it is because they highlight factors which strongly impact on one's feelings. In such cases, then, admitting exceptions to the norm excluding killing the innocent means subordinating rational judgment to emotion. That is simply to abandon morality."[25] The attempt to "rationalize" suicide based on proportionality arguments may fail because of improper estimations of the permanency of one's current condition of suffering. If the cause of suffering is emotional or psychological pain (as is the case in depression) or physical pain and disability due to a chronic medical illness, suicide may be a disproportionate choice in which adequate pain relief (emotional and physical) or technological disability assistance may be achievable. In any such situation, the intentional removal of an intrinsic human good, such as life, can still hardly be viewed as a proportional act.

Suicide as a rational act must also be viewed in the context of the *principle of justice*. Suicide, properly distinguished from heroic self-sacrifice, is always an unjust act. It frequently imposes unreasonable burdens on other individuals, institutions, and communities and leaves unfulfilled individual duties to such. It also violates the *principle of justice* by its incompatibility with love. Grisez elaborates, "[It] entirely deprives a person of bodily life. It does not admit of more or less, and so there can be no insignificant degree of it. … Suicide motivated by feelings of sympathy or sadness is incompatible with volitional love, since willing that someone be deprived of the intrinsic good of life is incompatible with willing his or her complete good."[26]

Suicide and Competence

If suicide is an irrational act, does a suicidal patient have the capacity to refuse treatment? All fifty states have laws that accommodate third-party intervention to protect a suicidal patient even in a situation in which such a patient refuses medical intervention. In the state of Kentucky, a licensed medical provider may obtain a district court order compelling a suicidal patient to a seventy-two hour hospitalization until such a patient can have a formal psychological evaluation.[27] However, this state law does not specifically address imposing medical treatment and procedures on an unwilling patient. Very few states explicitly address the dilemma of DNR orders in the setting of suicide.[28]

Most of the literature addressing the issue of capacity in the suicidal patient comes from the legal community. A significant portion of such discussions were initiated by life insurance companies in an attempt to determine whether life insur-

[25] Ibid., 479.

[26] Ibid., 480.

[27] KY. Rev. Stat. Ann. § 202A.041(1) § 202A.028(1).

[28] Cynthia Geppert, "Saving Life or Respecting Autonomy: The Ethical Dilemma of DNR Orders in Patients Who Attempt Suicide," *The Internet Journal of Law, Healthcare and Ethics* 7.1 (March 2, 2010), http://ispub.com/IJLHE/7/1/11437.

ance policies should be paid out on the policy of a patient who intentionally takes his or her own life.

There seems to be no real legal consensus about the relationship between suicide and an "unsound mind." The debate ranges across a spectrum: on one end, anyone who attempts suicide is mentally ill and, therefore, of unsound mind; on the other, only those patients meeting the determination of legal insanity are of unsound mind. The most common legal definition of insanity derives from the M'Naghten rules, promulgated in nineteenth century England: "An individual is not guilty by reason of insanity if he or she does not know the nature and quality of the act or does not know the act was wrong."[29]

However, depression can result in distortions of decision making that may be much more subtle than frank psychosis or delirium.[30] Judging the competence of a patient can be particularly difficult. Mood disorders such as depression can overcome and distort reasoning, potentially rendering the suicidal patient incompetent despite knowing that ending their life is wrong.[31] Studies reveal that more than 90 percent of people who committed suicide were clinically mentally ill at the time of their death. The patient's suicide is generally a conscious attempt to end unbearable mental pain or circumstances.[32]

In the absence of the opportunity to do a real-time detailed psychological assessment of someone presenting with suicide attempt, a medical provider must assume, based on available statistical data, that the patient likely had diminished capacity at the time of attempting suicide.

Suicide and Catholic Teaching

The *Catechism of the Catholic Church* recognizes suicide as contradictory to nature, in that the human being has an intrinsic inclination to preserve and perpetuate his or her own life.[33] Human beings are not owners, only stewards, of the life that God has entrusted to us: "It is not ours to dispose of."[34] The Catholic Church recognizes suicide as contrary to the just love of self and neighbor, as well as violating the *principle of solidarity* "because it unjustly breaks the ties of solidarity with family, nation, and other human societies to which we continue to have obligations."[35] Likewise, it is contrary to just love for the living God who created that life for a specific purpose.

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[29] Robert I. Simon et al., "On Sound and Unsound Mind: The Role of Suicide in Tort and Insurance Litigation," *Journal of the American Academy of Psychiatry and the Law Online* 33.2 (June 1, 2005): 176–182.

[30] Mark D. Sullivan, "Depression, Competence and the Right to Refuse Lifesaving Medical Treatment," *American Journal of Psychiatry* 151.7 (July 1994): 971–978.

[31] Harold J. Burztajn et al., "Beyond Cognition: The Role of Disordered Affective States in Impairing Competence to Consent to Treatment," *The Bulletin of the American Academy of Psychiatry and the Law* 19.4 (1991): 383–388.

[32] Simon et al., "On Sound and Unsound Mind."

[33] *Catechism of the Catholic Church*, 2nd ed. (Washington, DC: Libreria Editrice Vaticana, 1997), n. 2281.

[34] Ibid., n. 2280.

[35] Ibid., n. 2281.

The Catechism also indirectly addresses the diminishment of judgment in many of those who attempt or commit suicide: "Grave psychological disturbances, anguish, or grave fear of hardship, suffering, or torture can diminish the responsibility of the one committing suicide. We should not despair of the eternal salvation of persons who have taken their own lives. By ways known to him alone, God can provide the opportunity for salutary repentance. The Church prays for persons who have taken their own lives."[36] However, it remains seriously contrary to justice, hope, and charity: "It is forbidden by the fifth commandment," and thus always a grave sin.[37] *Gaudium et spes* lists suicide among the crimes that are offenses against life itself: murder, genocide, abortion, euthanasia, and *willful suicide*.[38] Austin Flannery notes, "All these and the like are criminal: they poison civilization; and they debase the perpetrators more than the victims and militate against the honor of the Creator."[39]

Autonomy, Beneficence, and Cooperation with Evil

The *principle of autonomy* rests in the capacity for self-determination and is frequently used to justify suicide, physician-assisted suicide, and euthanasia. Human beings should be allowed to freely choose what to do based on their own value systems, and the human will should not be compelled toward performing an act that conflicts with what it views as the good. However, once again, our choices, while remaining free, do not make what we chose to do good or bad. The *principle of autonomy* cannot make licit an action that is intrinsically disordered.

The response to this argument from those seeking to justify suicide, assisted suicide, and euthanasia rests in a faulty dualistic proposition that there exists a difference between "biological" life and "personal" life. The latter consists in "meaningful" life: the ability to communicate, reason, participate in relationships, and so forth.[40] In this dualistic view, once "meaningful" life has disappeared, "personal" life has ended. The human being is supposedly then only living a "biological" life that can be justifiably ended—and possibly should be ended. Ignoring any debate over this dualistic view of the human being, a fundamental problem still exists: the human *being* remains a *being.* This first human good of *being* itself remains intact as long as biological life exists. Any action taken to eliminate this basic human good is an object and intention ordered contrary to the good of that *being* and can thus never become a moral act.

"Beneficent" is defined by the *Oxford English Dictionary* as "doing good or resulting in good." It is literally derived from the Latin *bene facere* or "do good (to)."[41] In the health care profession, *beneficence* as a principle is derived from the

[36] Ibid., nn. 2282, 2283.

[37] Ibid., n. 2325.

[38] Paul VI, *Gaudium et spes* (December 7, 1965), n. 27.

[39] Austin Flannery, ed., *Gaudium et spes: Pastoral Constitution on the Church in the Modern World,* in *Vatican Council II*, vol. 1, *The Conciliar and Post Concilliar Documents* (Northport, NY: Costello Publishing, 2004), 928.

[40] Ibid., 257.

[41] Soanes and Stevenson, eds., *Concise Oxford English Dictionary*, s.v. "beneficent."

Hippocratic Oath to "first do no harm." In other words, the good, and never the bad, of the patient is to be pursued. Thus beneficence first and foremost involves protection of innocent life as the primary principle in medicine. Any patient committing suicide, while it may be an autonomous act, is violating the *principle of beneficence* against their own life. Any medical provider failing to save an intentionally taken life likewise violates this principle by failing to pursue the good in such cases.

Part five of the *Ethical and Religious Directives for Catholic Health Care Services* states, "The truth that life is a precious gift from God has profound implications for the question of stewardship over human life. We are not the owners of our lives and, hence, do not have absolute power over life. We have a duty to preserve our life and to use it for the glory of God. … Suicide and euthanasia are never morally acceptable options."[42]

Respect for *autonomy* does not require that one person be compelled to cooperate with another's actions in order to respect that individual's autonomy. Autonomy is not an absolute and foundational value, but the extent of its appropriateness lies within the context of community. Autonomy is thus a middle value. This is readily noted in all societies in which laws are enacted to regulate absolute autonomy in the interests of that society.

"Voluntary co-operation in suicide is contrary to the moral law."[43] If suicide is an intrinsically evil act, health care providers are not only compelled to prevent or reverse such an act, if possible, but likely *cooperate* with evil if they fail to act accordingly. In the specific case at hand regarding a suicide attempt in the setting of a DNR order, strict adherence to patient autonomy would not outweigh the risk of cooperating with an evil act. As opposed to physician-assisted suicide, the cooperation is not formal because the health care provider does not share in the intention of the principal agent, the patient. The cooperation would not be immediate either, since the provider did not participate in circumstances essential to bringing about the evil act.

However, if a provider fails to attempt resuscitation of a potentially reversible suicide attempt, *mediate material cooperation* with evil occurs. In such a case, there would be a failure to achieve a proper proportionality between the goods to be protected (patient autonomy) and the evil avoided (irreversible loss of life). Additionally, the cooperator's failure to act would not be itself good or morally indifferent because it would violate the principle of *beneficence*. Therefore, the provider's failure to act would be an illicit mediate material cooperation with evil.

In our society, the population is rapidly aging. With the increased mobility of our culture, there is a diffusion of family across geographical space. Many of the elderly will be dealing with chronic debilitating illnesses in the setting of social isolation from family, possibly leading to increased incidence of depression. They are becoming the most susceptible members of our society to suicide. They also have the highest

[42] US Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (Washington, DC: USCCB, 2009), n. 25.

[43] *Catechism of the Catholic Church*, n. 2282.

rate of advance directives and DNR orders. Cases of failed suicide attempts with preexisting DNR orders presenting for emergency care will undoubtedly increase.

Some segment of our society will likely view these cases as sad but understandable—that they should be allowed to have their death wish. These cases may even come to wrongly be viewed as a "good." However, the *principle of autonomy* cannot make a bad act good. Providers are constrained by *beneficence* and *avoidance of evil* to act to protect and preserve life, despite the wishes of a patient who may or may not have the competence to make such decisions about DNR orders in their present state of mind. The default response of medical professionals should always be to defend life at all its stages. Catholic health care providers witness to the love of Christ when they do so without fear of litigation or persecution.