
CASE REPORT

Suicidal ideation at end-of-life: The palliative care team's role

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(RECEIVED November 11, 2002; ACCEPTED June 15, 2003)

ABSTRACT

Objective: To report on the case of a terminally ill patient who expresses suicidal ideation.

Methods: As this case demonstrates, suicidality at end-of-life poses numerous challenges for the palliative care team. In this case, a 49-year-old man with locally extensive head and neck cancer refused all life-prolonging treatment and expressed a desire to hasten his own death. Other issues, such as chemical dependency and lack of social supports, complicated his care.

Results: Suicidality lessened as continuity of care, with ongoing assessments and interventions, addressed sources of suffering and built relationships with health care professionals.

Significance of results: This case highlights the observation that desire for hastened death fluctuates for patients at end-of-life and may be influenced by factors under the control of the palliative care team.

KEYWORDS: End-of-life, Terminal illness, Suicide, Hastened death, Chemical dependency, Pain and palliative care

INTRODUCTION

A subset of patients with advanced medical disease express a desire for hastened death (Doyle et al., 1998; Miller et al., 1998; Chochinov et al., 1999; Rosenfeld et al., 1999; Van Loon, 1999; Barrio, 2000; Breitbart et al., 2000; Breitbart et al., 2000; Emanuel et al., 2000; Varghese & Kelly, 2001). Some patients request physician-assisted suicide or euthanasia. Others exhibit signs of suicide ideation or express the wish for death to come quickly. Although psychological symptoms, such as depression and anxiety, have been closely linked to the desire for hastened death, other factors are also important and can influence patients' will to live. These include hopelessness, social isolation, feelings of helplessness or loss of

control, prior psychiatric histories, substance abuse, poor family supports, and inadequate symptom control (Doyle et al., 1998; Rosenfeld et al., 1999; Van Loon, 1999; Barrio, 2000; Breitbart et al., 2000; Emanuel et al., 2000).

Desire for death has been shown to fluctuate in patients with advanced disease. It is not uncommon for patients to vacillate at end-of-life, with some moving from a desire for death to an expressed wish to live (Chochinov et al., 1999; Breitbart et al., 2000). This suggests that mitigating factors can affect the desire to live. It also highlights the importance of continuity of care, with ongoing assessments and interventions, for this subset of patients (Doyle et al., 1998; Miller et al., 1998; Van Loon, 1999; Varghese & Kelly, 2001).

The wish to hasten death introduces a complex dimension to end-of-life care. To illustrate this challenge, a case example is presented wherein suici-

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dality and intent diminished as treatment strategies were implemented and effective relationships with health care practitioners developed.

CASE REPORT

Mr. V., a 49-year-old patient with neck and tongue pain, was admitted to the hospital for evaluation and diagnosed with head and neck cancer. Doctors advised him his prognosis was favorable if treated with surgery. His hospital roommate had undergone a similar procedure and described a negative outcome after two surgeries. Mr. V. reacted with distress and fear, refusing surgery and leaving the hospital against medical advice. He left precipitously, still in his hospital gown.

Three months later he was readmitted for bleeding and pain in addition to other symptoms such as fatigue, excessive saliva, and difficulty eating. Requesting pain medication he refused all other treatment including surgery and radiation treatment. He expressed anger with staff when a urine drug screen was requested. This reaction combined with the refusal to accept treatment resulted in a psychiatric consult to assess capacity. The psychiatrist reported that although capacitated, he was suicidal. Compounding this was the patient's difficulty communicating with staff because of dysarthria and pain caused by the disease.

On the last day of his admission he was referred to the pain and palliative care team for consultation. When the consult team explored his risk for suicide he denied any suicidal thoughts. He was motivated to communicate with them because of his need for adequate pain management, including assistance with financial resources because he had no insurance or money. Advocating for him at discharge, the team began to establish trust by focusing on his immediate expressed needs. They coordinated appropriate prescribing of medication, obtained an emergency 2-week supply, and provided education on the medication regime. An appointment was also set for outpatient follow-up. These interventions sent a message of the team's commitment to his continuing care and respect for his articulated priorities.

During subsequent outpatient visits, Mr. V.'s story gradually unfolded. He was healthy prior to the cancer diagnosis despite smoking for 40 years and drinking vodka and six beers a day for 30 years. He had not seen a doctor for 25 years and waited for months to see one after the pain began in his neck and later in his tongue. This stoic reaction and ability to endure were consistent with his history as a Czech freedom fighter brought to the United States by Amnesty International in 1980. Family

members, including his mother, his children, and their mother, remained in the Czech Republic. He refused to speak of them except to say his mother should not be contacted.

Mr. V.'s living situation and ties to social support were tenuous. Forced to move after finding his roommate shot in the head, he lived in the unfinished attic of a friend's house. It had no running water or phone. Illegal activities occurred in the house that precluded him accepting home or hospice care. Other than the family with whom he resided, the patient identified one friend who occasionally loaned him his cellular phone and sometimes helped him communicate with the team by speaking to the social worker and passing on her messages.

The confusion and communication barriers Mr. V. experienced became apparent by the second outpatient visit with the social worker. Of his own accord, he brought two illustrations he had rendered of the trajectory of his disease. The diagrams showed his tongue as healthy, then developing a cancer-related crater that grew progressively larger, and finally with the tip cut off twice for biopsies. A note on the second drawing stated, "This part [of the tongue] was cut off TWO TIMES! WHY 2X!" intimating his anger with the health care system. Another note, "BOTH TIMES IN HOSPITAL THEY GAVE ME RADIATION," expressed the belief he was treated with radiation against his wishes and despite his objections. Because hospital records showed that pain medication was the only treatment he received, it is likely he mistakenly thought diagnostic tests, such as computerized tomography (CT) scans, were the radiation treatment he had refused.

Mr. V. also shared, during this second outpatient visit, his conviction that he would die within weeks or months. He stated that when the time came he would put a bullet in his head. He denied any immediate thoughts of suicide and said he did not have access to a gun, although his environment seemed to be one where a gun might be available.

The patient's case was brought back to the pain and palliative care team meeting to discuss his plan to kill himself "before it got too bad," to create a plan, and to provide supportive guidance to the social work clinician who had become the primary therapeutic contact. The team undertook the task of understanding the multidimensional aspects of his case. They assessed the impact of his history and lifestyle on the level of care. The illustrations he provided of his disease progression were distributed to team members. His background as an immigrant, his relationship to authority, and his trust issues were all discussed. After careful consideration, the team determined that there was no immediate risk

and that emergent psychiatric intervention was not necessary. They focused on setting preliminary goals of care designed to support the patient and clinician, provide vigilant and careful prescribing of pain medications, and demonstrate a commitment to the patient's expressed needs.

The first priority in patient care was pain control. The social worker engaged him by offering to assist with applications for financial health benefits for pain medications through Medicaid, a social service agency, and pharmaceutical company patient assistance programs. During the first outpatient visit she arranged for him to meet one of the team's physicians in order to assure continuing medical care. Subsequent visits were held with both the social worker and the physician, and always occurred on the pain and palliative care inpatient unit.

The physician's assessment included an inquiry regarding current drug use. Mr V. admitted to the use of cocaine, which he got from a friend who was a dealer, once or twice a day. He said it helped with pain and the medication side effect of drowsiness. He stated that he would use cocaine even if the pain and drowsiness were better controlled. He also said he drank alcohol.

The patient was prescribed both long-acting (Dura-gesic patch) and short-acting (morphine sulfate immediate release) opioid medication. He was prescribed Robinul for excessive saliva. Fatigue diminished as controlling the pain eased his difficulty with eating. He was scheduled for biweekly visits to allow for regular reassessment of his pain, suicidality, substance abuse and use of prescribed medications. Mr. V. was instructed to bring receipts for medications purchased and medication usage was reviewed at each visit. He had no phone or means of transportation. Appointments were sometimes missed. To ensure consistent care, regular follow-up was conducted, particularly after missed appointments, prompt rescheduling was facilitated, and every effort was made to accommodate him if he came late or at unscheduled times. The structure, outreach, and availability of staff served to increase his feeling of being cared for by the health care system.

Contemporaneously, the social worker and physician worked with Mr. V. to explore his wishes regarding end-of-life care. Besides regularly assessing his wish to live, this included obtaining a written health care proxy and documenting his do-not-resuscitate status. When he was admitted on an emergency basis to another hospital, the social worker and physician communicated with the treatment team there to ensure that his wishes were honored.

Two months after beginning to work with the team, the patient requested admission to the pain

and palliative care inpatient unit, familiar to him from outpatient visits. His condition had worsened since his last visit 1 week earlier. Pain had increased accompanied by sleeplessness, and his ability to communicate had deteriorated due to cognitive changes. The social worker provided support and expedited the admission process, talking with staff and assisting with the transition of care to the nurses and physician on duty. After admission, Mr. V.'s pain was controlled and he eventually relaxed and went to sleep. He died early the next morning.

DISCUSSION

When the pain and palliative care team met Mr. V., he was socially isolated and chemically dependent, his symptoms were inadequately managed, and he was experiencing loss of control related to his health care. He admitted to using cocaine once or twice a day and drinking alcohol. He was suspicious of medical practitioners whom he thought had given him radiation treatment against his will. Until he met the pain and palliative care team, he refused to engage with hospital staff.

Although reported to be suicidal, he did not seem to be at imminent risk of suicide. Therefore, the initial intervention started where the patient was, focusing not only on helping him obtain symptom management and medication, but also on promoting his engagement with other health care professionals. The team's aggressive symptom management and commitment to his care helped him see alternatives to his plan for suicide. Symptoms effectively managed and no longer in conflict with health care practitioners, his isolation decreased and he ceased discussing suicide. When questioned he denied thoughts of ending his own life.

Respect for autonomy, self-determination, and beneficence, the ethical principles underlying the team decision-making process, were key factors in selecting appropriate interventions for the patient. These principles ensured that the team's first priorities were symptom management and advocacy for medications, communicating their commitment to his care, and demonstrating their expertise in not allowing "it to get too bad."

Also important was the team's attention to his end-of-life wishes. Formal documentation through health care proxy and do-not-resuscitate forms concretely represented their support for his decisions and put the control of his health care back in Mr. V.'s hands. The team's advocacy for him within the hospital and when he was admitted to another institution further demonstrated their ongoing commitment to his choices.

The team collaboration, support, and decision-making process helped to create a flexible approach to the patient's care that allowed for consideration of his individual needs. Despite known substance abuse, pain medications were provided. Mr. V. was closely monitored and frequent appointments were scheduled to provide a structure that ensured safe use of medications. This approach was the basis of an effort to build a gradual, trusting relationship.

CONCLUSION

The literature recommends immediate attention by clinicians, including assessment of risk and appropriate intervention, to patients expressing a desire to hasten death (Doyle et al., 1998; Miller et al., 1998; Van Loon, 1999; Varghese & Kelly, 2001). Miller et al. (1998) present an assessment model designed to help clinicians understand patients' desire for death. Van Loon (1999) suggests that expressing a wish for death may be a way for patients to gain control over their circumstances and deal with the uncertainty of death and dying. The ensuing discussions can promote coping as patients communicate their concerns and request help with specific problems, such as symptom control. Other professionals (Doyle et al., 1998; Van Loon, 1999) emphasize the benefit of allowing patients to express their desire to hasten death, establishing a rapport that allows for open discussion, and addressing concerns by means of normalization, validation, and practical interventions.

Varghese and Kelly (2001) report on various studies related to the wish for death in terminally ill patients. These studies indicate that suicidal thoughts are not necessarily linked to severity of illness. Social isolation, chemical dependency, lack of family support, inadequate symptom control, and feelings of loss of control and helplessness are all predictors of suicide in terminally ill patients (Doyle et al., 1998; Rosenfeld et al., 1999; Van Loon, 1999; Barrio, 2000; Breitbart et al., 2000; Emanuel et al., 2000; Varghese & Kelly, 2001). Of the many factors affecting the desire for death, Varghese and Kelly (2001) surmise that patients' relationships, including those with their doctors, play an important role and have the potential to profoundly affect how they perceive their situation.

This patient embodied all the predictors reported by Varghese and Kelly. Despite this, with the pain and palliative care social worker and physician working together to manage his pain as a primary goal, suicidal ideation was not ultimately an issue.

The team's willingness and ability to respond to his most immediate fears and expressed needs and to act as an advocate for his health care priorities resulted in adequate management of pain and empowered Mr. V. in an area where he previously felt no control. The team's concrete and symbolic interventions created avenues of support and connection, decreasing his isolation and mistrust. This case illustrates that relationships are a key factor in the fluctuating wish to die (Varghese & Kelly, 2001). The patient's relationship with the team allowed him to receive the care he needed and to die a relatively peaceful, pain-free death, on his own terms.

ACKNOWLEDGMENTS

The author would like to thank Terry Altilio, ACSW, Myra Glajchen, DSW, Russell K. Portenoy, MD, in the Department of Pain Medicine and Palliative Care, Beth Israel Medical Center, New York City, and David Wollner, MD, in the Department of Palliative Care Services at the Veteran's Administration, Brooklyn, NY, for their help and support with this article.

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