Treat Request for Hastened Death as an Emergency

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TAMPA — A patient's request for a hastened death—either an explicit request or a hint—should be considered a clinical emergency that offers an important therapeutic opportunity.

"When you're in the office and somebody asks, 'Doctor, will you help me die? I just want to end it all,' that is a true clinical emergency," Dr. Ira R. Byock said at the annual meeting of the American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association.

"It's as if somebody develops crushing chest pain or fibrillates and codes in your office. Somebody's life is at risk here. That person may have a progressive illness, but that doesn't mean that [his or her] life is at any less risk or that it's any less of an emergency," said Dr. Byock, who is director of palliative medicine at Dartmouth-Hitchcock Medical Center in Lebanon, N.H.

Such a request is "a remarkable therapeutic opportunity," he said. "The very fact that the patient has shared this with you … opens up a therapeutic window."

Occasional thoughts of suicide or a desire for death are fairly common among people living with a serious illness.

In Oregon—where physician-assisted suicide is legal in certain circumstances—65 prescriptions for lethal medications were written in 2006, and 46 people died by lethal prescription that year (out of a total of roughly 31,000 deaths in the state). The 1997 Death with Dignity Act allows terminally ill Oregonians to end their lives through the voluntary self-administration of lethal medications, prescribed by a physician expressly for that purpose.

"Certain diagnoses are particularly associated with a request for assisted suicide and receipt of a lethal prescription," Dr. Byock said. Based on data through 2006 in Oregon, patients who have amyotrophic lateral sclerosis are about 35 times as likely to use physician-assisted suicide or to ask for a lethal prescription as are patients with chronic obstructive pulmonary disease, he said. HIV/AIDS and cancer also are particularly associated with a request for assisted suicide and receipt of a lethal prescription.

Research also has shown that many terminally ill patients meet the diagnostic criteria for major depression, which is an important risk factor for a request for suicide. "In treating depression, I think we often just reach for the SSRI or the psychostimulant, all of which can be valuable," Dr. Byock said. But don't forget to look for other causes of the depression, such as hypothyroidism, adrenal dysfunction, or the side effects of other medications.

And because many of the somatic symptoms of depression—including fatigue, anorexia, loss of energy, sleep disturbance, and mild confusion—are common in terminal illness, the psychological symptoms are more useful in identifying depression in these patients. Look for hopelessness, helplessness, guilt, worthlessness, loss of meaning, and preoccupation with death and suicide.

When a patient with advanced illness asks for help dying, it's important for physicians to recognize their own emotional responses to such requests. At the same time that a physician is moved by the patient's suffering, "at times, to a physician's ear, the expression of a wish to die can sound to us like a condemnation of our care," Dr. Byock observed. Acknowledging this is part of the therapeutic challenge.

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A patient's request for a hastened death is both a clinical emergency and "a remarkable therapeutic opportunity," Dr. Ira R. Byock said.

The fact that the patient makes such a vulnerable statement is testament to the patient's trust in his or her physician. The most important thing a physician can do in these situations simply is to listen—an act that has therapeutic value in itself. The act of listening "helps people feel acknowledged and helps them feel like you're accompanying them on this difficult journey.

"Even if one is deeply, morally opposed to assisting a patient in suicide, it is possible and essential to be able to listen to the requests and accept the patient's feelings in a nonjudgmental manner," Dr. Byock said.

Expressing empathy—with comments such as "I can't imagine how hard this must be for you"—can also help to strengthen the therapeutic relationship, "which is itself a powerful tool for treatment," he said.

It's important to clarify a request for death, as many patients are confused about end-of-life care. Some assume that by not accepting every possible treatment—antibiotics and dialysis, for example—they are essentially committing suicide. "We can often alleviate their anxiety and help them distinguish between actively shortening their lives and simply not using medical treatments that aren't consistent with their preferences and desires," Dr. Byock said.

Even simply informing patients that they can decline medically administered nutrition and hydration to allow a "natural" death can satisfy their concerns.

Sometimes patients will hint or make provocative statements. One of Dr. Byock's patients told him that, "they should dig a hole and just shoot me." Statements like these are valuable openings because they express the patient's fears and feelings, he said. They are also a way for patients to test their physician. "If we respond 'oh, don't talk like that,' we've given a strong message," he said.

Patients also may use provocative statements like, "I hope you'll help me die when it's time" as a way of assessing their physician's commitment to not letting them suffer. What sounds like a request for death may "simply [be a desire] to be assured of a way of escaping suffering if it becomes unbearable," he said. "It's important to understand whether they're referring to assisted suicide/euthanasia or just adequate analgesia."

In treating pain in this patient group, Dr. Byock recommends making it explicit to the patient, in the chart, and to medical colleagues that there needs to be a detailed pain management plan in place in case pain gets out of control.

This means taking a multimodal, layered approach using patient-controlled analgesia and scheduled, as-necessary, and crisis medications. It's also important for patients to have specific telephone numbers to call after hours to get a prompt response.

"We pursue symptom-directed treatments even when patients are seriously ill," Dr. Byock said. These patients may benefit from regional blocks, axial analgesia, or neurolytic procedures.

It's also a good idea to get a formal consultation with palliative care or pain services. Dr. Byock tells his patients that there always is the option of palliative sedation if no other options are working and pain is unbearable. "This is not only ethically acceptable, I would assert that it's ethically required, if nothing else is working," he said.

Many patients with advanced illness worry about being a burden on their families or caregivers. Dr. Byock tells his patients that although they can't take away the burden, their behavior and attitude can influence how their family responds to it. "The way people die stays in the minds and hearts of those they leave behind," he said.

There is some evidence that by committing suicide, a person is putting first-degree relatives at greater risk of suicide themselves. "I rarely say that, but there are some times when it's worth sharing," he said.

Patients who have children can provide a model for their children and grandchildren of living with dignity to the very end of life. A patient can be reassured that this "has value in and of itself," Dr. Byock said. ■

Responding to a Request for Death

One of Dr. Byock's patients, Mr. B, was a 68-year-old man with colon cancer that had metastasized to the liver, lungs, and bone. He presented with increasing, severe left hip pain after a minor injury. He was on hydrocodone/acetaminophen (Vicodin) every 4 hours for pain relief.

He was very anxious, and at times seemed unable to understand the information given to him, Dr. Byock said.

Mr. B had retired after a career in industry. "He was a gentle, well-mannered man. His passions included walking in the wilderness and gardening, interests that he shared with his wife of 22 years," Dr. Byock recounted.

According to Dr. Byock, Mr. B volunteered that he had been thinking about "ending it all." He spoke of a neighbor who had committed suicide by gunshot to the head because of severe cancer pain.

"I don't want to end up like that. I hope you will help me die before I get to that point," Mr. B told his physician.

While hospitalized for the hip pain resulting from the minor injury, he was treated with long-acting morphine, an NSAID, and lorazepam for his anxiety.

A geriatric psychiatrist on the hospital staff was consulted about Mr. B's desire to die.

Mr. B told the psychiatrist that he was feeling fine at the moment but he was in fear of being in constant, uncontrollable pain.

He added that he knew his wife would be devastated if he committed suicide.

When Dr. Byock learned that the real problem was fear of pain, he was able to reassure Mr. B that he could achieve sufficient pain control to live a high-quality life at home.

Mr. B was started on mirtazapine for depression, and his anxiety decreased during the course of his hospital stay. The medication also helped his sleep and appetite.

Before he went home, he was counseled about his pain management plan and assured that there was no circumstance in which he would suffer for more than a very short time.

Mr. B still talked about suicide when asked by a member of his palliative care team, but he no longer brought up the subject.

He said that his feelings hadn't changed but that he felt more confident that he wouldn't have to turn to suicide, Dr. Byock said.

He died at home in hospice care several months after he was discharged.