Responsibility

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EDITOR'S NOTE

Through this column, we hope that practitioners in general medical settings will gain a more complete knowledge of the many patients who are likely to benefit from brief psychotherapeutic interventions. A close working relationship between primary care and psychiatry can serve to enhance patient outcome.

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One of the elements we teach in residency training programs involves taking responsibility. It is part of what is left of the patriarchal nature of becoming a doctor. It assumes that the physician has a more complete fund of medical knowledge than the patient. Typically, this assumption is correct.

Elements of palliative care include establishing an advanced directive. This directive specifies the patients' wishes for how they will be treated at the end of life when they can no longer express these wishes. Should they be resuscitated if their heart stops? Should they be intubated and given artificial respiration? The patient is asked to specify his or her medical decision maker by the process of establishing a medical power of attorney. We care about what he or she thinks and do not want others (family members, friends) making these important decisions for him or her.

Some patients nearing the end of life apparently decide that anything they might gain from further treatment is no longer worth tolerating given the accompanying consequences. They decide, therefore, to end their life. When they commit suicide, some elements of society seek to assign blame for this decision. It seems that one is encouraged to decide *not* to be resuscitated or *not* to be intubated; however, it is not always acceptable to decide to take one's own life.

This discussion is not aimed at resolving this issue; rather, we hope that it will encourage providers to discuss it. When a patient at the end of life decides to commit suicide, whose responsibility is it?

CASE PRESENTATION (DR FRANKLIN)

Mr A was a 62-year-old Vietnam veteran with a history of clear cell renal carcinoma. He had undergone a radical nephrectomy with clear margins in June 2014. He presented 5 months later with abdominal pain and an 8-cm abdominal mass as well as a 2.8-cm lesion in the surgical bed. He was also noted to have a mass in the tail of the pancreas consistent with metastatic disease on biopsy. He was referred to the palliative care team for assistance with pain and anxiety.

Mr A served in the US Navy, including a tour of duty in Vietnam, where he participated in the evacuation of Saigon at the end of the war. Following his military service, he did construction work. He was married and divorced twice. He had 3 children, 1 of whom had died. One daughter lived on a plot of land with her mother and a 7-year-old son who had attention-deficit disorder. Mr A lived in a separate building on the property ("the doghouse"), which had no bathroom facilities.

Mr A's symptom burden included abdominal pain, dyspnea on exertion, constipation, depression, anorexia, weight loss, and existential pain. Although he was independent in all of his activities of daily living, he was lying down 21 hours a day. His Palliative Performance Scale[1] score was 50%, and his Eastern Cooperative Oncology Group[2] score was 3. Based on his extensive disease, palliative performance score, and history of malignant hypercalcemia, Mr A's life expectancy was a few months, if his disease followed its expected course. Mr A's goals of care included the following:

1. Quality time at home with his family.
2. Excellent symptom control (especially pain, depression, and dyspnea).
3. Quality of life, which was far more important to him than quantity of life.
4. Dignity, autonomy, and independence.
5. A peaceful, comfortable, natural death at home without machines.

Palliative care interventions included the addition of long-acting opioid therapy and adjustment of breakthrough opioid treatment. A trial of methylphenidate aimed at relieving depression and fatigue was initiated, but he developed nausea and vomiting, which he attributed to the medication, and it was discontinued. He was treated with oral chemotherapy with cytoreductive surgery to be considered at the completion of oral chemotherapy.

When seen in follow-up 3 weeks later, Mr A's pain was significantly improved, and he was requiring only 2 doses of breakthrough opioid per day. Dyspnea was much improved. He was now spending only 17 hours a day lying down. His appetite was better.

However, when seen in follow-up a month later, Mr A had begun to develop worsening fatigue, nausea, pain, and anorexia. Repeated imaging showed progression of disease and new metastatic disease in the lungs while Mr A was on oral chemotherapy, thus cytoreductive surgical resection was no longer an option. When seen in the palliative care clinic at that time, Mr A recognized "I am getting worse. I am getting sicker."

Mr A was now lying down 20 hours a day, but he remained independent in all activities of daily living. He had lost 11 lb in the previous month. He was started on antiemetic therapy.

Twelve days later, Mr A's daughter contacted me to say that he was not doing well. He had eaten minimally in the previous 4 days. He continued to have nausea and vomiting. He stopped oral chemotherapy on his own. He was now requiring assistance with activities of daily living. His Palliative Performance Scale score had decreased to 40%. His life expectancy was now weeks to a month. I recommended initiating home hospice services, which he and his daughter had previously declined. I also suggested that he move out of the doghouse, where he used a trashcan as a toilet, and move into the main house with his daughter and ex-wife. He agreed to initiate hospice services that day.

DISCUSSION (DR FRANKLIN)

The next day, I received a message from Mr A's oncologist stating that he had committed suicide. When hearing this news, I was shocked. I had a physical reaction to the news. I became shaky and developed piloerection. I felt my heart racing. I called Mr A's daughter. She had last seen him the night before in the doghouse just before going to sleep. The next morning, when he did not come to her house, she went to the doghouse to see him. The door was locked. When she looked in the window, she saw her father sitting on the floor, propped up against the bed with a bullet hole in his forehead and blood spattered on the wall.

His daughter questioned whether she should have seen this coming. In retrospect, she saw no indication of him being suicidal. Likewise, when talking with Mr A the day before, he had agreed to initiate hospice services and to move into his daughter's house. Although I saw no indication of a threat to harm himself, I found myself thinking, "What could I have done to prevent this? Why hadn't I seen this coming? Did I miss some obvious clue?" I reviewed his chart. I reviewed the quotes I had entered in my palliative care note. "I do not want to have my daughter come into my room and wipe my ass," he said. "I want to go to sleep at night and not wake up. I do not want to get so bad that I cannot make decisions on my own. If getting healthy is not possible, then I want a quick and easy death."

In retrospect, had any of these statements foreshadowed what was to come? Had I failed the patient? I counsel my hospice and palliative care patients to pursue the Frank Sinatra method (from the lyrics of his song "My Way"). I counsel patients to figure out what is important to them—what they want more of and what they want less of. What is most important to them? How do they want to travel this road? I encourage the patient to do it "your way." With regard to Mr A, was taking his own life morally different than choosing to not have resuscitation or life supports? Was his suicide the ultimate expression of autonomy and control? These were questions that do not have easy "yes" or "no" answers. I sought the support of various palliative care team members. I found the supportive discussions personally helpful in coping with my feelings about my patient's suicide.

CONCLUSION (DR SCHUYLER)

It is a common finding that providers are among the grief-stricken survivors when a patient commits suicide. One reaction of survivors is to attempt to find an explanation for the patient's action. Another typical reaction while seeking an explanation is to find a scapegoat. It is customary for providers to wonder what else they might have done that could have altered the outcome.

At times, an acceptable response is that there is nothing else a provider could have done. It clearly helps a responsible party to speak with a colleague about how he or she feels and what he or she thinks. At times, it may help a provider to write about his or her thoughts and feelings. Sometimes the decision to end one's life may be related to a rational decision to take control of an uncertain situation. Whatever the explanation may be, the suicide of a patient presents the family and the providers with one of their most difficult situations.

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