Responding to Requests to Hasten Death–
A Psychosocial Perspective

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Take Aways

• Talking about and embracing death, being ready to die not necessarily suicidal

• Understand the patients perspective, motives, and values

• A good (not necessarily easy) death can be a continuation of a good life when patient values are understood

• Be aware of your own moral compass as you discuss these issues
“[The field mouse’s] life is eating to live, to catch up, to keep up; never getting ahead, moving always in the narrow way between a death and a death; between stoats and weasels, foxes and owls, by night; between cars and kestrels and herons by day.”

H.A. Baker, *The Peregrine*
• Ever feel like that field mouse?

• Like our nonhuman friends, bio-behavioral processes operating outside awareness keep us alive.

• Even Kübler-Ross thought death seemed alien to us.

• The human mind is unique in that it sometimes entertains a conscious and conspicuous fear of death.
ACT and Death

• This human mind, shaped to avoid or delay death, also enables us to construct death.

• Probably the only species that consciously self-destructs

(sorry lemmings, not even you)
Different Functions of Constructed Death

- **Suicide**
  - Escape from a deficient self, shame, sadness
- **Altruistic Self-Sacrifice**
  - Preservation of kin, community, species
- **Violence**
  - Escape from fear, domination, perceived injustice
- **War**
  - Preservation of liberty
- **Hastened Death**
  - Termination of pain, turmoil, fear
• Our ability to derive rules: *If, then statements*

• If suffering is deemed inherent to life, then individuals might end life to end suffering.

• *If* I die
  – *then* the pain will end.
  – *then* I will be with my wife in Heaven.
  – *then* I won’t be a burden to my kids.
  – *then* I won’t be in this skilled nursing facility.

• Negative problem orientations do accompany psychopathology
  – So get around to asking
• But stripped of emotion, some of these statements are true.
"The Big Squeeze" – Pema Chodron

Provider values, assumptions, Core beliefs

- Life is sacred, precious
- Death is traumatic
- Spiritual Beliefs
- Cultural Beliefs

Growth, Insight

Patient’s Reality

- Disparities and social injustice
- Intractable pain
- Distress
- Uncertainty
- Will to die

Anxiety
Assessing Suicide

• Being aware of your clinic policy can put you at ease about asking

• Offer, “Sometimes when people are feeling this way they might also have thoughts of suicide. I’m wondering if you have thoughts like this.”

• Being compassionate and frank may make patients more comfortable
Case Study

6:00 AM. Raining in metropolitan Chicago
Noon. EPIC crashes. Miss Lunch. Drink more cold coffee
3:53 PM: Last note written.
3:59 PM: PAGED: Get over here! He’s thinking about death. I think he’s suicidal.
4:16 PM: Asked all the right questions, but wrong attitude or tone of voice. Pt says, “Take your CYA and shove it.”
4:42: Pt arrives in ER
8:30: Pt deemed safe and sent home.
  – Pt with a few months left felt cheated out of a night
Myths

  • You can still feel frazzled and good provide care
  • You probably feel worse than you look
  • Sometimes a little discomfort means you’re addressing the right things, remember the “Big Squeeze”

• Asking about suicide gives people the idea
  • You should ask if the patient is distressed
  • 9% of people consider, attempt or complete suicide
  • Passive thoughts of death much more common
Alternative View

• From the patient perspective: death could be a means to a valued end
  – Relief, Dignity, Spiritual Peace

• Could offer providers clues about unmet needs

• From our perspective: death need not be the only means
  – Aggressive Symptom Management
  – Counseling, CBT, ACT, Pastoral Care
  – Therapeutic Relationships that dignify patients
Many people wonder whether all patients should die in a state of acceptance. Somebody once asked me that, and I said you try to elicit the patient's needs. One nurse in the audience arose very angrily. "I have been angry and a rebel all my life and I hope I can die that way." My answer to her was, "I hope they let you die that way and not sedated to keep you 'nice, quiet, and peaceful.' "

It is very important to remember that the patients who have used denial all their lives may want denial and may die in a stage of denial. We should not project our own values onto the patient. The "stages of dying" affect not only terminally ill patients. You can apply these lessons to everyday living.

-Elisabeth Kübler-Ross
Counseling

• Willingness to discuss death on the patient’s terms
  – The Goldilocks Zone: Can avoid death or overdo it

• Take patient’s perspective
• Look for unmet needs
• Assess depleted meaning
• Commit to supporting the patient

• This would include assessment of suicidal ideation
  – Ideation, intent, plan, means, risk, and protective factors
Pain and Tunnel Vision Exercise

• Hold “Pain Card” close to your eyes
  [Included in packet: Index Cards with Pain, Sadness, Indignity, Loneliness]
  – What do you see?

• Hold “Pain Card” at Arms Length
  • Is pain totally gone?
  • What do you see now?
Changing our relationship to unavoidable pain

• Experiential avoidance: pain, distress seen as bad and unacceptable, something to hide
• Culturally programmed
  You can get very rich writing songs about this:
  • *Big Girls Don’t Cry* - The Four Seasons
    (and later: Fergie)

• Can pain be put in context as a natural consequence of living a full life?
  – Labor and delivery
Harder Questions

• Is there any meaning in pain or suffering?
  – What is this suffering in service of?

• Man’s Search for Meaning by Victor Frankl
  – Could there be virtue in suffering?
  – Could life in the midst of pain still be desired?

• Can we influence culture to change its view of pain?
  – I can’t think of any better group than this.
Take Aways

• Talking about and embracing death, being ready to die not necessarily suicidal
  – Don’t ignore this

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References