Psychiatric Assessment of the Suicidal Terminally Ill

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Terminally ill patients who refuse life-supporting treatments and express a wish to die are often viewed in the same light as suicidal patients who are medically well. Terminally ill patients who are depressed should be treated with antidepressants, but if the wish to die persists, it should be respected.

Introduction

In the last few decades, advances in medical technology have benefited thousands of patients who years ago would not have survived late stages of illness. Unfortunately, these advances have created a new set of problems for the hospital staff, who then must face difficult decisions and choices not always in the best interest of the patient.

For example, patients with terminal illness who are admitted to the hospital for maintenance care or an urgent surgical procedure often present a major challenge to the medical staff when the patient refuses this treatment. The patient's motives for refusing treatment are often questioned and challenged by the treating team: The patient is using poor judgment or is clinically depressed. Refusal of treatment by the terminally ill can be interpreted as a suicide wish associated with clinical depression and therefore requires careful evaluation.[1] This evaluation is especially important because a patient's mood disorder can affect cognitive capacity.[2]

In some cases, functional depression does not preclude the need to respect the patient's autonomy and wish to die by refusing further treatment. However, clinicians generally believe that if the patient is suicidally depressed, treating the depression will eliminate the patient's wish to die because clinicians tend to view the suicide wish as similar to that in the medically well.

Informed Consent and the Problem of Competency in Medical Settings

In medical settings, legal competence to refuse lifesaving treatment is usually presumed, and the burden of proof rests on the physician to prove otherwise. Sometimes, the need for a given procedure or treatment can seem imperative to the medical team but meets with resistance from the patient. How is the refusal of treatment then to be managed? Is the patient's competence to make appropriate decisions affected by a mental or affective disorder? Or is it simply that the patient lacks sufficient knowledge to make such a decision? Or further, is the patient making a rational decision in his or her own terms to avoid further suffering in the face of a hopeless and terminal illness?

These questions have become especially important since courts and legislatures across the country have articulated a right to die for seriously ill medical patients. This right has been implemented both through case law and natural death acts. So far, no court has rejected outright the right to die.[3]

The doctrine of informed consent is rooted in the patient's right to privacy, self-determination, and the promotion of well-being; therefore, no doctor, nurse, or institution should impose treatment on a patient. For patients to exercise informed consent, they must know their diagnosis, the reasons for doing tests and procedures and their risks, the degree of accuracy of the tests (ie, percentages of false-negative or false-positive results), what information will be derived from them, and what kind of treatment is recommended (surgery, radiation, drugs) and its risks and benefits. They must also understand the seriousness of their condition or illness and the purpose of the treatment (curative or palliative).[4]

Degree of Patient's Understanding

Even when patients seem to understand all the information given, they can still refuse treatment. Further, the way the information is communicated can alter the patient's feelings and ultimate decision substantially. Another factor in a patient's ultimate decision for or against treatment is the physician's ethical bias and moral values expressed during the interview. Further, physicians have different tolerances for and abilities to discuss these issues with patients. For example, they may experience feelings ranging from emotional fatigue, fear of their own death, guilt, insecurity, or anxiety and could have various beliefs about the sanctity of life and the right to die.[5]

The difficulty lies in determining whether the patient has failed to understand the information, whether the patient has been unduly influenced for or against the treatment, or whether the patient's competence is impaired because of clinical depression.[6] Of course, the patient's values, religion, and cultural background may have a substantial role in the patient's understanding and interpretation of the information the physician provides.

Sometimes physicians believe they have to go to extremes to convince a patient to pursue treatment, especially when the patient's refusal and apparent wish to die are based on an erroneous interpretation of his or her condition. In these cases, the doctor's persistence in not accepting the patient's decision could be lifesaving.

The following case illustrates this point: A 45-year-old man

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diagnosed with colon cancer told his doctor he wanted nothing done to prolong his life. The doctor, convinced that the man's cancer was curable, called a renowned surgeon to confirm this, and then, finally, a former patient who had been operated on successfully for a similar type of cancer 10 years earlier. The patient was convinced and finally agreed to the surgery. However, if the patient had not known the doctor for many years, the doctor's behavior could have been interpreted as harassment.

Competency in Cases of Major Depression

Sometimes treatment refusal by the terminally ill is interpreted as a manifestation of underlying depression affecting the patient's judgment. According to Appelbaum and Roth,[6] this association is particularly difficult to evaluate because depression can masquerade as a rational, understandable reaction: "That's just the way I would think if it happened to me." In other words, patients can offer convincing and rational explanations for the choices they make.

Many clinicians believe the terminally ill patient who refuses treatment because of an underlying depression will later accept that treatment once the depression is treated with antidepressants or electroconvulsive therapy. However, a recent study[7] showed that most patients who make treatment choices through advance directives do not alter their views for as long as two years after writing the directives.

Such consistency is more clearly apparent in acquired immunodeficiency syndrome (AIDS) patients who are terminally ill. These patients present great challenges to physicians because of the challenge of determining whether their refusal of further treatment is a manifestation of suicidal depression or an expression of a well-thought desire to end their suffering. When patients refuse lifesaving treatments, psychiatrists are sometimes called to evaluate and persuade them to change their minds or to treat the depressive illness affecting their judgment.

Sullivan and Youngner investigated the legal and bioethical literature on competence to refuse treatment and the possible impact of depression on treatment refusal. They reported that the patient's capacity to make medical decisions is impaired because the depression is easily seen as a "reasonable response to a serious illness."[8]

Moreover, the depression distorts decision-making more subtly than delirium or psychosis. This effect means that patients with major depression retain the capacity to understand the risks and benefits of a medication but may reject its value for personal use.[9] In other words, depressed patients fail to recognize how medical facts and statistics apply to their individual situation.

In addition, the diagnosis of depression provides no definitive evidence that the patient's medical decision making is impaired. Presence of a major affective disorder may not always influence competence in making lifesaving decisions. The symptoms that satisfy the criteria for clinical depression in the *Diagnostic and Statistical Manual* (DSM-IV) are not necessarily the same symptoms that impair the ability to make lifesaving treatment decisions. For example, the diagnosis of depression may rely heavily on vegetative symptoms of insomnia and anorexia, which may certainly affect the patient's quality of life but would not necessarily impair the patient's competence in making medical decisions. Depressive symptoms affecting the decision-making capacity include distorted (negativistic) assessment of self, world, and future characteristics of depressive thinking.[10]

Other symptoms of depression can also seriously influence competence in making lifesaving decisions. For example, helplessness may result in underestimating the possible effectiveness of treatment of a serious illness. Feelings of guilt-and worthlessness can make the patient believe that suffering and death are deserved and should not be avoided. Anhedonia may make it impossible to visualize a cure and a new life which would make enduring any of the discomforts, pain, or indignity of medical illness worthwhile. Similarly, hopelessness may make visualizing a full life in the future difficult. All these cognitive symptoms can impair the patient's ability to make appropriate lifesaving treatment decisions even when the patient does not have a full-blown depressive disorder.

Depression in Terminally Ill Patients

A terminally ill patient may not expect much pleasure or realistically anticipate an attractive future given the reality of a terminal illness. Therefore, clinicians must realize that clinically depressed patients with a very poor medical prognosis may express a rational wish to die. "Depression can be diagnosed and treated in patients with serious medical illness. But after optimizing medical and psychiatric treatment and determining that the patient is competent to make medical decisions, it may be appropriate to honor the patient's desire to die."[9]

This dilemma is illustrated in the case of a 35-year-old man with HIV who had been diagnosed in 1986, treated with zidovudine since 1989, and had been hopsitalized 7 times. In a few weeks before admission for recurrent cytomegalovirus pneumonitis, his condition deteriorated steadily. Intubated when admitted and receiving oxygen by mask, he was gradually losing his sight because of cytomegalovirus retinitis in both eyes. He could not eat and was becoming cadaveric because of severe weight loss. The patient indicated that he did not want treatment of any kind, but maintenance care was nevertheless continued.

A psychiatric consultation revealed a diagnosis of major depression, and the patient showed mild improvement after a course of antidepressants. However, his refusal of further treatment and his desire to die did not change.

AIDS patients in the terminal stage often have few options. They are left with the prospect of a painful and undignified death, stigmatized by society, loneliness and helplessness in the final stages of the illness.[11] In this case, the patient's Living Will would only have helped stop or withdraw treatment if he had been unconscious. His desire to die was never honored during the final weeks so he endured the last 6 weeks of his life in agony. Further, the patient was too weak to consider suicide, and even then, without a lethal dose of medication, he would not have been able to terminate his life without violence.

Limitations of the Living Will

The Living Will applies only when the patient enters a comatose or persistent vegetative state. Sometimes the Living Will is rescinded verbally during hospital admission, and the patient's condition waxes and wanes and results in short spans of lucidity. This situation can further challenge the hospital staff, who must then determine what the patient really wants. Generally, adhering to the preferences expressed in the Living Will after a reasonable period of observation and repeated evaluation is best. In addition, maintenance care does not require informed consent.

Suicidal Ideation Versus Rational Request to Die

The diagnosis of depression in the medically ill is very difficult because several factors obscure the diagnostic criteria for depression. The diagnosis is complicated by an illness perceived as terminal and which engenders feelings that further treatment is futile.

The following factors should be considered in making the diagnosis of depression in a medically ill patient:

1) The depressive symptoms are often appropriate and a reaction to the stress of a serious illness, especially a potentially lethal one.

2) Many depressive symptoms are similar to those of the medical illness (fatigue, weakness, weight loss) and can wax and wane as the illness progresses.[12] Diagnostic criteria in the psychiatric nosology have been generally inadequate when applied to depressed, terminally ill patients.

3) Although recognized as a reliable predictor of suicide,[13] hopelessness is not necessarily pathologic in terminally ill patients. A patient's realistic appraisal of his or her condition and refusal of life-supporting measures may be the last attempt to retain control.

Vegetative signs and symptoms were omitted from the tables because symptoms of fatigue, weakness, insomnia, anorexia, and weight loss can occur in suicidally depressed patients as well as in terminal, depressed patients and therefore have no distinguishing value. (Table 1, 2)

Because of considerable overlap between psychologic and biologic processes in both the suicidally depressed patient and the depressed terminally ill patient, the best features for differentiating between these two groups of patients can be found in the social history, psychologic processes, and, specifically, underlying motives for the yearning for death.

When doubt exists, the depression should be treated with a course of antidepressants and the patient should be reevaluated. If the desire to die by refusing treatment is still present after the depression has lifted, this desire should be respected by stopping all aggressive treatment and maintenance care. The patient's wishes concerning life and death should take precedence and be respected even if they conflict with those of the staff. At that point, a helpful and wise approach would be to hold a staff meeting to understand the patient's problem and point of view and to promote consensus among all the caregivers and the family.

Table 1.—Psychosocial profile of suicidally depressed patients

Psychologic processes:
- orientation, coherence within normal limits
- spontaneity and affect present or absent
- mood depressed or agitated
- wish to harm oneself
- ambivalence
- internalized anger
- guilt and remorse
- shame
- pessimistic outlook on life
- wish for revenge
- poor self-image and low self-esteem
- hallucinations and delusions present or absent

History of losses:
- losses explained in terms of inadequacies or feeling victimized
- loss of prestige and status
- economic losses or extreme poverty
- loss of limb or severe disfigurement
- loss of a loved one by death, divorce, or abandonment
- loss of sexual capacity
- loss of capabilities from the infirmities of old age

Family history:
- family history of suicide attempts
- family history of alcohol or drug abuse or dependence

History:
- history of repeated suicide attempts when medically well
- history of dysfunctional relationships
- history of depressive episodes when medically well

Social history:
- poor communication with family members
- withdrawal from social relationships
- use of manipulative behavior
- lack of regard for other people's feelings
- major illness present or absent

Suicidal motivation:
- suicide seen in context of psychologic or interpersonal conflict
- method of suicide, considered or not
- thoughts of violent means of suicide such as jumping off a bridge or building, a car crash, or less violent means such as overdose often mentioned
- motivation for suicide often waxes and wanes

Comment

In the hospital setting, refusal of lifesaving treatment or a wish to die is often thought to be associated with major depression. This tendency is also true when the refusal occurs in a terminally ill patient. The best approach in these cases is to obtain a thorough social and psychiatric history. The attending physician may wish to obtain psychiatric consultation to determine not only the competence of the patient but also the basis for refusal of lifesaving treatment.

In cases in which depression seems to have a major role, giving the patient a course of antidepressant medication is wise. However, whenever the desire to die occurs in the absence of clinical depression and is clearly associated with the wish to avoid further suffering and indignity, respecting the patient's wishes is appropriate. In these cases, when the patient's wishes are

Table 2.—Psychosocial profile of terminally ill depressed patients

Psychologic processes:
- orientation, coherence within normal limits
- appropriate affect
- mood depressed or neutral
- psychotic trends absent
- feelings of being trapped by illness
- unwillingness to consider further experimental treatment or surgery
- concern about family's feelings and welfare
- worries about family's financial security
- fears about being a burden to spouse, family, and friends
- personal philosophy of living and dying sometimes expressed
- wishes to avoid further pain and suffering for the family
- bedsores, incontinence, nausea, and vomiting regarded as intolerable and demeaning
- concern over loss of dignity and self-respect
- no regrets about life achievements
- no feelings of guilt
- lack of moralistic or judgmental statements
- end-of-life decisions not felt to be immoral or wrong
- beliefs expressed about the importance of individual versus family well-being, the sanctity versus the dignity of life, the lack of real value in suffering
- Living Will consistent with the beliefs expressed
- patient's beliefs and preferences (when depression was not present) validated by family members

History of losses:
- past losses not associated with guilt, remorse, or resentment

History:
- history of psychiatric illness present or absent
- history of alcohol or drug dependence/abuse present or absent
- history of depressive episodes present or absent

History of present illness:
- terminal illness or incurable disease (amyotropic lateral sclerosis, acquired immunodeficiency syndrome, metastatic cancer)
- history of complicated medical treatment and lengthy illness
- history of intractable pain unrelieved by analgesic agents or surgery

Social history:
- past active and productive life
- warm and supportive relationships with family, children, and friends

Suicidal motivation:
- motive for refusing treatment based on wish to end the suffering
- feelings of futility linked to wanting to die
- death seen as a relief from suffering, indignity, and pain
- poor quality of life and poor prognosis mentioned
- religious guilt or inhibition in refusing further treatment not a factor
- refusal of treatment and request to die linked to terminal illness
- preference for physician aid in dying if it were available
- preference for nonviolent means of dying or even assistance with dying

ignored and aggressive life support is given, paradoxical suicidal ideation and behavior can develop.[14]

Clinicians also need to accept that some depression in the terminally ill is resistant to all antidepressant therapy. Knowing when to stop psychiatric treatment is just as important as knowing when to stop medical treatment and let the dying process proceed naturally. Providing relief with a course of benzodiazepine or narcotic agents may be the best treatment to offer to ease the pain and suffering of the terminally ill patient who refuses treatment that might prolong a painful life.

Conclusion

The need to die, as expressed by refusal of further lifesaving treatment in the context of a terminal illness, may or may not be associated with a psychiatric disorder. Clinical depression does occur and should be treated, but terminal patients may persist in refusing treatment and insist on dying. Their striving for a dignified death should be respected and honored. This attitude will help smooth what can be a very rough path for the dying.

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References

1. Brown JH, Henteleff P, Barakat S, Rowe CJ. Is it normal for terminally ill patients to desire death? *Am J Psychiatry.* 1986;143:208-11.
2. Howe EG, Gordon DS, Valentin M. Medical determination (and preservation) of decision-making capacity. *Law Med Health Care.* 1991;19(1-2):27-33.
3. Meisel A. *The Right to Die.* New York, NY: Wiley; 1990.
4. United States President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. Making Health Care Decisions: A Report on the Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship. Washington DC: USGPO,1982:18.
5. Ruark JE, Rafin TA. Initiating and withdrawing life support: principles and practice in adult medicine. *N Engl J Med.* 1988;318:25-30.
6. Appelbaum PS, Roth LH. Treatment refusal in medical hospitals. In: United States President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. Making health care decisions: a report on the ethical and legal implications of informed consent in the patient-practitioner relationship. Washington DC: USGPO, 1982:431.
7. Emanuel LL, Emanuel EJ, Stoeckle JD, Hummel LR, Barry MJ. Advance directives: stability of patients' treatment choices. *Arch Intern Med.* 1994;154:209-17.
8. Sullivan MD, Youngner SJ. Depression, competence, and the right to refuse lifesaving medical treatment. *Am J Psychiatry.* 1994;151:971-8.
9. Bursztajn HJ, Harding HP, Gutheil TG, Brodsky A. Beyond cognition: the role of disordered affective states in impairing competence to consent to treatment. *Bull Am Acad Psychiatry Law.* 1991;19:3838.
10. Beck AT. Thinking and depression. Idiosyncratic content and cognitive distortions. *Arch Gen Psychiatry.* 1963;9:32433.
11. Ogden R. *Euthanasia and assisted suicide in persons with acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).* New Westminster: Peroglyphics Publishing, 1994.
12. Kathol RG, Noyes R Jr, Williams J, Mutgi A, Carroll B, Perry P. Diagnosing depression in patients with medical illness. *Psychosomatics.* 1990;31:43440.
13. Beck AT, Brown G, Berchick RJ, Stewart BL, Steer RA. Relationship between hopelessness and ultimate suicide: a replication with psychiatric outpatients. *Am J Psychiatry.* 1990;147:190-5.
14. Pauker SL, Cooper AM. Paradoxical patient reactions to psychiatric life support: clinical and ethical considerations. *Am J Psychiatry.* 1990;147:488-91.