

## **FAST FACTS AND CONCEPTS #210 SUICIDE ATTEMPTS IN THE TERMINALLY ILL**

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**Background** Chronic or advanced medical illness is a significant risk factor for suicidality (1). This *Fast Fact* discusses evaluating and responding to suicidality in patients with life-limiting diseases. **Note:** this *Fast Fact* does not address cases of ‘physician assisted suicide’ which have occurred after a deliberative process including psychiatric screening such as in Oregon in the US (2).

### **Ethics**

- **Core Principles:** It is a core obligation of physicians to prevent a patient from initiating suicide and to intervene medically to prevent a patient from dying after a suicide attempt (3). This obligation can include detaining and restraining patients against their will and the use of invasive medical interventions such as mechanical ventilation if needed, although such restrictions to a patient’s liberty should be kept to the minimum necessary. Most suicidal patients are considered impaired by depression or other mental illnesses and their actions are not considered autonomous, thus justifying detaining patients and providing medical interventions against their will (4). Such interventions can create further opportunities to treat the patient’s psychiatric condition, and only 20% of people who are prevented from committing suicide subsequently complete another attempt.
- **Exceptions at life’s end:** The above logic is less compelling in terminally ill patients who have attempted suicide, particularly with short prognoses (e.g. <1 month). In these patients most medical interventions are unlikely to restore health or significantly alter the dying process in a way that would materially benefit the patient. Clinicians may opt to forgo certain interventions (e.g. mechanical ventilation), particularly if family/proxy decision makers consider such interventions inappropriate in their dying loved ones. In these situations clinicians are advised to 1) verify the certainty of the very short prognosis, utilizing consultants liberally, 2) discuss with proxy decision makers all possible treatment plans including, when feasible, less-invasive supportive care options with treatment limitations (e.g. ICU monitoring, gastric lavage and charcoal administration for an overdose, but establishing a do-not-resuscitate/do-not-intubate order even if the patient deteriorates), and 3) seek ethics consultation.
- **Advance Directives:** Advance directives such as living wills stating a patient’s wish to not be mechanically ventilated are not binding in the setting of a suicide attempt. However, they should be honored in patients with short prognoses per the discussion above. Advanced directives specifying treatment limitations should be re-evaluated if it is suspected those statements were made during a period of undetected depression (5,6).

**Epidemiology and Risk Factors** There has been limited research into specifically ‘terminally ill’ populations, hence the rate of suicide in the terminally ill is unknown. What is clear is that advancing age and psychiatric comorbidity are risk factors for suicide along with male sex, AIDS diagnosis, a family history of suicide, and uncontrolled pain (7,8). Cancer patients have nearly twice the incidence of suicide than the general population (rate of 31.4 vs. 16.7/100,000 patient-years) and the first year after diagnosis carries a higher risk (6,9). Lung, prostate, pancreatic, and head and neck cancers have the highest suicide rates among all cancer types (9). Up to 8.5% of terminally ill cancer patients express a sustained and pervasive wish for an early death, and in one survey 10% of terminally ill patients reported “seriously pursuing” physician assisted suicide (10,11). Rates of actual suicide attempts are presumably lower.

**Assessment** All patients with life-limiting illnesses should be routinely assessed for depression and mood disorders (see *Fast Facts #7*, 43); depressed patients should be screened for suicidal thoughts. Patients who admit to suicidal thoughts or a desire for hastened death should be asked about specific plans for self-harm, past history of suicide attempts, access to firearms or other lethal means to carry out a suicidal act, and level of support/supervision available in the home (e.g. family caregivers). Although some clinicians may be concerned that exploring suicidal thoughts may make suicide more likely, there is no evidence that this occurs. Many ill patients who express a desire for death are simply communicating unresolved emotional and existential concerns about dying: see *Fast Facts #156 & 159*.

**Responding to Suicidal Intent** All patients who are seriously threatening self-harm, or who have pervasive thoughts of ending their life, should be evaluated urgently by a psychiatrist (12). Immediate resources depend on local availability and can include prompt evaluation by an established psychiatrist, medical or psychiatric urgent care clinics or emergency departments, or even voluntary hospital admission. Options include voluntary psychiatric treatment, arranging 24 hour safety monitoring from the patient's family and friends, introducing home hospice or home nursing support, removing means to carry out a suicidal act, and imposing emergency detention. For disabled patients close to death, removing the means of self-harm (e.g. limit access to pain medications as long as a reliable family member can administer them) and providing close supervision through, for instance, hospice services are often sufficient and minimally restrictive.

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**Version History:** Published November 2008; copy-edited June 2012; re-copy-edited July 2015 with reference #9 added and incorporated into the text.

**Fast Facts and Concepts** are edited by Sean Marks MD (Medical College of Wisconsin) and associate editor Drew A Rosielle MD (University of Minnesota Medical School), with the generous support of a volunteer peer-review editorial board, and are made available online by the [Palliative Care Network of Wisconsin](#) (PCNOW); the authors of each individual *Fast Fact* are solely responsible for that *Fast Fact's* content. The full set of *Fast Facts* are available at [Palliative Care Network of Wisconsin](#) with contact information, and how to reference *Fast Facts*.

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