

Dying in the Psychiatric Ward

Adiel Doron, MD,^{1,2} and Shlomo Mendlovic, MSc, PhD, MD^{2,3}

¹ Lev-Hasharon Mental Health Center, Netanya, Israel

² Sackler Faculty of Medicine, Tel Aviv University, Ramat Aviv, Israel

³ Shalvata Mental Health Center, Hod Hasharon, Israel

Abstract: General hospital staff is experienced in dealing with the death of a patient. However, aside from cases of sudden death among psychiatric inpatients, psychiatric medical staff faces such situations considerably less frequently. Many chronic psychiatric patients do not have a family or home, a situation which may become even more painful if the patient is dying of a physical illness. Coping with a terminally-ill oncology patient is a difficult task for the multi-disciplinary staff and for fellow patients in chronic care psychiatric departments. The authors describe the slow deterioration of two psychiatric inpatients who were also diagnosed with advanced cancer, and present the dilemmas involved with continued treatment of terminal oncology patients in a psychiatric ward when the psychiatric status no longer warranted inpatient psychiatric care.

Introduction

Death and dying have been increasingly addressed in the medical literature as has the role of the psychiatrist as a consultant for terminal patient care (1, 2). Medical students were found to lack coping strategies when confronting the dying patient (3). Concerns regarding psychiatric inpatients who are terminally ill with cancer and the effect on the staff and fellow psychiatric patients have not been adequately discussed. Since general hospitals usually do not admit patients unless urgent medical care is indicated, chronic psychiatric patients could die in psychiatric wards. The lack of attention in the literature to terminally-ill psychiatric patients remains troublesome and reflects a lack of adequate teaching and supervision in this field (3, 4). This is also evident from the fact that the psychiatric syllabus prepared by the Israeli psychiatric association does not address the topic of death and dying in psychiatry. This gap in training affects not only general practitioners and psychiatrists. Nurses spend more time with patients who are facing death than any other member of the health care team. Yet, studies have shown that many nurses feel inadequately prepared to provide end of life care (5).

We present case reports of two inpatients with schizophrenia, who also suffered from a terminal illness (cancer). In our opinion, they illustrate some of

the major dilemmas associated with the terminally-ill patient in the psychiatric department. Accordingly, we raise three practical recommendations concerning this issue.

Case Report 1

T., who died at 45 years of age, was first admitted to a psychiatric hospital at the age of 29 with a diagnosis of schizoaffective disorder. She was repeatedly hospitalized in mental health care facilities throughout the last 10 years of her life. T. was aggressive, cursed patients and therapists and repeatedly threatened to commit suicide. Attempts to switch or adjust pharmacotherapy were unsuccessful, and her psychiatric disorder was unremitting.

During hospitalization, a routine blood examination revealed hyponatremia, initially attributed to psychogenic polydipsia. Further examination, including an x-ray, discovered a space-occupying lesion in the lung, and a biopsy confirmed a small cell carcinoma. T. was treated with chemotherapy, with no improvement. Her condition rapidly deteriorated and within a few months she developed spinal cord compression, she was no longer able to walk and chemotherapy was stopped.

The psychiatric staff had to decide whether to allow T. to remain in the psychiatric ward or to trans-

fer her to another facility. Medically, there was no need to admit her to a general hospital. From the psychiatric standpoint, she could have been discharged, as she was at that time calm and cooperative. However, T. had no home and her condition was not suitable for hospice referral. Her siblings were neither willing nor able to take her in. The staff members were apprehensive about dealing with death in the ward; nevertheless it was ultimately decided that since for the past years T. had resided in the psychiatric ward, she should be allowed to die "at home."

T. was afraid of dying. Her suicidal thoughts completely disappeared as her condition worsened. She began asking whether she had cancer, cried a lot and told everybody that she "was going to die."

Some members in the staff had difficulty dealing with T.'s suffering and tried to calm her by promising that she would be cured. Others wanted her to know the truth. The benefit of her knowledge and the impact of that knowledge on the other patients were questioned. Staff consultations concluded that she should be told the truth. When T. asked whether she would die, she was told that "everything would be done to help you." When other patients asked if she had cancer they were told that "T. is very sick." Interestingly the patients did not ask for more details and respected her privacy. T.'s roommates reacted affectively. N., T.'s roommate, was hospitalized after the death of her father. She took care of T. and recalled memories of her father's death. It was suggested that N. should move to another room to spare her the stress of another death. N. refused to leave T. and found her support of T. meaningful. The second roommate accused the staff of not providing adequate care for T., and thought that she should be sent to a general hospital where "they will know how to help her."

A few months after T. was diagnosed with cancer, her physical condition deteriorated. It was decided that she would be transferred to a hospice in a general hospital, to spare the other patients her actual death. Two days later she died.

The ward staff had many unanswered questions following T.'s death. Was she transferred to the hospice "at the last moment," or did she die as a result of that transfer. Perhaps it would have been better for T. to die in her room. Was she transferred because of

the staff's difficulties in coping with a dying patient? Some felt guilty for not having been able to help T. in her final moments, while others thought that T.'s transfer to the hospice illustrated the staff's recognition of its limits. The overall impression was that an appropriate end-of-life curriculum in nursing and in medical schools would have enabled the staff to treat T. until her last breath.

Case Report 2

M. was diagnosed with schizophrenia at the age of 23. For the next 19 years, she was repeatedly hospitalized for psychotic decompensations, and was treated with various anti-psychotic agents. Between hospitalizations, she partially functioned at a semi-sheltered accommodation.

M.'s support system was frail. Her parents were divorced and her father lived far away. M. had three siblings. One sister suffered from schizophrenia and was frequently hospitalized. The other sister had a handicapped child who required all of her energy and time. M.'s brother was too young to help, and her mother was torn between her children, and despite immense efforts could not provide M. all the practical and emotional support she needed.

M.'s last psychiatric hospitalization, which began 11 months before her death, followed a psychotic breakdown with no apparent trigger. Agitated, she was admitted to a closed ward. At admission, she notified her treating psychiatrist of an abnormal PAP smear. Intensive investigations performed during hospitalization revealed a disseminated, apparently inoperable, carcinoma of the cervix.

Following diagnosis of the potentially fatal disease, a strategic intervention was initiated, which involved M., her mother, the treating psychiatrist and the department nursing staff. M., who was psychotic at that time, refused any further investigational or therapeutic procedures. She was fully aware of the implications of her disease, and of the consequences of her decision to halt medical procedures.

Due to the potentially fatal consequences of M.'s decision, the legal and ethical aspects of her decision were presented at the institutional staff meeting. The forum supported allowing M. to decide what actions should be taken concerning her illness. M. expressed her desire to remain in the ward, still refusing medi-

cal treatment. The department staff responded positively to M.'s request.

Understanding that her medical condition could not be kept as a secret, M. revealed her terminal illness to the other patients on the ward. This resulted in an emotional recruitment of her fellow patients. Some initiated open-hearted talks and some just asked how she was feeling at dinnertime. M. accepted some help, especially from female patients, and refused others.

Five months after admission, M.'s physical condition deteriorated. Although her psychosis attenuated, she refused to be transferred to an open ward. She expressed her doubts as to whether dying in the ward would be possible. Touchingly, she pointed out that the medical staff was not "capable of treating a patient like me." Acknowledging M.'s sensitivity, the staff suggested various alternatives. M. and her mother finally decided, seven months after hospitalization, to move to a hospice, where she died four months later. Staff members remained in close contact with M. while she was in the hospice, and brought her regards from fellow patients on the ward. The staff periodically updated her friends on the ward as to her condition. The entire medical staff of the closed ward attended her funeral.

M.'s death was revealed by one of the patients in the closed ward. We immediately gathered the patients, shared the information with them and discussed M.'s demise. Following her death, the vast majority of patients expressed appreciation of the staff's efforts in treating M. Two departmental staff meetings were devoted to M.'s process of dying and to the staff's reaction.

Discussion

How much should the dying patient know about his or her medical condition?

In a study performed in China among non-psychiatric patients, awareness of dying was identified as the foremost essential element of a "good death" (6). According to the Israeli "Law of Patients Rights" (1996), a patient has the right to know all medical information concerning his/her medical state. Preventing the patient from seeing the medical chart requires the approval of the ethical committee, is relatively rare, and is assessed on a per-case basis (7).

When discussing terminal diagnoses with psychiatric patients, the amount of medical information and the rate of exposure should be commensurate with the individual's capacity to grasp and deal with such information. For example, when the patient has a blunted affect and impairment in thought content and process, the therapist must be very well acquainted with the patient in order to decide how much information he can handle. In addition to the cognitive and affective incapacity, it is frequently difficult to understand what the patient really wants to know. Indeed, the patient's desire is the main indicator for provision of information. As in T.'s and M.'s cases, it is best to let the patients reveal the information that they choose to reveal. The clinician should however carefully provide sensitive information in accordance to the patient's wish and capabilities.

Who makes treatment decisions?

The provision of medical care for all competent patients, including cancer patients, should be guided by the patients' choices. M. was fully aware of the implications of her disease, and the family agreed with her decision not to receive palliative chemotherapy. This helped the therapists comply with M.'s choice not to receive chemotherapy. However, in the case of incompetent patients, the Supreme Court of Massachusetts ruled that the probate court is the proper tribunal for making decisions whether to give or withhold "life prolonging treatment" for terminally-ill patients (8). Arnold Relman, editor of *The New England Journal of Medicine*, argues that treatment decisions for terminally-ill, incompetent patients should be made by the physician in consultation with the patient's family (9). We suggest embracing similar guidelines, and adjusting them to the resources available to the medical system in Israel (e.g., Institutional Ethical Committee, the District Psychiatrist).

Where should the terminally-ill, chronic psychiatric patient die?

Approximately two-thirds of cancer patients, when asked about the preferred place of death, wish to die in their homes (10). Our patients preferred to stay in the ward which had become a home-replacement for them. There are many differences between dying at home and dying in a psychiatric ward. At home pa-

tients have their family, have all their belongings and can have their privacy when necessary. A psychiatric ward is occupied by other patients whose conditions must be considered (e.g., some are loud; others intrude upon the privacy of the dying patients). On the other hand, the psychiatric ward offers continuous medical help and security which can reassure the patient's fears and take care of all his physical needs. In our opinion, the final decision concerning the question of where the dying patient should be is to be considered jointly by the patient, family and the medical staff.

There is a general consensus that home is the best place for the dying. In T's and M's cases, the psychiatric ward had become their home, so it was relevant to allow them to remain there for as long as possible. Yet, in both cases, the staff could not cope with the death itself and transferred the patients to a hospice in the final stages of the illness. Though each case is unique, we would like to put forward three recommendations:

1. The decision to transfer a patient to a hospice should be a joint decision, made by the patient, family and psychiatric hospital staff. If hospice care is an option, it may sometimes be beneficial to transfer a dying patient to a hospice at an earlier stage of the illness when he or she can still adjust to that environment. Once the decision has been made, appropriate steps should be made for comfortable implementation.
2. Appropriate supervision of the nursing staff and good cooperation between the psychiatric hospital and a hospice may enable the psychiatric ward to care for terminally-ill patients for as long as possible. Attention should be given to the short- and long-term effects of a patient's death on the other psychiatric patients in the ward.
3. The topic of the management of death and dying should be adequately addressed in an appropriate

end-of-life curriculum in medical and nursing schools. It is not enough to present the subject theoretically as a basic science, but rather it should be repeatedly dealt with throughout pre-clinical and clinical years.

Acknowledgement

The authors would like to thank Rena Kurs for her assistance in preparation of the manuscript.

References

1. DiMaggio JR. Educating psychiatry residents about death and dying. *Gen Hosp Psychiatry* 1993;15:166-170.
2. Wood S, Bisson JI. Experience of incorporating a mental health service into patient care after operations for cancers of the head and neck. *Br J Oral Maxillofac Surg* 2004;42:149-154.
3. Williams CM, Wilson CC, Olson CH. Dying, death, and medical education: Student voices. *J Palliat Med* 2005;8:372-381.
4. Rhodes-Kropf J, Carmody SS, Seltzer D, Redinbaugh E, Gamer N, Block SD, Arnold RM. "This is just too awful; I just can't believe I experienced that...": Medical students' reactions to their "most memorable" patient death. *Acad Med* 2005;80:634-640.
5. Marshall PI. End of life care: Ethical issues. *Kans Nurse* 2001;76:4-7.
6. Mak MH. Awareness of dying: An experience of Chinese patients with terminal cancer. *Omega* 2001;43:259-279.
7. Burke G. Ethics and medical decision-making. *Prim Care* 1980;7:615-624.
8. Buchanan A. Medical paternalism or legal imperialism: Not the only alternatives for handling Saikewicz-type cases. *Am J Law Med* 1979;5:97-117.
9. Relman AS. A response to Allen Buchanan's views on decision making for terminally ill incompetents. *Am J Law Med* 1979;5:119-123.
10. Tang ST, McCoorkle R. Determinants of place of death for terminal cancer patients. *Cancer Invest* 2001;19:165-180.