Case Report | Psychiatric, Psychological, Social, and Spiritual Issues in Palliative Medicine and Palliative Care

The patient living with the deer: the special charm of home care visits in palliative care described in a case report※

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Background: Home care visits are crucial for individuals with palliative care (PC) needs, as they allow them to stay in the comfort of their own homes for as long as possible or to pass away surrounded by loved ones. These visits also provide PC teams with the opportunity to understand the patient as a whole person, replete with their own individual stories and needs. One aspect that can be particularly significant in a patient's life is their relationship with animals and pets. So far, there are no case reports on patients living with a deer at home.

Case Description: In this case, a patient with advanced non-Hodgkin's lymphoma was discharged from the emergency room to return home due to their desire to be with their loved ones. The hospital's PC team was consulted to ensure that the patient's needs were met at home. On the following day, the team was surprised to discover a special family member at the patient's residence: a deer. This deer was deeply affected by the patient's passing and was seen crying throughout the process.

Conclusions: This case highlights the importance of supporting patients to die at home, not only for the patient and their loved ones but also for their beloved animals. In this case, if the patient had passed away in the hospital, the deer would not have had the opportunity to say goodbye and may have struggled to understand and process the loss.

Keywords: Home care visits; palliative care (PC); animals; case report

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Introduction

Although most patients with advanced cancer wish to die at home (1), not many patients can die at their preferred place of death (2). The chance of dying at home can be enhanced by home palliative care teams (HPCT) (3,4). When timely referral to palliative care (PC) is carried out (5,6), and when home-based palliative cancer care programs are available, a positive effect on the patient's end of life can be observed (7). The number of patients with advanced cancer who were able to die at home was shown to have increased when early referral to HPCT was implemented (8,9). As demonstrated by previous studies, the referral to home palliative care (HPC) occurs rather late for patients with advanced cancer (10,11), and this is often seen as too late by most bereaving families (11). By integrating HPC in accordance with medical oncology, the late referral policy could be improved (12).

In Austria, HPC is provided by mobile PC teams (MPCTs) (13). The goal of these multi-professional teams is primarily aimed at assisting carers at home and in the home (e.g., medical staff, nursing staff, physiotherapists,

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and relatives). An MPCT provides experience in pain therapy, symptom control, PC, and psychosocial support in an advisory and instructional capacity. The MPCT also supports the transition between hospital and home care (13). One of the care goals of MPCTs in Austria is to make special palliative medical and nursing expertise available in the patients' respective environments. Depending on the local and geographic situation, the mobile palliative team can also act as a counseling team in hospitals, homes, and day hospices. To interlink intramural and extramural structures between the hospital and the care provided at home, palliative consultation services (PCS) in the hospital work closely together with hospital facilities and MPCTs (13). The PCS is provided by a multi-professional team in the hospital, which primarily addresses the attending medical and nursing staff in wards and outpatient clinics, and secondarily focuses on the patients and their relatives. The PCS advises and offers know-how in pain therapy, symptom control, holistic care, and psychosocial support. Measures and implementations are then ultimately decided upon by the attending physicians and their employees.

Very often, MPCTs and PCS comprise one team (13). At our University Hospital in Krems, the Palliative Care Unit consists of a ward with eight beds (approximately 300 admissions per year), an inpatient clinic (approximately 200 patient contacts per year), a PCS (approximately 10,000 contacts per year), and an MPCT. The MPCT makes approximately 200 home care visits per year. One of these visits was very special and unforgettable; for the first time in my life, I was visiting not only a patient but also a deer at home.

This case is unique because there is no report in the literature about a deer mourning for his human friend. We present this case in accordance with the CARE reporting checklist (available at https://apm.amegroups.com/article/view/10.21037/apm-23-91/rc).

Highlight box

Key findings

- This case report highlights the presence of a deer as a beloved animal companion in the home of a patient with advanced non-Hodgkin's lymphoma during their end-of-life care.
- The deer displayed signs of emotional distress and mourning upon the patient's passing, shedding light on the deep bond that can exist between humans and animals.

What is known and what is new?

- Home care visits are crucial for individuals with palliative care needs, allowing them to stay in the comfort of their own homes and be surrounded by loved ones during their final days.
- Palliative care teams aim to understand patients as unique individuals with their own stories and needs.
- This manuscript presents a unique case where a patient with a deer living at home highlights the significance of animal companionship in palliative care settings.
- To the best of our knowledge, this is the first reported case of a patient living with a deer at home during their end-of-life care.

What is the implication, and what should change now?

- The case emphasizes the importance of supporting patients' wishes to die at home, not only for the patients themselves but also for their beloved animals.
- Palliative care teams should consider the emotional needs of animal companions and support their presence during end-of-life care whenever possible.
- Further research and exploration are needed to better understand the role of animals in palliative care settings and to develop appropriate guidelines or policies that address the needs of both patients and their animal companions.

Case presentation

All procedures performed in this study were conducted in accordance with the ethical standards of the institutional and/or national research committee(s) and with the Helsinki Declaration (as revised in 2013). Written informed consent was obtained from the patient's wife for the publication of this case report and accompanying images. A copy of the written consent form is available for review by the editorial office of this journal.

In June 2022, while working as a consultant in the PCS/MPCT service in Krems, I was called to see a 75-year-old man in the emergency department (ED). This patient had been diagnosed with follicular lymphoma in 2014. He received six cycles of rituximab-bendamustin from January 2015 to May 2015. After this, he received rituximab maintenance therapy. Because of progression, six cycles of obinutuzumab-CHOP (cyclophosphamide, hydroxydaunorubicin, oncovin/vincristine, prednisone) were applied. Progression in inguinal and iliacal lymph nodes on the left leg occurred in 2018. He received PC involving field radiotherapy on these sites. Another recurrence emerged in 2019 in the retroperitoneal lymph nodes, and another course of radiotherapy to ease his pain was performed. In June 2020, further progression was treated with idelalisib and rituximab, followed by chlorambucil.

The patient then had a stable disease for almost two years, but in 2022 the lymphoma progressed again in iliacal and inguinal lymph nodes, which caused vena cava inferior syndrome, and he began to suffer from edema in his legs and his penis. He was sent to the ED on June 26th because

Figure 1 Hansi the deer in the living room, reluctant to eat pretzel sticks from the author.

of postrenal kidney failure and an inability to urinate due to penis edema, for which the urologists applied a urinary catheter. Another problem that required the patient to be sent to the ED was because he refused to eat and drink, was very tired, and had stopped taking his regular medication. The lab work showed significant anemia, thrombopenia, and leukopenia, as well as kidney failure and elevated inflammatory parameters. A chest X-ray revealed pleural effusions on both sides. Symptom-wise, the patient suffered from pain and dyspnea.

The doctors in the ED were a little desperate because the patient insisted on going home despite his bad clinical condition. When I visited the patient, he told me that he was fully aware of his bad condition, and it was his wish to die at home. He was sent to the hospital because his wife was worried about his inability to urinate and his symptoms of pain and dyspnea. "*Please*, *doctor*, *make it possible for me to stay at home!*" he begged. I called his wife, who sounded quite confident on the phone that she could take the patient back home, despite my telling her that we expected him to die soon. She told me, "*I am used to this. I was already with my grandmother and mother when they died. Don't worry, doctor, we will manage!*" I also explained to her that I would prescribe opioids to mitigate his pain and dyspnea and told her how she could administer these drugs. In addition, I offered her assistance from our MPCT. We made an appointment for the next day; I told her that a nurse on our team would call to see if they needed anything at home. The patient was sent home and was very happy that he did not have to stay in the hospital. Before his departure, I prescribed medications to alleviate his pain related to his progressive disease and dyspnea, which was caused by low hemoglobin levels and pleural effusions. In addition, opioids and non-opioids (metamizole) were prescribed to ease his pain due to the massive lymph node progression. We applied a fentanyl patch in the ED, and I prescribed morphine for breakthrough pain or breakthrough dyspnea.

The next morning, his wife called our MPCT rather desperate, telling us that her husband was dying and in discomfort. She told us that he was breathing heavily and seemed to be in pain. Hence, we drove to the patient's place and entered his house, and upon arrival, we were met with a big surprise. The patient was lying in his bedroom, and in his living room, there was a living deer (*Figure 1*). The patient was in his final phase of life and showed signs of pain and tachypnea. Death rattle was already present. His wife was very happy that we had arrived, and she told us that Hansi, the deer, was very desperate because he felt that his human was dying. Hansi did not enter the bedroom, and the patient's wife told us that he had not done so since the patient was in his final phase. He had been living with the family for almost 14 years now. When he was a fawn, he was found by a hunter; the fawn's mother was dead. The patient and his family gave the fawn a new home. Hansi had lived in their house since then and was also able to use their garden.

When our team was in the living room and I turned my back to Hansi, he tried to attack me, but it was only a sham attack, because his hoofs did not touch me. The patient's wife told me that Hansi wanted to defend the patient, but he would not hurt me. That was a little frightening, and I hoped that the deer would not follow us into the bedroom. Hansi did not; he stayed outside, so it was easier for me and the nurse to perform symptom control without being attacked by a deer. We applied a scopolamine patch to relieve his death rattle, 5 mg of morphine subcutaneously, and 1.25 mg of lorazepam sublingually because he seemed quite agitated. After a while, the patient became calmer. Suddenly, the deer began to roar pathetically and very loudly. He did not stop; the patient's wife tried to calm him down. Only a few minutes later, the patient took his last breath. Then, he was dead. Hansi kept roaring but did not enter the bedroom. After a couple of minutes, he ran outside to the garden. We helped the patient's wife take care

of her dead husband. She was crying persistently, telling us how glad she was that her husband was able to die at home. "*You know, he did not want to leave Hansi! He loved this deer so much! How shall Hansi and I live without him?*"

After the situation stabilized and the other relatives arrived to take care of the patient's wife, we drove back to our hospital. We were still impressed, but also sad, by the mourning of the deer. Such events are always sad, and sometimes I must cry myself when desperate relatives mourn at the deathbeds of their beloveds. But seeing and hearing the desperate Hansi cry was heartbreaking. I was so surprised by the fact that even though Hansi was not in the room, he knew when the patient had taken his last breath. For this, I do not have a scientific explanation, and I am glad not to have one.

A couple of weeks later, I visited the patient's wife to take a picture of Hansi. The patient's wife told me a lot of stories of her dead husband and some funny stories about Hansi. She was very sad, but talking about her dead husband made her feel at ease. I was given some coffee and a chocolate cake. She was feeding the deer with pretzel sticks and inviting me to do the same. However, Hansi would not take pretzel sticks from me, even if I laid them on the floor. He even lowered his head, and every time I turned my back on him, he would jump at me, without touching my back, and I was a little scared. I realized that Hansi was protecting the patient's wife from intruders after one of his beloved humans had died. And that he remembered me as a person who was maybe in his opinion responsible for the death of his friend? I think this was one of my most exciting and touching home care visits. The patient's wife promised me that I could come and visit Hansi again as often as I liked. I think that I might visit Hansi and his owner again to get some chocolate cake, and maybe, if Hansi gets used to me, he will also take the chestnuts I offer to him.

Discussion

Studies have revealed that owning a pet can assist an individual in managing challenging situations, preventing feelings of isolation, alleviating depression, enhancing daily activities, and promoting social interactions (14). The introduction of pets in elderly care facilities has been linked to a reduction in the use of psychiatric medications and an over 50% decrease in healthcare expenses (14). However, there is a scarcity of research on the utilization of companion animals in hospice care. An article by Geisler includes a summary of medical research related to companion animals and personal accounts highlighting the significance of companion animals in end-of-life care (14). According to a study by MacDonald and Barrett, animals have a significant impact on the lives of individuals receiving PC (15). Utilizing animal companionship as a form of support can also enhance the patient experience. Healthcare professionals providing PC should thus be cognizant of the role that companion animals play in their patients' lives and consider incorporating animal therapy into their care delivery, where feasible (15).

A thorough examination of the available literature on the topic of PC and companion animals, with a specific focus on the evidence and understanding of the role of companion animals for individuals nearing the end of their lives, was conducted by Chur-Hansen *et al.* (16). In this study, several databases, including PubMed, PsycINFO, Medline, Scopus, and Google Scholar, were searched for relevant studies pertaining to companion animals, end-of-life care, and hospice PC. Out of the studies found, only six dealt specifically with empirical research, while the rest addressed the topic indirectly or through personal accounts. The current evidence and understanding of the benefits of companion animals in hospice and PC are thus limited. Further research is needed to determine the appropriate conditions under which companion animals can aid in patient care, such as acceptance by staff, family, and other patients, as well as the welfare of the animals themselves.

For dogs or cats, it could be possible to gain access to a hospice or, on some occasions, even to the hospital for patient visits. However, there are some animals that do not fit in a hospital or hospice, such as deer and snakes, for example. We once had a patient with a lot of snakes at home, and, of course, these animals could not be brought to visit the patient in the hospital. In this case, some of our team members were also reluctant to make a home care visit. We had already made plans for which members of the team would be willing to do the home care visits, but the patient died before she was able to go home. In this case, particularly, I will admit that I was not sad that I did not have to visit the snakes (some of them were very poisonous).

It should also be kept in mind that coming into the surroundings of a hospital or hospice could be very stressful for the animals. This thus indicates another advantage for patients to be able to die at home: they can be with their beloved animals.

Conclusions

The treatment goals in PC are different from those in

emergency medicine. A treatment goal we wish to establish in PC is allowing patients to die at home to enable them to be with their beloveds, whether they be humans or animals. Additionally, those in PC should seek to gain the trust of animals they would never expect to meet at home during a bereavement visit. Our patient would never have been able to be in the company of his beloved deer when he died in the hospital. Accordingly, MPCTs can help patients to be able to die at home, but also make it possible that animals can be with their beloved humans in their last hours of life.

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