Viewpoint

Suicide in palliative care setting

Chloe Hui-Ling Choy

King's College London, Guy's Campus, London SE1 1UL, UK

Correspondence to: Chloe Hui-Ling Choy. King's College London, Guy's Campus, London SE1 1UL, UK. Email: chloe.choy@kcl.ac.uk.

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Suicide has consistently been associated with depression and treated as such by medical professionals. However, we must remember that it is an independent entity, with numerous factors contributing to such feelings, and should approach it accordingly, looking to understand the patients' perspective. Suicide in terminally ill patients is no different, and steps to prevent the hastening of death should be taken in line with the intentions of palliative care.

Incidence of suicide

Literature on the incidence of suicide in specialist palliative care is sparse with only 2 relevant journal articles found on PUBMED using keyword "palliative", "suicide".

The retrospective postal survey revealed a total of 21 suicides in 34 palliative care units in UK over the period of 1990 to 1994 (1). And in the Italian palliative home care programme, 5 patients committed suicide during the period of 1985 to 1997 (2). Both have similar suicide rates of 0.03% of their total patient population, impressing that suicide is a rare occurrence under palliative care.

However, much has changed in 20 years when these were published- from the types of ailments and treatments to the standard of care that patients have access to. The socioeconomic environment is different too. All can impact the mental state of the patient, influencing their thoughts and decision to commit suicide.

Oncology related suicides has increased. In 2014, 7% of a small sample of suicides had terminal illness in England (3). The 18.6% indicated having suicidal thoughts in the previous 2 weeks during a study of desire of hastened death in the palliative population in UK (4). Will the suicide rate of 0.03% in the palliative care setting still be possible in our current times? If so, there must be protective factors specific to the terminally ill that has persisted over the years, and would be worth identifying.

Why are suicide statistics important?

Knowing the numbers not only enables us to clearly display suicide's prevalence in palliative patients, it also allows us to identify what characteristics these patients had- what was their line of thinking, what was their biggest stressor, what was their attitude towards death and more. Risk factors particular to this population group may be elicited from shared qualities of patients. We can see if any changes in the way we care for the terminally ill has had a positive impact, or if further improvements need to be initiated. In line with suicide prevention, examining the patient's journey will enable us to reflect on what maybe we could have done differently and possibly change the outcome. By bolstering our efforts to track and follow patients who voice suicidal ideations or attempt suicide, we may prevent some deaths in future. Past experience may also teach us how to react appropriately to a suicide attempt to prevent further attempts. As aforementioned, we could identify any protective factors, and understand the large discrepancy between the number with suicidal ideation and completed suicide in this high-risk group.

However, it is puzzling: why has there been a lack of collection suicide statistics in palliative care settings in recent times? Is it because of its rarity? Or is it a reflection of our attitudes towards suicide in terminal illness? That we are understanding of patients' choices in relation to their circumstances- that it awards a sense of control over the situation for some? Or that it is a form of hastening death when medicine is unable to provide such means? Or that we feel it is a failure on our part to provide compassionate

care that led to such decisions, or the failure to foresee and prevent, and is not to be publicised?

Conclusions

The dearth in suicide statistics needs to be remedied along with an examination of palliative healthcare professionals' attitudes towards suicide among their patient group. The results may demonstrate how suicide is currently managed and can highlight differences in ideas that exist within the profession that may stimulate debate. It can help to explain why such numbers have not been collected with as much as enthusiasm as that of suicidal ideation or thoughts of hastened death.

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Footnote

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References

1. Grzybowska P, Finlay I. The incidence of suicide in palliative care patients. Palliat Med. 1997;11:313-6.
2. Ripamonti C, Filiberti A, Totis A, et al. Suicide among patients with cancer cared for at home by palliative-care teams. Lancet 1999;354:1877-8.
3. Moss Z. A Hidden Problem: Suicide By Terminally Ill People. 15th October 2014. Dignity in Dying. London 2014.
4. Price A, Lee W, Goodwin L, et al. Prevalence, course and associations of desire for hastened death in a UK palliative population: a cross-sectional study. BMJ Support Palliat Care 2011;1:140-8.

