Dealing with the dying patient

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Remember

- Openly acknowledge that you cannot cure the patient's disease, but that you (and the patient and family) can do a lot to manage this final stage of the illness.
- Set clear and practical goals to control symptoms and support activities of daily living. People like to have a plan.
- Death is a taboo subject. There may be pressure on both doctor and patient not to mention the 'D' word. No patient should be denied the knowledge that he or she is dying. Any desire from the family to keep the patient in the dark should be sensitively overruled. A family conference may do much to explore and deal with family fears.
- Do not assume that the patient knows that he or she is dying and that the specialists will have dealt with the 'prognosis issue'. Some specialists are still less than frank about death. Even when patients have been told that they will die, they will often not remember being told. The prognosis issue goes on being an issue after the patient is made aware of it.
- Dealing with dying patients will often bring up our own fears about mortality. Death is unpleasant and most of us would rather avoid the whole topic. Try to be aware of this and not let it interfere with the consultation.
- Acknowledge spiritual challenges if appropriate.
- Three psychological syndromes are common in the dying patient: depression, anxiety and delirium. These cause a deal of distress to the patient and family. They must be recognised and addressed.

Assessment

- Most people cope with their impending death without either overwhelming anxiety or depression. Be wary of dismissing psychological symptoms with 'If I were in his position I'd feel like that too'.
- In this population, the biological symptoms of depression (loss of appetite, weight loss, sleep disturbance, concentration difficulties) are of less value than usual. Ask the patients if they feel they are depressed. Are they depressed all the time (or nearly all the time)? If you could wave a magic wand and cure their disease, would that make everything all right?
- A request to die early or to be killed should be regarded as a strong indicator of depression or other reversible distress. 'Rational' requests to be killed do occur but are quite uncommon.
- Look for symptoms of anxiety, such as agitation, sweating, restlessness, hyperventilation and panic attacks. Take care to differentiate these from a drug reaction or delirium.
- Delirium presents as an acute and fluctuating change in cognition and the ability to focus attention. Patients may be hyperactive or hypoactive and there is usually a reversal of the sleep–wake cycle.
- Delirium is usually due to a number of factors. Common causes include: the underlying disease, hypoxia, drugs, infection and metabolic problems due to organ failure.
- Opiates and benzodiazepines may be associated with delirium or depression. Reaction to centrally acting antiemetics, such as metoclopramide, may present as anxiety or restlessness, as may withdrawal from drugs like benzodiazepines, opiates and nicotine.

Management

- In most cases, simple support and good symptom management will meet the patient's psychological needs.
- You should become part of a management team that includes palliative care physicians, hospital and community nurses, social workers, grief counsellors,

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and pastoral care workers or chaplains.

- Give the patient as much control over management as he or she wishes. Many patients wish to remain at home as long as possible. When this is the case, you should try to facilitate it, bearing in mind the limits of the family's resources, the team's resources and your own.
- Take the time to listen to your dying patients and to understand the fears contributing to their distress. Many patients are not so worried about being dead so much as how they will get there. An honest, gentle discussion about modes of death may do much to diffuse anxiety. Patients also worry about how those left alive will cope. This issue is particularly intense for patients with young children. It too should be openly addressed with the patient and family.
- Avoid anxiolytics unless no other management strategy is available or effective. If anxiolytics are required, use benzodiazepines, preferably in a short course. Long acting benzodiazepines, such as diazepam (Antenex, Diazemuls, Ducene, Valium) are usually preferable unless the patient has hepatic impairment.
- If antidepressants are required, consider the selective serotonin reuptake inhibitors (SSRIs) – in regimens similar to those in other patients. Watch for drug–drug interactions with the SSRIs.
- The delirium may respond to simple environmental measures, such as family presence, consistent staff, good lighting, uncluttered surroundings, and access to reading glasses and hearing aides.
- Try to remove or to modify some of the underlying causes of the delirium. Hypoxia can be eased by supplemental oxygen in the home. Simple subcutaneous fluids (0.9% normal saline, 500 to 1000 mL/24 hours) can help dehydration. If opiates are thought to play a large part in the delirium, try changing to a different opiate, but take care not to diminish pain control.
- If delirium persists and is distressing, consider using small doses of haloperidol (Serenace) – such as, 0.5 to 2 mg orally or subcutaneously once or twice daily. If agitation continues, as it may in the persistent restless terminal stage of the illness, benzodiazepines may be added as well.
- Managing the family's distress will help the patient immeasurably.
- Young children of the dying person should be sensitively handled, to the limit of their understanding. They should not be left completely in the dark. Most likely, they will have already guessed that something is badly wrong and may be blaming themselves for their parent's illness.
- The relationships established with the family at this stage of a patient's illness will provide an entrée to allow you to provide or co-ordinate whatever support the family may need after the death. MT