Helping a patient with suicidal ideation: an ethical perspective

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"To be or not to be" is a well-known monologue from Shakespeare's play *Hamlet*. The monologue reflects the internal mental conflicts that many people face in complex situations. Although we are not all protagonists of a play, everyone faces plenty of ethical dilemmas in their daily life. Ethical dilemma occurs when a moral problem involving two or more mutually exclusive, morally correct actions.[1] Indeed, healthcare practitioners also face plenty of ethical dilemmas in practice. It is crucial for healthcare practitioners to have a mindset that is legal, ethical, and socially responsible,[2] because their decisions influence the outcome. Very often healthcare practitioners and patients have different perspectives of views on the same issue. Bioethics is a set of moral principles that practitioners should follow, but these principles can conflict with patient autonomy. An example case[3] has been selected from the literature because it provides an example of a common encounter of ethical dilemma in clinical practice (Box).

Autonomy or beneficence

The patient in this example (Mr X) unintentionally placed the nurse in an ethical dilemma. When Mr X disclosed the suicidal ideation (SI), the nurse had two morally correct choices: conceal the truth or report the SI. Concealing the truth would respect the patient's autonomy; however, this violates the code of ethics for nurses. Reporting the SI to members of the team not providing direct care to the patient would comply with the beneficence principle, or 'duty to warn'. This principle is an obligation for healthcare practitioners to warn the potential victim if a patient reports an intention to cause imminent danger or harm. However, reporting the SI would violate the patient's autonomy and breach patient confidentiality, and this is particularly so in the Hong Kong setting. The dichotomy between patient autonomy and beneficence leads to a dilemma. Neither can be chosen without violating the other.

Autonomy refers to the right of the patient to make independent decisions for their care. Healthcare professionals should respect patient decisions without influencing or interrupting.[4] Beneficence is the obligation of healthcare professionals to act for the benefit of the patient and to remove conditions that cause harm,[5] and to enhance patient health and well-being. In addition to these two principles, non-maleficence should also be considered. Non-maleficence is the obligation of healthcare professionals to 'do no harm' to the patient through negligence.[6]

It is a sophisticated decision to choose between autonomy and the beneficence. Placing a priority on identifying whether Mr X had the ability to make an appropriate decision was required. Patients with cancer are more likely to have very strong psychological reactions, including suicide attempts[7] or making "irresponsible" decisions that induce severe consequences. In this situation, healthcare professionals must override patient autonomy.[8] Mental assessment and physical examination can identify whether the patient can make informed and appropriate decisions. If mental disorders or unstable emotional conditions are diagnosed, practitioners must guide them back to the right track by good clinical practice and offer coordinated care. To avoid unnecessary harm, the nurse should pick beneficence and non-maleficence in this situation. Choosing to conceal the secret would satisfy Mr X but could lead to traumatic consequences for Mr X's family and potentially even the healthcare providers involved. Choosing to tell the truth would satisfy his family and healthcare providers. The family members could spend more time with Mr X, and the healthcare providers could fulfil their duty. Therefore, reporting the secret is considered the more ethical choice, despite going against the wishes of the patient.

BOX. Example case[3]

The patient was a 57-year-old man with aggressive prostate cancer. He was diagnosed with prostate cancer but refused treatment and did not have urology follow-up examination for 7 years. Subsequently, anaemia and hypoproteinaemia emerged. After examinations, it was found that the cancer had metastasised to the bones and lymph nodes, and a primary tumour found in his bladder was partially obstructing the left kidney. It was suggested that the patient might have only around 4 to 6 weeks to live. Surgical or medical interventions would not be applicable in this situation, and palliative care regimen was the only option. The patient was disheartened over his terminal condition and contemplated suicide. He confided to the nurse-in-charge that he was planning to commit suicide and asked the nurse to keep it a secret.

Evaluation and treatment of patients with suicidal ideation

Some patients with terminal illnesses have the desire for hastened death, and some request assisted suicide or exhibit signs of suicidal ideation (SI).[9] Suicidal ideation is correlated with psychiatric disorders that adversely affect the patient's emotional and psychological behaviour.[10] Patients with cancer have higher prevalence of psychiatric disorders.[11] Despite the high prevalence, <50% of cancer patients with psychiatric disorders are identified and assigned the appropriate care.[11] Thus, it was fortunate that Mr X was willing to express SI to the nurse. Symptom assessments and psychological care in palliative care are warranted. The patient's psychiatric symptoms or stressors should be identified before they manifest.

Patients with end-of-life illnesses often experience severe pain and anxiety, leading to psychological distress. However, psychological support is insufficient in most cases. Under the intense working environment in the medical ward, medical practitioners often focus more on clinical treatments rather than supportive care such as recognising the patient's needs and relieving the anxiety of the patient and their family. Furthermore, management and training in palliative care and end-of-life care are often neglected in medical education,[12] and this remains the case in Hong Kong. Psychiatric symptoms or even SI are often overlooked.

There are noticeable differences between common clinical care and palliative care, which is more holistic. In addition to the traditional components of clinical assessment, palliative care includes four unique domains: physical, psychological, social and family, and spiritual. Clinical knowledge and skills are the focus of medical training programmes, but the beliefs and values that underpin professional medical practice are seldom addressed. Owing to societal norms in Hong Kong, patients are reluctant to discuss the topic of "dying" openly with their physicians. Gaps are found in medical assessment in palliative care patients.[13] To alleviate the issue, more training in palliative care, end-of-life issues, and ethical principles, should be included in the curriculum for medical training.

Palliative care is patient- and family-centred care.[14] Families and family caregivers can play a significant role in providing support and encouragement. This can help the patients to redefine themselves, and eventually improve their physical status and intrapersonal features. Furthermore, patients are more willing to talk with family members instead of practitioners, improving the possibility of identifying any abnormalities in the patient's mental and physical condition.

Conclusion

Practitioners' decisions and actions affect patients' lives and care. It is important for practitioners to assess which action is most appropriate for the situation, even where there are two or more morally correct approaches. Practitioners must be responsible for the choices they make, and should refer the patient to relevant services to support their decisions. They should refer to and analyse the code of ethics and related literature before making ethical decisions.

Author contributions

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Analysis or interpretation of data: Both authors.
Drafting of the manuscript: SHL Ho.
Critical revision of the manuscript for important intellectual content: Both authors.

Both authors had full access to the data, contributed to the study, approved the final version for publication, and take responsibility for its accuracy and integrity.

Conflicts of interest

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