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Author

Strouse, Thomas

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Palliative Medicine and Psychiatry: A Reply

Thomas Strouse, MD

Dear Editor:

In the April edition of this journal, Sandy Macleod, a New Zealander who is both a psychiatrist and palliative care physician, outlines why psychiatric skills and knowledge—and, at least ideally, psychiatrists—are important in the landscape of caring for patients, families, and clinicians coping with catastrophic medical illness and death.¹

His argument seems straightforward. Not only are psychiatrists experts in assessing and treating the “ordinary” psychiatric components of advanced medical illness, such as problems with mood, anxiety, coping, and delirium; Macleod also posits that the neuropsychiatry of palliative care patients has become more complicated as a function of treatment advances that extend survival but may also be associated with greater central nervous system toxicity and longer periods of time for patients to experience existential uncertainties. However, Macleod’s praise of psychiatric expertise in palliative care is faint: although the circumstances he outlines might call for more psychiatrists rather than fewer, his view is that they are too scarce in palliative care clinical settings to do much good: “The relevant knowledge and skills obtained from the discipline of psychiatry are not, and will never be, delivered by its expert practitioners in a palliative care unit.” And therefore his view is that nonpsychiatrist palliative care docs need to develop skills to make up for psychiatrists’ absence.

Too fatalistic? Perhaps. Psychiatrists have labored at the interface of medicine and psychiatry for decades, and there is reason to be optimistic that their presence will grow. This work is central to the field of consultation/liaison psychiatry,² psycho-oncology,³ and hospice and palliative medicine.⁴ Forty years ago the British psychiatrist Colin Murray Parkes was instrumental in early efforts to demonstrate improved outcomes for hospice enrolled patients and their survivors, as well as the safety and efficacy of the use of opioids, at St. Christopher’s Hospice in London.⁵ The American psychiatrist William Lamers founded the Hospice of Marin in Northern California and was instrumental in introducing palliative care content into medical school curricula.⁶ Jimmie Holland’s pioneering work in the field of psycho-oncology now includes a three decades old psycho-oncology fellowship training program that is closely linked with palliative care training at MSKCC;⁷ a comprehensive textbook of psycho-oncology now in its second edition;⁸ and nationally endorsed evidence-based treatment guidelines for cancer-related distress⁹ and has

spawned second and third generations of psycho-oncologists who invent new approaches, some of which Macleod mentions in his editorial. The Institute for Palliative Medicine at San Diego Hospice recently chartered the first palliative care psychiatry fellowship program in the United States.¹⁰

In addition to a history rich with clinical and scholarly collaboration by psychiatrists with other physicians in the palliative care setting, two new forces may work in favor of greater psychiatrist presence in the future. The first is the growing evidence that supports “integrated care” for the management of psychiatric disorders co-occurring with medical illnesses.¹¹ Medically ill patients with comorbid psychiatric problems tend to do better both medically and psychiatrically, while consuming fewer health care dollars, when their mental health care is provided in the medical setting. Health care delivery organizations that are accountable for the care they provide understand this more positive outcome, and are making it a priority to embed sophisticated behavioral health services into primary care—an approach that many progressive cancer care delivery systems have been practicing for years.¹² The second factor is impending health care reform in the United States. Health systems will need to adopt deliberate, quantitative, population-based strategies to care for the millions of newly insured patients who are likely to be seeking services. These strategies will necessarily include building and expanding palliative care and behavioral health/psychiatric consultation services, since both disciplines have repeatedly demonstrated their value in improving care and lowering costs.

A related “leading edge” trend is the evolution of the clinical role of the psychiatrist/psycho-oncologist into that of a more fully formed palliative care physician. The interrelatedness of psychological distress or frank psychiatric disorder with physical aspects of advanced medical illness are optimally evaluated and treated by physicians with both interest and expertise in these related areas. Just when primary oncologic physicians are most inclined to be “splitting,” the psychiatrist/psycho-oncologist-palliative care physician is “lumping”—by remaining clinically present, and by defining as broadly as possible the scope of symptoms and problems he or she will attend to as the emphasis moves away from disease-modifying treatments and on to relief of suffering and improving quality of life.

Psychiatrists trained in the last 30 years generally possess the “standard equipment” needed to function well as palliative

care physicians. Those attributes include interpersonal skills, group leadership experience, the capacity for clinically effective empathy, the ability to tolerate intensely painful affects in oneself and others, good collegial communication abilities, cognitive expertise in the interactions between medical and psychiatric illness, psychopharmacology skills, and physical diagnosis skills. This multidimensional role is not for psychiatrists who “fled the physically sick early in their careers,” as Macleod puts it in his editorial. But it is ideal for the psychiatrist who seeks to enhance his core identity as a physician even as he or she focuses on a specialty involving brain and mind. The emerging palliative care physician must maintain current knowledge about contemporary treatment of malignant diseases, advanced heart failure, neurodegenerative diseases, and the other illnesses afflicting the majority of patients who are referred to palliative care and hospice programs, and to develop expertise in pain management and the assessment and management of other common physical symptoms. These skills can be obtained in formal postgraduate palliative care fellowship training programs,¹³ “on the job” from mentors/colleagues, from a variety of excellent handbooks and textbooks, at CME courses, and through membership in any number of organizations dedicated to palliative care, including the American Pain Society, the American Academy of Hospice and Palliative Care Medicine, and others. A register of the approximately 100 Accreditation Council on Graduate Medical Education (ACGME)-approved Hospice and Palliative Medicine (HPM) fellowship training programs in the United States is available at the ACGME website.

In a recent history well known to most readers of this journal, the American Board of Medical Specialties granted subspecialty status to hospice and palliative medicine in 2006. The first certifying exams were offered in 2008, a collaborative work product of the American Board of Internal Medicine and the nine other parent boards whose diplomats are potential candidates to sit for the HPM exam (surgery, emergency medicine, pediatrics, family medicine, psychiatry/neurology, anesthesiology, physical medicine and rehabilitation, obstetrics and gynecology, and radiology). To date, 58 psychiatrists and 41 neurologists have achieved HPM subspecialty certification (personal communication); efforts are now underway to survey how they are spending their clinical time (personal communication). The grandfathering era which permitted individuals with demonstrated clinical expertise to sit for the exams despite a lack of formal fellowship training has now expired; as a result, all future applicants for exam seats will need to demonstrate successful completion of a one-year postgraduate HPM fellowship program. It remains to be seen whether psychiatry and neurology candidates will compete for those fellowship positions and thus pursue formal HPM subspecialty certification.

Hospice/palliative medicine and psychiatry have both occupied what Macleod describes as a “somewhat outcast position” in the family hierarchy of contemporary Western medicine, although perhaps for different reasons. HPM, often associated with end-of-life situations, seemed at odds with the mid-20th-century Western cultural fixation with

the high-tech “war against disease” and its attendant stigmatization of the losers of that war;¹⁴ psychiatry, meanwhile, seemed too soft, not scientific enough, and linked with one of the few things as fearsome as mortality—mental illness. As all palliative care clinicians know, our society is only just now ambivalently making its way towards acknowledging that death is the natural outcome of life. Psychiatrist palliative care clinicians are ideally suited to help us along the way.

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Address correspondence to:
Thomas Strouse, MD
757 Westwood Plaza
Room 4230B
Los Angeles, CA 90095

E-mail: tstrouse@mednet.ucla.edu