VCU Palliative Care ECHO*

January 27, 2020

Severe depression at the end of life: is mental illness ever a terminal disorder?

*ECHO: Extension of Community Healthcare Outcomes

Continuing Medical Education

January 27, 2020 | 12:00 PM | teleECHO Conference

Physicians: VCU Health Continuing Medical Education is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. VCU Health Continuing Medical Education designates this live activity for a maximum of 1 ***AMA PRA Category 1 Credits™.***

Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Continuing Nursing Education: 1 CE Contact Hours

VCUHealth is approved as a provider of continuing nursing education by the Virginia Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

Disclosures

January 27, 2020 | 12:00 PM | teleECHO Conference

In compliance with the Accreditation Council for Continuing Medical Education (ACCME) *Standards for Commercial Support of CME*, VCU Health Continuing Medical Education discloses all relevant relationships which program faculty and planners report having with "any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients." VCU Health Continuing Medical Education has procedures to resolve any apparent conflicts of interest.

The following Planning Committee and Presenting Faculty Members report relevant financial relationships to disclose:

The following Planning Committee and Presenting Faculty Members report having no relevant financial relationships:

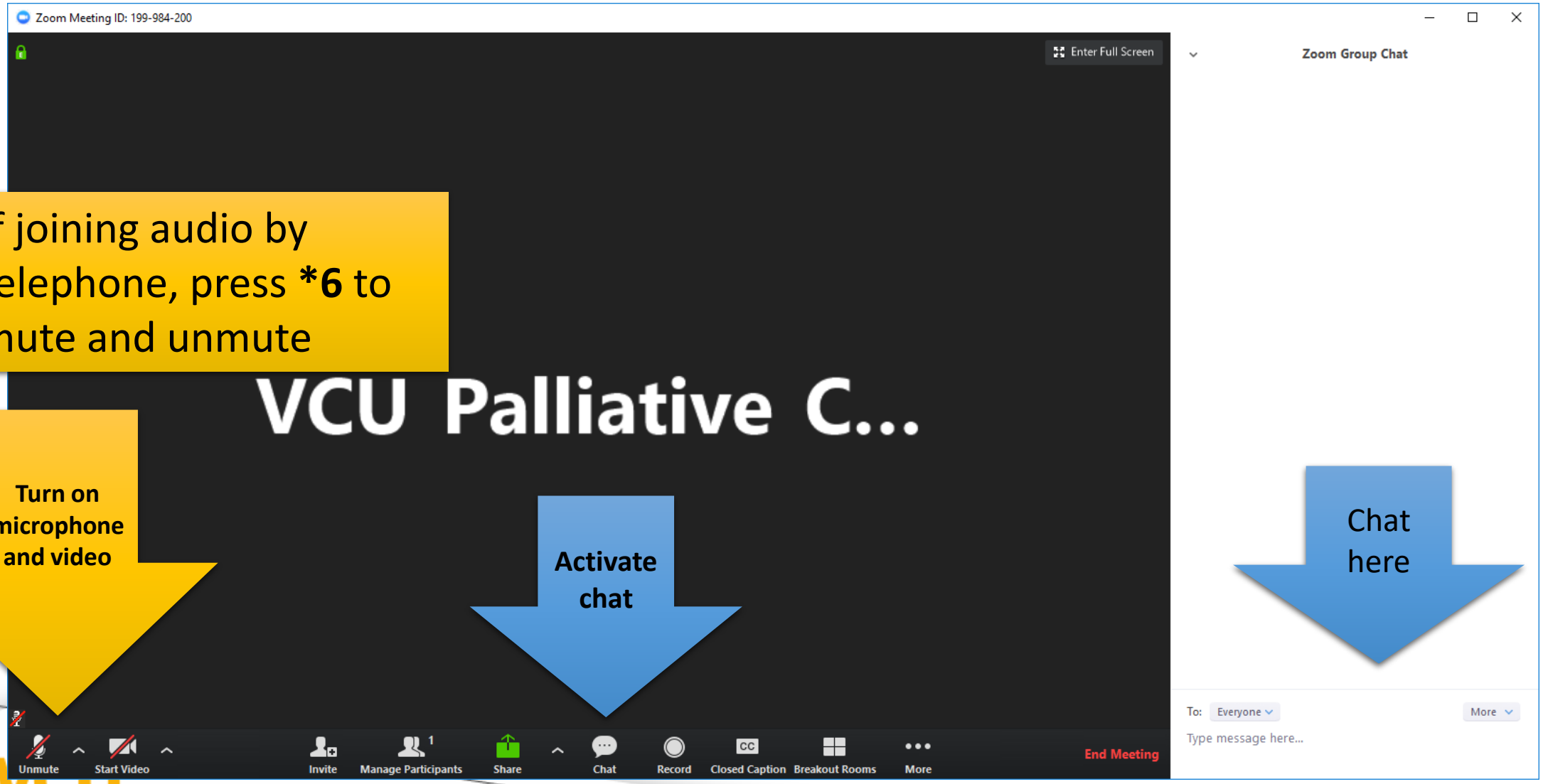
Danielle Noreika, MD

Paul Zelensky, MD

No commercial or in-kind support was provided for this activity

Share your name

Audio and Chat



If joining audio by telephone, press ***6** to mute and unmute

Turn on microphone and video

Activate chat

Chat here

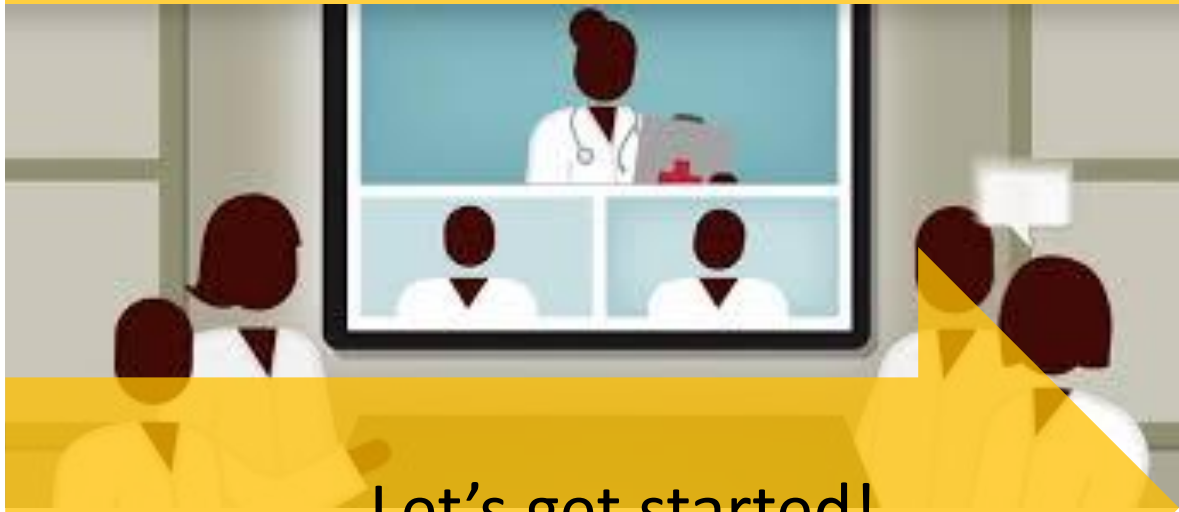
What to Expect

I. Didactic Presentation
   - Questions and discussion

II. Case Discussion
   - Case Presentation
   - Clarifying questions from spokes, then hub
   - Recommendations from spokes, then hub
   - Summary (hub)

III. Closing and Questions

- Monthly tele-ECHO sessions (1 hour)
- Didactic presentations developed by inter-professional experts in palliative care
- Website: www.vcuhealth.org/pcecho
- Email: pcecho@vcuhealth.org



Let's get started!

Our ECHO Team: Planning Committee

Clinical Leadership	**Egidio Del Fabbro, MD** VCU Palliative Care Chair and Program Director **Danielle Noreika, MD, FACP, FAAHPM** Medical Director/Fellowship Director VCU Palliative Care
Clinical Experts	Candace Blades, JD, RN – Advance Care Planning Coordinator Brian Cassel, PhD – Palliative Care Outcomes Research Jason Callahan, MDiv – Palliative Care Specialty Certified Felicia Hope Coley, RN – Nurse Navigator Diane Kane, LCSW – Palliative Care Specialty Certified Tamara Orr, PhD, LCP – Clinical Psychologist
Support Staff	
Program Managers	Teri Dulong-Rae & Bhakti Dave, MPH
Telemedicine Practice Administrator	David Collins, MHA
IT Support	Frank Green

Introductions

Severe depression at end of life:

Is mental illness ever a terminal disorder?

Paul Zelensky, MD

Hospice and Palliative Medicine Fellow, Class of 2020

How much is too much?

Palliative care in refractory mental illness

Paul Zelensky, MD

Danielle Noreika, MD

Egidio DelFabbro, MD

Objectives:

- Describe a case of an elderly patient with treatment refractory depression and an advanced directive limiting care
- Define the challenges of determining life limiting illness in the setting of severe persistent mental illness
- Recognize the limitation of advanced directives in patients with mental illness

Case description

- 84 yof, pmhx of recurrent major depressive disorder, with psychotic features, prior CVA, presents from nursing home for not eating or drinking and refusing her medications, stating she “only wants to talk to hospice”

- Psychiatry admitted patient under temporary detention order (TDO) for treatment of depression, psychosis, and further assessment of suicide risk.

- Patient later placed on FMO/FTO, which included receiving electro-convulsive therapy (ECT) treatment 1-2 times/week.

Case Continued

- Long history of severe depression with multiple admissions for intensive ECT and maintenance ECT inbetween
- Patient not suicidal but expressed passive death wish
- Palliative care consulted secondary to patient request for hospice referral
- Due to lack of PO intake, court ordered dobhoff tube and artificial feedings were initiated

Case Concluded

- ECT discontinued after stroke during admission
- Dobhoff tube became clogged, was discontinued, palliative care recommended against PEG placement, recommended trialed on PO feeds
- GI evaluated patient, and did not offer PEG placement, as they felt risks outweigh benefits
- Psychiatry service in contact with husband over the course to discuss course and consider options over time
- After some improvement in PO intake and activity level patient was eventually transferred to long term geriatric psychiatry facility

Questions Discussed in this Case

- Hospice referral-–the original question—she did not qualify
  - CVA was not severe enough previously or during this hospitalization
  - No other known medical issues
  - Depression is not a terminal diagnosis that qualifies for hospice
  - Even if hospice aligned with some other life limiting illness, would have obviated trial of ECT
  - Weight, even prior to initiation of artificial nutrition, was not in the malnutrition category

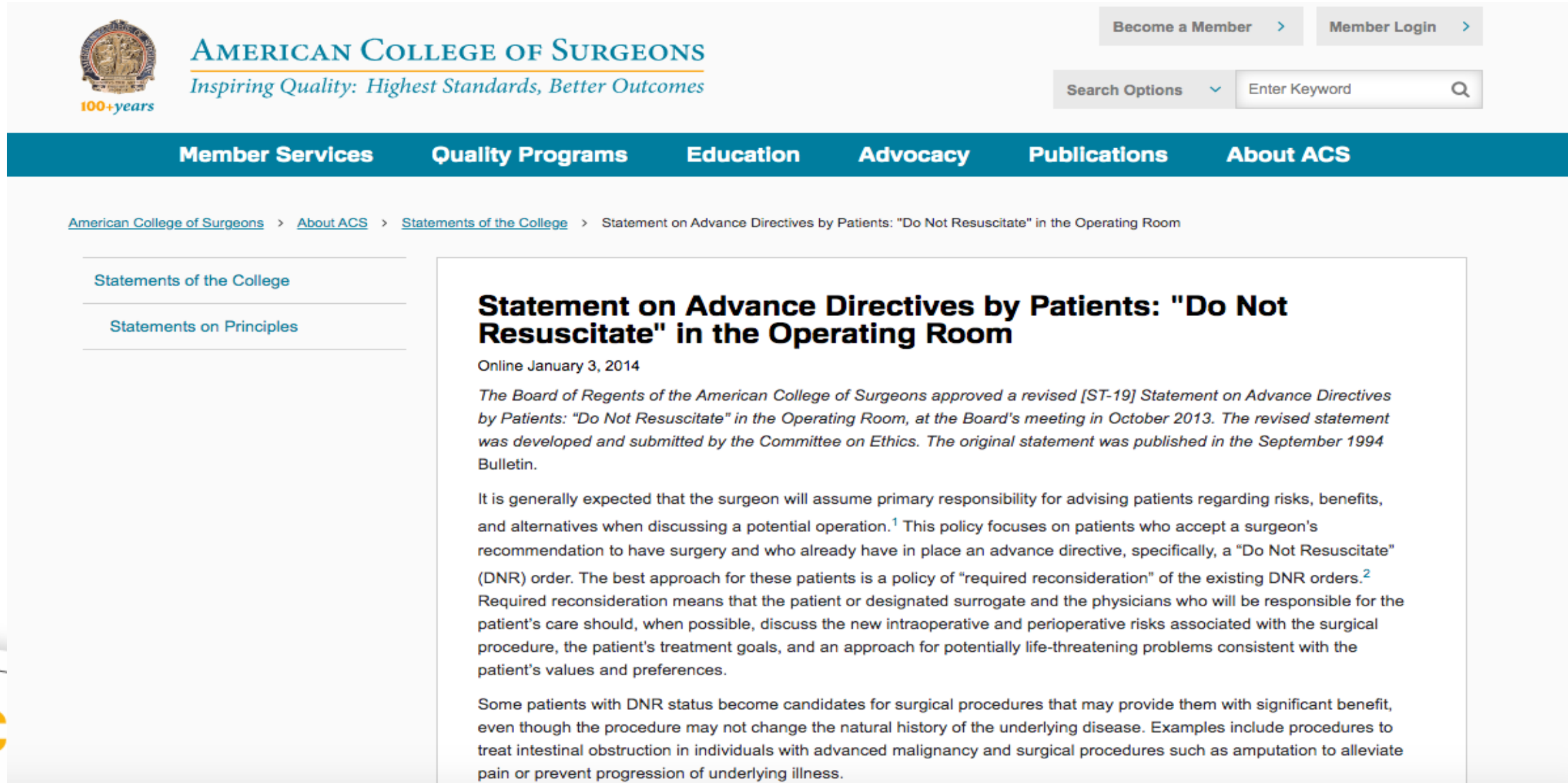
Should this patient have been DNR? If so, who should sign the order? Also—recommendations for code status during ECT?

Capacity?

Patients with psychiatric illness do not automatically lose medical decision-making capacity.[3,8,9] Some do have difficulty understanding their illness and appreciating options for care,[10] but most are very capable of making medical decisions[11,12] and have as much of a right to refuse care as other patients. Like everyone else, however, psychiatric patients must base that refusal on something, on some analysis of benefits and burdens or appreciation of risks and consequences. Patients may not like the way a medication makes them feel; they may not want to be tied down to treatments that limit daily activities. These may be acceptable reasons, but psychiatric illness does not free patients from their responsibility to make thoughtful medical decisions. While their reasons do not have to be yours or ours, they must be part of a deeply held and stable part of their personality—not a temporary reaction to news that they cannot understand or assimilate.

Tunzi M, et al. *Prim Care Companion CNS Disord.* 2014.

Peri procedural DNR?



AMERICAN COLLEGE OF SURGEONS
Inspiring Quality: Highest Standards, Better Outcomes
100+years

Become a Member › Member Login ›

Search Options Enter Keyword

Member Services | Quality Programs | Education | Advocacy | Publications | About ACS

American College of Surgeons › About ACS › Statements of the College › Statement on Advance Directives by Patients: "Do Not Resuscitate" in the Operating Room

Statements of the College
Statements on Principles

Statement on Advance Directives by Patients: "Do Not Resuscitate" in the Operating Room

Online January 3, 2014

The Board of Regents of the American College of Surgeons approved a revised [ST-19] Statement on Advance Directives by Patients: "Do Not Resuscitate" in the Operating Room, at the Board's meeting in October 2013. The revised statement was developed and submitted by the Committee on Ethics. The original statement was published in the September 1994 Bulletin.

It is generally expected that the surgeon will assume primary responsibility for advising patients regarding risks, benefits, and alternatives when discussing a potential operation.[1] This policy focuses on patients who accept a surgeon's recommendation to have surgery and who already have in place an advance directive, specifically, a "Do Not Resuscitate" (DNR) order. The best approach for these patients is a policy of "required reconsideration" of the existing DNR orders.[2] Required reconsideration means that the patient or designated surrogate and the physicians who will be responsible for the patient's care should, when possible, discuss the new intraoperative and perioperative risks associated with the surgical procedure, the patient's treatment goals, and an approach for potentially life-threatening problems consistent with the patient's values and preferences.

Some patients with DNR status become candidates for surgical procedures that may provide them with significant benefit, even though the procedure may not change the natural history of the underlying disease. Examples include procedures to treat intestinal obstruction in individuals with advanced malignancy and surgical procedures such as amputation to alleviate pain or prevent progression of underlying illness.

What are next steps months into ECT course with continued challenges with artificial feeding? PEG tube?

How does the advance directive apply in this circumstance?
What if she has an undiagnosed neurocognitive disorder in addition to severe depression?

Patient's Advance Directive

- If at any time my attending physician, and a second physician or licensed clinical psychologist, after personal examination, determine in writing that I have a terminal condition where the application of life prolonging measures would serve only to artificially prolong the dying process I direct that, with the consent of my agent, such procedures be withheld or withdrawn and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort, care, or alleviate pain.
- A terminal condition means a condition caused by injury, disease or illness from which to a reasonable degree of medical probability I cannot recover and either: (i) my death is imminent or (ii) I am in a persistent vegetative state.

Patient's Advance Directive

- When the conditions in Paragraph A have been met, and the primary life prolonging procedure is the artificial administration of food and water by gastric tube, intravenously, percutaneously or otherwise, I direct that Nutrition and Hydration (food and water) be withheld or withdrawn from me.
- AD executed 2016

VIRGINIA ADVANCE DIRECTIVE SUPPLEMENT FOR MENTAL HEALTH CONDITIONS

I, _____, willingly and voluntarily
Printed Name of Individual Making This Supplement for Mental Health Care (Declarant)

make known my wishes in the event that I am incapable of making an informed decision about my health care. This document is intended to supplement my advance directive for health care, which I executed on _____.
Insert Date

This document includes specific instructions to govern my health care if I am experiencing a mental health crisis.

I: SPECIAL POWERS OF MY AGENT TO AUTHORIZE HEALTH CARE OVER MY OBJECTION

This section includes my specific instructions about my health care if I am objecting to health care that my health care agent and my physician believe I need.

(CROSS THROUGH ANY POWERS YOU DO NOT WANT TO GIVE YOUR AGENT.)

The powers of my agent shall include the following:

1. To authorize my admission to a health care facility for the treatment of mental illness as permitted by law, even if I object.

2. To authorize other health care that is permitted by law and that my health care agent and my physician believe I need, even if I object. This would include any type of health care unless I have indicated otherwise by my specific instructions written in this document, in my advance directive, or in the space below.

❒ I do not authorize these specific types of health care:

_____

_____

[TO GIVE YOUR AGENT ANY OF THE POWERS SET FORTH ABOVE, YOUR PHYSICIAN OR LICENSED CLINICAL PSYCHOLOGIST MUST SIGN THE STATEMENT IN THE BOX BELOW.]

I am a physician or licensed clinical psychologist familiar with the person who has made this advance directive supplement for health care. I attest that he or she is presently capable of making an informed decision and that he or she understands the consequences of the special powers given to his/her agent by this Section I of this advance directive supplement.

_____
Physician or Licensed Clinical Psychologist Signature — Date

_____
Physician or Licensed Clinical Psychologist Printed Name and Address

II: ADDITIONAL MENTAL HEALTH CARE INSTRUCTIONS, IF ANY

([IF YOU WANT TO GIVE ADDITIONAL INSTRUCTIONS ABOUT YOUR MENTAL HEALTH CARE, YOU MAY DO SO HERE. YOU MAY USE THIS SECTION TO DIRECT YOUR MENTAL HEALTH CARE EVEN IF YOU DO NOT HAVE AN AGENT. IF YOU DO NOT GIVE SPECIFIC INSTRUCTIONS, YOUR MENTAL HEALTH CARE WILL BE BASED, TO THE EXTENT ALLOWED BY LAW, ON YOUR VALUES AND WISHES, IF KNOWN, AND OTHERWISE ON YOUR BEST INTERESTS.]

A. I specifically direct that I receive the following mental health care if it is medically appropriate:

_____

_____

B. I specifically direct that I not receive the following mental health care:

_____

_____

C. [INSTEAD OF WRITING INSTRUCTIONS ON THIS FORM, YOU MAY DIRECT THAT YOUR MENTAL HEALTH CARE BE PROVIDED IN ACCORDANCE WITH A CRISIS PLAN. IF YOU HAVE PREPARED A CRISIS PLAN, CHECK THE FOLLOWING BOX AND ATTACH THE CRISIS PLAN TO THIS DOCUMENT.]

❒ I direct that my care be provided in conformity with the preferences I have expressed in the accompanying crisis plan to the extent authorized by law.

AFFIRMATION AND RIGHT TO REVOKE: By signing below, I affirm that I understand this advance directive supplement for mental health care and that I am willingly and voluntarily executing it. I also understand that I may revoke all or any part of it at any time as provided by law.

_____
Date — Signature of Declarant

The declarant signed the foregoing advance directive in my presence. [TWO ADULT WITNESSES NEEDED]

Witness Signature _____ Witness Printed _____

Witness Signature _____ Witness Printed _____

NOTE: THIS ADVANCE DIRECTIVE SUPPLEMENT FOR MENTAL HEALTH CARE SHOULD BE KEPT WITH YOUR GENERAL ADVANCE DIRECTIVE.

If you have legal questions about this form or would like to develop a different form to meet your particular needs, you should talk with an attorney. It is your responsibility to provide a copy of your advance directive to your treating physician. You also should provide copies to your agent, close relatives and/or friends. For information on storing this advance directive in the free Virginia Advance Health Directive Registry, go to http://www.VirginiaRegistry.org. ▲❋❋

Is there a point at which continued ECT and medication therapy can be considered “failed” where burdens may outweigh benefits?

ANZJP

Australian & New Zealand Journal of Psychiatry
1–15
DOI: 10.1177/0004867419839139

© The Royal Australian and New Zealand College of Psychiatrists 2019
Article reuse guidelines:
sagepub.com/journals-permissions
journals.sagepub.com/home/anp
SAGE

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Royal Australian and New Zealand College of Psychiatrists professional practice guidelines for the administration of electroconvulsive therapy

Alan Weiss[1], Salam Hussain[2,3], Bradley Ng[4], Shanthi Sarma[5], John Tiller[6,7], Susan Waite[8,9] and Colleen Loo[10,11]

The Royal Australian & New Zealand College of Psychiatrists

1) ECT is a very effective modality for refractory depression, especially in the elderly
2) Treatments must be consented to by the patient or courts
3) Patients must be anesthetized for the procedure
4) Side effects may include memory impairment
5) There is up to a 50% relapse rate
6) There is no mention of maximum doses or what to do if the treatments do not seem to be beneficial

VCU

Can mental health conditions be considered terminal illnesses?

Schizophrenia and end of life care

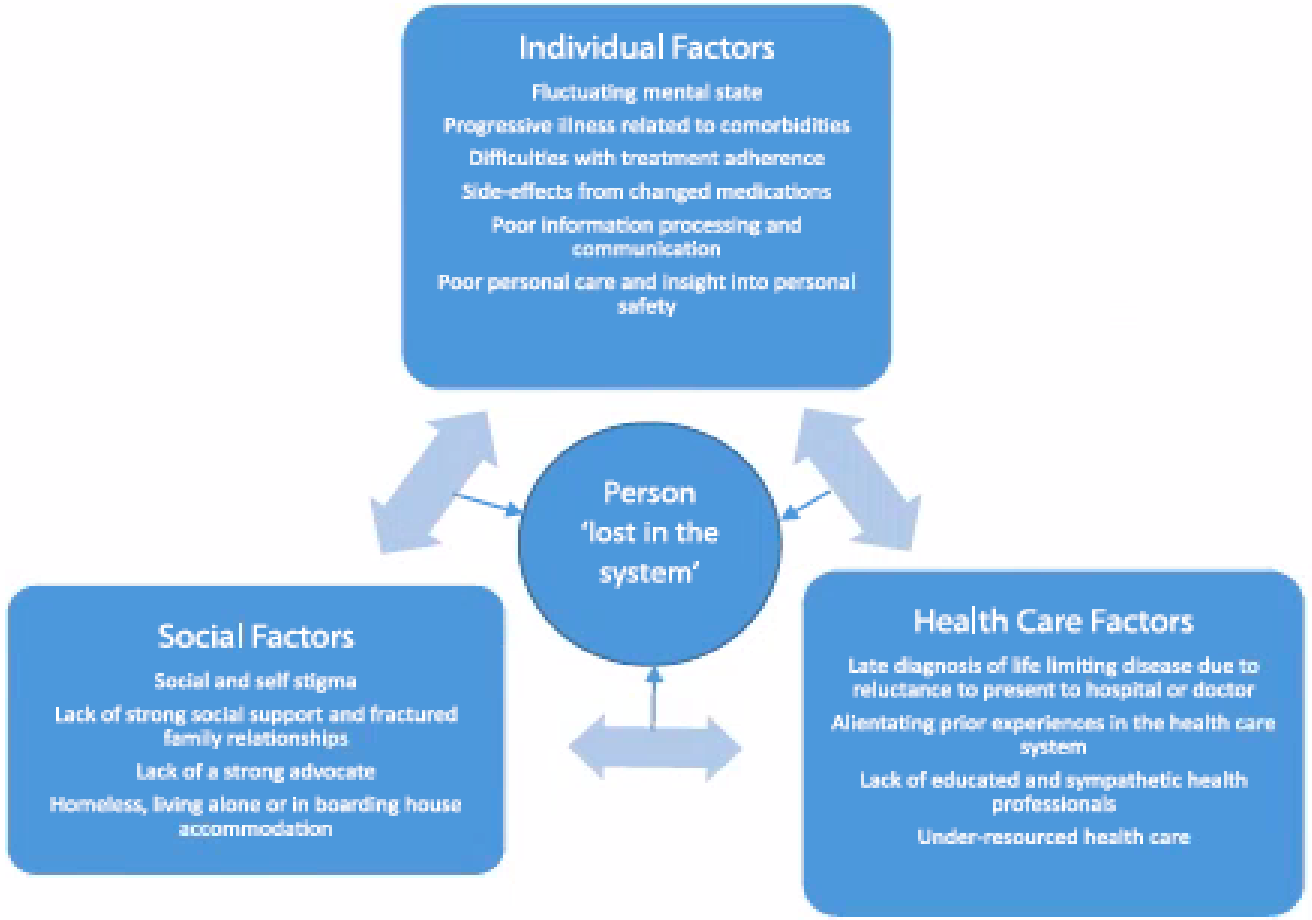


Fig. 1 The interrelationship between factors that may affect people with schizophrenia at the end of life

McNamara et al, *BMC Palliative Care,* 2018.

AMA Journal of Ethics
Illuminating the Art of Medicine

alive, because to Dr. C, any possibility of life is preferable to the finality of death? Is it appropriate for Dr. C, or anyone, to define death as a good or poor outcome for Ms. G and, if so, on which and on whose terms?

In my experience, for many seriously ill patients there often comes a time at which hope for a good outcome becomes the hope for a good death, for example, a peaceful death, or a death with as little pain as possible but, notably, a death under the control of the person dying [9]. Is it possible that this is what Ms. G wants? A good death for Ms. G might mean an end to her painful symptoms without causing others (her father, especially) pain. Dr. C's hoping Ms. G will change her mind could, once again, be indicative of countertransference. Dr. C's inability to accept Ms. G's death (and death wish) reflects Dr. C's feelings about the loss (or pending loss) of Ms. G, not Ms. G's readiness for death.

Perhaps an ethical way through for Dr. C lies in the consideration of Ms. G's condition as terminal. The difficulty here is elucidated by Michael F. Myers and Glen O. Gabbard in their book, *The Physician as Patient*:

> Most of medicine is palliative, except for certain infectious diseases and surgical procedures. Some outcomes are not preventable. Psychiatrists in particular may have difficulty accepting the idea that some psychiatric disorders in some patients are terminal [10].

George CE. *AMA Jour Ethics.* 2016.

“Palliative Psychiatry”?

Risks of a palliative approach to psychiatry

One possible reason for the current lack of explicitly palliative care directed at mental illness (especially SPMI) is the lack of consensus about the meaning of “futility” in this context. Despite the substantial body of literature on futility in somatic medicine [36], the concept has so far been discussed in relation to the treatment of mental illness only within the contexts of severe persistent anorexia nervosa and dementia [18, 37]. Lopez, Yager, and Feinstein [38], the first authors to link the terms “medical futility” and “psychiatry” in the title of an article, suggested the following criteria for treatment futility: (1) poor prognosis; (2) unresponsiveness to competent treatment; (3) continuing physiological and psychological decline; and (4) the appearance of an inexorable and terminal course. In our view, the discussion around futility in psychiatry can be substantially advanced by the development of evidence-based disease staging for mental illness, similar to those in cancer care [39]. For example, while duration of illness, previous treatment attempts, or level of associated disability must be taken into account, it “is clear that a 14 year old adolescent with a 3 month history of anorexia nervosa would present differently to a 40 year old woman who has battled the illness for 25 years with multiple hospital admissions and has attempted cognitive behaviour therapy several times” [40] (p. 1). At present, for even the most severe cases of mental illness, there is no consensus about how “advanced illness” might be conceptualized [18], and future research and discussion should address the extent to which the psychiatric profession is willing to discuss and accept such concepts.

Trachsel M, et al. *BMC Psychiatry*. 2016.

MAID: Challenges in Psychiatry

MAiD for non-terminal disorders is permitted in Belgium, the Netherlands, Luxembourg, and Switzerland. The literature on its use is small but building. Although psychiatric MAID is relatively uncommon, its use appears to be rising in Belgium and the Netherlands and for a diverse range of disorders and emotional states, including personality disorders and loneliness (2, 3). Concern has been expressed regarding the oversight of the assessment of eligibility, and from the exclusion of family from the process.

Whether MAiD is acceptable and ethically justifiable is controversial, especially so when the person requesting it is not terminally ill (4–6). In addition, there are concerns whether the capacity of a person with mental disorder to request MAiD can be valid for example where depression or psychosis may cause impairment in judgement. Most tests of competence to consent to medical treatment require that the person can "weigh" the information and "appreciate" consequences of their decision (7), yet the ability to do this may be impaired by the effects of mental disorder. Indeed, there are concerns that capacity is not reliably assessed before MAiD (8). Conversely, some view that attitudes are too paternalistic in assuming that people with mental disorder are unable to consent to MAiD (9). The American Psychiatric Association [APA (10)] and the Royal Australian and New Zealand College of Psychiatrists [RANZCP (11)] have considered and rejected the use of MAiD for people who request it for mental disorder. However, the consideration of mental illness as the primary indication for MAiD is likely to be encountered in more jurisdictions.

Jones RM, Simpson AI. *Front Psychiatry.* 2018.

The troubled 29-year-old helped to die by Dutch doctors

By Linda Pressly
BBC News, The Netherlands

9 August 2018

In January a young Dutch woman drank poison supplied by a doctor and lay down to die. Euthanasia and doctor-assisted suicide are legal in the Netherlands, so hers was a death sanctioned by the state. But Aurelia Brouwers was not terminally ill - she was allowed to end her life on account of her psychiatric illness.

"I'm 29 years old and I've chosen to be voluntarily euthanised. I've chosen this because I have a lot of mental health issues. I suffer unbearably and hopelessly. Every breath I take is torture…"

A team from the Dutch TV network, RTL Nieuws spent two weeks recording Aurelia as she journeyed towards her date with death - 2pm on Friday, 26 January. On a whiteboard in her home, she crossed off the days with a heavy black marker pen.

The NEW ENGLAND JOURNAL of MEDICINE

SUBSCRIBE OR RENEW

This article is available to subscribers. Subscribe now. Already have an account? Sign in

Perspective FREE PREVIEW

Physician-Assisted Suicide and Psychiatric Illness

Joris Vandenberghe, M.D., Ph.D.

In exceptional cases, suicide might be considered a rational choice of a competent person, even in the presence of psychiatric illness. But unless a truly rigorous prospective review system is in place for such cases, countries should not legalize the practice.

March 8, 2018
N Engl J Med 2018; 378:885-887
DOI: 10.1056/NEJMp1714496

Purchase this article

This Issue | Views 29,257 | Citations 63 | Altmetric 547 | Comments 1

Download PDF | More | Cite This | Permissions

Original Investigation FREE

April 2016

Euthanasia and Assisted Suicide of Patients With Psychiatric Disorders in the Netherlands 2011 to 2014

Scott Y. H. Kim, MD, PhD[1]; Raymond G. De Vries, PhD[2,3]; John R. Peteet, MD[4]

Author Affiliations | Article Information

JAMA Psychiatry. 2016;73(4):362-368. doi:10.1001/jamapsychiatry.2015.2887

Questions and Discussion

Accessing CME and CEU Credits

Setting up your account (one time only)

To set up your account to claim CE by text message, text your email address to

(804) 625-4041

Pro tip: Add this number to your contacts!

Claim Credit for January 27, 2020

Text course code to (804) 625-4041

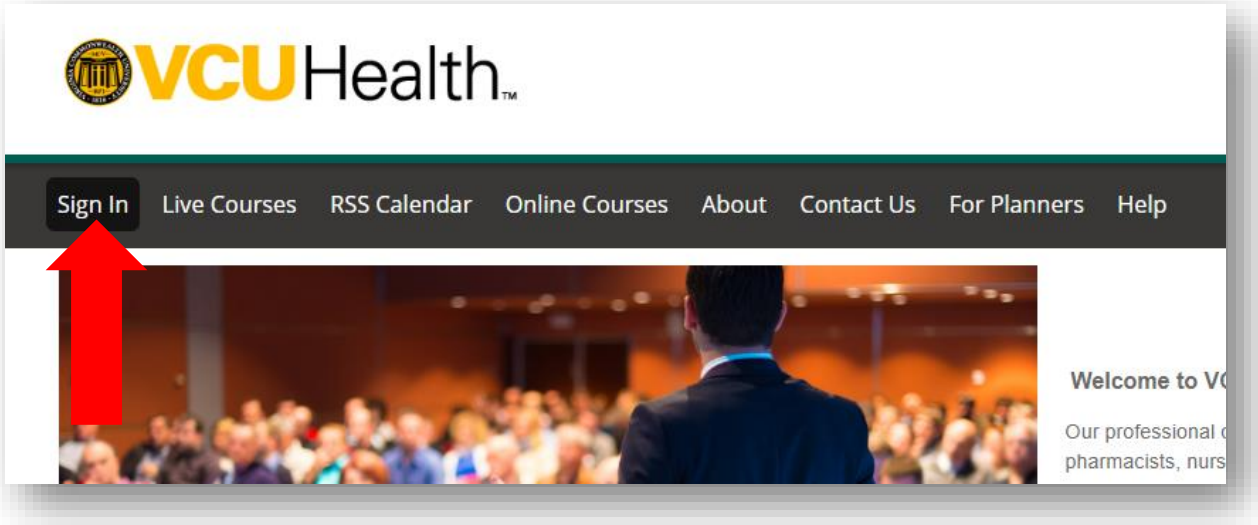
Course Code:

17204-17203

You will receive a confirmation text that your attendance has been recorded

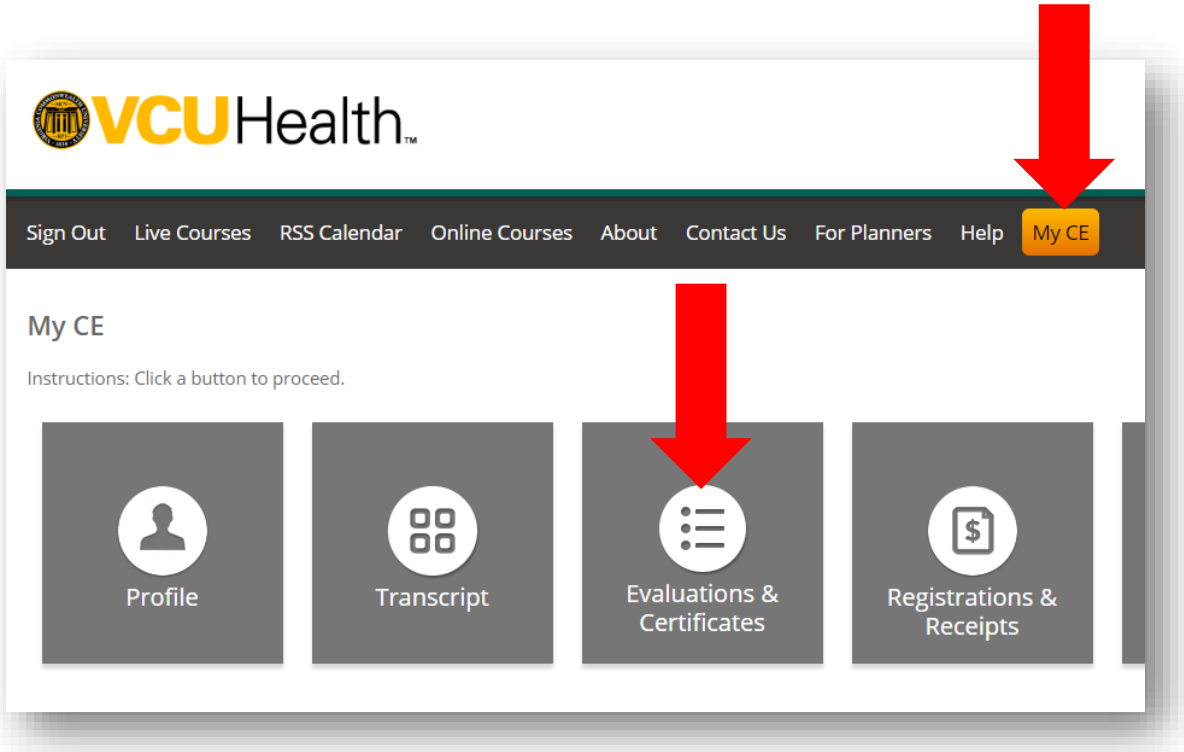
Complete Evaluation & Claim Credit

- After recording attendance, you must complete evaluation
- Can be done on computer or in CloudCME app (available in app store)
- Go to https://vcu.cloud-cme.com
- Sign in using email you used to register/log attendance

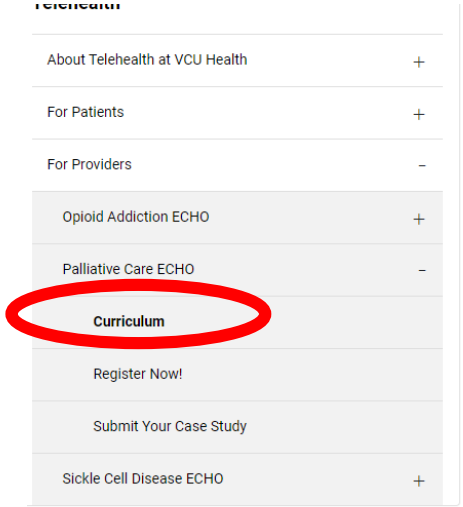


Complete Evaluation & Claim Credit

- Click “MY CE”
- Click on Evaluations & Certificates
  to view evaluations that need to be
  completed for sessions you have attended. This also allows you to view/print/email certificates



View recorded sessions at www.vcuhealth.org/pcecho



Register now for an upcoming session on palliative care.

Upcoming Sessions

11/14/19, Existential and Spiritual Assessments
Presented by Jason Callahan, MDiv.
Learning Objectives:

- Identify existential distress in patients, families and caregivers.
- Select appropriate interventions in addressing existential distress.
- Discuss grief and bereavement issues.

12/12/19, Five Key Takeaways from the Center to Advance Palliative Care (CAPC) National Seminar
Presented by J. Brian Cassel, PhD; Danielle Noreika, MD

Previous Sessions

02/14/19, Introduction to Palliative and Supportive Care
Presented by Danielle Noreika, MD
Learning Objectives:

- Define palliative care and differentiate from hospice.
- Describe reasons for referral to palliative care.
- Describe basic structure of palliative care team.

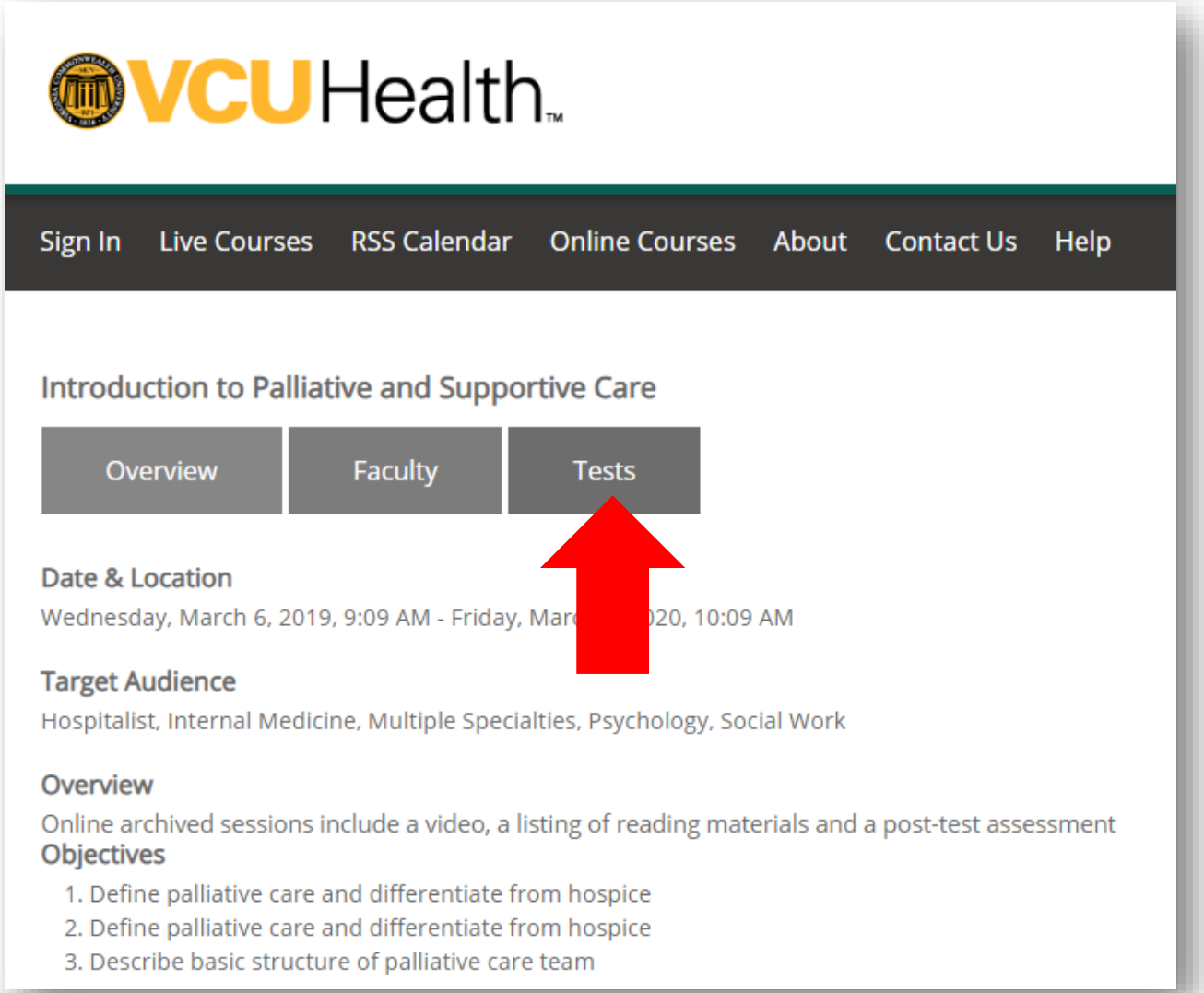
View session for CME
View slide presentation

02/28/19, Surgical Palliative Care
Presented by Emily Rivet, MD
Learning Objectives:

- Define surgical palliative care.
- Compare considerations in palliative patients undergoing surgery.

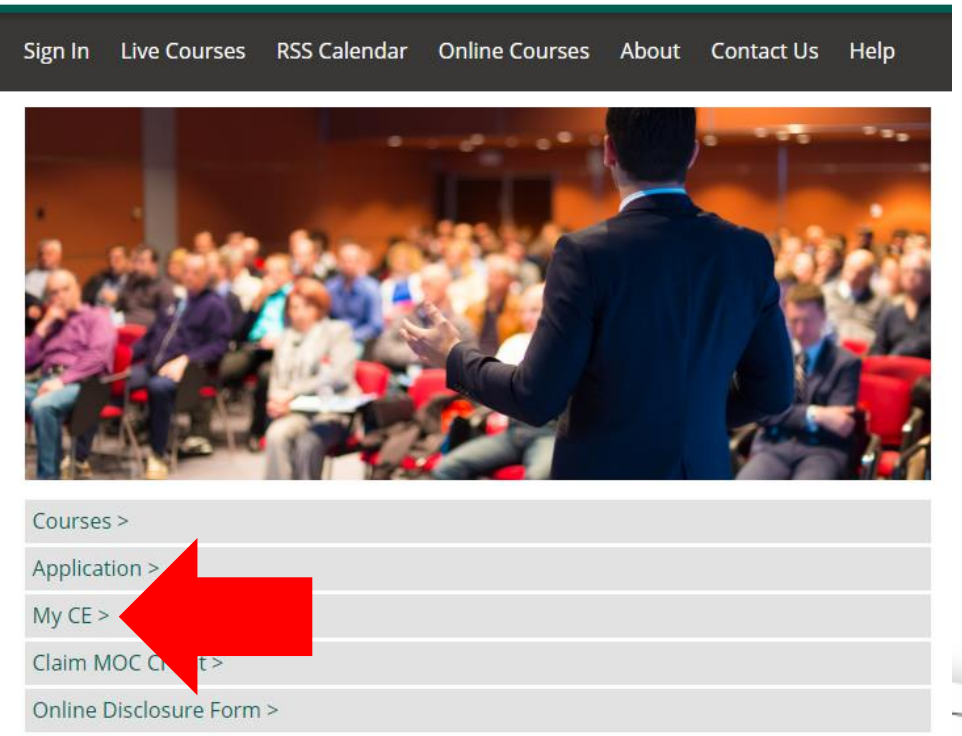
View previously recorded ECHOs for CME

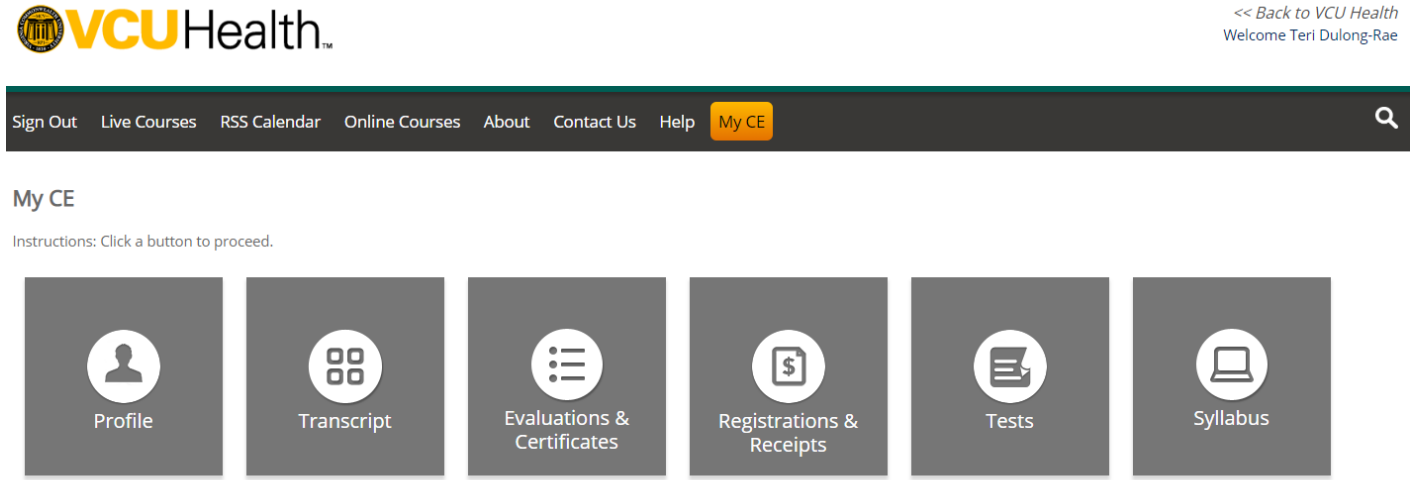
Click “Tests” to view video of the session and take a short quiz for continuing education credit



View your CME/CEU transcript

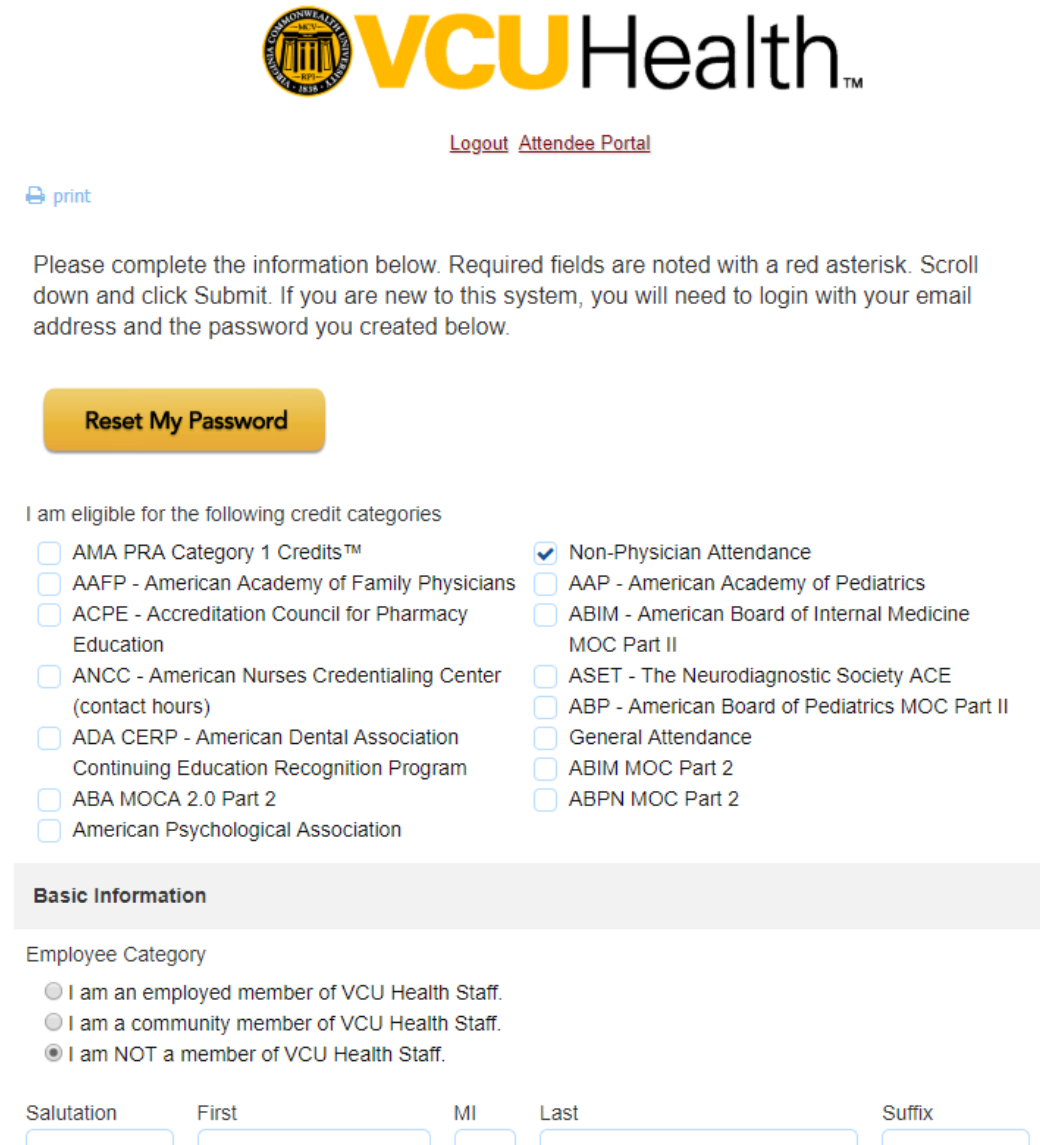
- Go to vcu.cloud-cme.com and click “My CE”
- Log in with the email you used to register for our ECHO session





View your CME/CEU transcript

If you have never logged in before, you may be prompted to enter more information before you can view your transcript



THANK YOU!

We hope to see you at our next ECHO