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RESEARCH ARTICLE

ROLE OF PSYCHIATRY IN PALLIATIVE CARE - A CASE REPORT

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Abstract

Palliative care aims to improve the quality of life for individuals facing life-threatening illnesses by addressing physical, psychological, social, and spiritual needs. While palliative care traditionally emphasizes symptom management and pain relief, the role of psychiatry in this field has gained recognition as an essential component of comprehensive patient-centred care. This case report provides an overview of the evolving role of psychiatry in palliative care, highlighting its significance in addressing the complex emotional and psychological aspects of end-of-life care.Psychiatrists play a crucial role in assessing and diagnosing mental health conditions that often co-occur with serious illnesses, such as depression, anxiety, and adjustment disorders. Identifying and addressing these conditions is vital to improving patients' overall well-being. Psychiatric interventions are valuable in managing distressing psychological symptoms, including anxiety, depression, delirium, and existential distress. Appropriate pharmacological and psychotherapeutic interventions can alleviate suffering and enhance the patient's overall comfort. Collaborating with Palliative care specialists, psychiatrists provide psychosocial support to patients and their families, helping them cope with the emotional challenges that arise during the end-of-life journey. This includes facilitating open and honest communication, addressing complex family dynamics, and assisting in advanced care planning.In conclusion, the role of psychiatry in palliative care is expanding to meet the complex needs of individuals facing life-limiting illnesses. Recognizing and addressing the emotional and psychological aspects of end-of-life care not only improves the patient's quality of life but also contributes to a more compassionate and comprehensive approach to palliative care. Integrating psychiatry into palliative care services ensures that individuals receive the support they need to navigate the challenging journey of serious illness with dignity and comfort.

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Introduction:-

Palliative care psychiatry is an emerging subspecialty field at the intersection of Palliative Medicine and Psychiatry. The discipline brings expertise in understanding the psychosocial dimensions of human experience to the care of

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dying patients and the support of their families. This article briefly defines palliative care and summarizes the evidence for its benefits, to describe the roles of psychiatry within palliative care in the form of a case report.

Palliative care is specialized medical care for people with serious illnesses. This care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness – whatever the diagnosis. The goal is to improve the quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide an extra layer of support. Palliative care can be appropriate at any age and at any stage in a serious illness and can be provided together with curative treatment" [1].

The most important – and frequently misunderstood – elements of this definition include the focus on preserving the quality of life, attention to suffering in both the patient and caregivers, care that is provided by a team with interdisciplinary expertise, and support that can complement disease-oriented treatments throughout the entire course of an illness for persons of any age.

Palliative care is different from Hospice, as when a cure is no longer possible, or when disease-modifying treatment is no longer desired, palliative care may become the sole focus of care. Hospice delivers enhanced palliative care, wherever patients live, when the prognosis is short and the goals of therapy are to optimize quality of life and function in the final phase of life. Uniquely, hospice services also include bereavement care for family members up to and after a patient's death [2]. In the United States, hospice care is available to patients with a prognosis of 6 months or less, and the services provided are largely governed by the guidelines of the federal healthcare benefit.

Case presentation

We present the case of a 6-year-old male, with a history of adenovirus pneumonia at age 4, followed by multiple recurrent lung infections and pneumonia that were not adequately treated due to the family's religious beliefs. The boy was brought to the paediatrician after his 6th birthday for his follow-up vaccination when the paediatrician noted the boy was having difficulty breathing. On obtaining an X-ray of the chest, the boy was diagnosed with complicatedpost-infectious bronchiolitis obliterans with hypoxemic and hypercapnic acute on chronic respiratory failure.

With poor feeding and aspiration due to coughing, the boy had also developed liver dysfunction, portal vein thrombosis, oesophageal varices, and malnutrition. He was a candidate for a lung transplant, but due to a complicated case and few chances of survival, he was denied a lung transplant atChildren's Hospital.

With worsening respiratory failure and BIPAP dependence, the patient has been transitioned to comfort care and is a candidate for hospice.

Palliative care was started and the parents were informed about the patient's terminal diagnosis. The boy developed increased anxiety due to difficulty breathing and was not able to tolerate BiPap, due to a fear of desaturating. The boy also had a panic attack while going for a DEXA Scan. The psychiatry team was consulted along with psychologists and a treatment plan was set.

Psychiatry prescribed- Hydroxyzine 2.5 mg as needed, to decrease anxiety with Lorazepam 2mg as needed for second line.

Psychologists along with palliative care specialists, helped with therapy and tried to make him comfortable with the hospital environment.

Discussion:-

All physicians, regardless of specialty, should be competent in providing basic or "primary" palliative care: attending to whole-person and family concerns, rooting treatment in an understanding of the illness experience, clarifying basic goals of therapy, and giving due weight to symptom relief and quality of life. A subset of physicians, with further experience or formal training in this set of skills and knowledge, will practice specialized or "secondary" palliative care, often in the role of palliative care consultants and part of a multidisciplinary team. Finally, "tertiary" palliative care is needed for the most challenging cases; it is provided by experts who are also involved in the research and education of new trainees in the subspecialty [3].

Lastly, Hospice and Palliative Medicine is a subspecialty medical field, formally recognized in 2006 by the American Board of Medical Specialties and the Accreditation Council for Graduate Medical Education. Ten medical boards, including the American Board of Psychiatry and Neurology, sponsor the Hospice and Palliative Medicine subspecialty certification. As of 2012, qualification for the Hospice and Palliative Medicine subspecialty board required completion of an ACGME-accredited 1-year postgraduate fellowship [4]. As mentioned, palliative care is provided by interdisciplinary specialty teams, and specialist-level training experiences and/or competencies also exist for palliative care nursing [5], social work [6], and chaplaincy [7].

Benefits of Palliative Care

An exhaustive discussion of the benefits of palliative care is beyond the scope of this review, and several excellent summaries can be found elsewhere [8]. The following focused review captures the most important clinical and economic benefits that have been seen with palliative care.

Quality of Care

A number of studies have looked at clinical outcomes in different palliative care settings. These include observational and quasi-experimental designs, and, more recently, randomized trials. In general, many of these show improvements in symptom relief, and most show improvements in quality of life. For example, in a retrospective study of over 400 cancer patients, an outpatient palliative care intervention was associated with significant reductions in pain, fatigue, dyspnoea, insomnia, depression, and anxiety, as well as significant improvements in overall quality of life [9]. In addition, surveys have consistently reported high levels of satisfaction among families and caregivers. In a nationally representative sample of family members of deceased patients, for example, those who used home-based hospice services (as compared to home health, nursing home, or hospital) reported improved relief of pain, higher levels of emotional support for both patient and family, increased treatment with respect, and higher overall quality of care [10].

Costs and Resource Allocation

In another line of research, several studies have examined the relationships between palliative care and medical costs or resource allocation. For example, in a small prospective pre/post-performance improvement study, inpatient palliative care consultation was associated with significantly reduced length-of-stay in the ICU, from 16 days with standard care to 9 days with palliative care [11]. Also, in a large study of Medicaid beneficiaries at four acute-care hospitals in New York State, palliative care consultation was associated with substantial reductions in average total costs per admission – with savings of just over $4,000 per patient [12]. Lastly, looking at palliative care in the very final stages of life, a recent study examined data from a longitudinal survey of a nationally representative cohort of older adults. Substantial reductions in cost were found for hospice enrollees relative to non-hospice matched controls, largely independent of the duration of hospice enrolment [13].

Survival

Concerns are sometimes raised that the cost savings associated with palliative care stem from poorer survival among patients receiving these services; i.e. “palliative care saves money by shortening life.” To the contrary, recent data from well-designed trials indicates that, in some conditions, palliative care interventions may confer a survival benefit. In a 2010 study of adults with metastatic lung cancer at the time of diagnosis, participants were randomized in two treatment arms: standard cancer care alone, or standard cancer care plus palliative care. Patients in the palliative care arm experienced higher scores on measures of quality of life, reductions in depressive symptoms, reduced exposure to “aggressive” care, and improved survival – living on average more than two and a half months longer than their counterparts [14].

Conclusion:-

Palliative care achieves better clinical outcomes than standard care alone. Patients feel better, they report improved quality of life, and caregivers report higher levels of satisfaction. When delivered by a specialist consultation team in a hospital, or in the hospice setting at the end of life, palliative care appears to be less costly than standard care alone, when matched by diagnosis and severity of illness. And finally, emerging data from at least one well-designed study suggests that under some circumstances there may be improvements in survival as well.

References:-

1. Saunders C. The treatment of intractable pain in terminal cancer. Proc R Soc Med. 1963;56(3):195–197.
2. Clark D. `Total Pain,' disciplinary power and the body in the work of Cicely Saunders, 1958–67. Soc Sci Med. 1999;49:727–736.
3. Meier DE, Beresford L. Growing the interface between Palliative Medicine and Psychiatry. J Palliat Med. 2010;13(7):803–806.
4. Billings JA, Block SD. Integrating psychiatry and palliative medicine: the challenges and opportunities. In: Chochinov HM, Breitbart W, editors. Handbook of Psychiatry in Palliative Medicine. 2nd Edition Oxford University Press; Oxford: 2009. [Google Scholar]
5. 2009 APA Gold Award Integrating mental health services into hospice settings. Psychiatr Serv. 2009;60(10):1395–1397.
6. Chochinov HM, Breitbart W, editors. Handbook of Psychiatry in Palliative Medicine. 2nd Ed Oxford University Press; CITY: 2009. [Google Scholar]This text, edited by two central pioneers in the field, represents the first comprehensive attempt to capture the knowledge base for palliative care psychiatry
7. [Accessed March 2013];Center to Advance Palliative Care: Public Opinion Research on Palliative Care 2011. Available at http://www.capc.org/tools-for-palliative-care-programs/marketing/public-opinion-research/2011-public-opinion-research-on-palliative-care.pdf.
8. Hanratty B, Hibbert D, Mair F, et al. Doctors' understanding of palliative care. Palliat Med. 2006;20(5):493–497.
9. Ogle KS, Mavis B, Wyatt GK. Physicians and hospice care: attitudes, knowledge, and referrals. J Palliat Med. 2002;5(1):85–92.
10. Brickner L, Scannell K, Marquet S, Ackerson L. Barriers to hospice care and referrals: survey of physicians' knowledge, attitudes, and perceptions in a health maintenance organization. J Palliat Med. 2004;7(3):411–418.
11. Ferris FD, Balfour HM, Bowen K, et al. A model to guide patient and family care: based on nationally accepted principles and norms of practice. J Pain Symptom Manage. 2002;24(2):106–123.
12. von Gunten CF. Evolution and effectiveness of palliative care. Am J GeriatrPsychiatr. 2012;20(4):291–297. [PubMed] [Google Scholar]This short piece provides an exceptional overview of the evolution of palliative care in the U.S
13. von Gunten CF, Lupu D. Development of a medical subspecialty in palliative medicine: progress report. J Palliat Med. 2004;7:209–219.
14. Morrison LJ, Opatik Scott J, Block SD, et al. Developing initial competency-based outcomes for the hospice and palliative medicine subspecialist: phase I of the hospice and palliative medicine competencies project. J Palliat Med. 2007;10(2):313–330.