A TALE OF TWO PATIENTS

How Collaboration Across Disciplines Improves Patient-Centered Care

ABSTRACT

Improving palliative care for people living with persistent psychiatric illness requires increased cross disciplinary collaboration between psychiatry and palliative care (PC). We discuss two similar patient cases involving the care of patients with persistent psychiatric illnesses in a community-based hospital setting. These cases demonstrate the importance of the partnership between the psychiatry and PC teams working with patients and their surrogate decision-makers to improve their care and quality of life.

INTRODUCTION

The standard of care for patients with any chronic, potentially life-limiting illnesses often includes access to PC. Long-term mental illnesses require ongoing and intensive psychiatric treatment and need to be considered as chronic, persistent illnesses associated with mortality.[1,2] As such, patients with these persistent, severe mental illnesses need to have access to palliative care services due to the unique medical, psychiatric, and ethical challenges faced by this population. However, data suggest that PC services provided to these patients is poor.[2]

In the setting of terminal illness, patients often lose their therapeutic relationship from their psychiatric providers due to poor collaboration between mental health professionals and PC providers and the lack of experience in PC from psychiatric providers and organizations.[3,4,5] When PC and psychiatry work in collaboration for patients with schizophrenia, researchers have found improvement of end-of-life planning. For example, one study at the VA showed that of veterans with schizophrenia who had PC involvement, over half completed advance directives, 63% had a physician DNR order, and 55% ultimately enrolled in hospice.[7]

"Patients with persistent, severe mental illnesses need to have palliative care services."

"Integrating psychiatry and palliative medicine to work in collaboration results in person-centered goals of care."

Case Descriptions

PATIENT A

Patient A is a 76-year-old female with a 20-year-plus history of schizoaffective bipolar type presented from her assisted living facility. She was ruled out for acute medical conditions, her head CT was negative for acute changes, and she was diagnosed with delirium.

During her hospital course, Patient A was inconsistent with her oral intake and refused nursing care. Patient A required a feeding tube, which she self-removed four times. Both psychiatry and the PC team were consulted on day 17 of Patient A's hospitalization due to the concern for prolonged delirium. An interdisciplinary team, including the psychiatrist and the PC team, held a family meeting to discuss goals of care.

The patient was diagnosed with catatonia; after meeting with family, a plan was agreed upon to ensure aggressive medical management of catatonia. The family was clear to communicate to the care teams that Patient A has always expressed the desire for a natural death, and not to use artificial life support measures, including any feeding tube, to prolong her life if she was in a terminal state.

A temporary feeding tube was placed while patient remained in restraints to ensure uninterrupted medical management for a short-term trial. Patient A's condition improved to allow nursing care to continue, her restraints were removed, and the temporary feeding tube was removed. Patient A was transferred to an outside hospital, and after one month, Patient A had complete resolution of signs of catatonia and she was discharged back to her assisted living facility, resuming her life as she had prior to admission.

PATIENT B

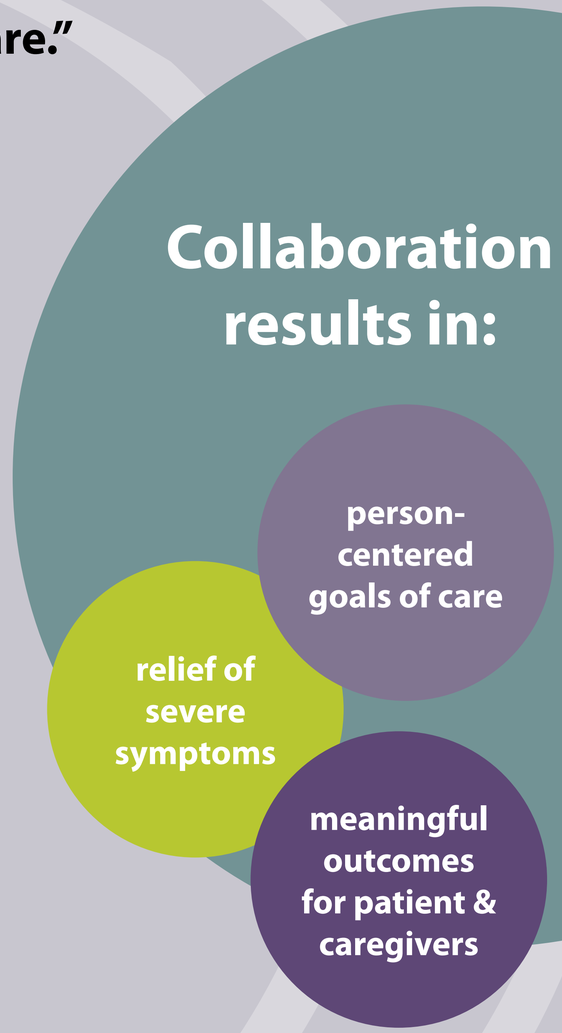
Patient B is a 63-year-old male with a 25-year history of schizophrenia who was admitted from his assisted living facility. The patient was recently discharged from another hospital following a long hospitalization for failure to thrive and schizophrenia symptoms. Patient B had a legal guardian who was his surrogate decision maker, and his family lived out of the state but remained supportive of the patient and in contact for discussions with the guardian.

During his hospitalization, Patient B refused any oral medications, food, or drink. The psychiatry team, hospitalist, and patient's legal guardian agreed to apply restraints to provide scheduled IV medications. The PC team was consulted on day 13 of Patient B's hospitalization due to the concern the patient did not demonstrate any improvement from his psychosis and often remained sedated during the day.

The PC team worked with psychiatry and nursing staff to wean any sedating medications and to provide hand feeding for the patient, but the patient refused to eat or drink or take any of his oral medications and was maintained on IV fluids. The PC team and psychiatry team agreed that the patient was at the end-stage of his psychiatric illness and it was appropriate to have end-of-life care discussions.

Patient B's guardian spoke with the PC team and did not agree that the patient needed to have advance care planning discussions, as Patient B "only has schizophrenia, and it is not a terminal disease." The guardian wanted to continue to keep Patient B in restraints to continue medication and fluid regimen, but Patient B's family disagreed and felt that Patient B was suffering and wanted to ensure a dignified end of life. It was agreed to have the ethics team involved to provide support for all parties.

The PC, psychiatry, and ethics teams worked together to support the guardian with these difficult conversations. When the guardian understood that schizophrenia progresses and evolves into a terminal state just as any other persistent, progressive, and chronic illness, he verbalized and supported the family's plan to provide a natural and dignified end of life. Patient was discharged to a hospice facility shortly thereafter.



Conclusion

These two cases demonstrated that integrating both psychiatry and PC to work in collaboration on complex cases with surrogate decision-makers resulted in: identification of person-centered goals of care, the relief of severe symptoms, and reaching meaningful outcomes for the patient and their caregivers.

When patients with serious, persistent, psychiatric illnesses are presenting with acute psychiatric symptoms, all attempts should be made to treat these symptoms to control the mental illness. If this becomes unachievable, then a timely goals of care discussion needs to be considered, which may provide the patient with a dignified and comfort-driven end-of-life care plan.

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