Addressing Advanced Care Planning Difficulties in Patients with Terminal or Advanced Illness with Comorbid Mood Disorders and Suicidal Behavior

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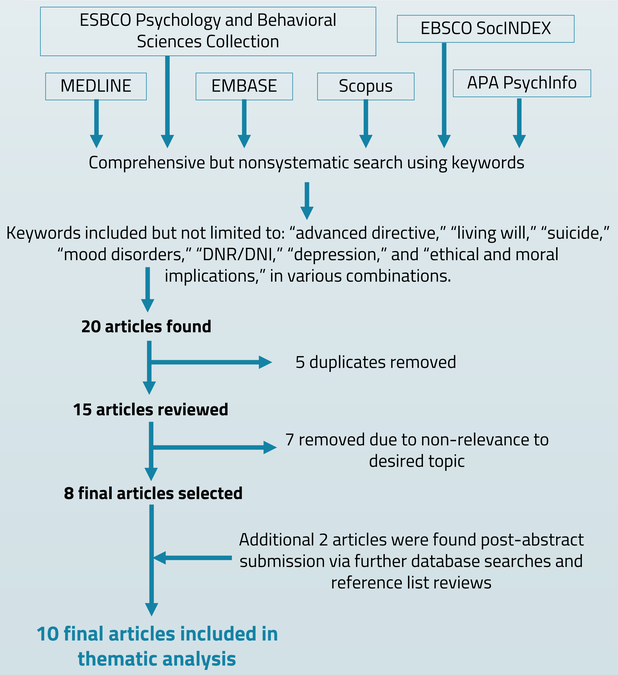
Background/Significance

Modern medicine is becoming more capable of treating chronic and severe diseases and keeping people alive longer by using external and artificial measures. Thus, more people live with chronic and severe illnesses than ever before, and in the setting of widespread increased mental illness (depression ranges from 9.5% to 25% among chronically ill and from 25% to 77% among terminally ill), it is more important than ever to have a framework on hand for treating these patients as their chronic illnesses inevitably progress.

One of the steps a clinician can take with these patients is to address goals of care in the form of advanced directives (AD). Advanced care planning has shown long-term benefits in treating physical and mental illness, such as enhancing patient autonomy and engagement in treatment plans, improving continuity of care, decreasing the number of hospitalizations, promoting physician-patient alliance, and patient-family discussions about patients' end-of-life wishes. Unfortunately, advanced directive planning in patients with severe medical and concomitant psychiatric conditions, specifically depression and suicidal thoughts/behavior, can raise ethical and moral questions regarding the patient's treatment wishes, decision-making capacity, and appropriate timing to discuss these topics.

Consult-Liaison psychiatrists (CLP) are often recruited late into the care of these patients when there are disagreements between treatment plans and patients' choices.
In this poster, we will present three scenarios along one possible illness trajectory in order to explore the influence of mood disorders and suicidal thinking on advanced care planning in the setting of severe or terminal medical illness.

Methodology



Results

The final 10 articles included clinical cases, fictional scenarios, and ethical discussions related to mood disorders, suicidal ideation, and suicidal behaviors among chronically and terminally ill patients. Clinical practice and rationale for treatment decisions regarding advanced directives varied significantly, even after consultation with ethics management teams. However, common ethical questions were found after thematic analysis, both theoretical and at-the-time applicable. These questions appeared to occur at specific stages of the medical condition and were categorized into 3 distinct scenarios:
1. Terminally or severely ill patient without a current comorbid mood disorder.
2. Terminally or severely ill patient with a comorbid mood disorder.
3. Terminally or severely ill patient with suicidal ideations or behavior.

Discussion

Scenario 1: Terminally or severely ill patients without a current comorbid mood disorder.

a) Paternalism versus Autonomy

Physicians have long struggled with the dilemma of balancing patient autonomy versus providing appropriate care [1]. Since the birth of bioethics, respect for autonomy has been regarded as a foundational ethical principle and is legally protected by The Patient Self-Determination Act (PSDA) of 1990. Therefore, upon any disagreement between the primary team and the patient, the patient's wishes should be respected until a proven lack of decisional capacity [2].

At this stage, most of the patients are considered capable, and there is a favorable consensus for respecting the patient's right to make decisions or what is stipulated in the advanced directives, even if it ultimately leads to his or her death.

Discussion continued

Scenario 2: Terminally or severely ill patients with a comorbid mood disorder.

a) Does the presence of depression imply incapacity?

Many psychiatrists conceptualize that depression affects cognitive abilities as well as thoughts about death. Therefore, depressed patients should be considered incapable of making rational decisions, and their capacity should be revocated until improvement, including invalidating any treatment decision or advanced directive planning made during this time [3, 4]. Although, not all psychiatrists share the above conclusion. Data has shown that most depressed patients can perform well on all measures of decision-making competence [5], and their choices were not affected by depression [6].

b) What forms of judgment have been used when capacity was questioned by a mood disorder?

It has been suggested that when capacity is questioned by a mood disorder, it could be supplemented by the substituted judgment, which represents an earlier decision of the patient being implemented at the current circumstances [7] or by the judgment of the authenticity and durability that is based on the consistency over time of the patient's decision.

c) Are the reasons for treatment refusal different in patients with physical versus mental illness?

Most physicians have a cognitive bias in regard to decision-making capacity, especially in treatment refusal, between patients with physical versus mental illness. Patients with only physical illness are akin to scenario 1 and are usually considered capable of decision-making, but patients with mental illness are thought unable to rationalize their illness and consequences effectively. However, the reasons that most impact the decision for treatment refusal in patients with only medical or medical with concomitant psychiatric illness are the same. Loss of autonomy and pain are considered the major themes that determine poor quality of life [8], and poor quality of life is the major factor for refusal of treatment, including life-sustaining treatment.

Scenario 3: Terminally or severely ill patient with suicidal ideations or behavior.

a) Is decision-making capacity, including decisions regarding life-sustaining treatment, impacted by depression severity?

Most psychiatrists believe that the patient's suicidal behavior can deprive them of the necessary rationality to make an informed-capable choice about their treatment [4, 9]. Also, the potential fluctuation of suicidal ideation, its possible improvement with psychiatric care, and the plausible change reflected in treatment preferences versus the gravity of the clinical decision regarding life-sustaining treatment are, for most, enough to invalidate informed-capable choices [1]. Some studies back up this idea by showing that the DNR decision can be influenced by suicidal thoughts [10]; however, others argue that even suicide can be rational.

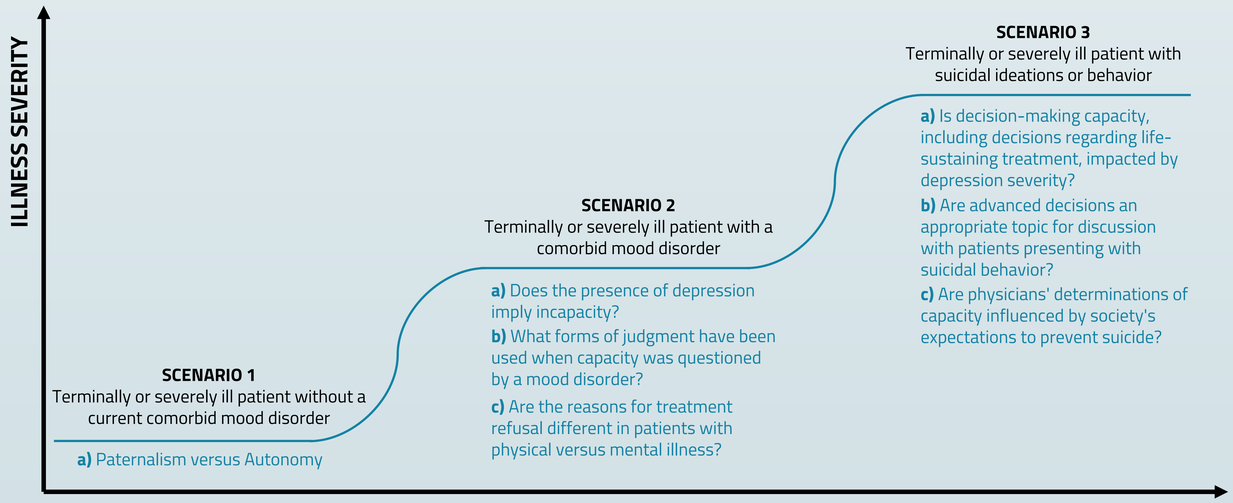
b) Are advanced decisions an appropriate topic for discussion with patients presenting with suicidal behavior?

Suicidal thoughts or behavior in depressed patients are considered important factors of increased disease severity and increased risk for suicidal attempts. Some may also suggest that the advance decision to refuse treatment in the setting of suicide ideation should be considered a preparatory action or part of a suicide attempt and evidence of distressed and disordered thinking [1]. Therefore advanced directive planning is not recommended during this time.

c) Are physicians' determinations of capacity influenced by society's expectations to prevent suicide?

Although suicide and attempted suicide have been decriminalized, there is a societal expectation that suicide should be and can be prevented. All U.S. States have the power to "protect" those who, because of "legal incapacity," are unable to protect themselves, and is manifested by laws establishing involuntary hospitalization and involuntary treatment to prevent suicide [9].

Scan the QR code to see the list of references, the full poster and abstract on submission.



Ethical questions at 3 stages of the terminal or severe medical condition correlated against illness severity and time. Each question is debated in detail in the Discussion section above. Listed references can be found in the QR code.

Conclusions/Implications

Most chronically or terminally ill patients will develop depression at some point in their disease progression. As their depression intensifies and suicidal ideations appear, patients' decision-making capacity can be more strongly influenced. At this point, medical ethics agree on prioritizing treatment against patient wishes, but some believe that even suicide can be rational.

We propose that advanced directives are best discussed early in collaboration with patients with revisions throughout the illness. Patients' wishes for treatment and their understanding of the quality of life should be assessed and outlined clearly. Topics like depression and suicidal behavior and what they could represent in treatment changes should always be part of the discussion. We advise even further assessment, bringing up topics such as treatment choices upon a suicidal attempt and wishes of withholding/withdrawing treatment after a suicidal attempt. Physicians should also encourage patients to discuss these topics openly with family. If and when capacity is challenged by a mood disorder, CLP and families may use the principles of substituted judgment and/or authenticity and durability to respect the original wishes of the patient.