

TAKE-HOME NOTES:  
**Psychiatric aspects of terminal care**

Dr John Mitchell

Terminal illness care is becoming more important because of the ageing population and increased age comorbidity. Recent developments in palliative medicine include a community focus, an increased awareness of psychological issues and a broadening of disease group interest. Controversy exists as to the consideration of certain psychiatric conditions as terminal illnesses.

Depression is no more common than in the seriously chronically ill but can be difficult to differentiate from adjustment and other conditions. Delirium is much more prevalent in the terminally ill and is often missed. Anxiety may be related to organic factors and medication. Dementia poses particular problems. Specific rating scales exist to assist in diagnosis and measurement of symptom intensity.

Reasonable attempts should always be made to optimise a patient's physical state. Psychotropic medication is useful but should be thoughtfully prescribed. Electroconvulsive therapy (ECT) can be used. The best psychotherapy is supportive listening. Blanket counselling of cancer patients has no positive effect and can be harmful. Quality of life can be improved by improvement in practical issues to do with finance, housing, the reparation of relationships and preparation for death. Spirituality and religious issues should be explored if appropriate to the patient.

Antidepressants are effective but need careful choice to match the patient's physical state and symptoms. Diazepam must be used with care owing to the build up of its metabolites – lorazepam is better for rapid tranquillisation in combination with haloperidol. Palliative care physicians are comfortable using antipsychotics as they use them commonly as antiemetics and they are familiar with delirium.

Antipsychotics work for all sorts of delirium, not only as sedatives but also to reduce the length of the delirium. There is little advantage in atypical over typical antipsychotics in this regard. Palliative care physicians are familiar with the neuropathic analgesic actions of amitriptyline and lorazepam and anticonvulsants. Psychostimulants have an important place in relieving depression and can be safely used.

Pain relief is delivered using an analgesic ladder with opiate above non-steroidal inflammatory agents. Corticosteroids have important uses and side effects.

Denial and shock, anger, bargaining, depression and acceptance are classic stages of adjustment to a terminal diagnosis. Freudian defence mechanisms can have positive and negative effects on patient and staff well-being. Spirituality and religious views are important.

The Mental Health (Care and Treatment) (Scotland) Act 2003 makes provision for the detention in any hospital of a mentally disordered patient for treatment of their mental disorder without or against their consent. Mental disorder includes delirium and dementia. The Adults with Incapacity (Scotland) Act 2000 makes provision for the provision of medical treatment of a patient lacking capacity.

Living wills describing future medical treatment and advance statements describing future psychiatric management should be considered by medical teams but can be deviated from for clinical reasons. The ability to make a valid will (testamentary capacity) is a regular issue in the terminally ill who have comorbid mental disorder.

## Reflection

(1.6) Do you think some psychiatric illnesses can progress to the extent that palliative care approaches are appropriate?

(2.7) How many symptoms of delirium can you list? Would you say they are hyperactive or hypoactive symptoms?

(2.15) What particular problems might occur in the palliative care of patients with dementia?

(5.3) Which side effects do you know of that are associated with corticosteroids? How would you normally respond to any such side effects?

## Tables and figures

[\(2.5\) Endicott criteria](#)

[\(4.2\) Characteristics of antidepressants and mood stabilisers in terminal care](#)

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### Further reading

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