Episode: *Author Interview:* "*What Should Clinicians Know About Palliative Psychopharmacology?"*

Guest: Awais Aftab, MD
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[bright theme music]

TIM HOFF: Welcome to another episode of the Author Interview series from the *American Medical Association Journal of Ethics*. Joining me on this episode is Dr Awais Aftab, a clinical assistant professor of psychiatry at Case Western Reserve University in Cleveland. He's here to discuss his article, "*What Should Clinicians Know About Palliative Psychopharmacology?*," in the September 2023 issue of the Journal, *Palliative Psychiatry*. Dr Aftab, thank you so much for being on the podcast. [music fades]

DR AWAIS AFTAB: Thanks so much for having me.

HOFF: You wanted to start with our traditional second question in this podcast, so let's begin there. What's the most important thing for health professions students and trainees to take from your article?

AFTAB: So, my article focuses on clarifying what constitutes palliative use of psychiatric medications. A superficial impression is that palliative psychopharmacology involves the use of symptomatic agents, while a curative approach involves disease-modifying agents. But in my opinion, this distinction is misleading. Some authors have distinguished curative psychiatry from palliative psychiatry by characterizing symptom reduction as a curative goal in psychiatry. I think both views have limitations, and there are recognizable instances of using disease-modifying agents as well as symptom reduction to improve quality of life in palliative medicine generally. In my view, the relevant distinction in palliative psychopharmacology is not etiology versus symptoms or symptoms versus quality of life, but rather modifiable versus modifiable aspects of illness in relationship to quality of life.

The essence of palliative care, I suggest, is when we are forced to work around an aspect of the illness to enhance quality of life. This aspect will be different in different situations. Classic examples would be working around the inevitability of death from illness progression or anatomical damage in conditions such as advanced COPD. In palliative psychiatry these unmodifiable aspects may be advanced cognitive impairment, terminal anorexia nervosa, chronic psychosis, persistent functional disability, etc.

HOFF: So, with those conceptual details laid out, let's return to our usual first question. What's the main ethics point of your article?

AFTAB: So, my article focuses on the notion of unmodifiability as the essence of palliative care, and it is important to recognize that unmodifiability is a spectrum. So, where exactly we draw the line, the threshold at which the characterization of our clinical approach begins to shift from curative to palliative, it's a clinical and pragmatic matter. Broader or narrower notions of "palliative" offer different advantages and disadvantages. The direct ethical implication of this is that clinicians have an ethical imperative to clearly formulate goals of care in a dynamic and

ongoing process of shared decision making with their patients. Due to current conceptual confusion, clinicians and patients may not be clear on whether they are using a medication for palliative purposes or not. And to make matters complicated, a medication may be started with curative intent but continued for palliative purposes. If a pharmacological treatment is being employed palliatively, both the clinician and the patient need to be aware of that. Understanding that treatment is palliative is important. It relates to informed consent. It relates to nonmaleficence, and also epistemic justice. So, gaining more clarity on what the treatment seeks to modify and what it leaves unmodified will help patients better understand the nature of their psychiatric care and will ensure that clinicians do not ignore potentially modifiable causes.

HOFF: And finally, if you could add a point to your article that you didn't have the time or the space to fully explore, what would that be?

AFTAB: I think our thinking around psychopharmacology has often relied on simplistic and reductionistic ideas. I advocate a move towards explanatory pluralism, and we should embrace interactions at multiple levels of explanation via multiple pathways that involve both top-down and bottom-up causal influences. We have to understand medication effects in terms of cognitive and psychological mechanisms such as salience, belief updating, and psychedelic experiences. Different pathways of therapeutic action may be involved in different individuals. [theme music returns] When we ask how medications work, there may be no singular answer, only a set of processes by which relevant changes in outcomes may be obtained.

HOFF: Dr Aftab, thank you so much for your time on the podcast today, and thanks for your contribution to the Journal this month.

AFTAB: Thanks again.

HOFF: To read the full article, as well as the rest of this month's issue for free, visit our site, journalofethics.org. We'll be back soon with more *Ethics Talk* from the *American Medical Association Journal of Ethics.*