

Episode: *Ethics Teaching and Learning: When Should Psychiatric Care Be Palliative?*

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[mellow theme music]

TIM HOFF: Welcome to the new *Ethics Teaching and Learning* podcast series from *Ethics Talk*, the *American Medical Association Journal of Ethics Podcast* on ethics in health and health care. I'm your host, Tim Hoff. In this series, we talk with educators about teaching ethically complex content to health professions students. We'll discuss strategies for navigating tension between challenging students and trainees and supporting them as they navigate ethical ambiguity and uncertainty. We'll focus specifically on relationships forged among patients, clinicians, and organizations when we work, teach, learn, and assess learning together.

Today, we're joined by Dr Cynthia Geppert. Dr Geppert is the lead health care ethicist, Western Region, and director of ethics education at the Veterans Affairs National Center for Ethics in Health Care and a professor of psychiatry and internal medicine and the director of ethics education at the University of New Mexico School of Medicine, as well as an adjunct professor of bioethics at the Alden March Bioethics Institute, Albany Medical College. Dr Geppert is here to talk about how teaching health professions students and trainees about palliative psychiatry reinvigorates core philosophy of medicine investigations into what health care is for. Dr Geppert, thank you so much for being back on the podcast.

DR CYNTHIA GEPPERT: Oh, Tim, thanks for inviting me on. Medical education is probably one of my very favorite subjects to talk about. [music fades]

HOFF: How do you introduce palliative psychiatry to health professions students or colleagues who are unfamiliar with why it's interesting and important and complex?

GEPPERT: So, I actually find that outside large academic medical centers, especially sort of on the two coasts, it is an unfamiliar topic, and that's for good reason. It's the formal idea of palliative care psychiatry is really comparatively new than, say, psychiatry itself or even palliative medicine, which is just new compared to surgery. And if you look at PubMed, Medline, you'll find that the first articles are really less than 20 years ago and then a steady increase. Now, that doesn't mean that psychiatrists and palliative care doctors weren't practicing palliative care psychiatry, yet it wasn't well known as an established entity. In 2008, when the American Board of Medical Specialties recognized hospice and palliative medicine, we were very fortunate that psychiatry was one of the many disciplines—it's a very multidisciplinary field—that was eligible for both to train in fellowships and to take the Board exam. And yet the latest data, 2021 data, from the American Academy of Hospice and Palliative Medicine lists only about 160 psychiatrists that are certified. Now, I'm quite sure that there are more or more people practicing it than didn't take the, you know, aren't Board certified, but that are doing great work in it.

But I will say when I took the very first exam that was offered, a colleague from Internal Medicine came up to me and said, "Go home and stop wasting your time. You'll never pass a medicine test." So, I think that it shows that psychiatrists are doctors, too, and this

is an area where we can use both our medical skills and our palliative and our psychiatric skills in palliative care. So, it is really complex field. We as a field are young and small but making a big impact, and I think, in a very, very profound area.

We're still working toward a consensus definition, but we have close approximations. And really, one of the most compelling things about palliative care psychiatry is that it emerged from the ground up. It was a clinical need rather than driven from research or a quality improvement. It wasn't an institutional. It was really a individual encounter with patients and clinicians realizing that this really was a gap that needed to be filled with compassionate, competent people.

My experience of teaching this is that even students and residents who find it daunting and something that temperamentally they're not disposed to pursue as a career, they find it interesting. [00:04:32] And the reason I think, and this is a little, a theme of my talk is that it lies at the intersection of medicine and psychiatry. It's right there in that area. We're geriatric psychiatry consultation-liaison. And I don't think there's any area in psychiatry or medicine that's quite as suffused with ethics, because if you think of the richness, granularity of mental health ethics, and then you superimpose that end of life and all those ethical issues and concerns, you have a really tapestry of ethical issues. And as the population ages, and with COVID, I think more and more trainees, they came up against, they confronted these dilemmas, even if they wouldn't put the name on it of palliative care psychiatry.

HOFF: So, which features of palliative care psychiatry are hardest for students or colleagues, especially those who are unfamiliar with it, to navigate both cognitively and affectively?

GEPPERT: This was such a good question. Because I often find after 25 years of teaching that psychiatry residents often have a difficult time with patients dying and death. Not all of them. That's, you can never make generalizations. And some non-psychiatric professionals have a hard time with patients who have serious mental illness. Again, those are generalizations. There's people who can handle both. And so, there are two areas that, even before I realized I was doing palliative care psychiatry, I think are the most difficult, both for learners and also my colleagues.

I've spent most of my career in medicine, not in psychiatry, so I kind of know both sides. And there are two things that are hard both to understand intellectually and handle emotionally. And those—I'll talk about them in turn—are determining decisional capacity and diagnosing depression and the wish to die in patients living with serious illnesses, both psychiatric and medical. And not that I'm endorsing a dichotomy, but just to delineate it. And sometimes asking a few Socratic questions to learners, especially in team rounds, can really bring insights that help resolve the intrinsic distress, right, of seeing people who are suffering in different ways and have real strengths, but also vulnerabilities and do this good but very hard work. And because the *AMA Journal of Ethics* is clinically oriented, I'm going to use a few examples.

So, I still am a practicing palliative care physician and practicing consult psychiatrist as well as doing ethics full time. And so, we had a series of cases that were brought to me because of my overlapping skills. And it's a familiar scene. It's got a patient who's older, who has failure to thrive, and who is brought in, and everyone's a bit confused about what's going on. Some people, naturally, the medical folks are worried about depression. Sometimes there's a referral for palliative care or even hospice. There's some chronic medical issues, but nothing acutely that looks like it's going to end the patient's life. And

yet they're very sick, and they're not engaging in life activities. And so, when I see them, I often bring representatives of two teams from palliative care or medicine, hospitalist, and psychiatry together to interview patients, because we each have different skills and knowledge. And it brings mutual learning, and I think, benefits the patient.

So, often these patients aren't eating, and they say they just want to give up, or they're done, or they want comfort care. And so, we just ask a very simple sort of literal question, "What do you mean by comfort care?" Because people were thinking, well, this means he's ready to die, and he doesn't want any treatment. And the, [chuckles] the patient said, "I want a comfortable bed and someone to take care of me and food I like," which is what the average person would say makes them comfortable. It's actually a pretty famous country song. And so, one of the residents volunteered along with, to go across the street and get some food that this gentleman really liked. And sometimes that's a hamburger. Sometimes it's something we really know in palliative care. [00:09:28] Brought the food to him. Ate everything on his plate, asked for more, and said, "I hate hospital food." So, I then said to the resident psychiatric and the palliative care fellow, "[Does] this look like somebody with melancholic depression?! Would that be their response? Or would they say, 'I don't even care what I eat. You know, I just...I don't want anything'?"

And you could see the lights in their eyes, the light bulbs go off, and immediately they're able to think that this isn't a patient meeting a criteria for severe depression. And they could see the difference between someone. And it turned out in a number of these cases, whoever the caregiver was for the patient had died or was very ill and couldn't take care of them, and the patient was overwhelmed. They just figured they hadn't any choice but to die. They weren't really depressed, but they really wanted to be taken care of and have some space to grieve. And they certainly didn't, weren't actually asking for comfort care in the way we think of that in a hospice sense. So, I hope that example helps a little bit because everybody was distraught about what's going on and how to help the patient who perked up after the hamburger and is, most of them are now doing better. And if not, then you realize, you push harder, you try to figure out is this really a complicated depression, is it bereavement, or is there something we've missed medically, or is it truly, truly that they're starting to decline?

HOFF: Yeah, that case provides a great example of how hands-on clinical teaching environments can benefit students and aid assessment. But I imagine that doesn't translate as well to classroom-based instruction. So, which features of this content make it hard to assess whether and how students are learning what you're teaching?

GEPPERT: So, I think you still have to use cases. And I provide articles about specific issues such as how to diagnose depression in patients who are very ill or how to distinguish depression from apathy and dementia. And so, I always do provide clinically-oriented articles, often case-based. But I think you can't really, it's very difficult to teach the subject outside of the clinical encounter or at least referring to the clinical encounter. So, asking trainees to bring in cases that they've seen that they might not have put in this frame, but that with sort of the didactic background about what palliative care does and what palliative care psychiatry does and how they interface will come to mind.

I always have a series of articles on the difference between palliative care consults and psychiatry consults, and ethics consults and psychiatry consults, and palliative care and ethics consults and try to really have a Venn diagram of how those all overlap, and to teach, especially palliative care fellows and other types of residents when do what, which consult? What are the indications there of who can help you best? And hope everybody can have some basic skills in all three.

I also teach graduate students in bioethics, and some are biomedically trained. Many of them aren't. And they're the first to acknowledge what you just asked, which is discussing issues in the abstract is very different than caring for patients that are confronting those same questions in their lives. And so, like much of the best medical education, the underlying theoretical philosophy's casuistry, case-based learning. [00:13:02] And when you treat older populations, I think you can try to help them see paradigms of the cases and give them reading about that, like the one that I just went over with you about failure to thrive and what's the differential diagnosis there? And you want them to get, what's difficult about assessment is you want them to get exposed to enough complicated cases that they can see those patterns and the nuances. And it has to be clinically-based because you could read about a passive wish to die and say it's autonomy and the patient has the right, and then realize that you need to bring in the contextual features of a spouse that died and horrible hospital food and all the real grounding, everyday realities. So, certainly we teach about diagnosable depression and that it's not the same to even have a passive wish to die, but it isn't the same as actual acute suicidal ideation.

And also, I think coming up with ways to interview and techniques that will be helpful. I've been the most successful in assessing palliative care fellows' learning because we see more patients, and so we can reinforce the teaching. There is a topic that bridges both didactic and clinical, and that's decisional capacity. And as I mentioned in the answer to the prior question, this is one of the most difficult concepts. Many trainees learn or are taught in a purely pedagogic way that if a person has a major neurocognitive disorder or chronic schizophrenia, they just don't have decisional capacity. It's black or white; it's absolute. And then you can bring in that clinical learning in the classroom and use different cases to show that patients may not be able to make complex medical decisions—say, do I want surgery, radiation, or chemotherapy for my cancer and in what order—but they can almost always express fundamental what I call elemental values and preferences about treatment and life and death. [00:15:05] You know, do they want a chance? Do they want to have their just pain relief? Do they, you know? I've seen patients with pretty moderately severe dementia tell me, "My hip broke. It hurts. I want to get it fixed. I want to be able to walk." And then, of course, they can't consent for all the ins and outs of the surgery, the risks and benefits.

And even more primordial than that is most patients, except in acute psychosis or very advanced dementia, can say who they trust and love to help them make hard end-of-life decisions. And so, when you talk about decisional capacity and you give them, you explain these myths and then you explain the truths in a classroom setting, and then they can translate those into clinical reality and realize much of what they learned may not be accurate. And I'm also very proud when I can see a resident or a fellow see a patient with serious mental and physical illness who's told the team that they're ready to die, and they come back and tell me, "They're not suicidal. They don't want to live like this. They prefer a palliative approach. But no, they don't need acute psychiatric treatment." So, I assess it in seeing an improvement in the comfort level and the confidence and in the competence of my trainees dealing with palliative care psychiatry cases.

HOFF: It sounds like students benefit from that one-on-one hands-on clinical environment.

GEPPERT: Yes.

HOFF: But I'm wondering what strategies you recommend for integrating this content more robustly into health professions curricula more broadly.

GEPPERT: So, I'm a big believer, as I said, in providing clinical ethics content in case-based education and clinically-focused didactic material. I think especially when something's difficult or new or fearful, it's the very best way. I'm a Hippocratic physician. I believe in mentoring and apprenticeship, and so I share lots of my cases and experiences. I tell the residents at this stage of my life that, "I'm getting old, and all I do is tell stories. So, tell me when I've told you these before." But in a variety of specialties, multidisciplinary teaching really helps. I think teaching, for medical specialties, teaching them the basics of psychiatry: diagnosing depression, dementia, delirium, looking at end-of-life concerns medically, psychiatrically, ethically.

For mental health trainees, it's really important, going back to what I said in the first question, to focus on the medical parts: How do you know? How do you exclude that? How does pain or, you know, how does that affect, what are other medical factors that go into failure to thrive? Appetite wise, constipation is a very common one. So, bringing both the medical and psychiatric knowledge in the classroom to help them look at that. And then, as I said, translating it in their formulations and treatment plan, diagnostically in their treatment plans for patients.

And integration. It's all about integrating all of these parts and then focusing them, honing them on the trainees' particular discipline. If you're family medicine, let's take this in the outpatient setting, and let's think about that. I also ask them to do reading. I always assign reading and reflect and then bring that reading in, reflect on their own experiences, even if they're personal, professional, even if they didn't recognize them at the time. [00:18:26] Often residents will say, "Gosh, I had 26 patients, but I didn't realize now that this person probably had a serious mental illness, or they were at the end of life." So, I think those are the most helpful ways to work this content into the curriculum.

HOFF: And finally, you've contributed to the Journal a few times in the past. And in fact, you have a new article that just came out this month. For folks who are interested, it's *Is There a Case for Palliative Care Addiction Psychiatry?* in this month's, September 2023's, issue of the Journal. So, can you talk a little bit about how you've used what you've published with us to motivate students or colleagues' ethical inquiry?

GEPPERT: So, thank you. And thanks to *AMA Journal of Ethics*, who I've worked with for many years, for this issue about palliative care psychiatry and for letting, for accepting my article on addiction palliative care psychiatry, which is a whole nother area where I teach and about end stages of addiction. So, I have used a number of my articles over the years to, again, they're case based and also commentaries. It's one of my, *AMA Journal of Ethics*, is one of my primary sources of teaching material even in my undergraduate, postgraduate I mean, medical student courses, ethics courses. And I use, I almost always assign them. They are the perfect vehicle for the kinds of teaching I've been talking about because they begin with a case, and then they have commentaries and background material. They have history. And so, I will certainly be using my case and all the others in this issue in teaching palliative care psychiatry. There isn't, as you can imagine from the answer to the first question, a whole wealth of material out there. There are some very great theoretical articles and kind of overview of the field, and I'll be providing one of those in the notes.

One of the ironies about doing this podcast on teaching the ethics of palliative care psychiatry is that one of the very first papers I ever wrote in medical ethics was a submission for the John Conley Ethics Essay Contest.

HOFF: Oh, really? [music returns]

GEPPERT: I was a medical student a long, long time ago, and it was called, the title was, *The Rehumanization of Death*. And didn't know it then at all, but from that vantage point, I can recognize that that was an early effort in palliative care psychiatry and ethics.

HOFF Well, Dr Geppert, thank you so much for your time on the podcast today. It was great to have you back. And thank you for your past, current, and hopefully future contributions to the Journal that help build up resources in these important and neglected topics like palliative psychiatry.

GEPPERT: Thank you.

HOFF That's all for this episode of *Ethics Teaching and Learning*. Thanks to Dr Geppert for joining us. Music, as always, was by the Blue Dot Sessions. For more articles, podcasts, continuing education opportunities, and more, all free to access, head to our site, journalofethics.org. Follow us follow us on [Twitter](#) and [Facebook @journalofethics](#). And we'll be back with more *Ethics Talk* soon.