

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

Is There a Case for Palliative Care Addiction Psychiatry?

Cynthia Geppert, MD, PhD, DPS, MA, MPH, MSB, MSJ, HEC-C

Abstract

This commentary on a case suggests how palliative care psychiatry can facilitate compassionate resolution of ethical conflicts in end-of-life care decision making with persons with substance use disorders.

The American Medical Association designates this journal-based CME activity for a maximum of 1 AMA PRA Category 1 Credit™ available through the AMA Ed Hub™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Case

Mr R is a 52-year-old man with methamphetamine-associated cardiomyopathy (MACM) admitted to an acute medicine service for failure to thrive for the second time in 6 months. Mr R has a 3-decade history of methamphetamine use in various forms, including injection.¹ Mr R has received evidence-based therapy, including outpatient and residential treatment. His longest period of sobriety (7 months) was 9 years ago when he participated in a contingency management program.² Advanced MACM was diagnosed about a year ago when his ejection fraction was less than 40%. Three months before his diagnosis, Mr R had stopped using methamphetamine because he did not have the stamina to obtain and prepare the drug. Mr R lives alone in an apartment; home health services personnel visit him several times a week. His ex-wife, S, is designated as Mr R's durable power of attorney for health care and has been assisting him with meals and transportation. S reports that Mr R eats little during meals before he becomes exhausted. Mr R has lost 10 pounds since his last inpatient admission.

Dr C, a cardiology consultant, documents Mr R's increasing adherence to his medication regimen, notes that medical care options are maximized, and recommends a palliative care consultation. Dr W, an addiction psychiatrist and palliative care physician, follows up, meets Mr R, and confirms Mr R's classic symptoms of advanced heart failure: fatigue, apathy, anhedonia, and anorexia. Dr W notes Mr R's passive thoughts of being better off dead and his frustration with not being able to do anything but sleep. For previously diagnosed depression, sertraline and bupropion provided little benefit, and Mr R was unable to tolerate venlafaxine due to worsening hypertension. Dr W notes that Mr R has no active suicidal ideation, intention, or plan and attributes Mr R's current depression to his heart failure experiences. Dr W informs Mr R and S that he meets criteria for hospice care and recommends a care plan focused on promoting Mr R's

quality of life and end-of-life goals, including interacting with his ex-wife, playing with his dog, and listening to music.

Mr R expresses interest in trying low-dose methylphenidate to improve his appetite, energy level, and overall well-being while in the hospital. The attending hospitalist, Dr H, and the clinical pharmacist on the team, Dr B, decline to follow Dr W's recommendation, however, and express both clinical and ethical concerns about prescribing methylphenidate for a patient whose end-stage cardiac disease is partially due to methamphetamine use. S also expresses fear that, given Mr R's history, he will not be able to control his use of the methylphenidate.

Members of the care team, S, and Mr R consider how to best respond to Mr R's needs.

Commentary

An analysis of National Survey on Drug Use and Health statistics on nonelderly adults found that, from 2015 to 2019, methamphetamine use among US adults increased 43%; frequent use increased 66%, and overdose deaths from psychostimulants, excluding cocaine, increased 180%.³ These and other data indicate that, alongside the far more publicized opioid crisis, America is also suffering from a stimulant epidemic. After overdoses, MACM is the second leading cause of death among individuals using methamphetamine.⁴ Veterans like Mr R are increasingly diagnosed with the condition.⁵ Patients with MACM tend to be younger, present later, and have more severe disease than patients with other types of heart failure.⁶ However, despite the more advanced stage of their cardiomyopathy, these patients' abstinence from methamphetamine and adherence to cardiac medications can improve their prognosis.⁷ Unfortunately for Mr R, his cessation of methamphetamine and recent adherence to medical management came too late to significantly reverse his cardiac damage.

Consultation-liaison psychiatrists have long used psychostimulants like methylphenidate and dextroamphetamine to treat depression, fatigue, and apathy in the medically ill.⁸ The evidence that these drugs are effective for **treatment of fatigue** in patients with cancer is insufficient for them to be recommended for treating cancer-related fatigue⁹; for treatment of depression, the evidence of efficacy is equivocal.¹⁰ Side effects include induction of mania or psychosis, agitation, anger, and—most pertinent for Mr R's case—increase in blood pressure and pulse rate with potential exacerbation of heart failure.¹¹ When effective, psychostimulants can stimulate appetite and improve mood.¹² One major advantage of using them in palliative care is their rapid onset of action; clinical benefits or adverse effects can both be detected in a matter of days as opposed to the weeks it may take for antidepressants to become effective.¹³

Ethical Analysis and Recommendations

Palliative care psychiatrists have helped to identify, analyze, and propose ethically justifiable approaches related to end-of-life treatment for patients with severe and persistent mental illness.^{14,15} Similar attention has not yet been directed to addiction and the ethical issues that arise in cases like that of Mr R, although it is sorely needed.¹⁶ There is a small but growing body of hospice and palliative medicine literature that considers ethical aspects of opioid prescribing for patients with a diagnosis or history of opioid use disorder, such as stereotyping,¹⁷ that may be applicable to Mr R's case. Physicians like Dr W, who recommend psychostimulants for palliation in patients with methamphetamine use disorder, are likely to encounter the same knowledge deficits, fears of liability, and unconscious bias toward addiction as practitioners trying to palliate

symptoms of life-limiting illness in persons with opioid use disorder. To overcome these barriers, Dr W can underscore to the treatment team that Mr R is experiencing 2 end-stage disease processes: MACM and amphetamine use disorder. Mr R's life expectancy from their combined burden is limited, and Dr W has determined that Mr R meets hospice criteria. The focus of the treatment team should now shift to promoting Mr R's goals of care, enhancing his quality of life, and improving his comfort.¹⁸ Dr W thinks that a trial of methylphenidate would seem to offer at least a reasonable chance of obtaining these aims. Drs H and B have legitimate concerns about the risks involved in prescribing methylphenidate to Mr R. Based on their response to Dr W's suggestion and the literature, their concerns would seem to reflect 4 obligations stemming from core ethical principles, such as nonmaleficence, respect for autonomy, and justice.¹⁹ Dr W will need to satisfactorily address each of these to obtain the multidisciplinary support needed to implement his recommendation.

The first concern is that the prescription of methylphenidate will result in Mr R being unable to manage his use of the drug safely and responsibly. Dr W can advise S and the treatment team that several clinical trials of methylphenidate to treat methamphetamine use disorder have shown that methylphenidate might decrease cravings for methamphetamine.^{20,21,22} Similar to the use of buprenorphine and methadone to treat opioid use disorder, prescribed psychostimulants like methylphenidate may have less potential for abuse and reduce overall harm and thus enable Mr R to control his use of the drug. These trials show that Dr W is not recommending just the same substance Mr R was addicted to, as the treatment team assumes.

The second ethical concern is that even low-dose stimulants could worsen Mr R's MACM and hence do more harm. Dr W could discuss this uncertainty with S and Mr R during the informed consent discussion. He may also be able to leverage research suggesting that the etiology of MACM is more complex and multidetermined than the treatment team believes—that is, that methamphetamine use is not the sole cause of MACM²³—in discussion with other members of the treatment team. These data may enable the treatment team to respond with what philosopher Hanna Pickard has referred to as a stance of “responsibility without blame.” Pickard explains this view as it relates to caring for patients like Mr R: “Hence the clinical task with such patients is not to deny their agency and rescue them from blame by pathologizing their behavior, but to work with them and help them to develop their sense of agency and responsibility to support and empower them to make different choices.”²⁴

Third, there are understandable prudential fears in this case. Dr W, perhaps with the assistance of an ethics consultation, can emphasize that good documentation of a sound informed consent discussion with Mr R and his ex-wife is the best defense not only to any legal challenge but also to any risk management challenge, such as Mr R becoming addicted to the medication or the drug worsening his heart failure. The ethics consultant might remind the treatment team that the use of methylphenidate for Mr R is a prime example of harm reduction: an efficacious and established public health approach to substance use disorders.²⁰

Fourth, and more difficult to elicit and address, research suggests that the treatment team may be **stigmatizing** Mr R as a person with a substance use disorder.⁷ Dr W can empathically help his colleagues to see that stigma and health disparities also shaped Mr R's sad situation and that prescribing a trial of methylphenidate is a small act of

social justice.²⁵ Even offering the medication to Mr R conveys a level of respect for his dignity and trust in him as a moral agent that he may seldom have received from the health care system and that can, independently of the medication, have a healing impact on the remainder of his life.

References

1. Goodwin JS, Larson GA, Swant J, et al. Amphetamine and methamphetamine differentially affect dopamine transporters in vitro and in vivo. *J Biol Chem*. 2009;284(5):2978-2989.
2. Substance Abuse and Mental Health Services Administration. *Treatment Improvement Protocol (TIP) 33: Treatment for Stimulant Use Disorders*. Substance Abuse and Mental Health Services Administration; 2021. SAMHSA publication PEP21-02-01-004. Accessed May 30, 2023. <https://store.samhsa.gov/sites/default/files/pep21-02-01-004.pdf>
3. Han B, Compton WM, Jones CM, Einstein EB, Volkow ND. Methamphetamine use, methamphetamine use disorder, and associated overdose deaths among US adults. *JAMA Psychiatry*. 2021;78(12):1329-1342.
4. Osekowski M, Trytell A, La Gerche A, Prior D, Maclsaac A, Paratz ED. A comprehensive approach to managing methamphetamine-associated cardiomyopathy. *Am J Cardiovasc Drugs*. 2022;22(4):385-393.
5. Nishimura M, Ma J, Fox S, et al. Characteristics and outcomes of methamphetamine abuse among veterans with heart failure. *Am J Cardiol*. 2019;124(6):907-911.
6. Curran L, Nah G, Marcus GM, Tseng Z, Crawford MH, Parikh NI. Clinical correlates and outcomes of methamphetamine-associated cardiovascular diseases in hospitalized patients in California. *J Am Heart Assoc*. 2022;11(16):e023663.
7. Somma V, Osekowski M, Paratz E, Bonomo Y. Methamphetamine-associated cardiomyopathy: an addiction medicine perspective. *Intern Med J*. 2023;53(1):21-26.
8. Pary R, Scarff JR, Jijakli A, Tobias C, Lippmann S. A review of psychostimulants for adults with depression. *Fed Pract*. 2015;32(suppl 3):30S-37S.
9. Breitbart W, Alici Y. Psychostimulants for cancer-related fatigue. *J Natl Compr Canc Netw*. 2010;8(8):933-942.
10. Candy M, Jones L, Williams R, Tookman A, King M. Psychostimulants for depression. *Cochrane Database Syst Rev*. 2008;(2):CD006722.
11. Duflou J. Psychostimulant use disorder and the heart. *Addiction*. 2020;115(1):175-183.
12. Olin J, Masand P. Psychostimulants for depression in hospitalized cancer patients. *Psychosomatics*. 1996;37(1):57-62.
13. Huffman JC, Stern TA. Using psychostimulants to treat depression in the medically ill. *Prim Care Companion J Clin Psychiatry*. 2004;6(1):44-46.
14. Westmoreland P, Parks L, Lohse K, Mehler P. Severe and enduring anorexia nervosa and futility: a time for every purpose? *Psychiatr Clin North Am*. 2021;44(4):603-611.
15. Trachsel M, Irwin SA, Biller-Andorno N, Hoff P, Riese F. Palliative psychiatry for severe persistent mental illness as a new approach to psychiatry? Definition, scope, benefits, and risks. *BMC Psychiatry*. 2016;16:260.
16. Datta P, Kruk JS, Jordan K, Fisher KA. Dying with dignity: the challenges of end-of-life care in patients with substance use disorders. *BMJ Case Rep*. 2021;14(11):e240945.

17. Flaherty A, Hossain F, Vercelli A. Meeting at the crossroads of pain and addiction: an ethical analysis of pain management with palliative care for individuals with substance use disorders. *J Opioid Manag.* 2021;17(3):207-214.
18. Westermair AL, Buchman DZ, Levitt S, Perrar KM, Trachsel M. Palliative psychiatry in a narrow and in a broad sense: a concept clarification. *Aust N Z J Psychiatry.* 2022;56(12):1535-1541.
19. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics.* 7th ed. Oxford University Press; 2013.
20. Rezaei F, Emami M, Zahed S, Morabbi MJ, Farahzadi M, Akhondzadeh S. Sustained-release methylphenidate in methamphetamine dependence treatment: a double-blind and placebo-controlled trial. *Daru.* 2015;23(1):2.
21. Aryan N, Banafshe HR, Farnia V, et al. The therapeutic effects of methylphenidate and matrix-methylphenidate on addiction severity, craving, relapse and mental health in the methamphetamine use disorder. *Subst Abuse Treat Prev Policy.* 2020;15:72.
22. Ling W, Chang L, Hillhouse M, et al. Sustained-release methylphenidate in a randomized trial of treatment of methamphetamine use disorder. *Addiction.* 2014;109(9):1489-1500.
23. Reddy PK, Chau E, Patel SV, Yang K, Ng TM, Elkayam U. Characteristics of methamphetamine-associated cardiomyopathy and the impact of methamphetamine use on cardiac dysfunction. *Am J Cardiol.* 2021;154:86-91.
24. Pickard H. Responsibility without blame for addiction. *Neuroethics.* 2017;10(1):169-180.
25. Earnshaw VA. Stigma and substance use disorders: a clinical, research and advocacy agenda. *Am Psychol.* 2020;75(9):1300-1311.

Cynthia Geppert, MD, PhD, DPS, MA, MPH, MSB, MSJ, HEC-C 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. Her clinical work and scholarly interests lie in the areas of ethics education, clinical ethics, consultation liaison, addiction and palliative care psychiatry, theology and religion, and health law.

Citation

AMA J Ethics. 2023;25(9):E678-683.

DOI

10.1001/amajethics.2023.678.

Conflict of Interest Disclosure

Authors disclosed no conflicts of interest.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.