



REVISTA COLOMBIANA DE PSIQUIATRÍA

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Letter to the Editor

Futility and palliative psychiatry in mental health: New clinical and ethical challenges[☆]



Futilidad y psiquiatría paliativa en salud mental: nuevos desafíos clínicos y éticos

Dear Editor,

The concept of futility is used frequently in the medical field. Although many definitions and approaches have been proposed,¹ in general, futility refers to the intrinsic relationship between an action and an expected objective, and there are three distinct types: physiological, quantitative and qualitative.² The term futility is accepted in general medicine, but in mental health there are discrepancies, and it is little used. Various articles have recently been published in the literature on its use and/or its legitimacy in this field.^{1,3,4} It has been suggested^{2,3} that the futility judgement in some mental illnesses, such as anorexia nervosa, should be appropriate if there is evidence of poor prognosis, the indicated treatment does not provide an effective therapeutic response, there is progressive physical and psychological deterioration, or there are signs of an inevitable and terminal outcome.

Use of the concept of futility in mental health has not been exempt from criticism and even debate as to whether it is clinically meaningful and ethically and legally justifiable.^{5,6} Despite the lack of consensus on its legitimacy, the theory that a healthcare professional should not be obliged to offer treatments that are not beneficial or which are inefficient for the patient is usually accepted, but that does not exempt them from dialogue and discussion about therapeutic alternatives. Although there may be a lack of effective treatments for the specific case, this does not invalidate the need to try palliative care.

In this context, we have seen the idea of "palliative psychiatry"^{7,8} gradually being introduced, a concept particularly relevant in anorexia nervosa, schizophrenia and/or borderline personality disorder.⁹ Trachsel et al's proposal⁷

maintains that this approach improves the quality of life of patients and their families in terms of coping with the problems inherent to mental illness. It is a proposal that affirms life, but which, without wanting to anticipate death, recognises that there may be situations where the condition is incurable. It has a bio-psycho-social and spiritual approach, so it is applicable along with other therapies aimed at prevention, healing, rehabilitation and recovery.

Despite being widely accepted in literature, critics debate whether an exclusive definition for psychiatry is needed.⁶ Nevertheless, palliative psychiatry in patients with mental health problems has already begun,¹⁰ and palliative tools are even being developed for people with serious mental illnesses.¹¹

This new approach highlights a great respect for people, in that it seeks to introduce the values and preferences of patients (this could even be done by anticipating decisions through an advance directive document or advance care planning¹²) and their families to improve their quality of life. Therefore, we face a new paradigm, which seeks not only to cure, but also to care for people, but that requires psychiatry to be both critical and reflective, with its foundations and medical praxis. It should therefore be an ethical and clinical imperative to humanise mental healthcare to prevent suffering and futile measures, and to care for incurable patients, and thus seek to provide comfort, psychological support, and inherent respect for dignity.

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DOI of original article: <https://doi.org/10.1016/j.rcp.2020.10.002>.

[☆] Please cite this article as: Pozón SR. Futilidad y psiquiatría paliativa en salud mental: nuevos desafíos clínicos y éticos. *Rev Colomb Psiquiat*. 2022;51:87-88.

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2530-3120/

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<https://doi.org/10.1016/j.rcpeng.2022.06.001>