AFMO launches Web site for family medicine research
The Academic Family Medicine Organizations (AFMO) has developed a Web site providing information about funding opportunities for research, projects by American Academy of Family Physician's (AAFP) National Research Network, research meetings and conferences.

CMS eliminates grace period for expired codes
The Centers for Medicare and Medicaid Services (CMS) has eliminated the 90-day grace period formerly allowed after new International Classification of Diseases (ICD-9), Current Procedural Terminology (CPT), and Healthcare Common Procedure Coding System codes.

AAFP publishes resource for starting a medical practice
AAFP has published a guide to help physicians who want to open their own practices. This resource, "On Your Own: Starting a Medical Practice from the Ground Up," provides information on licensing regulations, insurance requirements, supplies, and start-up costs.

AAFP board approves recommendation to double EB CME credit
At the August meeting, the AAFP Board of Directors approved a recommendation from the Commission on Continuing Medical Education that doubles the continuing medical education (CME) credit awarded for educational activities designated for AAFP evidence-based practice.

CDC releases state-specific breastfeeding data
In August, the Centers for Disease Control and Prevention (CDC) released state-by-state data on the percentage of mothers who are breastfeeding their infants and for how long. The new data were gathered as part of the CDC's 2003 National Immunization Survey.

FDA approves new treatments for HIV patients
In August, the U.S. Food and Drug Administration (FDA) approved two fixed-dose combination drug products for the treatment of human immunodeficiency virus (HIV) infection: Epzicom (abacavir/lamivudine) and Truvada (tenofovir disoproxil/emtricitabine).

NACHC report confirms uninsured patients are using emergency departments for routine care
In a report, "Nation's Health at Risk: Part II," from the National Association of Community Health Centers, Inc. (NACHC), the data suggest that uninsured patients are using hospital emergency departments for routine care. According to the report, uninsured patients are more likely to use emergency departments than insured patients.

Two studies focus on the causes of health care disparities
Results from two surveys reveal the nature of health care disparities in the United States. The study from the Memorial Sloan-Kettering Cancer Center in New York City and the Center for Studying Health System Change (CSHSC), Washington, D.C., conclude that disparities exist across all areas of health care, including access to care, quality of care, and outcomes of care.

Asthma update: Part II. Medical management
The 1997 guidelines from the National Asthma Education and Prevention Program (NAEPP) (1) noted that inhaled corticosteroid therapy offered multiple benefits in patients with persistent asthma, but some uncertainty remained about its use in certain patients.

Diary: from a week in practice
Monday When beginning a week on inpatient service, I always wonder what catastrophe might befall us—and today my fears are realized. Our first patient is a 21-year-old woman with type 1 diabetes.

Identifying and managing preparatory grief and depression at the end of life
Identifying and Managing Preparatory Grief and Depression at the End of Life

Author: Vyjeyanthi S. Periyakoil, James Hallenbeck
Date: March 1, 2002

Grief and depression present similarly in patients who are dying. Conventional symptoms (e.g., frequent crying, weight loss, thoughts of death) used to assess for depression in these patients may be imprecise because these symptoms are also present in preparatory grief and as a part of the normal dying process. Preparatory grief is experienced by virtually all patients who are dying and can be facilitated with psychosocial support and counseling. Ongoing pharmacotherapy is generally not beneficial and may even be harmful to patients who are grieving. Evidence of disturbed self-esteem, hopelessness, an active desire to die and ruminative thoughts about death and suicide are indicative of depression in patients who are dying. Physicians should have a low threshold for treating depression in patients nearing the end of life because depression is associated with tremendous suffering and poor quality of life. (Am Fam Physician 2002;65:883-90,897-8. Copyright[©] 2002 American Academy of Family Physicians.)

Distinguishing between grief and depression in patients who are dying can be difficult. Many of the signs and symptoms traditionally used to diagnose depression are also present in patients who are grieving (Figure 1). Weight loss, anorexia, and sleep disturbance, for example, might reflect depression, grief, poor control of physical symptoms or the normal physiologic changes associated with dying. Survey instruments designed to detect depression have not been well studied in patients who are dying and lack specificity because questions addressing somatic, functional and affective criteria can generate false-positive results. The Geriatric Depression Scale,(1) for example, rates frequent crying. Crying can reflect depression or normal grief in dying patients. Differentiating between preparatory grief and depression is essential because of therapeutic implications. While some researchers have suggested that grief and depression differ in significant ways, evidence supporting such distinctions is lacking.(2)

Illustrative Case

An 82-year-old man with a history of metastatic prostate cancer was admitted to an inpatient hospice unit because of progressive debilitation. His pain was well controlled, but he had a poor appetite, was losing weight and had crying spells. When asked about possible depression, he replied that he was not sure if he was depressed. One of his daughters who lived near him and helped care for him felt that his crying indicated that he was finally coming to terms with his terminal diagnosis; another daughter felt that he was depressed. Statements the patient made like, "I can't believe I'm dying," suggested that he was grieving. The physician treating him was unsure whether he might also be depressed. The patient received psychologic counseling and started taking a selective serotonin reuptake inhibitor (SSRI) antidepressant. He demonstrated a good response—his affect and energy level improved. The patient died peacefully a few weeks later.

Depression

Virtually all patients who are faced with dying experience episodes of sadness. These sad feelings are usually very intense for a variable period of time and then often gradually diminish in intensity. In some patients, dysphoria is persistent and is associated with a sense of hopelessness and disturbed self-image. An estimated 22 to 75 percent of patients who are dying experience clinical depression.(3) However, depression is not inevitable and should not be considered a normal part of the dying process.

Depression shares common features with grief. Misdiagnosis can result in overlooking depression when it is present or inappropriately treating grief. Depression and grief are different conditions that require different treatments although, clinically, they often overlap. Patients with depression may benefit from counseling and pharmacotherapy.

Preparatory Grief

Grief is a reaction to any loss. As Freud(4) observed, grief is "the reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one, such as one's liberty..." Grief manifests as a progression of emotional, social, spiritual, physical, cognitive and behavioral changes through which a person attempts to reorganize and resolve or adjust to the loss at his or her own pace.(5,6)

Preparatory grief, as introduced by Kubler-Ross in "On Death and Dying,"(7) is "that [grief that] the terminally ill patient has to undergo in order to prepare himself for his final separation from this world." Preparatory grief is the normal grief reaction to perceived losses experienced by persons who are dying. (The terms anticipatory grief and anticipatory mourning are commonly used to refer to grief experienced by family members or friends before the death of a loved one. The grief experienced by patients as they prepare for their impending death is different from anticipatory grief as defined by the extensive body of existing literature. Consequently, preparatory grief, as defined by Kubler-Ross(7) in reference to grief experienced by the dying person, is used here.)

Persons who are dying prepare for their death by mourning the losses implicit in death. The anticipated separation from loved ones is an obvious one. Simple pleasures of living may be grieved. People may reflect on their past and relive great moments and disappointments, and mourn for missed opportunities. Looking to the future, they may grieve the loss of much-anticipated experiences such as a child's graduation or the birth of a grandchild.(8) In the present, the person who is dying usually experiences a radical change in self-image. Previously independent, the person may now be weak and dependent on others for even the most basic needs. The old self-image has been lost and is grieved as the person who is dying and their family adjusts to a new, more fragile sense of self.

Grief, which is often experienced as a painful tearing sensation, is also a process by which the grieving person adjusts to a radical change in the relationship between the self and that which is being lost—an object of attachment or love called the "loss object."(9) Loss objects can be people or they can be simple pleasures like drinking coffee in the morning. The loss object can be a person's self image. Grief can be understood as the physical, psychological and cognitive changes that occur in response to an abrupt change in the relationship between the grieving person and the loss object. The grieving person moves, sometimes slowly, sometimes quickly, toward a new equilibrium as the changed relationship is redefined with the loss object.

Preparatory grief, while normal, can be facilitated through proper support. Grief per se rarely requires pharmacologic intervention. Inappropriate use of antidepressants or anxiolytics for treating grief may result in iatrogenic complications that have little, if any, benefit.

Differentiating Between Preparatory Grief and Depression: A Diagnostic Dilemma

Because many of the traditional signs of depression are also present in patients who are grieving, it can be challenging to separate the relative contribution of depression and grief in patients' presentations. The following questions can be used to explore a patient's moods.

* Do you feel depressed most of the time?
* Do you feel that you are better off than many other people in similar situations?

Some patients and their families will be readily able to identify depression. Others, however, may not be able to differentiate possible depression from grief or the normal changes that occur in the dying process. Figure 2 presents a process that can be used to help distinguish grief from depression. The following points highlight differences between preparatory grief and depression.

Temporal Variation. Grief is often experienced in waves, which are usually triggered in response to a specific loss. New waves of grief may be "predictably" triggered in response to a new loss (e.g., when an ambulatory patient becomes bedridden), or "unpredictably" triggered by seemingly minor incidents (e.g., hearing a treasured song or noticing a stranger's resemblance to a loved one).
Progress with Time. In most cases, patients progress through grief and it slowly diminishes in intensity over time. Patients may periodically experience intense waves of grief (an acute grief reaction), but the overall intensity wanes.

Depression is a pathologic state. Patients can “get stuck” in this state without treatment.

How Long the Patient Is Likely to Live. Treating depression in patients who only have a few days to live necessitates the use of psychostimulants.

Possible Side Effects to Avoid. For example, drugs with anticholinergic effects are unsuitable for use in patients with benign prostatic hypertrophy or dementia, and can exacerbate dry mouth.

Side Effects That Might Enhance Patients’ Quality of Life. For example, mirtazapine (Remeron) has appetite-stimulating properties that can be useful in patients who have a poor appetite. Tricyclic antidepressants are useful in treating neuropathic pain.

A detailed review of the treatment of depression is beyond the scope of this article. Some of the features of antidepressants that are relevant to managing depression at the end of life are presented.

Psychostimulants, such as methylphenidate (Ritalin) or dextroamphetamine (Dexedrine), can be helpful when a rapid response (within 24 to 48 hours) is desired. These agents are most effective in patients with psychomotor retardation. Their use should be avoided in patients who are agitated, confused or delirious. Treatment with psychostimulants can provide a relatively quick test to show whether antidepressants are likely to be effective.

(2) Positive side effects include increased energy and appetite, and counteraction of opioid-induced sedation.

SSRIs are often preferred agents for treatment of depression because they have a relatively rapid onset of action and fewer side effects, compared with tricyclic antidepressants.

Patients can be started on a combination of a psychostimulant and an SSRI. The psychostimulant can be tapered off one to two weeks after the SSRI has an effect. Trazodone (Desyrel) should be considered in the treatment of patients with depression who are also experiencing insomnia.

Final Comment

Caring for patients who are dying and their families can be challenging yet rewarding work. Recently, much-needed attention has been given to addressing pain and other physical symptoms experienced by these patients. However, not all suffering related to dying is physical. Grief and depression, as distinct but related processes, can result in intense suffering. Fortunately, much can be done to help patients deal with grief and depression. Grief can be supported and facilitated, and depression can be treated. Excellent care requires the support of a skilled interdisciplinary team and a partnership with patients and their families.

The authors indicate that they do not have any conflicts of interest. Sources of funding: this work was supported in part by the Department of Veterans Affairs Geriatric Research and Extended Care Center, Palo Alto Veterans Affairs Health Care System.

VYJEYNTHI S. PERYAKOIL, M.D., is medical director of Stanford Hospice, Stanford, Calif., and a staff physician with the Palo Alto Veterans Affairs Health Care System, Palo Alto, Calif. Dr. Peryakoil earned her medical degree from the University of Madras, Madras, India. She completed a residency in internal medicine at San Joaquin General Hospital in Stockton, Calif., and a fellowship in geriatrics at the Stanford University School of Medicine, Stanford, Calif.

JAMES HALLENBECK, M.D., is clinical associate professor of medicine at the Stanford University School of Medicine and medical director of the Veterans Affairs Hospice Care Center, Palo Alto, Calif. Dr. Hallenbeck earned his medical degree from Emory University School of Medicine, Atlanta, Ga., and completed a residency in internal medicine at the University of California, San Francisco, School of Medicine.

Address correspondence to Vyjeynthi S. Peryakoil, M.D., Hospice Care Center, Bldg. 100-2C, 3801 Miranda Ave., Palo Alto, CA 95304. Reprints are not available from the authors.

REFERENCES


Advanced preparatory grief is frequently confused with depression, and patients may be inappropriately treated for depression. Figure 1. Preparatory Grief in the Context of Life-Limiting Illness.