When People with Serious Mental Illness Get Cancer

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My colleague Dr. Kelly E. Irwin, who is a member of the Psychiatric Annals Editorial Board, is leading the fight to get better cancer care for people with serious mental illness (SMI). She has taught me that well-meaning oncologists predict that people with SMI will not be able to understand their cancer diagnosis, their cancer treatments, their cancer protocols and, as a result, people with SMI are systematically excluded from participating in potentially lifesaving research. Even during routine care and outside of research, people with SMI are more likely to experience disruptions in cancer care (ie, delayed diagnosis, delayed treatment, and uncompleted treatment). The net result is that, on average, they die sooner from cancer compared to those without SMI. Mental health professionals medical care for people with SMI tends to be fragmented, including care for their cancer. The literature on the psychiatric care of cancer patients covers treating the depression, anxiety, and stress associated with a cancer diagnosis, but too little work covers the medical care of people with SMI.

Part of the problem in getting the best cancer care is that many oncologists (and many of our nonpsychiatric medical colleagues) experience people with SMI as “other.” When this happens, physicians’ unconscious implicit biases come into play, which leads to assumptions associated with people with SMI, such as they can’t make competent decisions or judgments, they can’t be reliable, they will be difficult patients, and they will take up too much time. And if oncologists have not spent enough time with people with SMI and vaguely recall their psychiatry rotation during their now-distant medical school experience (which many may have experienced as irrelevant to their chosen field of oncology), isn’t it probable that they would respond to people with SMI with implicit biases?

Most of our medical systems include the psychiatric care of people identified as medical patients with sophisticated models of integrated “behavioral health” (a vague and innocuous term). In contrast, few medical systems include onsite, integrated, readily available medical care for those with SMI co-located where these people get their psychiatric (notice: not “behavioral”) care. We should reconsider how we care for patients with SMI, educate our oncology colleagues like Dr. Irwin is doing, and find systems of care that can reduce the 8- to 25-year gap in mortality between people with SMI and those without SMI.

REFERENCES
1. Irwin KE. The patients we have to see. Oncologist. 2017;22(9):1020-1021. doi:10.1634/theoncologist.2017-0172.