Dealing With a Patient Who Has Given Up

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EDITOR'S NOTE

Through this column, we hope that practitioners in general medical settings will gain a more complete knowledge of the many patients who are likely to benefit from brief psychotherapeutic interventions. A close working relationship between primary care and psychiatry can serve to enhance patient outcome.

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For nearly 8 years now, I have worked on the palliative care team at the Ralph H. Johnson Veterans Affairs Hospital in Charleston, South Carolina. I work mostly with internists and nurse practitioners, who were all trained somewhat differently than I was. For most of my time with the palliative care team, I have met for 30 minutes 3 times a week with the third-year medical resident on geriatric rotation. We have discussed what some see as pertinent issues and others see as "wasted time."

Last July, this practice was halted, as we had no board-certified attending physician on geriatrics. Several internists had retired. Therefore, no resident was assigned to this rotation. When there were residents assigned in the past (for over 7 years), we discussed the diagnoses of anxiety, depression, and psychosis; relationship issues and how to establish a working relationship; and the importance of seeing significant others. This discussion represented an attempt to compensate for areas neglected in their training.

Additionally, one day a week, I go to the oncology clinic and see cancer patients who have been referred to me. My bias was that any patient diagnosed with cancer was likely to want to speak with someone about it. Often, these patients were reluctant to impose this task on family or friends. For many years, I would speak with 3 or 4 patients each Wednesday morning. In addition, each patient filled out a distress inventory. If 4 or more items were checked, they would be referred to me for psychotherapy.

I would call each referred patient at home and offer them an opportunity to meet with me and talk. Also, the oncology fellows (who do the bulk of the work in the clinic) could refer a patient to me for a psychiatric evaluation.

Mr A was referred to me by an oncology fellow. The fellow felt that Mr A's desire to not undergo treatment for cancer warranted his speaking with another doctor.

CASE PRESENTATION AND PSYCHOTHERAPY

Mr A is a 70-year-old white man, born in San Francisco, California, whose mother died of cancer. His father had a lengthy life, dying of heart disease at age 90. Mr A is the oldest child in his family, with 2 younger brothers and a younger sister. The youngest child had bipolar disorder and spent many years in hospitals.

Mr A graduated from high school in San Francisco and then attended college out of state. After graduation, he served in the Navy for 2 years. He never married. Mr A worked as an engineer in California for many years and moved to Charleston in 2004. His health had always

been good. He smoked cigarettes for many years, finally stopping 5 years ago. Alcohol intake has never been a problem.

Mr A has never been depressed and describes himself as "not an anxious person." He sleeps well, has a normal appetite for food, and has not lost or gained substantial weight. He has normal energy and doesn't tire easily during the day. His memory is good, and his moods are normal.

He was admitted to an assisted living facility 2 years ago when he was diagnosed with rectal cancer. He has had several colonoscopies. He now is afraid to eat because food "seems to be followed by rectal bleeding." He reads extensively and often but keeps mostly to himself in the facility where he lives. He acknowledges often being bored. He sees no purpose in getting treatment for cancer and has declined chemotherapy. He thinks about the future and sees little that encourages him. When he gets these discouraging thoughts, he often dwells on them and sometimes extends them.

I have told him that this is usually not a winning strategy. We all get thoughts, but some of us are able to divert our thinking in a direction that is more reasonable. I suggested that he try to do this.

We made another appointment to meet and talk in 2 weeks. It is his right to decline treatment for a major medical problem. I have no right to impose a strategy on him. Perhaps the power inherent in establishing a relationship will result in his forming a reason for living.