Issues in Palliative Care

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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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Once upon a time, Geriatrics at the Ralph H. Johnson Veterans Administration Medical Center in Charleston, South Carolina, was directed by Cheryl Lynch, MD, MPH. We had a good relationship and spoke together often on a variety of issues. I told her about the many articles I had written for the *Primary Care Companion for CNS Disorders* in the section called Psychotherapy Casebook. She directed me toward the third-year medical residents who spend 2 weeks on their geriatric rotation. "You should meet with the trainee on geriatrics for 30 minutes 3 times a week," she said, "and have them read your psychiatry articles and then discuss issues in palliative care with them."

And so, nearly 6 months ago, I began to spend 30 minutes 3 times a week with the medical resident on geriatrics service. Each time, I assigned 2 brief (generally 2-page) articles to be discussed 2 days later. I was sure to include newer articles as they were written and always asked the trainee about his or her experiences caring for the types of patients in question.

We discussed aging.[1] We covered thoughts about illness, loss, control issues, and identity. Aging patients often cling to an identity formed earlier in life instead of establishing an identity more fitting their age.

We discussed anxiety.[2] I asked the trainees what typically causes nervousness in older patients. We noted medical illness and thoughts concerning it. We spoke about all the time medical inpatients spend alone and "alone with their thoughts." These thoughts sometimes run like a tape recording in their mind. I emphasized the importance of pointing to the patient as the principal cause of anxiety, rather than the circumstance. We discussed the patient's engagement in a variety of activities as a good way to avoid a unitary focus on "creating" anxiety.

We discussed responsibility.[3] We teach the trainee to assume responsibility for the treatment of the patient. Unfortunately, some older patients with severe medical illness decide that the restrictions inherent in the problem they have make for a life they no longer wish to lead. They decide, therefore, to end their life by committing suicide. When some members of the family deal with the loss of a loved one by suicide, they seek a scapegoat in their search for a meaning. Some blame the doctor, in this case the medical trainee. I believe that there is value in being exposed to this problem, especially for the trainee who has not previously confronted it. This article[3] pointedly does not take a side in terms of assigning right and wrong. Rather, it poses the problem, defines the situation, and asks the readers to decide for themselves. It presents an opportunity to discuss the experience the trainees have had with this situation and exposes them to a chance to think about it if they have never encountered it.

We discussed demoralization.[4] This is not depression, although it shares multiple symptoms with the psychiatric syndrome. It features helplessness that does not respond to any known medication. It emphasizes to the trainee that there are some problems for which it may be therapeutic to have a discussion with the patient. Treatment requires conversation focusing on what the patient and others can do. Sometimes, a "moralizing lecture" can be helpful.

I spoke with each trainee about caregivers. Emphasis was placed on how little is often offered to people who invest a lot of time in taking care of others. We discussed caring for an ill spouse.[5] I told each trainee

the story of a caregiver who accompanies a patient to the hospital. I asked if they have spoken with the caregiver, in part, to learn about their patient and, in part, to learn the role of a caregiver. I then described in detail the lengthy telephone relationship I have had with a woman caring for her ill husband.

It is my hope that by emphasizing the psychological role inherent in providing care, the trainee will be encouraged to provide that aspect of care to his or her patients.

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