Issues in Palliative Care: Part Two

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I meet with third-year medical residents 3 times a week to discuss psychiatric issues in palliative care. Most often, they read the assigned articles and talk with me about their experiences treating patients.

I give them an article written with a nurse practitioner discussing end-of-life patients.[1] It is meant to show them the type of patient we will be speaking about.

As a cognitive therapist, I emphasize the thoughts that patients have. When veterans are in the hospital, their thoughts are often dominated by the medical illnesses they have. Rarely do they ask the resident doctor to utilize his or her knowledge of physiology and medicine to explain their condition. Therefore, typically patients recycle the same concerns that occur in their minds. I wrote about this in an article entitled, "What Do We Think About?"[2] Unfortunately, this rather typical approach serves mostly to generate anxiety in the patient.

I was struck by the fact that most people who work in health care see themselves as "poor patients" when they get sick. After all, they often have a lot of useful knowledge. It is apparently difficult to apply that knowledge to oneself. It is said that the "shoemaker's son may have a hole in his sole." You would think that a craftsman who fixes others' shoes would not let that happen to a family member. Similarly, some in health care have a hard time applying the knowledge they have about medical illness to themselves.[3]

Many veterans don't seem to understand the value of hospice. They see it as "giving up on treating me." Hospice workers, whether coming to one's home or admitting one to their facility, put the patient in the center of their considerations. They emphasize all of the same concerns that palliative care specialists tend to stress: sleep, appetite, fatigue, anxiety, depression, and shortness of breath. In addition, they focus on caretakers and the responsibilities and issues involved in caring for an ill significant other. This is an important correction to make for the doctor in training.[4]

One area in which the psychiatrist can benefit a doctor in training involves the relationship he or she establishes with the patient. Some patients have an excellent relationship with many others, including their providers. Some patients don't have a good relationship with anyone, and their capacity for establishing one with their health care team members is poor. It is with this group that it is important for the trainee to work hard to form a good relationship. An article[5] that discusses such a patient is included in this experience between a psychiatrist and a medical trainee.

Many years ago, a religious figure in Great Britain established a group to work at befriending patients admitted to a hospital. He called his group "The Samaritans." The lesson is worthwhile today for trainees as well as their patients. I include an article[6] about his work for the residents to read.

Of the 12 residents I have taught, the vast majority took the subject matter seriously, read the articles, and then spoke in detail about their experiences. This interaction has added an important component to a 2-week experience on geriatric medicine.

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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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