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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Roles and Goals of a Palliative Care Psychiatrist

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What is medicine about? "Careful diagnosis, skillful management, effective treatment, and cure" is one version of what most health care providers would reply. When is this paradigm inappropriate? At the end of life.

What then defines how the doctor and his or her team approach the patient at the end of life? The guiding principles are those of palliative care.

What difference does this approach make? Cure is no longer possible. The end goal changes from cure to comfort. How is comfort defined? Relief from pain and nausea, promotion of sleep and appetite, maintenance of appropriate activity, and management of anxiety and depression provide one operational definition.

The patient's mindset becomes a primary concern of the psychiatrist on the Palliative Care Team. Has the patient reconciled key relationships in anticipation of dying? Has the patient completed a life review that validates a life worth living? Is there a level of comfort associated with dying?

For the psychiatrist working in palliative care, this set of tasks often qualifies as a new life stage for the patient. There is a group of tasks to identify and master. What is the patient's spiritual understanding of what comes next?

THE PSYCHIATRIST'S ROLE

Nearly 6 months ago, I was hired by the Department of Medicine to join a Palliative Care Team at a general hospital. I actively wondered at the time about what I would be asked to do, and whether I had the background and experience to do it. Now, nearly 6 months later, I have some beginning answers to the many questions.

The primary task involves patient care. In some cases, the medical team may ask the psychiatrist for an opinion. Is there a *psychological component* to the patient's distress, and, if so, how could we best approach it? In addition, how is the patient (and his or her family system) *adjusting* to the effects of the major medical problem and the life changes it has wrought? What can we do to help? Is there a component of *anxiety disorder*, either evoked by the current condition or chronically present, that we must address? Is there the presence of a *major depressive disorder* that complicates the management of the major medical problem? Does its treatment require chemotherapy, psychotherapy, or both?

Is the patient's circumstance complicated by *denial* of the medical problem? Is the education about a physiologic process lacking, or is a management approach (eg, hospice) understood in a way that is inadequate for the patient or family to accept help?

A psychiatrist in a medical setting won't escape being asked to contribute to the well-being of the staff, as well as the patients. In each of the medical settings in which I have worked, primary care clinic,[1] oncology clinic,[2] oncology outpatient practice,[3] and general hospital geriatrics program, I have been asked psychological questions of personal relevance by staff members. In addition, regarding staff welfare, there are additional services a psychiatrist may be asked to provide. Early in my stay at the general hospital, I was asked to create a monthly "staff care" meeting at which hospital personnel could deal with the loss of patients to whom they had become close.

PSYCHOTHERAPY

The psychiatrist's contribution is typically to see and evaluate a patient one time, to render an opinion, to speak with the medical team, and to write a note. In some cases, however, more may be required. If psychotherapy is indicated, is the psychiatrist available and equipped to provide it, at times, on a continuing basis? In my case, the format is typically cognitive therapy, and it is often brief in duration.

The hospital provides a nursing home unit to which a patient may be admitted and in which he or she may spend the latter part of his or her life. Adjustment to life on this unit is a task for every patient admitted. One such case has been described previously,[4] and others will be presented in the future. Management often engages the efforts of medicine and psychiatry as a team.

The format for psychotherapy identifies the onset of the new life stage beginning with the patient's admission, as well as the ending of the preceding stage. An adjustment to the rhythms, provisions, and personnel that make up the unit is required. Some patients make that adjustment smoothly. Others may benefit from an intervention that helps the adaptation to be made. Anxiety, whether acute or chronic, and depression may complicate the adaptation. The psychiatrist may contribute substantially to the management of these conditions. His or her presence at care plan meetings or ward rounds can ensure that the psychological viewpoint is represented.

EDUCATION

The general hospital provides medical, nursing, and pharmacology students and residents in training as well as medical and nursing staff. There are clinics in which outpatient care is rendered, with medical residents often offering the initial evaluation. In the "Doctors Room," the psychiatrist may present his or her viewpoint to the students and may be asked to see the patient and then discuss diagnosis and management with the students. The psychiatrist may also be asked to participate in the didactic program.

Areas of particular interest that the psychiatrist may teach include the importance of engaging the patient when doing a diagnostic evaluation. The psychiatrist may discuss interviewing and how best to present bad news and may educate staff and trainees on the diagnosis and treatment of anxiety disorders and depression.

CONCLUSION

Although it is considered forward-looking to employ a psychiatrist as part of a medical team, it seems easy to make the argument that a carefully chosen mental health professional can add to the services provided. In addition, the palliative care movement has begun making inroads into traditional medical thinking about end-of-life care. A psychiatrist, it seems, has real contributions to make to the provision of services in terms of patient care, staff education, and training in this area.

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