Teaching Our Young

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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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I was hired by the Veterans Administration Department of Geriatric Medicine in March 2010 to join a palliative care team. My job includes time on an inpatient nursing home unit, where my task is to help older veterans adjust to the end of life. I also work one morning per week in an oncology clinic, helping cancer patients adjust to a major life change. Finally, I attend a weekly geriatric clinic, where my charge is to aid the adjustment of older veterans to their medical illnesses.

Added to this 12-hour commitment is an opportunity to make rounds twice per week with the medical internist and the resident on service caring for medical inpatients. While I have learned a lot about medical illness, as a psychiatrist, I am tasked to answer the occasional question about emotional issues relevant to diagnosis. One day I realized that I had the opportunity to accomplish a lot more in an area of teaching, which often seems to be largely ignored.

Who teaches medical trainees to communicate effectively with their patients? Does patient engagement yield more and better information relevant to treatment? Today, someone accompanies virtually every veteran admitted for care. What can be learned from significant others? What does the medical trainee know about life stages or about personality underlying illness? About demoralization? About the need to maintain some control, as control tends to be diminished with aging? About facing uncertainty?

Is the trainee taught to use common language that can be easily understood, or does he or she automatically resort to medical jargon? Does the trainee take the time to express empathy with the patient? When the trainee takes a medical history, does this history go beyond the complaint and serve to illustrate more about who this patient is? Does the trainee establish a relationship with the patient? Does the trainee ask what the patient understands to be the cause of his or her problem?

Does the trainee identify sources of social support? Does the trainee elicit their patients' fears, especially important in geriatrics and at the end of life, or their responsibilities, choices, idea of a legacy, or regrets? Some people believe that individuals must forgive before they can achieve acceptance of death. How patients view themselves may be a particular issue at the end of life. A life review at this time is not unusual.

When patients at the end of life are offered hospice (whether as an inpatient or at home), what is the meaning they attach to the offer? When palliative care is proposed, how does that affect the doctor-patient relationship? To some, "hospice" means that the goal of a cure is over and "my doctor is giving up on me." To some, it means that, "I have been central to my treatment until now, and now my team plans to talk with someone else." Palliative care may convey "no treatment" or "no hope." For the treatment team, palliative care focuses on the patient's comfort. Palliative care keeps the patient at the very center of the team's concern and represents continued interest and involvement, while it is directed to the patient's expressed needs. The patient must be asked, in order to know what palliative care means to him or her.

There is much to learn from a psychiatrist in this setting, and the learning is often not available elsewhere. In order for the learning to be meaningful, there must be a relationship established between the psychiatrist and the medical trainee. How the psychiatrist is seen (and treated) by the medical

internist in charge is critical to impacting the trainee's attitude and learning.

In the geriatric population, there is also learning that is specific to psychiatry. Learning to recognize and treat dementia is vital. Differentiating the dementias from delirium is equally important. Depression and anxiety disorders may present different challenges in the elderly, and these patients may respond to different treatment approaches. The underlying personality may determine some behaviors otherwise seen as disruptive or mysterious.

Most third-year medical residents I have met in my 3-plus years at the Veterans Administration hospital have an impressive fund of medical knowledge. Their motivation to work hard on a clerkship in geriatric medicine is, however, more variable. Their level of comfort dealing with the dying patient and his or her family is more variable still.

But this geriatric medicine rotation needs to be about more than medical knowledge. If trainees are selected for traits that exclude communication, someone had better teach them the values inherent in language, empathy, relationship, and adjustment. A psychiatrist on a palliative care team is better situated than most to take on this task. The patient at the end of life illustrates these needs better than most. The end result of training in effective communication and needs assessment should be a doctor better equipped to treat patients, not illnesses.

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