Clinicians Seminar on
Using Clues to Achieve
Empathic Understanding

Case of Ms. G

From Detached Concern to Empathy
by Jody Halpern, MD

A psychiatric consult was requested for Ms G, a 56-year-old white woman with diabetes who had just had her second above-knee amputation. She was on hemodialysis three times weekly for kidney failure and was not a candidate for kidney transplant. Although she had willingly come to the hospital for surgery, she was now refusing dialysis, even though she knew that without it she would die in a matter of days. She refused to tell the medical team why, and they wanted an assessment of her decision-making capacity.

I walked into Ms G's hospital room and was shocked to see a child-sized, bony woman curled up under the covers, eyes closed, head shrouded with her back to the world. She was in obvious pain, face tensed and mouth wide open as if to yell, although silent, reminding me of Edvard Munch's painting *The Scream*. My first instinct was to run to her medical team and say, "Give her some morphine." But I remembered that the intern had said, "We're giving her enough morphine to keep a large man comfortable."

After introducing myself, I spontaneously started a guided imagery session with her, as is often done with cancer patients in severe pain who find answering questions too uncomfortable. I asked her to imagine herself in a more relaxing place – the beach, for example, to see and hear the ocean, feel the sand and the soft breeze on her skin. Her face spontaneously relaxed, she kept her eyes shut, and gradually her breathing normalized. She seemed briefly to go to sleep.

I returned a few hours later and found a group of Ms G's women friends talking anxiously outside her door. After telling me they were worried about Ms G, one of her friends said, "Ask her about her husband, that creep." When I walked into her room, she was again in terrible agony. I began another guided imagery session, and she relaxed and seemed much more comfortable. I waited for several minutes but saw that she was not asleep. Knowing that time was of the essence and that I needed to learn something about her state of mind, I then asked her, "Is there anything besides your body that is hurting you?" With her eyes shut, she began to speak to me for the first time. "Yes . . . but I don't want to talk about it," she murmured, "I just want to go to sleep." I waited silently to see if she would say more. After a long pause she spoke very quietly. "My husband doesn't love me anymore," she began. "He told me that he's in love with someone else. He moved in with her while I was in the hospital. He said that with my amputations and other medical problems, he could never be attracted to me." She started to cry.

But before I could say anything, Ms G turned to me and looked furious, and I felt almost afraid that she would throw something at me or hurt herself. She screamed out, "Why the hell did you

ask me to talk about this? I told you I didn't want to talk. I just want to be left in peace, to sleep and never wake up. Making me think about what he said is the cruelest thing anyone has ever done to me. Don't ask me any more questions! Get out of here!"

Earlier that day, Ms G had told her surgeon that she knew she would die without dialysis and that this was her preference. She felt that her future as a double amputee was bleak and knew she would suffer further complications of her diabetes, such as blindness.

I then went to meet with her long-standing internist, Dr L. who said, "What kind of life does she face now? Wouldn't you want to die if you had lost your spouse, your legs, your kidneys and faced a future of blindness and other medical problems? Let's not ask her any more questions, let's just make her as comfortable as possible and accept her decision to die."

As a trainee, I needed to consult a supervising psychiatrist. We discussed that only two years before, after her first above knee amputation, Ms G had felt very depressed and hopeless, yet with psychiatric treatment had recovered her optimism and energy. She had gone on to enjoy her work as an artist and continue her active social life. Her past recovery gave me hope that with enough support she could work her way through the current crisis. After all, she had voluntarily come in for surgery in a hopeful state of mind before her husband had told her he was leaving her, and her doctor's notes supported performing the surgery, implying that she had years of reasonable health and functioning ahead. Surely her reaction to this catastrophic news was severely restricting her current view of her future.

The senior psychiatrist emphasized that no evidence of cognitive impairment had been detected. He said to me, with resignation, "the decision is hers. She has the capacity to decide, even though she's very upset. We need to leave this woman to die in peace and guard against imposing our own wishes on her."

Edited by
David Clarke, MD

Questions to Consider

1. Does this patient have the capacity (rational judgment) to make a decision about continuing dialysis. If she does, should we accept the decision? If we disagree with her decision, what should we do?

2. Is this patient's grief and suffering rational or irrational? What evidence exists about this?

3. Has her grief reaction affected her caregivers' judgment?

4. What kind of person is the patient? What is the nature of her marriage both present and past and what does this say about her?

5. Based on your conclusions about the above, what intervention, if any, is appropriate in this case?