中國醫藥大學

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研習心得報告

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精神腫瘤科(Psychiatric Oncology): 癌症中心獨特的一隅

緣起: MD 安德森癌症中心(MD Anderson Cancer Center)

MDACC 安德森癌症中心為美國六大癌症研究中心之一，也是公認的世界頂尖研究中心。無論在臨床照護團隊的工作，還是基礎研究開發新療法，都是處於領先全球的優越地位。其宗旨「殲滅癌症」(Making Cancer History)更是人類醫療歷史中大膽的一筆。

儘管癌症的治療需要專業的介入、臨床技術、有效的藥物等等，心靈上的支持跟健全的全人(well-being)也是相當重要的一環。許多癌症病人在罹病的過程中飽受身體上的痛苦，而這樣的壓力情境更是容易將具有精神疾病遺傳易損性(genetic vulnerability)的個體誘發病情。近年來，越來越多的研究指出無論是情感性疾患(neurotic disorder)或精神病疾患(psychotic disorder)都跟先天遺傳特質有極大關連。這些個體在罹患重大傷病時，比一般人更容易出現精神科相關症狀，而這些精神症狀與實質器官病變造成的症狀互相混雜表現，往往使臨床醫師更難進行正確的醫療抉擇跟處置。因此，精神科部在提供癌症患者全人照顧的治療中，扮演著不可或缺的腳色。

常見與癌症相關的精神症狀

根據 2017 年發表在《精神病學年鑒》*Psychiatric Annals* 的文章「化學治療、免疫療法與精神藥物在癌症患者的應用：精神副作用綜述」(Chemotherapy, Immunotherapy, and Psychotropic Use in Cancer Patients: A Review of Psychiatric Side Effects)，癌症患者在治療過程中常出現的精神科相關伴隨症狀或治療引起的副作用包含：適應障礙症(adjustment disorder)、重度憂鬱症(major depression)、器質性精神疾病(Organic Mental Disorders)如譫妄(delirium)等等、焦慮症(anxiety disorders)、人格障礙(personality disorders)。而這些精神科疾患也的確是我在為期一個月的觀察見習(observership)中最常看到團隊被照會的原因，或門診遇到的情形。

My checklist: 學習目標清單

從被診斷罹患癌症的當下，一個人的一生就此改變。徘徊於對壞消息的否定、憤怒、討價還價、抑鬱、接受；面對身體的病痛、治療引起的副作用、身體外觀無法回復的改變、還有可能引爆的家庭變故、龐大的醫療支出、就業環境的歧視，還有最終面對死亡的恐懼。種種壓力堆積如巨浪，讓人面臨窒息的恐慌、焦慮、無助、無望；感到孤立於世不再與社會連結，或對信仰失去信心。據說，人類的同理心只建立於自身有限的相似經驗。這些情形非常人所能理解也就不無稀奇了。

精神腫瘤科醫師除了必須了解這樣獨特的情境，還須具備高度對癌症治療的理解。將患者本身癌症的病程、治療副作用納入診斷考量；注意複雜腫瘤科藥物與其他用藥的交互作用。規劃治療計畫時須將癌症治療的時程納入考量，對患者本身的預後也須有一定理解。有鑑於眾多細節繁複，我在出發前往 MD 安德森前列下一份學習清單。而也相當幸運地都有一一看見！了解何謂「精神腫瘤科」，還有醫師如何臨床照護

1. 譫妄的診斷與處理
2. 癌症相關因素引起的譫妄鑑別診斷
3. 癌症治療引起的精神科相關症狀
4. 如何面對、支持面臨重大疾病、死亡已無法避免的患者
5. 如何面對、支持正度過哀慟(grief)的病患及病患照顧者

6. 心理治療在臨床上的應用

觀察員日常

到科部報到的第一天，科主任：我的導師 Dr. Valentine 就跟我排定了行程。驚訝的是，他沒有直接給我一張見習醫學生常拿到的見習行事曆，而是問我 “Why are you here? What do you want to learn from us?” (你為什麼想來這裡？想來學什麼？) 英文還不大習慣的我，結結巴巴講得差強人意，大概就是試圖表達了一下先前列的學習清單。順便努力表示了 “I would like to be a psychiatrist in the future!” (我想成為精神科醫師！)。Dr. Valentine 首先有點疑惑，似笑非笑評論了 “interesting”。然後瀟灑表示 “Of course you will see things you expect to learn. If there’s anything we can help with, just ask.” 我的行程共四週，門診跟診一週、住院團隊一週交替進行。不時還有機會參與團體討論會、國際研討會等相關活動。既興奮又有點緊張，我的 observership 就此開始！

- 門診跟診

  精神科部共九位醫師不是每位都有在看診，而且輪流負責病房事務。因此我最後有實際跟到診的醫師只有六位。病人到櫃檯報到後有護理師先進行基本資料核對，生命徵象(vital sign)量測、填寫問卷包含 Edmonton Symptom Assessment Scale (ESAS)、Patient Health Questionnaire (PHQ-9)、Generalized Anxiety Disorder 7-item (GAD-7) scale、NCCN Distress Thermometer and Problem List for Patients、Substance use screening 跟 Body image scale。問卷會列印並在看診前送到醫師手中。

  醫師會親自到候診區招呼病人進入診間，每次初診(new consult)病人一定會有 60 分鐘的會談時間，複診(follow-up)病人也會有固定 30 分鐘的會談。初診醫師必定從主訴(Chief complain)、現病史(present illness)、過去病史(past history)、社經情形(social history)等細細確認，精神狀態檢查(mental status exam)也會逐一評估。即使看起來功能良好、行動獨立的成人也會進行認知功能檢查。另外獨特之處是會先跟病人確認電腦系統上記載的癌症病史、治療情形、現在服用的藥物、治療計畫，還有最近實驗室檢查的數據。

  診間備有一張單人扶手椅跟一張長沙發，有時還有一張直接鄰近醫師桌子的軟墊椅子，醫師會讓病人自由選擇座位。診間內有兩個時鐘，分別在房間的兩側。醫師解釋這是為了讓醫師跟病人都能注意彼此剩下的時間，對會談進度有所掌握跟理解。有時會談到一段落，醫師會在徵詢病人同意後去候診區邀請家屬一同進來討論。有時必須面對眼淚，有時和樂融融。必要時會建議轉介進行諮商。印象深刻的是，醫師對我解釋約診方式的運作模式。與台灣掛號繳費不同，如果病人約了時間沒出現，沒有電話通知取消或因無可避免的緊急狀況而無法來，他們依然會收到帳單需要付款。因此較少出現掛了號人卻沒到的情形。

  兒科外院病人會診也相當有趣，可惜由於時間有限，只有最後一週蜻蜓點水跟了兩次。

- 住院病患照護與會診：

  住院病人必須照會精神科以譫妄為多數，另外也有不少情感性疾患(mood disorder)。精神病(psychosis)極少且多情況穩定，照會原因多半是因為癌症團隊需要確認精神科藥物開立恰當。科內有一位輪值病房事務的主治醫師、兩位住院醫師、三位專科護理師、一位社工、跟兩名醫學生。

在病房照護團隊的時間，我多半跟著專科護理師 Lisa 一起行動。晨會結束便匆匆到長長天橋另一頭的主要大樓(main building)看病人。Lisa 總是親切地與病人、病人家屬交談，耐心討論治療策略跟癌症治療情形。對於老是忘記吃藥或忘記跟護理站拿藥的病患，她還會幫病人把要記得的事項一一寫在病床床頭的白板上。在病房間走動之餘，她也總是樂意教導我她選擇藥物的原因，或開藥方式的考量。住院醫師是團隊中最忙碌的一群，東奔西跑看病人，有時五點過後還是會在辦公室看見他們忙著敲病例的身影。

兩位來自貝勒醫學院(Baylor College of Medicine)的醫學生才進入臨床兩個多月。都相當拚命，沒事在休息室的時間都在念書，早上也都會在晨會前去看病人。病史詢問、身體檢查、晨會口頭報告一點都不像新鮮的路障克拉克(clerek)。閒聊下才知道，他們在醫學院時就有許多臨床前課程(pre-clinical training)，線上教學影片授課方式也是未進入臨床就先開始。臨床部門中的學習與學校課程分開，因此他們每週有兩天必須回學校上課。直接照顧(primary-care)的數量一人兩個，不過因為 MD 安德森系統的關係沒有權限打病歷。據說其他醫院也只會給他們打「學生病例」(student note)。

每次跟 Dr. Valentine 去看會診的經驗都令我印象深刻。他徹底示範了精神科醫師在醫療中心的不可取代性。他會在床邊快速分析病人造成病人焦慮的家庭動力、在急診說服精神病急性發作(psychosis)的病人同意轉至精神專科醫院、在譫妄會診時開立腦波圖(Electroencephalography, EEG)發現病人不是譫妄而是癲癇發作，還讓快跟醫療團隊鬧翻的家屬跟團隊和好！

- 照顧者討論會(Cancer is a Family Illness Discussion Group)：

根據統計，照顧者(care giver)照顧癌症患者的時間平均為兩年，每周平均花費 32.9 個小時，其中更有 32%的照顧者花費到 41 小時。其中莫約半數表示在照護的過程中有經歷相當的心理壓力(emotional stress)，然而這樣的苦衷往往無處可宣洩。一方面不想造成病人的罪惡感，另一方面也是為了躲避自己對感到疲憊的罪惡感。照顧者討論會由社工 Carmella 帶領。歡迎病人以外的照顧者(care giver)自由參加。在討論會中照顧者們可以盡情說出自己在照顧癌症患者過程中無法道哉的苦衷，可以哭泣、可以歡笑，讓情緒得以宣洩。Cremella 更會提供各種日常紓解壓力的活動清單給照顧者們參考，並提示幾點常被忘卻的事實：癌症的本質(Its Cancer)、你沒有造成癌症的發生；無法治癒或是控制病情(You did not Cause, Cure or Control it)、但是你能對促進健康或改善生活習慣有所行動(But you Can…coping skills and health promoting life style modification)。

- 專任牧師(chaplain)：

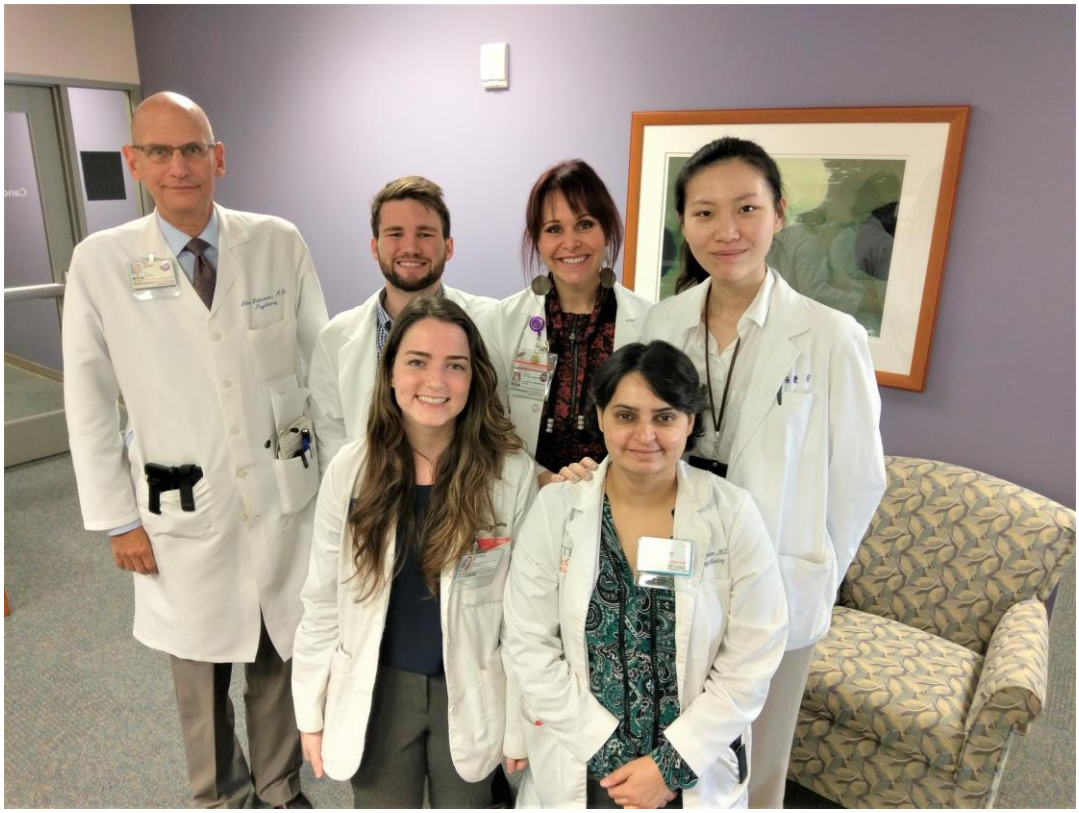
這是我自己向 Dr. Valentine 提出的行程，希望能藉由這次經驗得到一些關於宗教、心理與醫學的省思。想知道每次「FICA 靈性評估」(FICA Spiritual Assessment)後，宗教師參與照護的情形。簡而言之就是我想對「醫師、心理師、宗教師」對病人身心的介入方式有完整的理解。在 Dr. Valentine 的引介下我得以跟隨專任牧師 Carla 進行一個早上的晨間查房(morning round)。

癌症患者在極為重病或生命將盡時，常會面臨靈性的危機：對本身的信仰產生質疑、對信奉的神祉失去信心，進而感到無望而無助；又或者病人因為缺乏信仰系

統(belief system)，對死亡的未知恐懼。宗教師的角色即是在此時提供協助，評估病人靈性的完整狀態(spiritual well-being)，幫助病人發覺信仰可以提供的力量，或者提醒病人他們並沒有被他們的神祉被棄。

旅程結束之後

一個月太短，覺得還有許多錯過。對於精神科在癌症領域中的專業，我頂多是站在知識殿堂門口張望的程度。越看越是明白自己有所不足。深刻學到的倒是方向，以及人與人互相關懷的態度。誠如 Dr. Valentine 在第一天對我說：「語言隔閡確實是一缺憾，但不至於造成臨床溝通上的困擾。」剛開始我還半信半疑，直到觀察見習的尾聲我終於體會到：與其「想出一個完美的單字並標準的發音」，不如「打從心底知道應該要說什麼」。期許自己能將這段期間所學在未來應用於臨床，並莫忘這段旅程的初衷。



（圖）精神科部團隊成員：Dr. Valentine(左後)、住院醫師(右前)、專科護理師(右後二)、醫學生(左後二、左前)、觀察員筆者(右後)

Observership in MD Anderson Cancer Center, Psychiatry

Why MD Anderson

Psychiatry, a special department in the international cancer center is to provide expertise in the management of emotional and neuropsychiatric effects of cancer and its treatment for patients and caregivers.

According to the article published on Psychiatric Annals, 2017 "Chemotherapy, Immunotherapy, and Psychotropic Use in Cancer Patients: A Review of Psychiatric Side Effects", among the most common mental disorders identified in adults with cancer are adjustment disorders, major depression, organic mental disorders (including delirium and other psychiatric syndromes due to medications or medical conditions), anxiety disorders, and personality disorders.

Just as mentioned on the website of Psychiatric Oncology Center, MD Anderson Cancer Center: "A cancer diagnosis can bring a range of emotions, including anxiety, depression, grief and fatigue. These feelings can hit not only for the cancer patient, but their loved ones as well."

For patient care, psychiatry does play an essential rule for both in-patient and out-patient departments in the specific area of psycho-oncology.

My schedule, goals and purpose

Cancer makes huge loss. Once being diagnosed, everything is no longer the same. Just like other stress events people have to struggle with, cancer brings tremendous change for a person to cope with. Grief, anger, fear, anxiety, hopeless and helpless; feeling of isolation, disconnection, dissociation, and depression: there is so many descriptions could be applied. Everyone is a unique individual and no one is the same. Other than the emotional challenges, for psychiatrist in practice, there's also special concern about the physical adoption for treatment and the possible drug-drug interaction since treatment for cancer is usually a long run instead a sprint.

To ensure I can catch up with all these topics, providing better care for my patient in the future, I put done a list before I start my observership as follow:

1. General view of "psycho-oncology" and how physicians put it into practice.
2. Diagnosis and management of delirium.
3. Recognizing the cancer-related underlying cause of delirium.
4. Neuropsychiatric side effect of Chemotherapy, Immunotherapy and steroid use.
5. How to support patient with end-life issue, or irreversible illness when death is unavoidable.
6. How to support patient and the care-givers with grief.
7. Application of psychotherapy in clinical practice.

Fortunately, with my mentor Dr. Valentine's full support, all my goals are completed during my 1-month rotation. I got answers I have been longing for; I got experience more

than I used to expected to and I learned things from whoever I was working with and patients. I feel like I have got a new map though just explored a few spot on it.

I have done several things before my journey to the US, or even before I start to apply for the opportunity, include: reading several articles written by my mentor, studying with text books and search on the internet on topics frequently mentioned in the field of psycho-oncology (e.g. delirium, adjustment disorders, major depression, anxiety disorders, and personality disorders) and having a brief review with medications utilized in cancer patients (e.g. chemotherapy, Immunotherapy, steroid). Some questions get answers through my reading process while the rest are answered via the observership.

Day in the department

Dr. Valentine helped me to put my schedule the first day we met. Basically, we get the months divided into two parts: 2 weeks in the clinic and 2 weeks with the in-patient medical teams. There are always grand rounds and academic activities. I even got the chance to attend the SIXTH STATE OF THE SCIENCE CANCER SURVIVORSHIP RESEARCH SYMPOSIUM, having a glimpse of how great scientist from the field of public health, behavior science and physicians in practice carrying out clinical trials and make breakthroughs for science.

The time I enjoyed the most is sitting in clinic, seeing consulting with attending physicians in Psychiatric Oncology Center, Mays Clinic. A new consultation takes 60 min and a follow-up case takes 30 min. Patient are required to fill the Edmonton Symptom Assessment Scale (ESAS), Patient Health Questionnaire (PHQ-9), Generalized Anxiety Disorder 7-item (GAD-7) scale, NCCN Distress Thermometer and Problem List for Patients, Substance use screening and Body image scale so physicians can have a general view of their patients before they coming into clinic.

Each doctor does their consult in very unique way. Though they eventually would finish whatever history that should be taken, they are still different. The words they choose, the way they speak, the questions they ask, and the answers they give, come out in different style. What they do in common is that they listen, and they discuss carefully about the treatment plan with patients. Once in a while, when I have some time talking to Dr. Rashid, she told me "Medication is only a small part of the treatment. Patient education about changing the life style is much more important." In Dr. Lynn's clinic, she even told the patient "I can prescribe something for you if you like, but frankly, I don't think you need that."

I'm also lucky enough to have a chance to see how does psychotherapy work in the consult. Dr. Khan usually combined the idea of cognitive-behavioral therapy (CBT) in her conversation and provide practical suggestions for patients. Dr. Ignatius is the only one in the department specialized in psychodrama, and he is always willing to share and to teach.

Mary has multiple professions, and currently work as a therapist in MD Anderson. Sometimes she would give me a chance to sit in her clinic to see how a therapist work in the department of psychiatry! Most of the time she just listens, but in the end, she always

provides impressive point of view. She is a true therapist who act as a mirror, making people be aware of their default, their mood, their strength and their real self.

Cancer is a Family Illness Discussion Group is a special part of my rotation much more than my expectation. Facilitated by Carmella, the social worker in department, the support groups provide a time and space for patients and family members to discuss feelings, concerns and attitudes in a caring atmosphere. Where I learned about the idea of "6C's of Cancer" that can help with people dealing with the life-threatening illness: Its **C**ancer; You did not **C**ause, **C**ure or **C**ontrol it; But you **C**an…(coping skills and health promoting life style modification).

Inpatient consult is also a part of wonderful experience for me. After the morning meeting, I went ward round with Lisa, the advanced practice registered nurse. She deals with patients with patient and handle medical intervention with profession. She taught me a lot and share stories with me. Residencies are pretty busy, but they still managing to squeeze some time for medical students. And I noted that what they reminded us to study is in fact mostly related to the boarding exam! Besides me, there were two other medical students form Baylor College of Medicine. Different from us, they have pre-clinical training. So when they get into clinical practice, they are already well-prepared, knowing how to carried out history taking, physical examination, and how to give a brief present on morning meeting. Sometimes they made mistakes. But they tend to speak in the meeting and have their idea talked out loud. Sometimes people would either just laugh or give useful feedbacks.

We have new consults every day. Cases of delirium are relative common compared to other hospitals with psychiatry rotation. Aside from delirium, adjustment disorder, anxiety and depression are commonly seen as well. Residency will go see the patient, and meet up with the attending at bedside. Residencies are always willing to teach and sharing their clinical experience. I found myself enjoying the discussion between the attending, residency and the primary care team. We went through the whole process of differential diagnosis and decision making together. And I realize as long as my goal is being a qualified psychiatrist, I have to not only know about psychiatry but never ignore the importance of knowledge in other fields such as internal medicine, neurology, and so on. Dr. Valentine demonstrated the importance of psychiatrist in a medical center in a practical way. I saw him interview the patient and calm the patient simultaneously, helping with the decision of medical intervention in the aspect of psychiatrist, and facilitating the communication between the care giver and the primary care team.

I found the out-patient consult of pediatric psychiatry is worthy of seeing. Dr. Tan specializes in child and adolescent psychiatry. He helps children and the family dealing with cancer-related stress and psychosocial issues. Interviewing children and their parents is such a stressful work, and the problem of the child could be a crisis of a family. I wish I had more time to see how things work in child and adolescent psychiatry.

Working with chaplain is a special part of my observership. I went the morning round with Carla, chaplain in service. She showed me how chaplains approach a patient, evaluate

one's spiritual well-being, assist one to recognize the strength of their faith, and remind people that their prayer is always listened by God. In the end of consultation, we prayed together. In her prayer, I heard the strength in her words, and how she did that with the skill of active listening. She also told me what rituals they can provide, and the necessity of building stable relationship with patient and develop a chaplaincy plan. In the end of our round, I ask her about her expectancy for psychiatrists. She answered with smile that she expects we keep the importance of spiritual well-being in mind because it is an inseparable part of human being.

Souvenir: with a new page in mind

Though language plays a leading rule in communication especial in the field of psychiatry, as long as we are able to speak, it shouldn't be considered as such a barrier between patients and doctors. Just as what my mentor told me on my first day "Language barrier is a defect, but not a problem for clinical practice." I was not hundred percent sure about his words, but as times went by, I have confident to repeat that. Probably due to the multicultural environment in the US, I strongly feel that the key for communication is knowing "what to say" instead of "choose a precise word and pronounce perfectly". Caring is something beyond verbal. If one sincerely cares about the patients, they will definitely feel that.