Countering countertransference

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Frank is angry at me again. He says that I would be angry too if I had to live here.

Here is a nursing home that he has been forced into. When Frank arrived a few months ago, he made it abundantly clear that he had moved against his will. When he was living in his apartment, physically disabled from a stroke and short of breath from chronic obstructive pulmonary disease, he needed assistance only a few hours a week for housekeeping and help with meals. However, Frank also has dementia—just enough to cause trouble with the home support workers. He often wouldn't let them in or would yell at them to leave him alone. Soon the workers gave up trying to help him. He has no insight into his needs. He has no family, just 1 exasperated friend. Slowly losing weight and disheveled, Frank got pulled out of his apartment and sent to a nursing home for me to doctor until the end of his days.

Soon after his admission, I found that Frank, a long-time smoker, also had lung cancer. When patients get admitted to long-term care, all that accompanies them is a single woefully inadequate page summarizing a whole lifetime of medical history. I've developed the habit of further investigating my patients' medical histories by looking through their online hospital records. A year ago a radiologist had found a mass in Frank's lung and recommended that it be followed up with a repeat chest x-ray scan. Maybe his previous GP had missed this, but it is more likely that Frank had been too forgetful or belligerent to go. I requested a repeat chest x-ray scan, and the nursing home staff arranged transport and made sure that he got there. Unfortunately the second x-ray showed the mass had quadrupled in size and was likely malignant.

Frank and I meet and talk about what to do. He hopes we could ignore it, because all he wants is another "5 or 10 years." I tell him that no surgeon will want to cut out the mass given his comorbidities, but that radiation wouldn't be so bad. It would also help him reach his goal of living to his 80s.

He is anxious and, for once, not angry, and I finally feel comfortable in my role of a reassuring counselor. After meeting with the oncologist, his radiation begins, and it isn't as bad as he thought. He is no longer anxious and soon reverts to his usual demands and arguments when he sees me. "My other doctor cleans out ears better than you. This lump on my bum is hurting—how long do I have to keep waiting to see the specialist? You should pay my transportation costs for the radiation—all these appointments were your idea!"

Transference and *countertransference*. I vaguely recall my psychiatry rotation back in medical school. When Frank gets angry at me, I can feel myself getting angry back, getting defensive. I'm also indignant, as I'm a little impressed with myself for discovering his missed cancer. Part of me feels that he should be kinder and more appreciative for the initiative I've taken to get his past medical records. Too bad that Frank does not treat me with kindness or appreciation!

I'm embarrassed to say that sometimes I avoid him. If I'm having a hard day and see him wheeling down the hall toward me, I'll change my route and duck down a stairwell. Other days I'll not be so cowardly and will stand my ground, but I feel myself become tense, bracing for his barrage of criticism. My best days are when I can joke and squeeze a smile out of him or find some commonality. I even stretch my imagination and find a positive comment to say about Trump, as Frank is an American citizen and I know he mailed in a vote for him.

He desperately wants to go back home. I don't want to take away his hope and start another argument, so I agree with him. Maybe moving back home could be possible. Maybe if he stops smoking he can have the breath to exercise a little more. Maybe if he starts attending physiotherapy on a regular basis, instead of on the very rare occasions when he feels like it, he can get out of his wheelchair. Maybe his plan to move back to the United States and room with one of his old Air Force buddies isn't as far-fetched as I think it is.

Is this giving of hope merely a lie or part of the "art of medicine"? My usual trick for bonding with patients is to genuinely like them, which isn't hard because I *do* like most people. But to like Frank *is* hard. The best sympathetic emotion I can conjure up is pity. I pity him because I know his life hasn't been easy. He was raised by his grandparents, and then he joined the Air Force in his late teens. He says he has been taking diazepam since he was 12. Rumour has it that he is divorced and hasn't talked to his ex-wife in years.

Pity doesn't help you connect with others though; it's a patronizing and separating perspective. I've come to realize my job is to not let Frank push me away with his spite, like he has with others throughout his life, but to be a patient and dependable listener. To have compassion for a fellow human who has grown old and frail, as I will be one day. To not focus on what divides us, but on our common human need for contact and understanding. This patient has had a lifetime of bitterness, but as long as there is life, there is hope. Hope of healing from cancer. Hope of connection. Hope of getting to a place that feels like home.

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Acknowledgment
This is a true story. The patient's name has been changed and he is now deceased.

Competing interests
None declared