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Helping Staff Help a "Hateful" Patient: The Case of TJ

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"Ted Jacob," or "TJ," was a patient who tested the ethical resilience of most of the health professionals who worked with him.[1] He expanded the types of conflicts that can be generated among the principles of nonmaleficence, beneficence, respect for persons, and autonomy.

TJ was 36 years old when KSW, the attending psychiatrist on the Consultation-Liaison (C-L) Psychiatry Service, first saw him. Both authors had heard about TJ from numerous health professionals because of the enormous problems he created on each admission. Ted Jacob, diagnosed with borderline personality disorder (BPD — a personality disorder characterized by intense emotional relationships, frequent crises resulting in suicidal ideation, and impulsive behavior) had been physically and sexually abused by his adoptive mother and ignored by an emotionally unavailable father. Beginning at age 11, he had numerous psychiatric admissions for attempted suicide and poly-substance abuse. His longest period of sobriety was during a marriage that lasted several years. TJ attended college for three years and majored in psychology. By history, he was bisexual, although his only known homosexual relationship was with his sponsor from Alcoholics Anonymous.

TJ had 10 admissions for intentional drug overdoses and alcohol withdrawal within 12 months. He was first labeled a "hateful patient" when he was admitted to the hospital after telling his out-patient psychiatrist that he had eaten multiple boxes of rat poison with the intention of killing himself — many more admissions due to sequelae of rat poison ingestion would follow. TJ wanted to be on the Psychiatric Unit, not the general medical floor, but previous psychiatric admissions were not therapeutic; that is, admission to a short-term psychiatry unit only provided temporary relief for several problems that resumed once TJ was discharged. During a lengthy admission to stabilize him hematologically (the rat poison was warfarin), TJ wreaked havoc with relationships among the medicine team, but especially between Medicine and C-L Psychiatry.

The patient infuriated the Medicine team when only intravenous (IV), not oral, vitamin K would bring his prothrombin time closer to normal limits. It became clear that TJ was not swallowing his oral medication but was destroying it after the nurse left, although he denied it. TJ refused to go voluntarily to the county Crisis Stabilization Facility (CSF) until the IV was removed. (The CSF was where all county mental health patients were sent when they had been put on a "pink slip," that is, involuntary status, for assessment for transfer to an in-patient psychiatric unit in the county, or for discharge, or short-term stabilization and discharge from the CSF.) Despite the anger and turmoil that surrounded him, and in part was generated by him,

TJ talked about the hospital as "a safe environment," versus his apartment, which he described as "a black hole I crawl into at night and can't come out of until morning."

The Medicine team was extremely frustrated that Psychiatry did not "fix" the patient, did not accept him on the Psychiatry Unit, nor get TJ permanently discharged. C-L Psychiatry, recognizing the "splitting behavior" that is part of BPD, was frustrated by the behaviors of TJ and the Medicine Service. (Splitting behavior is a coping process in which an individual pits one person against another.) Medical students on the Internal Medicine rotation were so overwhelmed by the patient's behavior and the resulting discord that they presented him to the weekly ethics conference twice — with the C-L psychiatrist present. Many staff had talked with the clinical ethicist (JDS) about TJ, and a formal ethics consult was requested to try to help the Medicine Service focus on what was best for the patient: that is, respect him as an individual and help him to make "safe" decisions for himself.

The ethicist worked with C-L Psychiatry to help mediate the splitting behaviors among staff, which were unacceptable recorded in TJ's chart. The behaviors were harmful not only to TJ, but also to relationships between staff, and potentially to the institution legally; this is an example of the frustration portrayed in TJ's chart by a member of the Medicine team: "I am still not clear how Psychiatry evaluates a patient for suicidal potential, as every time they say it is OK to send patient home, patient comes back in not more than three days. Is there any way to predict at least one week?" and, "His mood is much improved, believe it or not, since admission." The potentially harmful notes in TJ's record were discontinued when the real and potentially negative outcomes of the comments were made clear to all involved.

Members of the staff realized that the dynamics of their interactions with this patient were different from other patients, and that relationships among staff were increasingly strained. Ironically, the relationship between the Psychiatry attending and Internal Medicine (IM) were not as strained as they could have been because the IM attending was a personal friend of KSW (and JDS) — but, at the same time, this relationship increased the pressure to manage TJ's care effectively, and provide relief for the IM service in dealing with this difficult patient.

Despite the anger and frustration of both Medicine and Psychiatry precipitated by TJ's behaviors, empathy was rekindled when TJ talked about his loneliness, and how his father never paid attention to him. TJ wondered aloud what it would take to get his father to show he cared. KSW wondered if he would ever find out before he died. The psychiatrist and ethicist worked together with the staff at these times to help them understand how sick and lonely Ted Jacob was, and how badly he needed our care — with carefully set and consistently maintained boundaries.

Trying to respect his right to make decisions for himself was difficult, since we did not know when to trust that he would not harm himself. When given choices about where to go when able to be discharged, he was clear he did not want to leave the hospital; he refused a group home; and refused to sign himself into the CSF voluntarily. When he continued to refuse the available options, he was sent involuntarily to the CSF. He returned to the hospital five days later due to nosebleeds (from the rat poison) and told us that the CSF had released him just 45 minutes after his arrival. The latest admission was more serious because he had ingested cadmium (while denying he had eaten batteries). TJ manipulated the system, not seeming to care whether he lived or died. He appeared to be almost euphoric to be in the hospital, despite complaints of boredom.

The ethicist and the C-L psychiatrist worked with staff individually and in groups to facilitate a healthy ventilation of their anger — especially after a nurse yelled at the C-L psychiatrist about getting TJ, who smoked, off suicide precautions to cut down on her work. (Patients on suicide precautions must be assessed every 15 minutes and must be accompanied by staff to smoke outside.) We made Groves's article, "Taking Care of the Hateful Patient," available to the staff, and worked to identify the negative and positive aspects of labeling.[2] We also asked staff what they believed they could do to help this man, while recognizing that patients with a diagnosis of BPD have been labeled "the Hemophiliacs of Emotion" in the literature, due to the extraordinary amount of time and energy they consume.[3]

We all realized TJ harmed himself more dramatically each time he was discharged from the hospital, and we tried to work together, for the most part, to do what we thought would help him, but anything we did was

undermined by the patient. The needs of staff and of the patient collided; staff felt they were going in circles. Groves described how "A psychologically naïve medical staff may regress to a helpless or vengeful position in response to the patient's ingratitude, intractability, impulsivity, manipulativeness, entitlement and rage."[4] Groves seemed to be describing how everyone involved with Ted Jacob felt at times.

The authors were not immune from strong feelings about both the patient and the staff. Our feelings covered a wide range, from impotence at not being able to protect the patient from himself — which we recognized was not always possible — to deep frustration with the system that seemed, at times, to assist TJ in harming himself. We were both amazed and ambivalent about the patient's tenacity; for example, he took massive doses of coumadin (warfarin) when he swallowed the rat traps, he overdosed on thorazine (an antipsychotic), he swallowed batteries, and drank heavily. We didn't dare to guess what he might do next, as he was both "creative" and tenacious. Due to experience, we were also probably more cognizant than most (that is, able to see beyond the "bad" behavior) of TJ's ability to be very pleasant when he was not taunting staff regarding what he had done. We were both frustrated with the notes written in the patient's record by the Internal Medicine residents, but this was particularly disturbing for KSW, as the notes became inappropriately personal toward Psychiatry.

JDS was frustrated at the unprofessional and unethical behavior of many of the staff, including the physicians, who were involved with the patient's care. Unfortunately, staff were noisily angry at each other in open areas of the nursing station, where comments could be overheard by other patients and families. While we recognized that the staff were ventilating their frustration and anger, this was not the appropriate place to do it. When health professionals need to express angry feelings, a secluded place, for example, an empty room, is better than an area where angry words can be overheard. (And this sounds simpler than it is!) There were also times when JDS became caught up in the splitting behaviors and had to step back to regain some balance. While both the psychiatrist and ethicist were glad to see progress in the recognition of splitting behaviors, this progress could vanish quickly when TJ flaunted his destructive behaviors. The phrase "hateful patient" blossomed for JDS in working with TJ and the staff. Working closely with the psychiatrist was helpful and supportive. Working with the staff was difficult and frustrating, but was often therapeutic.

Another issue was the hospital "grapevine," which raised serious ethical issues about how negative labels are used and the harm they may cause. Fortunately, in this situation, the article we distributed by Groves facilitated discussion of the label of "hateful patient," and helped to increase the staff's awareness of the dynamics of TJ's situation. It was evident that most of the health professionals who worked with TJ felt anger and frustration. Increasing staff's awareness of how their feelings were expressed, and learning how to deal with them — even on a small scale — seemed to be helpful.

TJ had more admissions to our institution before he was finally committed (to our relief) to the state psychiatric hospital by the CSF, because of his escalating self-destructive behavior. TJ continued his destructive behavior at the state hospital. He placed a plastic bag over his head, but was found before he was harmed; the entire ward was placed on suicide precautions as a consequence, however.

TJ was discharged and re-admitted to medical and psychiatric units several more times both in and out of his hometown. Six months after TJ's last admission to our hospital, many of us involved in his care were sobered to read his starkly brief obituary in the local newspaper:

> Ted Jacob, age 39 years, died suddenly in [large Midwestern city] where he had resided the last 6 months. He was employed as a carpenter and previously as a construction worker. He is survived by his father, wife, and brother. He was preceded in death by his mother. There will be no visitation and interment will be private.[5]

After reading of TJ's death, a number of us could step back from the chaos he generated and agree that we learned important lessons from him about caring for very difficult patients. He helped us acknowledge that there are times when we will feel powerless because we cannot protect patients from their self-destruc-

tive behaviors. TJ reinforced the authors' belief in the importance of thoughtful early intervention with healthcare professionals and patients to pre-empt the splitting behaviors generated by patients with BPD, which can irrevocably distort relationships between patients and staff, and among healthcare professionals. While TJ forced us to identify biases and limitations (as mentioned throughout this article) that affect how we care for such challenging patients, TJ also left us with the nagging question of whether there was anything more, any other intervention that was missed, that we could have implemented to save him.

NOTES

1. Ted Jacobs is not the patient's real name; it was changed to protect the patient's privacy.

2. J.E. Groves, "Taking Care of the Hateful Patient," *New England Journal of Medicine* 298 (1978): 883-7.

3. H. Straus, "Hemophiliacs of Emotion," *American Health* 7 (1998): 61-6.

4. J.E. Groves, "Difficult Patients," in *Massachusetts General Hospital Handbook of General Hospital Psychiatry,* ed. N.H. Cassem (St. Louis, Mo.: Mosby, 1997): 344.

5. The obituary was edited to preserve the patient's family's privacy.