An unfinished chess game

Reflections on the loss of a patient

Experience

Expérience

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A few years ago I was asked to provide a psychiatric consultation for a young man with a history of Crohn disease. James, as I will call him, had undergone surgery several times — once his condition was complicated by peritonitis — and had an ostomy in place. He was receiving multiple medical therapy, and just before I became involved in his care he had been started on home parenteral nutrition. I was asked to see him to rule out any anxiety or mood disorder and to provide support.

James had borne his disease since early adolescence and could no longer maintain adequate nutritional levels without relying completely on parenteral feeding. When I first began seeing him he was holding down a respectable and skilled job and was at the end of a grief reaction prompted by the loss of his first wife to cancer. He told me that he had been so depressed that for the first time in his life he seriously considered suicide. Over the ensuing months I had contact with James during his hospital stays for adjustments to his parenteral nutrition or because of line sepsis. I also treated him as an outpatient, sometimes weekly, to help him cope with the many stresses he faced in relation to work, personal relationships, his disease and living with parenteral nutrition.

Dealing with a chronic disease from a young age, James had had a particularly difficult life. The unrelenting nature of his illness created many difficulties, but he dealt with most of these in a heroic and admirable way. Although he could not eat or drink normally, he still maintained a rather minimal diet and would occasionally eat out despite having to pay the price of severe diarrhea and abdominal pain. He smoked marijuana regularly and drank alcohol almost daily; this was partly an attempt to compensate for being deprived of the pleasure of eating and drinking normally.

Just before his last admission to hospital, James had begun to bleed uncontrollably from his stoma. He was found to have liver failure. At first this was thought to have been caused by infectious hepatitis and the combined effects of alcohol, short-gut syndrome and parenteral nutrition. Hepatitis was ruled out, and it became apparent that the liver failure was intractable. He experienced extreme lethargy and cachexia, and a slow ooze of blood from his gums and venipuncture sites worsened and became uncontrollable.

As a psychiatric consultant, I continued to visit James regularly to provide supportive therapy. One of his great joys and early passions was the game of chess. He had once belonged to a national chess club whose members played games by mail. Some of these games would last as long as 2 years. I suggested that we, too, have an ongoing chess game and that at the end of each visit each of us could make a move. James responded gleefully to this suggestion. I had never done this with a patient — a kind of chess therapy, as it were. We started our game, and as the weeks went on we made our moves on a small magnetic chessboard at the bedside. This established a friendly connection between us, and we both looked forward to the game. Initially it was a means of diversion, a pleasant pastime to intellectually occupy us and perhaps offer some escape from yet another difficult time. I saw it as an enjoyable activity in the midst of my patient's illness as well as a means of connecting with him. However, my decision to initiate the game was instinctive. It just felt right.

On one visit, I found James sitting up in bed, gaunt and weak. He mentioned that the bleeding from his gums was worsening and told me that the lab technician

had had an exceptionally difficult time stopping the bleeding at his venipuncture site. We each made our next move.

By the next time I visited, James had markedly deteriorated. It had been suggested to him that moving to the palliative care wing would be the best option for him, but he rejected the idea, perhaps partly in denial of his condition. I walked beside him as the nurses wheeled him to a new room closer to their station for vigil. His wife was frightened and tearful. I will not venture to guess what the look in his eyes meant, that he knew the end was near. He was too sick to move a chess piece that day.

Over the next few days I returned to find James drifting in and out of consciousness. A bedside nurse asked for a lorazepam order because she felt he was panicking in periods of lucidity. Not long after, he died. Our chess game was left unfinished, in seeming parallel to a life cut short. Our moves made, our decisions cast, the game was now at an end, incomplete.

In my heart I cried. I had lost a patient and a friend. Through his therapy James had told me things he had told no one else. Perhaps I had identified with certain aspects of his experience. I had also met his mother and sister, both of whom had travelled far to be with him during his final days.

It seems as if I did not fully appreciate the degree and depth of my involvement with James until after he died. The personal and intimate details of his life that were shared, the degree to which I came to know him — these things were brought into relief by his death. I felt very helpless near the end. All I could do was be there, in compassion.

I grieved the loss of a patient who in his brief life demonstrated great strength, courage and heroism in the face of suffering from which he could take no vacation.

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