

“How Could You Do This, Doctor . . . ?”

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How could you do this, Doctor . . . ?” my patient asked as I finished discussing her poor prognosis and the lack of therapeutic choices. She had battled metastatic pancreatic cancer for more than 8 months and had failed 2 lines of systemic chemotherapy. In addition, we had attempted radioembolization, an experimental approach in this disease, to better control her liver metastases without success. I had admitted her the night before for jaundice and ascites and determined after several imaging studies that no viable therapeutic choices exist. That morning, I thought deeply as to how I should discuss her status. Although I believed she knew that her disease is progressing, I was fearful of her reaction as she just renewed her marriage vows 3 weeks prior and was determined to “beat” this cancer.

I sat down and spent an hour explaining the nature of her disease, why it is often fatal, and what we can do to help her. I concluded that I do not foresee additional chemotherapy as helpful and that I would recommend palliative measures only. I explained that any additional therapy is likely to cause more harm than benefit and that we should focus on her quality of life rather than quantity of days lived. I reassured her that I would continue being involved in her care after she enrolls in a hospice program and that I am not abandoning her; rather, I am in need for hospice services to help me provide her with better care.

Janet was quiet throughout the conversation, asking few questions here and there, attempting to digest why a “different” chemotherapy approach would not help and trying to comprehend where her ascites came from. I answered her questions in a simple to

understand language and assured that all her concerns are addressed. As I was ending my meeting with her, she asked with tearful eyes: “How could you do this?”

I was taken back by that question. I did not understand what she actually meant. Within split seconds, my mind started wandering and racing. Is she asking as to how dare I leave her without therapy? Is she inquiring as to how I could suggest hospice to her at the age of 55 and let her abandon her husband? Is she disappointed with how I approached her condition? Does she think that I should have spent more time explaining her condition and that I am ending my meeting with her abruptly? Is she upset or angry with me?

“How could I do what?” I inquired.

“How could you do this job?” She commented as her tears started coming down faster. “How could you go to bed at night everyday after telling so much bad news to so many patients?”

I have never been asked this question by a patient before. Often times, a consulting colleague would pose such a question to me as he calls asking my opinion about a young patient diagnosed with an unexpected malignancy. I hear comments sometimes from my friends, colleagues, and family as “I can never do your job,” “You deal with dying people all the time,” “Don’t you get depressed?” “Did you start drinking yet?” but never in my career, a patient asked me as to how I can do my job and to how I cope.

I was not prepared for such a question. I thought she would ask me as to when she will be released, is she going to be in pain, how are we going to manage the malignant ascites. I thought she would ask me to call her husband and reexplain what I had just stated, or she would request a second opinion from another oncologist. Instead, Janet was curious as to how I can simply deliver bad news and go on with my life unfazed.

I looked her in the eye and said: “I don’t deliver bad news all the time, Janet, and when I do, I still believe that I can help my patients even though I might not be

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prescribing chemotherapy. There are other ways to help when we cannot cure cancers, and not all of them are in the form of cancer-targeted therapy."

I continued to say: "I can do this because I know I am helping my patients. If I assure that they have no symptoms, I know I am providing help. If I assure that their family is not seeing them suffering and going through unnecessary treatments, I know I am helping. I can do this because helping patients comes in many ways, and one of them is assuring that their last days are dignified."

Janet seemed to be satisfied with my answer. She realized I was speaking from the heart as a human being before being a physician. She held my hand and squeezed it as few more tears came down.

As I exited the room, the question kept lingering on my mind. I was not sure how I cope with days like this nor if there is a strategy for physicians to maintain their daily lives without going through the emotional turmoil that losing their patients bring. I felt that sometimes my role as a physician transforms into "just a job" phenomenon where I do not pause to think about "what just happened." The rapidity of our lives and the busy schedules that we all have as physicians and oncologists make it extremely difficult to spend time discussing patients' emotions and feelings as they face death and prepare to leave this earth. I often times feel that I spend more time when my patients are starting a new therapy, switching to a new chemotherapy regimen, or when I discuss their diagnosis as opposed to when they need me to explain end-of-life issues. I asked myself as to how best I could approach a situation such as this and how can I minimize having these events affect my life adversely. I wished that I had a formal training during fellowship years as to what oncologists should do. I felt that learning how to cope as we discuss death in a "casual" way is as important as learning how to manage complex malignant diseases.

Before leaving work that evening, I received a phone call from a patient of mine that I have not seen in 2 years. He was diagnosed with acute myeloid leukemia that presented in blast crisis 5 years prior requiring aggressive therapy and allogeneic bone marrow transplantation. He has been following with a different physician for logistical reasons and had made sure to stay in touch with me every few months. As I greeted him, his excited voice came through saying: "Doctor, I got engaged today and I couldn't think of anyone else to call but you."

I was flattered and speechless. He went on to comment on how sick he was and on how he faced death to find himself moving on with his life without leukemia 5 years later. I thanked him and told him that I did my job and I was very happy that things are well. He finished his phone call by saying: "I just want you to know that you saved my life."

Right there and then, I knew how I cope and how I have been coping. It is these phone calls from cured patients that let me go through bad days and cases that I feel helpless against. It is the fact that we win the battle sometimes, although we wish we won it all the time. It is the fact that when I cannot cure cancer patients, I can help them to spend their last days comfortable, without symptoms, and with dignity surrounded by their loved ones. I started recognizing why hospice physicians do what they do and the level of satisfaction they achieve.

Coping can be taught and it should in the field of oncology. A stressful field with persistent emotional turbulence can have its toll on any practicing oncologist. Adding coping techniques and seminars should be part of fellowship programs and our lives as oncologists. Coping, however, could also be learned as I have grown to adjust my emotions by balancing successful stories with the not-so successful ones. I learned that many centers started conducting "Schwartz rounds," which are multidisciplinary conferences where caregivers from physicians, nurses, social workers, and other disciplines participate in discussing patient care and how specific events affected each health care giver emotionally and on a personal level. I was pleased to see our institution starting these rounds, as the urgent need to an outlet was very clear. Because we started conducting these rounds in January 2008, I have attended almost every conference and always left the meeting thinking that such event is as important as any glamorous educational scientific meeting. In our practice, we conduct bereavement services on a biannual basis where all members of our practice, physicians, nurses, and technicians, meet to remember patients we lost and to share emotional stories and what we have learned in the preceding year. I have found this event a very important part of our practice as it sheds some light on the "other" part of an oncologist's life. It is another part of my coping mechanism.

Coping with stressful events is important so that we go on with our lives. I learn from every patient I meet. Each one of them has helped me evolve my personality into what I am now. They make me a better physician every day.