Palliative and Supportive Care (2013), **11**, 357–358.
© Cambridge University Press, 2012 1478-9515/12 $20.00
doi:10.1017/S1478951512000119

ESSAY/PERSONAL REFLECTIONS

Fixing a broken bond

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I began training in oncology a little over 2 years ago, after I completed training in internal medicine. I was happy to have my own clinic, a room where I thought I could not only prescribe medications but also provide comfort. It was not long before I realized I was more successful in dealing with emotional issues of patients who would recover, than of those who were incurable. Many oncologists offer advanced lines of treatment as a way of boosting hope and managing emotional pain. However it is my impression that as lines of treatment fail, even though we prescribe hope, the patients become more anxious, depressed and, worst of all, experience loneliness.

A PATIENT

M was diagnosed with ovarian cancer at the age of 47. She was married and had raised two teenage daughters. The disease quickly relapsed after initial chemotherapy and surgery. Over the ensuing 2 years, she had several types of therapies including a promising investigational agent that resulted in a brief response at best. At our multidisciplinary meeting we decided to start another line of chemotherapy even though we knew the chance of a meaningful clinical benefit was negligible.

When I spoke to M about our recommendation, she wondered if it made any sense to subject herself to the side effects of chemotherapy after it had failed so many times. She did not want to give up further treatment, however; she just wanted a treatment that was going to work. I could not bring myself to admit to her that there was no effective therapy, and neither could the gynecologist to whom she turned, hoping he would have a magic solution. Both of us convinced her to start chemotherapy, which, as expected, did nothing but exacerbate her peripheral neuropathy.

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Why couldn't we stop a treatment that we knew was going to cause more harm than good? Why couldn't we speak to her truthfully about her prognosis?

A BOND

I think most of us who treat cancer patients cherish the unique relationship that exists between us and our patients. I derive a great sense of satisfaction and fulfillment from sharing my patients' joy and sadness especially when my words or deeds alleviate their anxiety. However, when we are faced with a terminally ill patient and seemingly have nothing to offer, things suddenly change. Our unique bond is broken and it becomes difficult to share the patient's emotions and to provide comfort.

A BROKEN BOND

Facing a patient with progressive disease without effective treatment is hard for most of us to bear. Some may feel guilty, some may think they have failed as physicians, and some fear death. For me, it is an unbearable feeling that the bond with the patient is broken. I feel guilty and angry. This is not because I cannot prevent the patient from dying, but because I cannot alleviate the patient's suffering, fear, and loneliness. The essence of our relationship with our patients is giving and helping. When we don't have anything to give it is easier not to be there at all.

I asked myself what it is that does not allow me to reach out to patients when medical treatment proves useless, and I remembered my first meeting with another patient, L, who also had recurrent ovarian cancer. At our first meeting, L told me about what she had felt when first diagnosed: "The word 'future' was erased from my life," she said. I have often reflected on those words. It sounds obvious that dying people do not have a future to look forward to. However, as most people do not really know what it is about dying that intimidates them, I took a moment

https://doi.org/10.1017/S1478951512000119 Published online by Cambridge University Press

to think about the meaning of "no future." It is comparatively easy for me to imagine giving up the long term future – my aspirations and my plans. However, when I think about the possibility that I might not have a tomorrow, it scares me. The thought that I will not have a chance to correct wrongs I have done to my loved ones, and that I have only today to give all I want to give, frightens me immensely.

FIXING A BROKEN BOND

This is what we mean by "closure." When we try to do and say in the present whatever we feel is needed, so that we can peacefully accept the absence of a future. Thinking about the few patients I knew who went through a process of closure with their families – either because they initiated it or in the rare cases in which we succeeded in initiating such a process – I realize that their imminent death was less frightening to me. I still minded that they were dying, however instead of feeling guilt and discomfort, I simply felt sad. It was these patients whom I was able to continue to comfort. Stopping antitumor treatment did not mean breaking the therapeutic bond.

Is it possible to direct our patients to reach death more peacefully? Experienced oncologists tell me it is not. They say acceptance depends upon the patients' personalities and culture, and that we can only follow their lead. These oncologists are probably right, but I keep hoping that we can improve our results if we have better tools.

While I was writing this article, I met M again. M has persistently refused to see our psycho-oncology team. Now she was hospitalized, her condition had deteriorated, and I decided to speak to her more truthfully. I tried not to let the conversation divert to subjects such as medications and blood tests, which we used to talk about. We did not talk about death, but instead I asked about her daughters and told her how important it seemed to me that she speak with them about her disease. I am not sure why this time I could finally reach her. Maybe it was because I insisted, or maybe it was because I deliberately steered clear of details of treatments and results of tests. It was the first time that she told me about her daughters' anger and fears, and about her extreme loneliness. We made plans for her to meet with the social workers to get help with talking to her family. As for me? I was sad but without guilt or discomfort. I felt I was helping.

WHOSE BOND IS IT?

It seems that we can direct at least some of our patients to engage in a process of "closure." As giving up active treatment is usually associated with fear and frustration, these processes should probably start before treatment is stopped. It might help some to face death more peacefully. We might be able to help only a minority of our patients, but the response rate will certainly not be worse than that of another round of chemotherapy. It seems to me that oncologists would do a better job if we acquire some psyco-oncology skills.

Some may say it should not be the job of oncologists, that we have social workers and psychologists for that. True, we cannot do everything ourselves. However, our role in our patients' lives is central. Both we and our patients have a need for a continuous therapeutic relationship. We need to learn how to continue our role as "helpers" when medications are of no use.

It takes two to bond.

https://doi.org/10.1017/S1478951512000119 Published online by Cambridge University Press