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ESSAYS/ PERSONAL REFLECTIONS

The final goodbye

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Despite great diagnostic and therapeutic advances in oncology, most patients will ultimately die of their disease. Dealing with end-of-life (EOL) issues can be stressful for the oncologist and other healthcare providers, and it can be devastating for the friends and family of the dying patient. There is a wealth of data on delivering bad news to patients and families about a terminal diagnosis (Ptacek & Eberhardt, 1996; Lo et al., 1999; Ambuel, 2001; Van de Kieft, 2001; Rosenbaum, 2004; Kalber, 2009). There are several models of communication strategies on how to most effectively deliver this information, which cross many disciplines in medicine and psychology (Fallowfield et al., 1998; Baile, 1999; Baile et al., 2000; Coulehan, 2001; Razavi et al., 2003; Back, 2005a; Watling, 2007; Baer, 2008; Lienard, 2008). The impact of these conversations is indisputable. The manner in which this information is delivered lays the framework with which the patient and family approach what will eventually become their final journey (Roberts, 1994; Singer et al., 1999; Sarensen, 2004; Lienard, 2008).

Much has been written about how terminal patients brings closure to their impending condition, how they come to terms with their prognosis, and how they say goodbye to family, friends, and colleagues. Both the lay press and the scientific medical literature contain abundant material that deals with this aspect of terminal illness. One of the bestselling works on this topic is "The Last Lecture" in which Randy Pausch, a computer science professor dying of pancreatic cancer, details his final journey (Pausch & Zaslow, 2008). However, very little is written in regard to how the practitioner says goodbye or the impact of that interaction on the physician's well-being (Meier et al., 2001; Back, 2005b). It would appear that we learn this critical skill from our mentors, not all of whom are particularly artful themselves. It is at this point where science meets art and compassion.

Consider the following case: A 20-year-old woman, a single mother with a five-month old child, was admitted to the hospital with a severe cardiomyopathy. Her condition worsened in spite of aggressive inotropic agents and placement of a left ventricular assist device. A heart transplant was recommended; however, the patient had no insurance and also refused to sign an informed consent, because of religious convictions. Discussions regarding home care and, ultimately, hospice followed. After weeks of care in a tertiary setting, with long demanding hours caring for the patient and extensive discussions with the patient and family, her care was suddenly and quickly downsized to the minimal of palliative comfort care, and she was discharged. The primary attending physician on the case completed the discharge summary and hospice referral plans but did not say goodbye to the patient. She died at home a couple weeks later.

Although not a cancer patient, this young woman nonetheless demonstrated much of the angst of someone with a terminal illness. At times frustrating, at other times emotionally devastating, the roller coaster of feelings that must have been experienced by the doctors and other caregivers over the several weeks that this young woman was aggressively treated with lifesaving intentions certainly took a toll on everyone. In the end, when comfort care was the plan and EOL was imminent, the patient was unceremoniously discharged and the staff found it difficult to simply say goodbye.

When discussing EOL care, the practitioner may rarely use the words "there is nothing more that we

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can do for you," but all too often that is the impression the patient receives. Physician trust is paramount in EOL issues for patients and their families (Quill & Cassel, 1995; Heyland, 2006). This feeling of trust, or conversely, abandonment, is a reflection of how the message is delivered. Patients must understand that even when further treatment is not effective, relief of suffering in all forms is still available from the healthcare provider.

However, at some point in the course of every terminal illness, the patient will teeter on the brink of imminent death. Despite control of pain and other types of physical suffering, the practitioner may be faced with the realization that, this time, goodbye may be the final goodbye. Just as the initial impression at the first meeting is important and sets the tone for the physician–patient relationship to follow, the manner in which the physician bows out at the end of the patient's life, gracefully and respectfully, is equally important. Unfortunately, this art of medicine is not routinely taught.

An appropriate "final goodbye" requires a unique combination of skill, experience, and connection with the patient and family. A general template that has been productive in our experience can be divided into discrete areas to be addressed.

1. Be prepared. Review the patient's treatment course and history. Know the disease and its natural course and prognosis. Was the treatment painful?
2. Are the patient and family ready for death? What was the previous experience with the delivery and acceptance of bad news? Will there be feelings of abandonment? Will EOL be a relief to the patient; the family?
3. Identify whom you will be saying goodbye to. Will you be saying goodbye to family members? Realistically, what was your sphere of influence in the treatment course?
4. Will there be future contact? What is the policy for attendance to funerals and services? What is the response to your speaking at the service? What is your availability for assistance with the grieving process?
5. How will transference and countertransference be handled? What are the patient's feelings toward the physician? During the course of treatment was the physician seen as a "lifesaver" or with some sort of omniscience?
6. What are you feeling? How will that affect what you say? Do you really feel that you as a physician did everything you could? (Is that appropriate?) Were heroic measures employed? Was a "do not resuscitate" order (DNR) in place? Did you as a physician agree with the patient's and family's plan of care for EOL?
7. What to say and, more importantly, what not to say. Platitudes such as "I will be seeing you later," "take care," and "see you soon" are all inappropriate and can certainly be iniminical for the patient and their families.

The Accreditation Council for Graduate Medical Education (ACGME) defines training requirements for all medical areas. Hematologists–oncologists are expected to gain experience in palliative care, including symptom management and appropriateness of hospice referral; however, the specific details of such experience are not well defined. Our list above could provide a reasonable template for training programs in all areas of medicine to teach young physicians how to deal with an inevitable facet of patient care, no matter what the specialty. Just as mentors are expected to assess how trainees counsel patients on the side effects of medications or the risk of procedures, it is just as critical that the art of saying goodbye at EOL be developed.

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