

Two Doctors, One Patient, and a Common Goal

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The crowd erupts with joy, champagne bottles pop open, and everyone around me is stunned. The Chicago Cubs have just won the World Series for the first time in over a century! I heartily share the exhilaration of others in my adopted hometown, but my elation quickly deflates as my mind wanders back to 2013 and to one particular patient with one particular disease, which showed that the doctor-patient relationship is not limited to the oncologist but often involves others.

The oncologist: The oncologist's schedule can be counted on to be overbooked, busy, and regrettably, dominated by patients with cancers that are rarely curable. It is not surprising that oncologists, myself surely included, yearn to see a lymphoma diagnosis in their crowded roster of patients. For when we see a lymphoma diagnosis, we immediately hope for a curable one, such as large cell lymphoma, for which the odds of a successful treatment are much higher than those of other lymphomas.

I was thinking about this when she walked into my office, unabashedly in full Cubs gear, even down to her socks. Her husband was by her side, in a male version of the same outfit. Hardcore Cubs fans who were getting ready for another hopeful season, until the C word struck. Cancer. She had been coughing for few weeks. Ultimately, a chest x-ray was ordered, after antibiotics failed to improve her symptoms. She had a diffuse large B-cell lymphoma (DLBCL) and was only 48 years old. Our visit lasted an hour; we reviewed the data and I ordered additional tests to stage her disease in order to formulate a treatment plan.

A few days later, she walked back into my office with her husband by her side. She was wearing the Cubs attire again, head to toe. I was ready to deliver good news of her early-stage disease when she interrupted, "Just tell me I will live until the Cubs win a few World Series." I smiled in return and countered, "More than a dozen, I hope."

She had early and curable disease—the cure rate can exceed 80%. I happily explained how confident I was about her chances. I recommended chemotherapy and we reviewed possible side effects, along with how we would treat or prevent them. We both agreed against radiotherapy and I ended our conversation by making clear that our goal was to attain a cure with little disruption to her lifestyle, especially because the baseball season was starting.

Time passed, and my optimism, and her smiles, dissipated. She developed fevers and chills while on powerful chemotherapy

and was so sick, unable even to watch the Cubs on TV. Her DLBCL was not following my plan and proved unrelenting. I diagnosed refractory disease; the synonyms for "refractory" perfectly summed up my patient's disease: stubborn, recalcitrant, and unmanageable. I was upset, angry, disappointed, and speechless. This was the disease I should have been able to cure; this was the diagnosis that cancer specialists enjoy treating because of its favorable outcomes.

As the three of us sat in a quiet exam room, I with the white coat and they with full Cubs regalia, we discussed options. "We still have hope to cure this," I explained. I recommended a stem cell transplantation, using her own cells. I was steadfast in my optimism and determined to project confidence. When she asked about percentages, I avoided the answer. I advised her to focus on the mission at hand and to ignore statistics that could easily eclipse our hopeful march forward. More chemotherapy, more tests, more visits, as we forged toward a transplant.

Her transplant was thankfully without complications; she was discharged 14 days after her stem cells were reinfused. The nurses cheered her as she exited the hospital and headed home. The baseball season was over. The Cubs did not win, but her Cubs hat remained a loyal guardian angel, covering her bald head and emphasizing her resilience as she fought this lymphoma tooth and nail.

On day 45 after her stem cell transplant, I saw her back. She was not feeling well; the anxious looks in her and her husband's eyes stabbed me in the heart. The three of us knew her disease was back—it probably never went away; here we were again. The room was quiet and we started talking options. We talked about doing another transplant, but this time using stem cells from a donor and not her own. We then discussed the inherent risks, clinical trials, and novel therapies. Before decisions could be made, the options vanished, one after another, because her disease was as remorseless as it was tenacious.

A few weeks later, I was preparing to leave for the International Congress on Malignant Lymphoma in the morning—a gathering of researchers, scientists, and clinicians where I would be presenting data on large cell lymphoma. I got a page from the intensive care unit (ICU): my patient had just been admitted through the emergency room with severe shortness of breath. Imaging showed her lungs were filled with "something funky." The resident offered an opinion that infection was likely and that his team would start aggressive antibiotics. He was maintaining hope, just like he was taught in

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medical school. The ICU team would monitor, as the fear of sepsis was looming. I hung up the phone but could not get back to sleep. As I stared at my bedroom ceiling, my mind was racing, both sickened and infuriated by the irony.

The intensivist: Every other day is an “on-call” day for the critical care team, and today was one of them. Taking admissions for 24 hours in the ICU is a mixed bag. No one wants more work on top of the already challenging cohort of patients on the service, but the opportunity to take care of patients in the midst of critical illness is a privilege. As an intensivist, more often than not, I haven’t met my patients before they are admitted to the ICU. For the doctors who have known them for years, as the internist or specialist caring for their chronic illnesses, trust and comfort has been built up and earned over time. I rarely have that luxury. My access to patients’ worlds is born out of the necessity of their critical illnesses: the onset of something acute or the progression of something more insidious. I get to ask the most personal of questions, place a stethoscope on their chests to listen to their hearts and lungs, palpate their organs to search for pain or tenderness, and put my hand on their skin to feel how strongly or weakly their blood flows. With this privilege of such intimate and personal interaction come amazing opportunities but also heavy responsibilities. To help heal and comfort. To offer hope and calm, amid the fear and angst that come with critical illness.

The charge nurse shouted a quick summary, alerting me to a new patient rolling into the ICU. Late 40s, refractory lymphoma, maybe pneumonia, short of breath. Only four pieces of information, but they painted a picture. No positive mental images came to mind. Angst and foreboding filled my chest. A quick scan of the chart, more words and phrases, and the picture went from bad to worse. “Multiple failed rounds of chemotherapy.” “Status post stem cell transplant.” “Progressive lung infiltrates without a clear diagnosis.” “Increased work of breathing and short of breath.” “Unclear” diagnosis. These were not words you wanted in your medical records.

I saw the date of her diagnosis and wondered how she and her husband dealt with that blow. Were they overcome with fear and despair? Did they get angry and defiant? Were they united in their reactions? Did they struggle together or separately, lying awake in a darkened bedroom before the light of dawn?

I read about the rounds of chemotherapy, but it didn’t tell me about the nausea, the vomiting, the loss of her hair and weight and possibly her sense of self.

I saw the date of her relapse. But it didn’t tell me if she took the weight of those words in stride or if they shook her to her core.

All told, these words described a young woman who was running out of options and time.

I knew this patient, like many with severe illness too early in their lives, had kept hope near her side. Carried it with her through it all. This is the worst part of my job. Along with the opportunity to help and heal, cure and comfort, I have an obligation to explain the painful truth about the limits of what medicine has to offer. The ICU is often a place where patient and doctor, disease and medicine, are all thrust together. Where hope meets reality.

Now I needed to go into the room. Knowing everything. Yet knowing nothing.

The oncologist: Before leaving for the airport, I headed to the hospital to visit her. It was early; her eyes were closed; her husband was resting on the bedside couch. I sat down on a chair by her bed, looking at the monitor’s green lines jumping up and down, showing her heart rhythm. The noises from various monitors punctuated my sullen thoughts. She opened her eyes and offered a gentle smile.

She said, “I thought you were leaving today.”

“Yes, but I wanted to check on you,” I replied.

We both knew her current state was not due to infection, even though we held onto this improbable hope. Hope, however, cannot replace reality; her cancer was getting worse and it was winning the battle.

We sat in silence. “Are you ready for your presentation?” she inquired. “Yes, but I will be further preparing on my way there,” I replied. “Good luck and be safe,” she said kindly. I had to leave; I stood up and was at a complete loss for words. What could I say? I wanted to wish her a speedy recovery, but knew that wasn’t even an option. I wanted to tell her and her husband that I would see them upon my return. But would I? I knew deep down that I would not and that saying so would be a lie. I struggled to find the right words. I wanted to keep the hope going, but wanted to be realistic. I wanted to wish her luck, but didn’t know where to find luck when you needed it the most. Our journey was ending. I mumbled something as I exited her room. To this day, I can’t even recall what I said.

The intensivist: I saw the oncologist leaving the room. I felt his anguish as we conferred briefly before he had to leave. The reality is that with growing trends toward hospitalists, a majority of admitted patients will be cared for by physicians they have never met, especially during times of significant decompensation in their health.

Most oncologists, however, continue to be an exception. Their relationships with patients are forged in the midst of a life-altering event: the diagnosis of a life-threatening illness, when patients are forced to face their own mortality. At a time when a patient is most fearful and vulnerable, the oncologist has the ability and the mandate to help ease fears and provide a path of hope. With trust and a bond earned over weeks and months of therapy, the highs and lows of treatments, and follow-up scans and labs, they move forward with a common mission and purpose. I often admire the powerful and deep relationships oncologists have with their patients. But I do not envy the burden those doctors carry, one of providing and maintaining hope.

I walked toward her room, soon to be the newest doctor in her life. In the next few minutes, I had some basic tasks. Establish a physician-patient relationship. Provide or confirm existing information about her disease. And outline the options for care to her family and her. The challenge was to do this while earning immediate trust, being honest and accurate about the severity of her terminal disease, fighting my own human instinct to present things in the most hopeful of terms, and emphasizing possible options without lingering on how few remained. I didn’t want to hurt her any more than the cancer already had. I wanted to be honest without crushing her spirit. This was where hope met reality.

How could I do this? I had no script. I headed to her room with a weight on my shoulders. But whatever burden I felt paled in comparison with hers. As I walked into her room, I saw her for the first time. I noticed her shirt, baseball hat, and socks.

This was the first thing I learned about her. I knew her heart bled Cubbie blue. I offered my hand and said hello.

REFLECTION

She died during that hospital stay. Although several years have passed, she was one of the first people we thought of when the Cubs won the World Series. The physician-patient relationship is not one sided. Hope, and the comfort it brings our patients, touches our hearts as well.

Doctors are not immune to the emotional challenges of recognizing, accepting, and communicating when our shared hope is no longer consistent with reality. For baseball, hope springs eternal. But unlike the Cubs, she did not have the luxury of an endless number of seasons to start over and try again.

DISCLOSURES

The authors indicated no financial relationships.