art of oncology

A Soft Spot

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I remember a day as a child when my father, a vascular surgeon, came home and immediately retreated to his bedroom. He did not emerge for some time, and when he did, he spoke very little to anyone. When I asked my mother why, she told me softly, "one of your father's favorite patients died today, and he is sad." This surprised me at the time that my father felt so deeply for his patients that it affected him for hours after coming home from work.

I understand it better now.

I first met Gary after his medical oncologist asked me to consider operating on him for colorectal liver metastases. During our initial visit, I observed that he was a quiet man: nervous, kind, and polite, saying little unless prompted. Over time, I came to learn that he was a solitary person who found fulfillment and purpose in his work, enjoying hunting and fishing in his spare time. He lived almost an hour and a half away in a rural part of North Carolina. Outside of his visits, we communicated mostly via his brother, because his cell phone rarely had reception.

In the months before our first visit, he had been treated heavily with chemotherapy and appeared to have had a good response to treatment. Although he had disease in both sides of his liver, it looked as though his disease was resectable with a two-stage operation: the first stage to remove the left part of his liver and the second stage to remove two metastases in his right liver. He was young—in his early 50s—and otherwise healthy, a good candidate for surgery. The first-stage operation went smoothly, but when I saw him back in the office to plan for the second, his imaging revealed significant growth in the two remaining metastases in his right liver. To make matters worse, his normal liver had failed to hypertrophy enough to allow for another resection. He silently stared at the floor, visibly disappointed when I shared this with him. I told him I was disappointed too.

Together with his clinical team, we then embarked on a series of treatments, beginning with microwave ablation therapy to the growing tumors. Unfortunately in the interim, he developed a new liver metastasis with resulting biliary obstruction. We attempted unsuccessfully to drain his liver with an endoscopic stent with the goal to restart systemic chemotherapy. At our most recent visit, I expressed my concerns that the endoscopic stent had not been effective and recommended a percutaneous drain to decompress his bile duct.

His gaze drifted back to the floor. Sensing he was upset, I placed a hand on his shoulder, hoping to convey a steadiness and confidence that might offer some reassurance. As tears formed in his eyes, I felt his discomfort at displaying emotion in front of me, so I offered him a few minutes of privacy with his brother. Although he had been willing to undergo repeated endoscopic procedures, it seemed as though the idea of having a drain outside his body—a visible and tangible reminder of his progressive cancer—was clearly distressing to him.

When I reentered the room, we reviewed our plan for him to have an external drain placed and then begin a modified regimen of chemotherapy next week, which he and I both knew would not be curative. We did not speak this aloud, but the eye contact he made with me communicated that we shared a common understanding. I silently hoped that it would buy him some time at least.

Two weeks later, I unknowingly clicked open an automated message in the electronic health record stating very matter-of-factly that Gary had been brought in by emergency medical services, dead on arrival, from a gunshot wound. I called his medical oncologist, who reluctantly confirmed the news. He told me he had hoped that I would not find out because he knew I would not take it well. Suffice it to say, he was right. Although most of the cancers I treat—pancreatic, metastatic colorectal, and cholangiocarcinoma—are aggressive malignancies with poor long-term survival, Gary was the first patient of mine to commit suicide.

When I first learned of Gary's suicide, my mind immediately returned to my last visit with him. Had I been too honest and direct, not buffering the concerns we discussed with enough hopefulness? Had he expressed signs of clinical depression that I had missed, misinterpreting his responses as normal disappointment when in fact they reflected a much deeper despair? Should I have confronted him more directly?

I called his older brother while the news still freshly stung, feeling a sense of urgency to make sure his family knew how much Gary mattered to me and to his treatment team. After we exchanged platitudes, I found myself telling him that I had always had a soft spot in my heart for Gary, which was true. I tried very hard then not to cry but failed.

As a private person myself, I have always felt a particular sense of community with introverts like Gary: a shared experience of a need for privacy, an appreciation for quiet and aloneness, and a discomfort with being overly expressive among anyone other than close friends or family. Nature or nurture, I inherited this trait from my mother, who preferred pursuing her solitary artistic hobbies over small talk. Like Gary, my mother also became deeply depressed when she was

ASSOCIATED CONTENT

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diagnosed with metastatic lung cancer, a depression that worsened when she experienced debilitating side effects of treatment, only to learn that these treatments had not even been effective. As her daughter and one of her caregivers, it was not her physical suffering but her emotional suffering that was most agonizing to witness.[1]

During my mother's experience with end-stage cancer, I gained an intimate awareness of cancer's emotional toll in a way never afforded by my formal training or in my clinical practice. Stepping beyond awareness toward confident intervention with my own patients, though, has remained uncomfortable for me. I listen, offering empathy and understanding, explaining treatment options when there are any, and comfort when not. For some patients and families, I morph into a punching bag, offering them an outlet for their anger when I cannot offer them anything else. With Gary, I tried to communicate to him that beneath his displays of hesitancy and reservation, I recognized the struggle he was experiencing, his hopes, and perhaps more importantly, his disappointments. Now, I do not feel like this was enough.

Losing patients to cancer is something I have experienced from both a professional and personal standpoint, and unfortunately, with which I have grown all too familiar. Knowing that a timid and kindhearted patient of mine felt a sense of hopelessness and despair this deep, however, is acutely and newly painful.

I imagine I will always carry a soft spot for Gary with me, a tender soreness that lasts. It may go unnoticed at times, forgotten temporarily with the distraction of another patient's triumph: a curative resection, a follow-up scan with no evidence of disease, or a grandchild's high school graduation witnessed. Yet, I expect it will sting again, just as a bruise does when pressed intentionally and gently, to confirm that it is still there. I will be reminded of him, feeling a familiar ache when I witness someone's growing despair. Next time, I will pause to ask: "Are you losing hope?"

Perhaps you will ask too.

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AUTHOR'S DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

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REFERENCE

1. Snyder RA: This quiet lady. JAMA 323:215-216, 2020

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