

Essay/Personal Reflection

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I met Mrs. M when she was a 74-year-old and quickly grew fond of the flowery scarves she wore all year round. She had been diagnosed with stage Ib pancreatic cancer and I had hoped that adjuvant chemotherapy would stack the odds in her favor. However, three months later her cancer had metastasized and we treated her with chemotherapy. As we offered supportive care, I got to know her closely. She showed me pictures from her youth and told me stories of a hard-working life; I met and bonded with her family. She kept her motherly tone to the very end of her life, making sure that I'd eaten lunch before our consult. A couple of months after she died her daughter summoned the courage to enter my office once again, with some beautiful dried flowers her mother had asked her to gift me.

A. was a 26-year-old engineering student, only one year younger than myself. I met him at the hospital, after his advanced colon cancer diagnosis. His abdominal CT shocked even the most experienced surgeons. During his months of chemotherapy, I progressively noticed as he flinched in fear every time a doctor approached him, exhausted of the recurrent poking and prodding. He passed away on 2018 New Year's Eve.

Mrs. L was a 47-year-old BRCA-2 positive breast cancer patient, stage IV, who came to my office at least once a month for 18 months: always cheerful, planning future travels with her children. She was the sole caregiver of her elderly mother and I admired her strength and determination. Eventually, she succumbed to liver failure.

As an Oncology resident, every patient has been a learning experience: I have discussed their cases, diseases and treatment options with seniors and developed my scientific skills as consequence. But their deaths have also left small scars that have accumulated over time, unaddressed. My fellow residents have experienced their own share of pain. Sometimes we seek reassurance with each other — did I do all I could? — letting our fear and insecurity briefly shine through our shell of objectivity. We carry the ghosts of all the patients we lost and can quickly count more deaths than most people experience in a lifetime. In a specialty that deals with incurable diseases, however, fatalities are rarely acknowledged: discussions on death are considered futile and there is no established mechanism to aid young doctors with their grief.

Death is, in many ways, the last taboo for Western society. The fear of death lies at the origin of many human behaviors and social constructs but is also a major propeller for the incredible advances in modern medicine in general and Oncology in particular (Breitbart, 2017; Granek et al., 2016).

Young oncologists like myself are encouraged to believe that we can eradicate death and cancer will eventually become a chronic disease. This attitude, however, has robbed us of some of our humanity: the opportunity to connect more deeply with our patients; the opportunity to provide them with complete prognostic information, to allow them to fully live their remaining days and to address their concerns accurately.

We have also burdened ourselves with the responsibility of helping the patient escape the inescapable (Granek and Ben-David, 2017). Seeing oneself, and one's mission, as a Guardian Against Death leads to constant feelings of failure when yet another patient is lost, despite a rational understanding of a poor prognosis: what did we do wrong? Was the care we provided inadequate? Did we make mistakes? Without discussions on the matter, anxiety, depression, and de-personalization creep up.

The mourning experienced by doctors after a patient's death is equally neglected (Eng, 2015; Granek and Ben-David, 2017). Every society in history has felt the need to establish rituals and strategies to cope with bereavement; young doctors, however, are rarely validated in their natural feelings of loss.

It is a well-known fact that patients' deaths impact young doctors. The problem deserves special support, training, and inclusion in medical curricula (Eng, 2015). Real-time supportive discussions and “teachable moments,” such as I lived as a resident in the Palliative Care (PC) rotation, may be the most effective tools in addressing this emotional impact. Juniors and seniors could and should debrief cases of lost patients together, acknowledging fears and addressing them with reassurance and support.

It is crucial that we substitute the current way of thinking for one of admittance and acceptance of the current limitations of science. Alongside offering patients therapeutic options

tailored to their individual needs, doctors must also recognize the proximity of the patient to the end of their life and allow them to own their death in a dignified way (Carrieri et al., 2020). The importance of PC teams in this balance, working closely together with oncologists, must be underlined (Kaasa et al., 2018). When caring for patients with incurable diseases, the emphasis should be on quality of life, symptom control, and patient empowerment; and the focus should be on personal priorities and goals. Therapies with prognostic impact must be discussed within the context of the whole individual, including their disease and comorbidities, beliefs and concerns. Given the complexity of this task, we must include these topics in medical training (Eng, 2015; Kaasa et al., 2018).

Our role as oncologists should, therefore, be regarded as very privileged (Carrieri et al., 2020). Through our practice, we are invited to reflect upon death and are given the opportunity to embrace its reality. This introspection will result in better care for our patients, more meaningful conversations, and shared decisions. It could even spill over into our personal lives, in gratitude for the wonderful gifts of everyday life (Meier, 2001). Mrs. M's flowers, neatly displayed in my home office, are my daily reminder of these truths.

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