

If Not Us, Then Who?

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“IF not you, then who?” These words were spoken to me by a wise and deeply concerned mentor during a time of extreme doubt that I was experiencing as a medical intern. I was wondering whether I had anything of value at all to offer the patients under my care who were dying from far-advanced cancer. This simple but profound rhetorical rejoinder to my expressed sense of inadequacy turned me on my heel, actually and metaphorically, to return and attend to my patients as they lay dying, with conviction no longer to be demoralized by the absence of my ability to prescribe a cure, but rather to be motivated to help reduce the burden imposed by their disease.

Several years later, and seemingly a world apart from that linoleum-lined county hospital, I was sitting in an oak and gilded board room of a prestigious cancer center at a meeting to discuss cancer care. Upper-echelon directors of the center were proudly reviewing the latest data demonstrating small but notable increases in five-year survival rates for patients treated there with certain solid tumors. Ebullience and congratulations were plentiful...until someone asked: “What happens to the other 48.3 percent of patients who don’t live five years, and the ones who live longer than five years, but still succumb to their disease?”

Whatever the opposite of “ebullience” is, it was, at that moment, positively palpable. A stunned and way-post-dates-pregnant silence gave into a deftly managed change in subject by our host, and the conversation meandered elsewhere. No one dared allude to, no less mention, the “d” word again.

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More than 30 years have passed since I witnessed my first cancer death as a health care worker. Yes, wonderful progress in the treatment of several malignancies has occurred, but metastatic disease still takes a terrible toll. I still am haunted by the images of that first experience and the many more that followed. It is not the physical ravages of this terrible group of diseases we subsume under the singular and terrifying term “cancer” that make me shiver as I conjure up these memories. I was amply prepared for the sights, the smells, the sounds of cancer; although they are not easy to get used to, we quickly adapt and we also learn quite effectively *to pretend* not to be bothered. We learn to parry the worst of what disease and trauma bring so that we can get past the revulsion and do what needs to be done. The latent image that refuses to be extinguished in my mind’s eye is that pathognomonic look of desperate loneliness embedded in the actual eyes of those patients as they lay dying—that, and more so, the realization that we unintentionally but no

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less actually contribute to it. We come and go and perform our duties, but we rarely *connect*, and it is *connection* that is so desperately needed. Our methods change and protocols become updated, but outside of hospice and palliative care settings, that outcome largely remains the same. We are taught to effectively manage our own horror by mastering the treatment imperative: focus on the disease; fight the disease. And, even in the face of overwhelmingly irrefutable evidence of progressive and irreversible disease, we promote the delusion of cure and equate this misdirected posturing with “hope.”

Early on, before cancer has spread, these warrior-like devices and noble aspirations may have great value and virtue. But in far-advanced metastatic cancer, the seemingly polar but equally fearsome forms of neglect, consisting of either highly aggressive and persistent “anti-cancer” treatment or “I have nothing further to offer” dismissiveness, are nothing more or less than cynicisms disguised as expertise. Osler recognized this temptation when he stated, “To accept a great group of maladies, against which we have never had and can scarcely ever hope to have curative measures, makes some men as sensitive as though we were ourselves responsible for their existence. These very cases are ‘rocks of offence’ to many good fellows whose moral decline dates from the rash promise to cure. We work by wit and not by witchcraft, and while patients have our tenderest care, and we must do what is best for the relief of their sufferings, we should not bring the art of medicine into disrepute by quack-like promises to heal, or by wire-drawn attempts at cure, adding ‘continue and inexorable maladies.’”¹

The misapprehension that acknowledging mortality, even imminent death, is somehow tantamount to acquiescing to disease, or inviting a premature death, opens the door to excessive suffering on one or both of these two all-too-common fronts: burdensome—and even torturous—treatments without likely therapeutic benefit, *and* abandonment. Grief can take a terrible toll, and the *denial of death*—as vibrant a cultural norm today as it was when the book of the same name was written a generation ago—fuels and protracts the paralyzing response to loss. In his seminal work, Ernest Becker observes: “As long as man is an ambiguous creature he can never banish anxiety; what he can do instead is to use anxiety as an eternal spring for growth into new dimensions of thought and trust.”²

But this cannot occur while symptoms are overwhelming the mind’s ability to gain clarity. That is where we enter, we physicians of all stripes, who can use not just the tools of our particular specialty to reduce the physical torments of pain in advanced medical illness, but our insights into the human condition and our empathy to connect with others’ suffering—to relieve it. If not us, then who?

References

¹ Osler W. *Canada Lancet*. 1909;42:899-912

² Becker E. *The Denial of Death* (New York: The Free Press, 1973), p. 92