

can make institutions of higher education and health care more collaborative and prompt educators, practitioners, and students to view health care and education from new perspectives while bolstering their work tackling today's complex challenges.

With the move toward value-based, population-focused models for payment and care delivery, problem solving that integrates all sorts of professionals in efforts to confront the challenges facing a community will be increasingly important. Whereas the fee-for-service model emphasizes deployment of complex technical

skills, value-based models reward working together to untangle knotty societal problems. Although we may not have all the answers about how best to conduct IPE, we have learned enough to know that it can provide the essential foundation for this new approach to health care. As the student quoted above made clear, IPE can train practitioners to work more effectively as teams and to deliver care that has a greater impact on patients.

Disclosure forms provided by the authors are available at [NEJM.org](http://NEJM.org).

From the Office of the Vice President for Health Sciences, Virginia Commonwealth

University, Richmond (A.D.); the Josiah Macy Jr. Foundation, New York (G.T.); and Harvard Medical School, Boston (G.T.).

1. Framework for action on interprofessional education and collaborative practice. Geneva: World Health Organization, 2010.
2. Institute of Medicine. Health professions education: a bridge to quality. Washington, DC: National Academies Press, 2003.
3. Cox M, Naylor M. Transforming patient care: aligning interprofessional education with clinical practice redesign. New York: Josiah Macy Jr. Foundation, 2013.
4. Lawlis TR, Anson J, Greenfield D. Barriers and enablers that influence sustainable interprofessional education: a literature review. *J Interprof Care* 2014;28:305-10.
5. Zorek J, Raehl C. Interprofessional education accreditation standards in the USA: a comparative analysis. *J Interprof Care* 2013; 27:123-30.

DOI: [10.1056/NEJMp1705665](https://doi.org/10.1056/NEJMp1705665)

Copyright © 2017 Massachusetts Medical Society.

## Abandonment

Ranjana Srivastava, F.R.A.C.P.

“Hospice. It’s where people go to die,” she says, surprising me with her sudden lucidity.

“And also for symptom management,” I add gently.

“Like my headache,” she notes.

And your homelessness, I think — the fact that your one-bedroom, upstairs council flat just won’t do anymore.

“I could go home,” she mutters, moving to squeeze my wrist with her good hand and realizing that her hemiparesis won’t permit her to turn. Then, just as suddenly as it had appeared, her lucidity vanishes, in its place a confused silence that grows denser by the day as my patient’s cerebral edema worsens.

Recently, on routine review, I had told her she was well. Exactly a week later, she landed in a distant hospital after having lost her way to the shops and been found

collapsed, her grossly abnormal MRI illustrating why. Cancer wraps all around her brain and has crept into every sinus. The ventricles are swollen, the brain squeezed. It’s a sheer miracle that she’s been asymptomatic all this time, and despite what everyone says, I am convinced that I missed the signs.

The patient’s daughter is her tireless advocate. She calls me to complain that countless providers have swung by, but their advice has been conflicting. Suggestions in just the past few days have ranged from strong opioids and rehabilitation to intrathecal chemotherapy.

“My head is spinning,” the daughter protests.

“Mine, too,” I admit.

Why are there so many doctors involved, and why aren’t they talking to each other? What will

a dying patient achieve in rehab? Why did it fall to the daughter to inform me? And what can I do for my patient in a faraway hospital where I have no admitting rights? Suddenly, her needs feel so overwhelming that I find myself looking for a quick exit.

“Listen, you need to demand better explanations from the treating team,” I say, instantly recognizing my prescription for what it is — a way of shielding myself from a story destined to end horribly.

Her voice falters. “I guess there is only so much you can do.”

Regret washes over me. “Get some sleep,” I say. “Leave it with me.”

“I knew you’d help,” she sighs.

I cringe at her misplaced confidence. She doesn’t suggest that if I had been more vigilant I could have foretold the impending

disaster and spared her mother the embarrassment of being found, incontinent, sprawled across a busy bus stop.

It takes many calls to locate a doctor, but eventually it proves straightforward to recommend a transfer to hospice for end-of-life care. The daughter's relief turns to tension, however, on the eve of discharge.

"Will you be there?" she asks, then answers her own question. "I guess you can't be everywhere."

True, the hospice is in a different part of town, but I can't bring myself to say that the real reason I can't manage her mother's care is that I feel sucked into a vortex of issues beyond my control. The daughter's estranged and testy father has suddenly reappeared after many years of absence. Her mother is deteriorating, and I am fielding multiple calls to soothe concerns and allay problems that are outside my usual domain. The better side of me values the trust placed in me, but the other side, the jaded side, resists the responsibility inherent in the trust. Guiltily, I find myself hoping that my patient's plight ends soon but that I am spared the details. I console myself that she is but one of many palliated patients, and I turn my mind to the patients in clinic awaiting important management decisions.

But as I have known all along, the distinction feels fake and eventually wears so thin that one night after work, I drive to the hospice, where my patient greets me with such obvious pleasure that my heart cramps. Before falling asleep, she strokes my hand and whispers my name. I am humbled and slightly aghast that there is room for me within her

failing cognition. Her daughter praises the hospice but laments her father's paranoia that "everyone is killing" her mother by sending her there.

"I know!" she exclaims, struck by an idea. "Why don't *you* talk to him?"

"I will let her doctors know — they are very good at this," I say, desperately keen to avoid the entanglement.

Some nights later, leaving my hospital, I automatically turn toward the hospice, this time driven only by the thought of making my patient smile. She is seated in a wheelchair, fresh from a trip to the luxurious garden. Holding a sprig of her favorite lavender, she smiles absently. She is mute; there is no sign of recognition.

In the room are her ex-husband, her daughter, and suffocating tension.

"Doctor, *you* tell him that I didn't give her diabetes by feeding her ice cream. She has a different kind of diabetes due to her brain problem."

Disbelievingly, I explain the difference between diabetes mellitus and diabetes insipidus, nettled that my patient's final days are being held hostage to pointless disputes.

"So she's stuck here for months, just because you say so?" the ex-husband corners me, threateningly.

"She won't be alive for months," I whisper.

Understanding dawns on his face, another reminder of the importance of hearing those words from the treating oncologist, even if the news has been discussed many times before.

At the front desk, I go to write a note, but I realize that there's nothing to say that the hospice team doesn't already know. Just

then, an elderly nurse breaks into my reverie.

"It's good you came," she says. "Many patients just feel dumped at hospice."

My face must reflect my surprise at her blunt term because she shrugs, "They do, they just don't tell you."

How can anyone feel "dumped" in this tranquil, respectful place where kindness and respect never feel optional? Here, there are flowers and sunshine and fresh air. Here, families can visit, stay, argue, and grieve and be supported by professionals. No one can feel "dumped" here, I silently object, but somehow her words put me on edge.

Did I recommend hospice because it was easier on my emotions, or right for the patient? What did I relinquish in the process — my day-to-day involvement or a broader duty of care? Will my patient sense my ambivalence, that I can't quite let go but neither can I stay?

A few days later, the daughter calls me. "Mum died peacefully the day after you saw her and, incredibly, Dad began to come around. She was too young to die, but thank you for all that you did." I am engulfed by a huge wave of sadness, and since every word feels like a platitude, all I say is, "You should be proud of your effort."

After the funeral, she calls me to obtain a letter for work. I have one chance to ask the question that has been pricking my conscience, though I can't bring myself to use the nurse's terminology.

"Some people feel abandoned in hospice. Do you think your mother ever felt that?"

"Abandoned? Oh god, no!"

My heart soars with relief. *I told*

*you so*, I quietly and gleefully retort to the nurse. I could have told you that the peripheral involvement of an oncologist is no match for the comforts and consolations of hospice, that advocacy can stretch only so far, that abandonment by the oncologist is a myth, that patients get over the fact that their oncologist can't be everywhere. From here it's short work to convince myself that per-

haps my job can end when patients enter hospice, that things will work out even without my exertions.

"But doctor, you know why, don't you?" the daughter continues, with renewed emphasis. I hold my breath for the denunciation. *You passed off her care*, I expect her to say, *but we got better doctors in the end*.

But no. Instead, I hear, "We felt

safe because we knew you had our back. Mum knew you'd take care of her no matter what. You were *always* going to be her oncologist."

Disclosure forms provided by the author are available at NEJM.org.

---

From the Department of Medical Oncology, Monash Health, Melbourne, VIC, Australia.

DOI: 10.1056/NEJMp1706793

Copyright © 2017 Massachusetts Medical Society.