

may help boost clinical efficiency by means of virtual scribes, assisted clinical decision making, and AI-generated or AI-facilitated documentation, but the benefits will come with trade-offs. Safety concerns and high implementation costs are significant challenges. Given the high per-user, per-month fees for some AI tools and generally thin organizational margins, it's likely that clinicians will be asked to see more patients to cover costs and generate additional revenue. In light of the potential time savings, payers may also adjust reimbursement rates, exacerbating the mismatch between job demands and resources. Thus, understanding optimal implementation strategies and rigorously evaluating whether the technologies are driving the desired effect will be critical to ensuring sustainability as these tools are rapidly deployed across health systems.

Predictive analytics and machine-learning algorithms are poised to challenge the status quo of work design by enabling a shift from a simplistic, short-term focus on financial returns to a more proactive, data-driven approach to determining work structure and resource allocation. Safety-management platforms with early-detection systems could be the next wave of health care innovation. Like tools for de-

tecting clinical deterioration, this type of electronic tool could provide organizational leaders with timely alerts when work design is leading to HCW harm, system inefficiencies, or patient and safety problems, permitting rapid, iterative adaptation. Health care leaders who are aware of the effects of increasing or decreasing an HCW's workload could then make data-informed decisions that take into account the trade-offs involved. For example, increasing the number of patients per hospitalist might seem to save a hospital money on immediate salary costs but could also lead to inefficiencies (e.g., longer lengths of stay), clinician burnout, or patient harm, potentially negating any financial savings.

Finally, evidence-based work design will continue to grow in importance as public scrutiny of health care costs and outcomes intensifies, cost burdens shift to patients, and workforce shortages create fierce competition for top talent. HCWs can be selective about their employers and want a voice in shaping their work environments. Evidence-based work design could be the solution that drives better organizational decision making, contributes to cultivating a thriving workforce and improving patient outcomes,

and helps ensure long-term organizational success. Organizations that embrace this paradigm shift may truly achieve health care's quadruple aim: to improve population health, enhance patients' experience, reduce costs, and improve the work life of HCWs.

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What I Wish I Had Done for a Grieving Father

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“Doctor, I mean no disrespect, but why am I even here?”

No patient wants to “belong” to a geriatric oncology clinic, but over the years I’ve developed an

acceptable explanation: “As people get older, they develop a variety of problems. The aim of this clinic is to help older people with cancer take advantage of cancer treat-

ments while shielding them from dangerous side effects.”

Noting the patient’s name and slight accent, I offer to get an interpreter.



“Why?” he retorts. “My English is perfect.”

Kicking myself, I hastily explain that half my patients require an interpreter and that I meant no insult.

The man, who is nearing 80 years of age, has gone for a routine vascular review and emerged with a finding of a liver mass. Noting that the mass appears to be malignant and unresectable, and the patient asymptomatic and disinterested, the surgeon sends him to me. The patient says he had no idea he was having a cancer workup — he just kept doing as he was told.

Patients attending this clinic answer questions regarding their coexisting conditions, functional fitness, emotional well-being, nutritional status, and social support, since all these factors influence decisions about cancer care. The man’s responses show him to be functionally fit and a candidate for treatment.

“They think it’s some kind of cancer.”

“Yes, we would need a biopsy to find out more.”

“Not for me,” he says.

I remind myself that if I keep quiet instead of jumping in with “but why?” I will soon find out.

But now we are sitting in total silence. He is staring at me, as I steal glances at him. I feel on edge but don’t know why. I remind myself that an emergency button is situated at my knee.

“I would never have chemotherapy because I know how it destroys people.”

I make eye contact. And he starts sobbing.

“Wait, do I know you?” I ask.

“You remember how chemotherapy destroyed my daughter’s life? After I see you, I am going to her grave.”

There is no imaginable way to say aloud what I’m thinking: *Of course! My team treated your daughter many years ago, but you were so much younger and more vital then. She was unforgettable; it’s just that I never expected to see you here.*

“I am sorry,” I say, desperately

hoping that this meager expression will convey the pulsating intensity of my feeling.

His daughter was the apple of his eye, a middle-aged woman with a mild acquired brain injury and a placid disposition. Her “good prognosis” cancer didn’t behave as promised. As her metastases landed in inconvenient places, we kept chasing them with chemotherapy, radiation, and increasing doses of opioids. But the gains we made always seemed to come at a high cost.

She could reliably report the symptoms she was experiencing — pain, lethargy, hunger, and headaches. But when metastases pressed on her spinal cord and paralyzed her legs, it fell to her father to appreciate the true extent of the threat to her life expectancy.

The relationship between oncologists and patients is serious and sacrosanct at one level and utterly simple and moving at another. I recall many of my patients with great fondness, for all sorts of reasons — the woman who brought a delectable home-baked cake to every visit even when she was nearing death, the man who shared travel recommendations when he could no longer fly, the patient who delivered birthday flowers in pouring rain, the one who brought baby clothes on my first day back from maternity leave. But my abiding memory of my experiences in the daughter’s case is that as she became weaker and our treatment options diminished, her father began arriving clutching a piece of paper. The paper contained a number: his bank balance. He would surreptitiously press it into our hands so we knew to spare

no expense in keeping his precious child alive.

His magical thinking broke my heart, in a country with universal health care, where public-hospital cancer treatment is free. Try as we might to reassure him, his foreign upbringing convinced him that with enough money, one could buy life.

excellent care from a team that earnestly dwelled on her problems. I remember our visits being long and our sympathies abundant. And though I did not expect plaudits after she died, I feel a little pained that her father exclusively remembers the bad bits, now with ramifications for his own care. It feels like a delayed

So when we thought we were presenting sophisticated treatment options, he could only perceive us asking him to shoulder more decisions. Although I believe we were kind, our kindness was measured out in clinic time — not nearly enough to pierce his loneliness. And whereas money had helped him purchase his daughter the softest clothes and the gentlest music, it had proved no match for bad biology.

Communication experts say that naming and acknowledging an emotion is a simple and powerful way of connecting with people. Of course we knew he was having a hard time, but I don't recall saying so to him very often; doctors like to fix problems, and his daughter's case was brimming with them. I also remember being so unsettled by his expectations that it felt easier to focus on her cancer. Now I wonder whether we sufficiently acknowledged the unfairness of the situation and grieved with him. Did we say "I know this sucks," instead of "Here is what you could do next"?

If I could hit replay, I would give no less time to the daughter but devote more to her father. I would expand the ring of social workers, palliative care clinicians, and others to embrace him as well as her, knowing that her terminal illness would be ever-present in his life. At the end of every visit, I would look at him and tell him he was doing a great job.

All these years later, I want to pull him back from the brink of his own suffering and ask, "What could we have done better?" But he isn't coming back. So the best I can do is never again assume that my care, no matter how high

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Those conversations are echoing in my ears now.

"It's OK to not want treatment," I say, "but could I introduce you to palliative care?"

At the end of her life, his daughter was bed-bound and required home hospice for weeks that seemed like years. Cruelly, the number on the piece of paper had kept growing as her reserve faded.

"I don't want to go near palliative care," he says fiercely.

I move to a final appeal.

"Then can I bring you back here to keep an eye on you?"

"No way," he says. "I will go without treatment and with peace."

His expression of horror at my suggestions mixed with consideration for my feelings says it all: oncologists are no friends of his.

With a heavy heart, I see him out to visit his daughter's grave.

I hate to admit that my first reaction is one of surprise. I would say that his daughter received

review that has downgraded me to an F where I'd given myself a B.

As the weeks go by and my calls to him go unanswered, I struggle to reconcile the world of professionals who believe they did their best with that of patients and caregivers who disagree. At such times, it's tempting to dismiss the latter as thankless or console ourselves that things might have gone far worse without our intervention.

But before I become indignant, I try to put myself in the father's place. His terminally ill daughter didn't fully comprehend her own situation, which left him in the invidious position of serving as both her physical caregiver and her psychological shield. Every piece of bad news had to travel through him to reach her. He had to decide how much to tell her and when, interpret her every wish and goal. The burden must have been oppressive.

by my standards, will be received as intended.

Entering the second half of my career, I wonder how to keep improving. I can't help thinking that this little dose of humility could go a long way toward mak-

ing my future patients — and their families — feel more fully seen and heard.

Identifying details have been omitted to protect the family's privacy.

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