

In Search of Redemption

She is halfway down the list of patients I am seeing while covering for a colleague. The work has been fairly benign thus far, allowing me to contemplate a good start to the weekend.

She is lying in her bed, a pink eiderdown turned back neatly at her feet. Her face is turned toward the sunny road that lines the hospital; her body is half-turned. A mop of shiny black hair adorns her small head. She turns to face me as I walk in. Her body is lithe and well-proportioned. Despite her stated 60 years, she could easily pass for someone a decade younger. She greets me with a warm smile as she eases herself in bed.

"I am the doctor on this weekend," I announce.

"I was expecting you," she greets back.

I am immediately enchanted by her dark brown, expressive eyes that set off her face like jewels. Her face is an even milk chocolate brown, painted by a skilled artist in a single stroke of genius. Her teeth are shiny, white, regular, and intact. The nightgown, black and white, drapes gracefully across her body. Two broadsheet newspapers lie well-thumbed. A pen rests beside a worn leather diary. Of the familiar signs of cancer—sympathy cards, flowers, photographs—there is none. I recheck my handover sheet. "Advanced adenocarcinoma, unknown primary," the notes state. She is looking up at me with anticipation. The checklist is automatic.

"How are you feeling this morning?"

"Not too bad."

"Your pain?" She has known bony metastases that are on the march.

"Okay." She strokes her right cheek. "The radiation will take a few days to work, I guess."

"Are the painkillers causing side effects?"

"I feel more awake on the reduced dose of morphine."

"Anything I can do to help you today?"

I smile internally. She is the perfect patient. Well-controlled symptoms, understands her disease, on minimal medications, with a clear plan of action. Also recognizes that I am filling in and will defer questions to her usual physician.

"No. I think I am just going to have a quiet day."

I haven't even sat down yet and she is finished. She has taken two minutes so far. Feeling unfinished, I try again.

"How are you doing emotionally?"

"How nice of you to ask! I think I am all right. I am quite okay."

I should have guessed! This graceful, sensitive, "with-it" woman seems safely adjusted to her diagnosis. Her face is beguiling in its innocence, not a wrinkle on its landscape.

She could probably teach the rest of us how to cope emotionally with what life deals us.

"Really?"

"Really." I have heard this a hundred times before, with the response often hiding a private world of stoicism, resignation, and built-up resistance to perceived gratuitousness. But I believe her. Her face is as peaceful as the statue of the Buddha that adorns a magazine cover at her bedside. There is no doubting her answer.

Inwardly grateful that I can move on to other patients, I say, "Well, I hope that you have a good weekend and get home soon."

"Thank you, Doctor."

Her mellifluous voice shimmers with amity and cooperation; it puts one at ease. A patient like her every day or two would brighten the dreariest clinic, I think.

Then, "Doctor, could you spare me an extra few minutes?"

I retrace my steps. Perhaps she has dropped her newspaper on the floor or wants me to chart some sleeping tablets or call her nurse.

"Are you from India?"

"Yes."

"So am I! All these years and I still miss home." Child-like eyes look up at me. But she couldn't have recalled me for this benign comment.

"I thought that because you asked how I was doing emotionally, I would tell you."

The notes state that she is a university professor. She is married with no children.

"I know that my cancer is bad and the last two years were unexpected. After all, the doctors gave me three months. It was very stable until recently, when it started going to the bones."

Last week's bone scan lit up ominously. There were new pelvic and truncal metastases, but the ones exacting the greatest toll are the lesions in the base of the skull, ambushing nerves at their exit and causing pain hard to describe and harder to treat. Morphine makes her somnolent and she complains of feeling drugged. While having pain in the region of the trigeminal nerve and receiving radiotherapy, she has now developed facial nerve involvement. She describes the sensation eloquently, as that of a feather tickling her throat. She squares herself in her bed, looks me in the eye, and says, "I don't want to die with one nerve going after the other. I know that many nerves travel through the skull."

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Her fear tallies my own so I reassure us both. “The radiotherapy will do a good job of controlling your pain and preventing further complications.”

“But you can’t cure the cancer.”

Cautiously I inquire, “What does your oncologist say?”

“He says there is nothing else. But he is very nice,” she hastens to add.

“I am afraid more chemotherapy would not be useful, but there is room for pain relief and radiation.”

“Can I talk to you unofficially?” she suddenly asks.

It is an odd request. I am intrigued.

“I am your doctor today and you can certainly talk to me,” I offer.

“When you asked me how I am doing emotionally, I said okay. And I am for now. But the more I think about it, the more afraid I am of the indignity of this slow death. I am always in pain. First one bone, then the next; first one nerve, then another. Unable to open my mouth properly, unable to taste, then to swallow, to speak, to have a conversation with my family. I am not complaining about life’s unfairness, but I just don’t want to live like this when things get worse. And we both know they will.”

Her words compel me to smell her fear.

“Maybe the radiation will stabilize things for quite some time.” She detects my noncommittal tone and responds earnestly.

“But think about it. The nasty thing is spreading. It will spring up elsewhere, perhaps next inside my brain. I don’t want to live like this.”

It is indeed remarkable that she has come so far, but the trajectory of her illness is now obvious. Various lines of conventional as well as complementary therapy have failed, and lately she has become increasingly symptomatic.

“I am not saying that I would. But how can I end it if it is no longer a life I want to lead?” She fixes me with an unflinching stare.

The sharp drawing in of my breath echoes through the spacious room. My heart pounds. In a flash, I am distressed, concerned, confused, and flustered.

I am not *that* kind of doctor! I want to counter indignantly, ending the conversation then and there. Her eyes, steeled with courage, have lost none of their charm. Her expression too is disarmingly soft. I can hear every part of her thinking, anticipating, preparing for my next words. She gently taps the luminous dial of her wristwatch.

“My entire family has placed its life on hold, and now, we are all waiting for the clock to strike 12. Eventually, there isn’t going to be any quality left in this waiting. Is it so wrong to want to go before then?”

I am stunned by her cold logic yet captivated by its lucidity. She is thinking aloud what has crossed the minds of anyone, physician or patient, who has witnessed

the trail of emotional and physical destruction that a terminal illness often lays down. How many times have we, as physicians, shared our thoughts behind closed doors with statements such as “I don’t blame her for wanting to die” or “I am glad he is finally gone,” our words belying our frustrated acknowledgment that sometimes the best symptom relief we offer is still not good enough for the patient who mourns the loss of quality of life? But those are strictly private thoughts, carefully shielded from our public persona.

I respond firmly. “Physician-assisted suicide is illegal in Australia. I am afraid I can’t help you.”

She sighs. “I know and I understand. I just hate losing control over this final aspect of my life that affects all those around me.”

“Does your husband know your wishes?”

A knock on the door makes me jump. I assume that someone has been listening, and my entire mien assumes a guilty appearance. Her husband walks up to her and strokes her hair before shaking my hand. I feel distinctly awkward that I have been talking about his wife’s death behind his back.

“Have a seat,” she tells him. “We have just been discussing that same thing.”

“Oh, yes,” he says briskly and warmly. “And does the doctor have any ideas?”

What sort of people are they? my mind screams. They refer to death as if it were a mere blood count or a prescription for antibiotics.

“Physician-assisted suicide is illegal here,” I restate more loudly than necessary. I need to hear myself say it because I also need to say what comes next: “I can see that you are fearful about your future.” In fact, in her fear I sense a vestige of the same existential question that gnaws at many of us, ill and well. What would we want if we were destined to die a slow and painful death? Would we favor survival over quality, and what would tilt us in which direction? Who could we entrust with respecting our final wish if it were the most important we had ever desired? She seizes my statement of sympathy as a breathless person clutches at oxygen.

“You understand my fear because you have seen lives become untenable. You *know* I am right.” Subtle accusation and stern conviction are finely mixed in the statement, so gently delivered yet hitting hard. I have often felt uncomfortable but never so insecure in the presence of a patient. I feel powerless, swimming hard against a mighty current but partially tempted to just succumb to it. I recoil at the horror of even contemplating euthanasia, mainly because it goes against the grain of everything I was taught as a physician. All I ever learned was that it was decried by the jury of one’s peers and punishable by law. But then, why can I not dismiss outright her request as absurd? Why do I find her argument compelling? How could I possibly see shades of my own reasoning in hers?

I feel trapped between what the law dictates and my conscience suggests.

“Have you met many patients with incurable cancer?”

“Yes.” It is the easiest of today’s questions.

“And how many have asked you to help them die?”

“None.” No one has been as deliberate, thus allowing me to explore other factors in the request such as untreated pain, depression, guilt, and anger.

“Are you depressed?” I inquire gently. “I know you have had a rough time recently. I could find you someone to talk to.”

“I am not depressed,” she says, without taking umbrage. “Like many rational people, I want to plan ahead.”

I believe her entirely. It is what I would want to do in a similar situation.

Her husband has been watching out the window at the street bustling with traffic and people. He picks up the newspaper and, pretending to scan it, muses, “You know, it happens more commonly out there than you think.”

His statement sears me. How far advanced are their plans?

“How are you going to achieve what you want?” I am not sure what I will do with the knowledge, and I secretly hope that she does not divulge any more.

“I think I will go to a country where it is easier. Luckily, we know other doctors. We don’t want to cause trouble.” She says this with utter frankness, as if negotiating a minor impediment. Then she looks into the street before sighing, “But what a shame I can’t die in the comfort of my own house, where I have lived the best part of my life.” It is this devas-

tating normalization that reminds me of her as a person and not merely a diagnosis.

The conversation comes to a natural halt. I don’t know what else to say, and they seem not to feel the need to continue. The more peaceful their demeanor, the more churned up I feel. It is as if I have done wrong by simply sanctioning this conversation, yet I know that her mind was made up well before she met me and that I was nothing more than a sounding board. But the second I contemplate her sobering future, my self-indulgence melts.

What do we say to patients like her? Do we dismiss out of hand their call for assistance beyond that which we are capable of or willing to provide? Or do we subject ourselves to deep soul-searching at the expense of creating chaos within? Can we trust ourselves to weigh the nuances with the sagacity and deliberation that this irrevocable act demands? And then, if the conscience is torn between professional obligation and personal conviction, will the profession find it in its heart to counsel and comfort, or will it disown those who venture into the unknown?

My response to this patient’s request was visceral in its intensity. I would be concerned if it were anything but. However, what troubles me is that I did not find her argument unreasonable or worthy of dissuasion. Today, I can obscure my haplessness by quoting the law. But how much longer will my respite last?

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