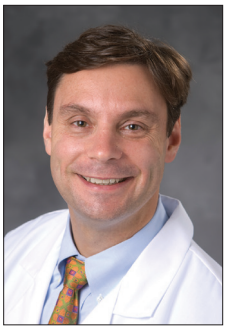
"Degriefing"



In this issue you will find a thoughtful and sobering essay by Drs Anthony Galanos and Matthew Labriola, my colleagues at Duke, called "How We Manage Grief." Reading their perspectives brought to mind some of my own more suppressed and unresolved experiences with grief. As the authors point out, grief is rarely discussed among colleagues, either professionally or personally; most of us have learned to deal with this burden through various forms of compartmentalization. This process is absolutely necessary and is largely sufficient in the short term; how else could we discuss end-of-life decisions with a patient and caregiver in one room, and then go in the next room and celebrate a promising test result? Over time, these compartments of sadness are suppressed to the unconscious, but not gone. So, what happens when these feelings resurface?

A few months back, I was on a Zoom call with hospital administrators and other medical leaders, discussing a new proposal of some sort. I must have compartmentalized the topic because I cannot even remember what it was. During the call, one of the attendees sent me a private chat to thank me for taking care of his close friend R. B., who had died of germ cell cancer. I was stunned! It had been more than nine years since R. B. had died, but a wave of emotions came over me, as if he had just passed away again. Images of his face came back to me, and I relived a heartbreaking conversation I had with him near the end of his life.

R. B. was a young man, married and in his thirties, when he presented with shortness of breath and a large chest mass that turned out to be a primary mediastinal germ cell tumor. We treated him aggressively with paclitaxel, ifosfamide, and cisplatin chemotherapy. He had a partial response, but his alpha-fetoprotein level never normalized. We resected his mass, but his tumor marker levels began rising shortly thereafter, and new pleural metastases developed. I then treated him with salvage chemotherapy, but his disease did not respond. He was admitted to the hospital with pneumonitis shortly after his third cycle of chemotherapy. His oxygen requirements quickly increased, and I met with him and his wife in his hospital room to discuss whether to put him on a ventilator.

I was aware that if he went on the ventilator he would never come off, but his condition had progressed so quickly that I had not prepared them for this step. I felt as if I had pulled the rug out from under them. And then, the next thing I knew, R. B. was comforting me! "It's alright," he said softly. He told me that he knew he was going to die, and that he was ready. The serenity that he expressed in that moment awed me, and has stuck with me ever since.

The Zoom call had almost finished before I could collect myself enough to write back to my colleague. I thanked him for sharing his memory of R. B. and said I had appreciated the opportunity to get to know and care for him through his cancer journey. But the truth is, R. B. did more for me that day than I was able to do for him.

Since that time, I have had many other patients experience progression and die of their cancers. I have improved my ability to anticipate complications and prepare patients for the possibility that we may need to focus on supportive care efforts, even while we are actively treating their cancer. I have become a staunch advocate for hospice services before patients start their end-of-life transition. I have witnessed the benefits of this "proactive" approach to hospice, including the family being better able to manage their grief associated with the patient's ultimate death. I helped my own father accept hospice services for my mother as her Alzheimer's dementia entered its final stage. Most recently, I recommended hospice to a close friend I have known since medical school, who was being treated at another academic medical center and was suffering.

Grief is still part of my everyday life. I accept that and will always compartmentalize these feelings during my busy working hours. But later, when things are quiet, I can open those compartments and reflect on the care and compassion I have given, and feel good about what I have done. Death is natural and is not something we can avoid. But dying can be a struggle, which is why the use of supportive services is so important.

One of the methods that Galanos and Labriola recommend for processing grief is the use of narrative medicine. I believe that sharing my story of R. B. with you is an example of such a narrative, and I did find it to be helpful. I thank you for that.

Sincerely,

Daniel J. George, MD