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Falling in love with the process

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Essay/Personal Reflection

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My parents left the Philippines to pursue the American Dream before I was born. Like most immigrants, they set clear goals for their new life in the land of opportunity and sacrificed to achieve those goals. Once my father established himself in his medical practice and my mother in business, my parents quickly turned their full attention to me and my siblings. My parents seemed to view our success as an extension of their own. They wanted a better life for me and my siblings, and it was our turn to achieve goals they set for us, goals that at times felt like insurmountable stone walls.

I was determined to check all the boxes on my parents' to-do list, the most important of which was achieving academic honors and accolades. I kept my head down and accomplished each goal with little time for friends or fun. My parents rarely if ever told me how proud they were or told me they loved me but instead showed their love with small gestures, like cooking my favorite meal or taking us out to dinner. I felt as though my parents' love was contingent on my academic and extracurricular achievement, and my identity as a future doctor was formed from their aspirations.

I was determined to achieve ever-loftier goals during university, where I earned high grades in premed courses and volunteered in the hospital to build my CV. My goals in medical school were also well defined: get the highest marks on written exams, write thorough H&Ps, and impress on rounds. I relinquished much of my humanity by competing with classmates rather than collaborating and connecting with them. Life remained a series of boxes to check.

My mindset changed dramatically during residency. I realized that many goals are difficult if not impossible to achieve. Life was no longer a series of discreet tasks. The more I tried to cure every cancer patient, reverse every cardiac arrest, and fix every chaotic family dynamic, the more I felt like a failure. I realized that some tangled balls of string are all but impossible to untangle. If I could not fix everything and everyone, then how could I measure my success?

I had an epiphany early in my palliative medicine fellowship. One evening while reclining in my living room after a particularly challenging day, I scanned my social media feed and came across an interview with Steph Curry, the future hall of fame basketball player. Reporters asked him about his newly achieved NBA record for successful 3-point shots in a month: "Steph does this blistering shooting streak feel any different than previous ones?"

Steph: "*I don't think about past games. Every game is a reset. I don't think about how many 3-point shots I'll make. I just keep shooting. I stay in the moment and get in the flow. I don't focus on results. I focus on the process. Shooting well makes me fall in love with the process even more. I always try to improve my craft and find ways to get better.*"

I was shocked that one of the greatest NBA players of all time, whose success is measured by numbers, ignores those results, and focuses purely on process. I realized that falling in love with the process applies equally well to medical practice.

This new guiding principle for my life was tested during a recent clinical encounter on our hospital palliative consult service. Ms. R was an elderly woman with metastatic cancer that progressed despite several state-of-the-art treatment regimens who was admitted for recurrent gastrointestinal bleeding related to tumor progression. Medical oncologists decided that she was no longer a candidate for disease-directed therapy or blood transfusions, so they asked us to assist with hospice transition. When we entered her darkened room, Ms. R was lying in bed, still and silent. We first thought she was delirious, since she barely responded to our introductions, but we soon realized she was just withdrawn. Her teenage granddaughter sat in a chair by her side, equally passive. The young woman's only words were to ask for us to wait for her mother to arrive.

Ms. R's daughter appeared a few minutes later and brought with her a frenetic energy and imposing presence. She extended her hand for a firm handshake and introduced herself as Faith. Her facial expression said, "Don't mess with me." We then turned our attention back to Ms. R and posed a few open-ended questions to try to engage her, culminating with, "Is there anything we can do to help you live or feel better?" Her response was barely intelligible: "I'm fine." I then explained that our team manages cancer-related symptoms and helps patients and families make decisions about goals of care, especially when treatments are not going well.

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This often includes discussion of hospice. Faith took over: "We know who you are," she scoffed. "You're the hospice people, right? My mom and I already told all the other doctors that we're not going to hospice." She said "hospice" as if it were a curse word. As she spoke, I felt the same sick feeling build in my throat and chest that I felt when I got a bad grade in school. I was failing at the goal established for us by the referring team. Ms. R was definitely a good candidate for hospice, yet Faith would hear nothing of it. Meanwhile, Ms. R remained passive, seemingly adrift in an ocean of resignation and sadness. This predicament seemed like yet another insurmountable brick wall.

As I contemplated Faith's ultimatum, I remembered Steph's love of process and focused on my process goals for the conversation rather than focusing on transitioning her to hospice. I encouraged Faith and Ms. R to express themselves, responded to emotion with empathy, and weaved in medical information when necessary to help them make well informed decisions. I started by saying, "Tell me more about what you and your mother discussed." Faith leaned forward as if to make herself even more imposing. "We've spoken to so many doctors who've told us that there's nothing more they can do. All of you doctors have your spiels, and your spiel is about hospice." Her use of the word "spiel" seemed dismissive, as if she viewed us as glorified salespeople. "If we go on hospice, I know we can't get any more treatments, and that's not what my mother wants." We were not seeing eye-to-eye, but at least Faith was expressing herself. Her words were clearly borne of strong emotions, so I seized empathic opportunities as they arose. "I can tell you care dearly about your mother and that you've been her biggest advocate during this difficult time. I know that it must have been difficult supporting her through all this."

"Thank you. It has been hard." Her voice was clipped, perfunctory.

"She must be a good mother and grandmother if you're fighting this hard for her," I said presumptuously.

"Even if she wasn't a good mother, I'd still be doing this for her."

Her words made me wonder what it was like growing up in Ms. R's household. Was Ms. R warm and nurturing? Emotionally distant? Overbearing? Where were Faith's father, husband, and siblings through Ms. R's illness? What are Ms. R's goals and why will she not express them? If only we had time to delve into a lifetime of their familial complexity.

I continued in the empathic process: "I can only imagine how hard it is to hear so many doctors tell you the same thing. It must be frustrating for all of you."

"I know you have to say what you have to say like all the others did but it's not going to change our minds. She's not going home on hospice." I did not expect this conversation to go easily, but I was surprised that Faith dug her heals in even deeper as we spoke.

My third process goal was to offer honest information compassionately to facilitate shared decision making. "Our most important duty is to do no harm. I wish we could do more for your mother, but blood transfusions will just keep her away from the comfort of her home or an in-patient hospice and prolong her suffering." Faith invoked what we often call maladaptive spiritual coping: "God will take care of us no matter what. While she's still on earth, we want her to continue getting blood." Like Steph Currey staying in the flow of the game and ignoring the scoreboard, I continued to explore Faith's perspectives, encouraged Ms. R to speak, responded to emotion with empathy, and weaved in biomedical information. However, the more I listened, the more Faith went in circles. In our group we often say that allowing patients and families to express themselves "lances an emotional boil," but Faith seemed increasingly inflamed the more she spoke. She glorified God's good graces, described her role as a pastor, and quoted scripture. She seemed of clear mind but blocked us out of the conversation like a basketball player boxing out an opponent under the hoop. After many minutes, an internal alarm sounded within me, telling me I needed to break this cycle before Faith worked herself into a frenzy. I finally interrupted her in mid-sentence and said, "Let's take a time out," while forming the letter "T" with my hands like a coach during crunch time. She forged on anyway. "I believe all people are called to a vocation, a duty to serve. I serve my church and doctors are supposed to help people. If you can't help us, then we want to leave." She then crossed her arms and closed the conversation on her terms.

It seemed clear that Ms. R would not transition to hospice during this conversation, regardless of what I said. Perhaps Faith needed time to think, pray, or meet with a chaplain. I had no intention of debating scripture with her because spiritual faith is never a matter of logic. I instead spoke from the heart: "I respect your faith and fighting spirit. This ordeal must be brutal for you, your mother, and your whole family. We want to help her live as well as possible, even if we cannot treat her cancer or offer transfusions." By the end of our lengthy conversation, Faith seemed convinced that everyone wanted only to wash their hands of her mother. Despite succeeding in my goal of focusing on process, I could not help but feel defeated.

As a palliative physician, I sometimes feel like a firefighter who runs into a burning building when everyone else is running out. I give patients and families the benefit of the doubt, always try to maintain my composure and professionalism, and remain present even when the disease is no longer treatable. No one hands out trophies or money for doing these things, so I take pride knowing I am doing my best regardless of outcome. Like Steph, I always strive to refine my craft by falling more deeply in love with process.

Soon after our conversation, Faith took her mother home without hospice. However, she returned to the emergency center with Ms. R a few days later and was readmitted. As always, I reviewed her medical record and formulated a plan before entering her room. When I did, Ms. R was alone and withdrawn like she was during our first encounter but still lucid enough to nod in recognition when I reintroduced myself. She seemed at peace, as if she had shed all her fears, sadness, and regrets. As I sat beside her, I decided to simply be present for this dying woman. Her hand was cold, but as I held it, warmth traveled up my arm, through my heart, and directly into my soul.

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