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ESSAY/PERSONAL REFLECTIONS

"Doctor, what did I do to deserve this?"

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In 2007, quarterly educational meetings were set up between gynecologic oncology fellows, residents rotating on the gynecologic oncology service, and representatives of the Department of Chaplaincy and Pastoral Education at The MD Anderson Cancer Center in Houston, Texas. The goal of this program was to improve communications between chaplains and physicians and to bring patients' spiritual issues, especially crises, to the attention of medical staff. These sessions focused particularly on improving young physicians' ability to hear and respond when conversations with patients turned to spirituality, and to refer them to chaplaincy. Favorable feedback has been received from participating fellows and residents.

During the first quarterly meeting of 2010, a staff chaplain (A.M.W.) presented 45 questions collected from MD Anderson patients and their caregivers. All of the questions related to how an individual experiences God or spirituality (or not). Meeting participants were asked to take several minutes to answer these questions or to jot down notes. This exercise was designed to prompt exploration of the many possibilities defining a patient's spirituality and, specifically, some of the spiritual crisis questions that often arise when a patient is facing the potentially life-changing effects of cancer. Crises might be worded as: "Do I feel angry at God?" "Is God angry at me?" "Is God punishing me?"

This exercise was also a tool for engaging the participating physicians' awareness of the existence or composition of their own spirituality and for bringing to light some of their own convictions and questions. With increased self-awareness of how they themselves might individually answer these questions (within the reference to which they see God), they might be able to understand better how their patients view and approach existential questions in their own lives. The following are examples of the nature of the questions: "Religion *has/has not* helped me to live, because _____; Prayer *is/is not* important to me, because _____; I consider God as my _____, because _____; If I have to describe God according to my experiences, I would say that God is _____, because _____; The day I changed my way of thinking about an existence after this life was _____, because _____; My faith is mine, or is my faith my parents' faith?"

After the initial review of the questions, the participants asked for examples of appropriate responses, and some gave examples from their own patient visits. I (L.M.R.) offered a recent dialogue with a patient who had advanced neuroendocrine ovarian cancer and whose coping ability seemed minimal. After I had gently reviewed her diagnosis and potential treatment plan, she asked me, "Why did this happen? What did I do to deserve this?" This was not the first time I had heard questions of despair. I have always felt compelled to try to relieve the patient of this pain. I responded, "No one knows why people gets cancer, it isn't anything you've done." I watched as my patient's anguish seemed to melt away. Such a response has always felt like the right thing for me to say, as the physician, to help lessen a patient's immediate suffering.

After my description of the type of response I prefer to give a patient experiencing such a spiritual crisis, a participating doctor (T.M.Z.) suggested that my type of response essentially places the clinician in a position of being a spiritual authority on God and the actions of God. By answering as I did, I was signifying, perhaps, that I could answer all of the patient's existential questions. He opined that responding with such "assumed authority" could later lead the patient to feel abandoned because I would

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not be able to continue as her spiritual guide. This comment surprised me. It had never occurred to me *not* to say "You did nothing wrong" because in my world, God did not punish. I did not want to believe that cancer was a punishment. Bad things have always happened to good people without explanation. And therefore, in my mind, I wasn't speaking for God. However, the concept that "bad things happen to good people" without reason is not shared by all faiths. In other belief systems it may be obvious that there is a cause for every joyous or tragic occurrence.

The chaplain agreed with the doctor and emphasized that physicians, chaplains, and other healthcare professionals needed to carefully consider the impact of their own beliefs when responding to a patient's existential questions. This mindfulness is especially important when a patient is facing a serious health crisis, which often creates a spiritual crisis. If the physician provides what he or she considers a comforting response in the form of a definitive answer, the dialogue may end and the potential for the patient's spiritual search abruptly terminated. In addition, the physician may unknowingly suggest the ability to provide further spiritual answers — a role that cannot be maintained as the patient's spiritual journey continues between appointments. Furthermore, rather than expressing theological knowledge, the physician is merely providing an opinion usually based on his or her own belief system. The doctor changed the focus of this meeting from *how* to *whether* healthcare providers even have the training to address patients' spiritual concerns.

Before this discussion, I might have thought that questions implying responsibility for one's own illness suggested the patient had impaired coping abilities. But when T.M.Z. said, "She might as well come to you for all the answers," I reflected further. I didn't mean to suggest that I have such authority, and I certainly don't think I have it. At the time, I did believe this patient was decompensating and seemingly lost in her despair. Her prognosis was definitely poor, but her ability to cope with the situation did not appear to be much better and her psychological, social, and financial situation did not seem to offer her the opportunity to embark on a reflective spiritual journey.

The session continued with the chaplain suggesting responses that physicians could try to encourage or initiate spiritual reflection by a patient, or at the very least to assess and possibly triage an individual experiencing a spiritual crisis. These responses could include simply listening carefully to what the patient said next and using communication techniques showing interest and concern. A physician could say, "I hear you saying, you feel like you are being punished; tell me more about this feeling," or "I appreciate you sharing your thoughts with me, and they are very important concerns. This journey can bring many spiritual concerns to light and I would like find a chaplain that can walk through these with you."

I don't know whether I would have been comfortable with either of these replies with this particular patient in her state of distress. The chaplain then suggested the phrase, "I do not know why cancer happens, but what I do know is that I do not believe cancer is ever a punishment." This statement seemed perfect to me, because it permitted me not only to comfort my patient and still leave her to explore her spirituality if she chose, but also to be true to my own beliefs. This response would also create an opportunity for me to take the conversation to a deeper level, perhaps when she was less panic stricken.

Caring for patients with cancer can be emotionally straining and exhausting but also enlightening and inspiring. We physicians are blessed to be able to interact with and ponder these big questions with our patients. Coping with cancer or being a caregiver does involve these "deep searches," as Thomas Moore calls them, and the elements of peace that can be gathered from those times of searching.

Talking with patients about existential issues requires practice. It is like performing a surgical procedure — it may take years to successfully encounter enough difficult situations before feeling fully comfortable with them. Patients do not follow scripts, just as their anatomy may not follow Netter anatomy! If a clinician does not ask patients how they are managing stress and what helps them to cope and doesn't respond to questions about mortality, s/he will never become comfortable discussing these issues. Although these big questions are sometimes overshadowed by more immediate concerns such as which chemotherapy regimen to undertake next, they are always present. Not querying patients not only denies them the chance to explore their life meaning but also may lead to unsatisfying and exhausting interactions for the physician as well.

A chaplain's "being present with the patient" in the latter's spiritual questionings is paramount to the patient's spiritual coping and healing. Chaplains are trained to identify layers of spiritual suffering and despair and how to facilitate awareness of hope in a patient's beliefs and elements of faith. Chaplaincy training also develops the many levels of awareness that allows this deep level of pastoral work. Spiritual counseling does not promote one particular type of evidence or knowledge about the answers to existential questions, and those highly trained in the field are very aware of their own beliefs as well as the dynamic qualities of expression and

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language used by those suffering spiritually. This concept is what T.M.Z. was implying during the meeting: sharing one's own beliefs (or truths) with a patient, such as by stating "You didn't do anything wrong," may ultimately move the physician from being *a healer* to being *the healer*.

Healing comes in many forms. A great many physicians who entered the field of medicine did so partly out of their desire to care and heal in a holistic manner, which includes a deep respect for and desire to interact with the spiritual side of their patients. Beyond caring for the physical body, a physician's job is to show patients compassion and empathy to the best of his or her ability. There is a fine line between empathy and projection. Being empathetic with someone in pain is difficult enough but, without training, potentially impossible in understanding cultural and spiritual beliefs other than one's own. On the other hand, projection can result in the physician losing sight of where a patient is in his or her feelings, pain, and spiritual journey. Physicians may not be able to learn how to take a patient on a spiritual journey, they may not have been trained or may not have the time, and most likely they have not given their own journey, through exercises in self-awareness, the time it deserves. Until then, and only then, can doctors learn how to assess, triage, refer, listen, and grow.

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