

Dr. Rachel Buchsbaum, Chief, Oncology and Hematology, Tufts Medical Center, Boston Mass, answers questions from Rabbi Rim Meirowitz.

1. The relationship between medicine and science goes back a long time to Maimonides (1135-1204 who was a doctor, rational thinker, philosopher and compiler of Jewish Law,) and it goes back even further to even the Torah, where we can look at the priests and that weird stuff about leprosy and sending people out of the camp as them playing some part in illness, though not using the scientific method, but rather the structure of the community and ritual to handle disease.

I know you are a deeply Jewish person. Can you talk about how your Judaism influences your practice of medicine? For example, when you presented case studies at our Yom Kippur discussion, you used fictitious names rather than say: "the patient" since you look at each human being as a whole person, in the image of God. Could you expand on that and other sources of your spiritual strength?

I think that all of the things that I am as a person inform what I am as a doctor. And that a lot of personal ethics go into doctoring. I see my ethics and my religious sense as the same. I don't know how I would be a doctor without them. But other people label them differently. I think my husband the atheist would have been a wonderful doctor if he had chosen that path.

For me Judaism is about seeing myself and everyone around me as a human being deserving of respect (at a minimum) and of true empathy (in the ideal situation), in the context of all the history leading up to today. The laws of Judaism that I've learned give a framework for respect, and the practitioners of Judaism that most inspire me are those that give me a vision of empathy. Most of us take the idea of respecting other people as a given, at least in theory, although it's easy to lose sight of that when we are stressed, rushed, or over-burdened. Getting to real empathy and understanding what the other person is seeing and feeling from behind their eyes is much harder. In cancer medicine that's really amplified. The doctor perceives her/his job as delivering information, and society has moved to structure the practice of medicine overall in terms of delivering full and accurate information. But the patient is hearing and processing (or maybe not processing) the information on many levels that are very different from the factual delivery. And respect and empathy can get lost in that mismatch.

I think it's hard/impossible for the doctor to get to where the patient is when there's a lot of information to convey, and I'm not sure they should. If I get derailed thinking about the pregnant mother with incurable advanced cancer and wondering who is going to look after her toddler, I can't give the dispassionate analysis of the data and options that she needs in order to make her own decisions. My patient needs me to be their doctor, not their spouse or friend or pastor. I think my best work is when I feel like the patient has safely heard what I've said at least in some way, when I've been able to hear what they are saying at least in some way, and

when I've been able to connect them to other people who can help them process on the level that best meets their needs.

This is all a process. Because serious illness and dying are generally done in places that are removed from modern daily lives, most people and families don't feel intuitively comfortable with the process. I see part of the job of medical caregivers as helping guide people through. Framed in modern personnel management vocabulary - this is "coaching". Sometimes people and/or their families get stuck on a fixed idea set because of a host of reasons. When we can't help them dig deep enough to move beyond that stuck point - that's when I feel that we fail them.

2 There are many goals to medical practice: the understanding of the body in general, the fight against disease and pain, and the understanding of what living a healthy life might look like. But the end of life is a natural part of all life. How do you think about the inevitable fact of death? And when does it come into play in your work with patients?

The medical teams see what will play out far before the patient and family do. One of the things we teach young doctors in training is how to give patients and families information when they are ready to receive it – meaning how not to avoid a question and how not to overwhelm someone who isn't ready. (I sometimes use the analogy of teaching your kids about sex. They'll ask you when they're ready to hear about it.) Toward the end of life, when the flood of technical information decreases and the options close toward the inevitable, it's important to be comfortable recognizing when and what people are ready to hear. I think that comfort with my Judaism helps me here, and allows me to be comfortable with the spiritual places that patients and their families often reach for, and not to dodge direct questions or deflect direct statements. These are most often not Jewish places but it doesn't matter. There is a version of Adon Olam that the choir sings that has an incredibly poetic English verse about being able to row across an otherwise uncrossable river together with one's love. I've given that verse to patients reaching for faith-based truths. Anyone facing death is struggling with how to cross that river.

3 The "right to die with dignity" movement is ethically complex. The very phrase "taking one's own life" assumes that one is in charge of one's own life. Yet we live in a web of relationships and love that deserves some honor and respect. And some would say that our own individual life does not belong to us—we ought not take it. But it is a gift that has value regardless of whether we are happy, comfortable, in pain, lonely, etc. Could you speak to that.

This is a very charged subject. I'm not sure what the question is. If it's whether I think ultimately do I as a physician have the right to end someone's life when they or their family ask me to – no, I don't believe I or anyone has that right. I believe that as a physician I have the obligation to make sure they are not suffering, to see to

it that their life is not artificially prolonged, in effect to allow them to die when their time comes and to ease their dying as much as possible.

Other people and many physicians feel differently, at both ends of the spectrum. Some feel the obligation to extend life as much as possible, no matter the human cost and suffering involved. Others feel comfortable with doctor-assisted suicide (where the doctor enables the patient to take their own life) or even euthanasia (where the doctor's own actions end the patient's life).

In the medical practice that I have I've found very few people who tell me they think they've had enough life. No matter where they are in life, more is preferable to less. Answering in the "spiritual" shifts that question from quantitative to qualitative. In medicine we often rely on the Palliative Care team and/or clergy to help patients work through those questions, in particular to help put the focus on all the technical details and discussions in the greater context of whatever is most important to the patient. In the medical care setting there are generally a lot of difficult questions and decisions to navigate toward and through the end of life. Having clarity on what is truly important makes it less painful and ultimately more comforting for people to face those awful decisions.

4. You said in one of your talks that "given the normal level of neurosis in a family, acting out of love towards your dying relative is the most important thing. Since death is coming anyway, to increase morphine to relieve pain and decrease awareness, or to withhold morphine so that more awareness can be present, are both valid ethical choices." Could you talk more about that?

To put it another way, in the midst of the complex situation of modern medical intervention, what are the primary principles that ought to be kept in the forefront of the patient's mind and the family?

In modern medicine there is often so much technical information coming at the family that it's almost impossible for any family to avoid wallowing in all the details and losing sight of the important things. Things that are really key to keep in mind:

-DO NOT BE AFRAID TO TALK TO EACH OTHER ABOUT WHAT'S ON YOUR MINDS (maybe the most important thing). Patients try to shield their families, families try to shield the patient. This is magical thinking, which doesn't work. No matter how much shielding is put in place, everyone always knows. Not talking about things robs the patient and families from going through this process in a way that's truly together. I have conversations with families where they want to control all information going to their parent, and also they want us to put in a feeding tube but not explain why. Somehow they think their parent won't notice the feeding tube.

-See the patient as the person they have always been – families can get consumed by details around IV medications, oxygen, monitors, feeding tubes, etc, essentially

playing doctor rather than being family to the patient and each other. When the family starts reporting to me the same information I get from the intern, that's when there's a potential problem. Interestingly, sometimes non-English speaking families are the best at being present with their dying family member, simply because they are somewhat protected from the flood of "medicalese".

-What things are most important to the patient? If the patient is comfortable dying at home/in hospice/ wherever the dying is taking place, don't sweat the small stuff. There's a lot we don't know about dying, but we do know love and respect are key. Keeping that in mind will guide you to the "right" decisions, whatever they are.

-How can the family help the patient get to what's most important/what things are keeping that from happening?

Although the illness and dying seem overwhelming, the patient is a person whose life is far far greater than the dying. Afterwards, the intensity of the death will fade and allow the memory of the life to come through. Unresolved issues have a way of taking over and skewing the healthy dynamic of grieving for a family group. People won't remember the medical details of the dying, but they will remember how they felt through it. Focus on supporting each other through the process – that's the thing that will help everyone live on and create real honor for the patient's memory.

From a Jewish point of view: When I see the inevitable for a patient, I try to help them and their family (defined as whoever is hurt most by their dying) reach a place of acceptance around the illness and dying that they can share together. If Judaism teaches that the "afterlife" is how we live on in the hearts and minds of those we leave behind, then that reaching toward acceptance might be the ultimate gift the patient and family give each other that helps build that "afterlife."