

# *Primum Non Nocere:* Reflections of a Bahá'í Oncologist about Treating the Dying Patient

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Dedicated to Carley Elle Allison  
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## *Abstract*

Medical oncology is a subspecialty of internal medicine that focuses on the treatment of cancer. Cancer is the second leading cause of mortality in the U.S. Therefore death is a frequent subject for oncologists. However, oncology training emphasizes cancer therapy with little guidance on counseling in preparation for death. Physicians such as the writer Atul Gawande are working to bring back the topic of death into the physician-patient conversation. Furthermore, many religions, including the Bahá'í Faith, can help to address how death is perceived and discussed by physicians. The purpose of this article is to review my personal experience as an oncologist and as a Bahá'í, as it relates to the topic of death.

## *Resumé*

L'oncologie médicale est une sous-spécialité de la médecine interne axée sur le traitement du cancer, qui est la deuxième principale cause de mortalité aux États-Unis. Les oncologues sont donc souvent confrontés

à la mort. Cependant, la formation en oncologie met l'accent sur le traitement du cancer et fait très peu de place à la relation d'aide en préparation à la mort. Des médecins tels que l'écrivain Atul Gawande veulent ramener le sujet de la mort dans la conversation entre le médecin et le patient. De plus, bon nombre de religions, dont la foi bahá'íe, peuvent aider à examiner comment les médecins perçoivent et abordent le sujet de la mort. Dans le présent article, je traite de mon expérience personnelle en tant qu'oncologue et en tant que bahá'í en ce qui concerne le sujet de la mort.

## *Resumen*

Oncología médica es una subespecialidad de la medicina interna que se encarga en el tratamiento del cáncer. El cáncer es la segunda causa de mortalidad en los Estados Unidos. Por lo tanto la muerte es un tema frecuente para los oncólogos. Sin embargo, la formación oncológica enfatiza el tratamiento del cáncer con poca orientación en la preparación para la muerte. Médicos, como el escritor Atul Gawande están trabajando para traer de vuelta el tema de la muerte en la conversación entre el médico y el paciente. Además, muchas religiones, incluyendo la Fe bahá'í, pueden ayudar a hacer frente a cómo la muerte es percibida y discutida por los médicos. El propósito de este artículo es de revisar mi experiencia personal como oncólogo y como bahá'í relacionando el tema de la muerte.

I sit across from my patient (we'll call him Mr. Smith) in an 8x8 ft. exam room. We have previously reviewed the fact that his pancreatic cancer appears

incurable with the presence of liver and bone metastases. His demeanor is calm, even serene. He speaks eagerly as if I am his confidant, the only person to grasp the precious news that he will soon die.

He quickly divulges that he does not fear death, but he is afraid of pain. When he pauses I try to reassure that we have good medicine to alleviate pain. I also begin to introduce chemotherapy options, but he waves me silent. He has made up his mind to start hospice care. He wants to spend his remaining time with loved ones in peace. No chemo side effects, no long waits in doctors' offices, no vein punctures, CT scans, IV drips. None of that. Just pure time at home and with the people he loves. He expresses sadness and mild guilt about leaving them, but he also makes it clear that he is ready for this. The subtle joy in his tone surprises me. I leave the room feeling a little let down by his decision, yet his serenity lingers.

I decided to sub-specialize in oncology during the third and final year of my general internal medicine residency. I was enticed by the burgeoning field of molecular science, along with the gravitas of treating cancer. Oncology offered me an opportunity to practice medicine with serious diagnoses and weighty decision-making. But I was not yet fully aware that death was the ultimate source of the gravitas.

In my previous three years of internal medicine clinic, very few, if any, of my patients died. Once I started my oncology fellowship, death became

commonplace. Patients whom I saw regularly in clinic regularly would stop showing up. The transition could be sudden and unexpected, making it difficult to believe they had actually died. It soon dawned on me that the practice of oncology took place on the "ceiling" of this world—a portal between the physical world and death. As an oncologist, was I to serve as a spiritual gatekeeper of sorts.

According to the American Cancer Society, the five-year survival rate for all types of cancer in the U.S. is approximately 68%, a substantial increase from the 49% of the mid 1970s. Yet in my experience (and I suspect most other oncologists feel similarly), death and the practice of oncology remain inseparable. Death hovers subconsciously in the conversations we have with our patients, whether in the discussion of the causes of cancer, the treatment, the side effects, the prognosis, the surveillance, the inheritance pattern. Death is a silent yet omnipresent backdrop. Its beckoning remains fixed in my mind as I tend to my patients. Death comes for all. It has already and will continue to call for my loved ones. It will call for me. Yet, despite its centrality in the field of oncology, death is seldom discussed openly. If so, it is often mentioned in a hushed, quick voice, a dirty five-letter word—the less articulated, the better.

Siddhartha Mukherjee's *The Emperor of All Maladies* describes itself as a "biography of cancer." Its brilliance lies in its ability to portray mankind's long struggle with the dreaded

disease. Mukherjee chronicles the history of humanity's experience with cancer, starting in 1000 BCE with the Persian queen Achoshta's breast tumor. He portrays mankind's evolution in studying, understanding, and treating cancer over the last three thousand years, and the book culminates with modern-day oncology and the development of "targeted therapy"—the so-called "smart bomb" medicine.

A central focus of the book is President Nixon's "War on Cancer," which started with the National Cancer Act of 1971, the political history of which is discussed in detail. The "war on cancer" becomes not only a central theme but also a metaphor throughout the book. Mukherjee makes it clear that we are at war with cancer on multiple levels: cellular, personal, familial, and, ultimately, social. The main theater of this war is the oncologist's office.

From their early days of training, oncologists adopt the "war on cancer" mindset. They study how to fight cancer and defeat it. Like a general, a good oncologist is always thinking about outcomes: What strategy will I devise when the current therapy stops working? What will be the third line of defense, fourth line? Perhaps a clinical trial with novel therapies will make the difference in this case. Chemotherapy's potential for toxicity is factored into the decision-making. But while the physician may view the dreaded side effects as unavoidable—a collateral attrition to achieve the goals at hand: reduction in tumor size, remission, cure—is the patient willing

and able to endure this grievous price?

Having lost many battles, I am ever aware of the strength and elusiveness of my foe. I witness the physical and emotional devastation that cancer causes on a daily basis. My skills as an oncologist are honed on treatment of cancer, so the greatest challenge, for me, is when and how to tell a patient to stop fighting. When Mr. Smith decides to forego treatment for his cancer, it is difficult for me not to experience disappointment, even when I clearly recognize the wisdom, and even the heroism, of his decision.

Several months after my discussion with Mr. Smith, I meet Mr. Jones, who has advanced colon cancer. He too has multiple liver metastases, but he is only fifty-four years old—twenty years younger than Mr. Smith—and is already on his third line of therapy since the initial diagnosis some sixteen months earlier.

We avoid mentioning the obvious, that his cancer is rather resistant to chemotherapy. I am keenly aware that once the current regimen stops working, there will only be one additional FDA-approved chemo regimen I can offer. This is in the forefront of my mind throughout our consultation, but I sense that he does not want to discuss his prognosis. Here is where I cannot be merely a clinician, I must somehow develop the skills, the instincts and intuition of a spiritual counsellor. None of this was taught to me in my medical training.

Ever optimistic, Mr. Jones makes repeated references to how well he is

tolerating the chemo. When we discuss the neuropathy (nerve pain) he has developed because of the chemo, he emphasizes the point that it does not limit him on the tennis court. He does admit to new episodes of right-side abdominal pain—not coincidentally, precisely the same location of his liver metastases—but he dismisses the symptom, attributing it to a muscle “tweak” sustained during a recent tennis match. I don’t want to worry him, but I feel obliged to inquire a bit further about the nature of his pain. Again he dismisses it, so I move on. We conclude the visit by agreeing to order a CT scan to assess how the cancer is responding to the current chemo regimen.

For reassurance (his or mine?), I review the one treatment regimen that still remains. I also point out that an experimental research protocol might be worth looking into. Implacably upbeat, he responds favorably, and tells me he will contact the National Cancer Institute. At no time do I mention the word “hospice.” At no time is the word “death” mentioned in our discourse. Such an encounter is more typical than my earlier one with Mr. Smith.

Professor John S. Hatcher’s introduction to *Life, Death and Immortality: The Journey of the Soul* describes our society’s current attitude toward death and our basic denial of its existence:

[O]ur culture has descended ever further into its moribund obsession with youthfulness, appearance, and hedonism. Ever more

steadfastly society seems bent on denying the obvious fact that no exercise regimen, however ingeniously devised, no amount of vitamins or potions or lotions can long deter the inevitable onset of our own aging and eventual death. Yes, however much we may wish to avoid discussing it, aging, dying, death, and whatever happens afterward are as much a part of our own lives as any other important periods or events—our wonderful teenage years, acquiring a driver’s license, achieving various levels of higher education, getting married, having children, and so forth. (Hayes xiii)

Hatcher also quotes the forward of Elisabeth Kubler-Ross’s book *Death: The Final Stage of Growth*: “Death is a subject that is evaded, ignored, and denied by our youth-worshipping, progress-oriented society. It is almost as if we have taken on death as just another disease to be conquered” (Hatcher xii-xiii).

Oncologists can become convenient allies in our society’s quest to live forever. Ironically, it is this same drive for immortality that is the hallmark of the cancer cell. When cancer cells are given the correct balance of nutrients, they will multiply ceaselessly. Thus, the drive for immortality in the physical world ultimately equates with the ethos of death. Conversely the body’s physical death (or “transition” and “change” in terminology appropriate to a religious or philosophical

perspective) paradoxically defines what it means to be alive, to transition, or, to cast aside this mortal frame to emerge immortal in our true spiritual form. In this light an underlying spiritual message begins to develop clarity. Perhaps mortality is not meant to be feared. Perhaps acceptance of our inevitable death is, in fact, a route toward a new mode of life, a better life.

Most of the world's faiths emphasize the point that death is not an end to our existence but rather a portal through which we are transported to a reality that, while indescribable and unfathomable, is glorious and totally felicitous. And yet, we might well ponder how so many of the world's diverse faiths can reach such a similar conclusion, if it were not a reflection of a deeper metaphysical reality that society does not yet understand.

While I find it comforting and inspiring that so many of the world's great religions offer congruous visions of an existence beyond the physical world, I myself am a follower of the Bahá'í Faith, so it is from the texts of this religion that I wish to share some examples about how a spiritual perspective can have a major impact on the work of every oncologist in the life/death decisions they must make on a daily basis.

The Bahá'í Faith posits that human reality is essentially spiritual in nature, driven by the power of the soul. It further asserts that the human temple—the body—is created to serve an important, but ultimately foundational, purpose. The body functions

in an associative relationship with the soul, which is gradually introduced to spiritual concepts through an indirect, or metaphorical, relationship with the spiritual realm. The soul is our essential self: spiritual, non-composite, and eternal. The body functions as a vehicle for the soul's willful sojourn toward an understanding of God; a journey that encompasses the period of one's physical life, whether that life be but a few hours or ninety years:

Thus, it is apparent that the soul, even as the body, has its own individuality. But if the body undergoes a change, the spirit need not be touched. When you break a glass on which the sun shines, the glass is broken, but the sun still shines! If a cage containing a bird is destroyed, the bird is unharmed! If a lamp is broken, the flame can still burn bright!

(‘Abdu’l-Bahá, *Paris Talks* 65–66)

As a Bahá'í oncologist, I hold the belief that the soul is eternal and that this essential human reality exists beyond the death of the body. It is the soul that constitutes an individual's true identity—as opposed to the temporal body, which ultimately ceases to function and, finally, decomposes. The prophet and founder of the Bahá'í Faith, Bahá'u'lláh, affirms the mysterious and eternal nature of the soul:

The human soul is exalted above all egress and regress. It is still, and yet it soareth; it moveth, and

yet it is still. It is, in itself, a testimony that beareth witness to the existence of a world that is contingent, as well as to the reality of a world that hath neither beginning nor end. (*Gleanings* 161)

The Bahá'í Writings are replete with multiple descriptions of the next world. In these passages the spiritual world is described in beautiful detail and its reality is exalted. Bahá'u'lláh observes: "I have made death a messenger of joy to thee. Wherefore dost thou grieve?" (*Arabic Hidden Words* n. 32)

Similarly, 'Abdu'l-Bahá, the son of Bahá'u'lláh and His successor as head of the Bahá'í Faith, describes the next world as "the kingdom of lights" where we will be "acquainted with all mysteries, and will seek the bounty of witnessing the reality of every great soul" (730).

Although my beliefs give me great comfort and enable me to see mortality in a spiritual light, the topic of death remains fraught with complexity in my daily practice of oncology. When and how does an oncologist discuss the topic of death? We are never trained to do this, even though it may be one of the most important conversations we can have with our patients. Whether or not the profession is ready to approach this critical absence in our training, how do I personally decide when to begin this discussion? Early in the illness? Later on? How do I gauge the effect my comments will have on the patient? In the discussion

of prognosis and death, how does one balance the necessity for truthfulness with desire to maintain hopefulness? And what if I am wrong, and suddenly an unexpected remission occurs or a treatment begins to take hold, and death is not as close as I had estimated?

In spite of the sobering statistic that cancer is the second leading cause of death in the United States (American Cancer Society), according to data from the Center for Disease Control the majority of people who are diagnosed with cancer do not die from their disease (*FastStats*). Many people are cured of their cancers, and only a small percentage of patients in the oncology office have a stage IV or incurable disease.

The topic of death, therefore, manifests itself in two different but interconnected settings. The first involves people who have potentially curable disease or who have completed their cancer therapy and are now in remission. The second setting occurs when a person has incurable, "terminal" cancer.

In the first scenario, when a person presents with a cancer that is potentially curable, the expectation is that the person will survive their disease rather than succumb to it. Nevertheless, a diagnosis of cancer is often received as a shock and also as a stigma. Consequently, questions immediately arise in the patient's mind: Why has this happened to me? Is this something I have brought upon myself? Have I not taken sufficient care of my body? Have I not eaten the right foods? Did

I unnecessarily or carelessly expose myself to some toxin? Why? Why? Why?

Another crucial part of this label of being a “cancer patient” is that this may well be a person’s first real awakening to the fact that they are mortal and will eventually die. Doubtless, this initial brush with death likely contributes to the stigma so often associated with a cancer diagnosis. Despite our society’s denial of death, subconsciously one is constantly aware of its inevitability (Yalom). Similarly, cancer’s inexorable growth pattern and our perception of it as a foreign invader within us, evokes a deeper psychological threat than most other chronic diseases. It is the physical ailment that most closely embodies the process of death itself, hence earning the moniker “the emperor of all maladies” (qtd. in Mukherjee xviii).

Along with the existential threat posed by a diagnosis of cancer comes the opportunity to change one’s life for the better. People often report that a diagnosis of cancer brings them a new view of life, of their relationships, and of their priorities. This transformative effect is largely the result of the patient becoming aware that death is a reality and that it may not be just a remote possibility, a mere abstraction forever in the future.

In this same context, Mukherjee quotes American poet Jason Shinder’s remark: “Cancer is a tremendous opportunity to have your face pressed right up against the glass of your mortality” (Mukherjee 398). Given

that all human beings succumb to the inevitability of death, this epiphany can create “new” opportunities for a person to live more thoroughly, more thoughtfully, more focused. It can urge us to re-prioritize important matters in our life. When viewed in this context, the prospect of our demise (or transition) can become a constructive rather than destructive force.

Despite the positive benefit that acknowledging death might bring, the topic is infrequently discussed in an open manner in oncologic care. More likely it is carefully avoided. Instead, the discussion focuses on treatment details—the side effects and symptoms, the imaging tests, the lab tests, and so on. But like background noise, the subject of death is almost always there during the office visit, and its theme reverberates for both physician and patient alike, whether or not they choose to acknowledge its strains.

Psychotherapist Irvin Yalom observes that death “whirs continuously beneath the membrane of life and exerts a vast influence on experience and conduct” (146). The discussion of one type of treatment over another, the timing of therapy (should we start now, or later?), the frequency of imaging tests, the plan for surveillance measures—all these particulars are measured against a silent but implicit concern about cancer recurrence and death. This is the silent but palpable tension present during even some of the most routine oncology visits.

What of the second setting in which the patient has stage IV

incurable cancer? Even in these circumstances the anticipation of death is not discussed as frequently as one would imagine. This is particularly true in the beginning phase of the diagnosis. There might be an initial (and often vague) discussion about estimated survival statistics during one of the early oncology visits, but thereafter the subject is frequently dropped, or even meticulously avoided. Instead, the majority of the conversations focus on symptoms, side effects, imaging results, treatment options, strategies, and statistics.

This somewhat predictable routine is not unlike embarking on a road trip. In the beginning, we give little thought to time, rather, our thoughts are occupied, with the details of the journey. We comment on the scenery, discuss when to stop for a meal, or remark on how smooth or rough the road is. It is not until we near the destination that our mind begins to focus on the journey's end, that inevitable destination. Suddenly, we can no longer avoid being attentive to what lies directly before us.

In his book *Being Mortal*, surgeon Atul Gawande calls attention to our society's ill-preparedness for mortality. Gawande discusses the case of a thirty-four-year-old woman named Sara Monopoli with newly diagnosed stage IV lung cancer. The diagnosis arrives when she is in the late stages of pregnancy with her first child. After the delivery, she embarks on multiple rounds of various therapies, but all to no avail.

The cancer continues to grow, and she eventually dies from the disease nine months after the diagnosis. Gawande notes that her death comes only days before she was to begin a new, experimental therapy. She dies while in the hospital and never receives the benefit of hospice care at home. On the contrary, she and her family remain in full "battle mode," as Gawande puts it, up to the last day. She narrowly escapes being placed on a ventilator when her mother, recognizing the futility of the situation, decides to forego extreme lifesaving measures.

Gawande interviews Dr. Paul Marcoux, the Harvard oncologist who cared for Sara Monopoli. Marcoux is well aware of the data that third-line chemotherapy for lung cancer is rarely successful in prolonging life. However, in "taking measure of the room" he quickly realizes what most oncologists often face: "a patient and family unready to confront the reality of their disease" (165). He goes on to say that "the signal he got from Sara and her family was that they wished to talk only about the next treatment options. They did not want to talk about dying" (165). Thus, instead of mentioning his concern that little time was left, and trying to discover the basic wishes of this young woman and mother, Marcoux reviews experimental treatment options. Gawande points out that doctors worry about sounding "overly pessimistic" and that discussing death is "enormously fraught," particularly in the circumstance of a young parent with a newborn child.



Gawande also visits his own involvement in Sara Monopoli's case. During her evaluation for lung cancer, she was coincidentally diagnosed with a thyroid tumor that had been discovered by a CT scan. While this was likely a slow-growing tumor with favorable prognosis, it was still a cancer, and it was Gawande's job to discuss the surgical options:

Sitting in my clinic, Sara did not seem discouraged by the discovery of this second cancer. She seemed determined. She'd read about the good outcomes from thyroid cancer treatment. So she was geared up, eager to discuss when to operate. And I found myself swept along by her optimism. Suppose I was wrong, I wondered, and she proved to be that miracle patient who survived metastatic lung cancer? How could I let her thyroid cancer go untreated? (168)

At no point did Gawande mention to Sara that the lung cancer prognosis was so grievous as to negate any threat of an indolent localized thyroid cancer. In essence, her surgical evaluation with Gawande for thyroid cancer was a waste of the short time allotted to this dying woman. In discussing her prognosis he states,

My solution was to avoid the subject altogether. I told Sara that there was relatively good news about her thyroid cancer—it was slow growing and treatable. But

the priority was her lung cancer, I said. Let's not hold up the treatment for that. We could monitor the thyroid cancer for now and plan surgery in a few months. ... I saw her every six weeks and noted her physical decline from one visit to the next. Yet, even in a wheelchair, Sara would always arrive smiling. ... She'd find small things to laugh about. ... She was ready to try anything, and I found myself focusing on the news about experimental therapies for her lung cancer. After one of her chemotherapies seemed to shrink the thyroid cancer slightly, I even raised with her the possibility that an experimental therapy could work against both her cancers, which was sheer fantasy. Discussing a fantasy was easier—less emotional, less explosive, less prone to misunderstanding—than discussing what was happening before my eyes. (168–69)

Sara Monopoli's case presents an extreme example of the challenges oncologists face in discussing prognosis with a patient who has terminal illness. A mother's bond of love with her newborn child is one of the strongest forces of attraction in this world. Her attachment to this physical world is therefore understood and justified. The thought of being separated from her child would certainly cause tremendous distress. Her physicians immediately sense this and understandably become complicit in her desire to

avoid mentioning what so desperately needs to be said.

Oncologists are not being negligent in their reticence. There is legitimate concern that discussing prognosis in frank terms might introduce psychological trauma, and that the emotional distress might detract from a possible therapeutic benefit. According to Dr. Daniel Rayson in the *Journal of Clinical Oncology*, many patients with terminal cancer prevent themselves from experiencing traumatizing thoughts of death by not acknowledging that death could be near (4371–72).

So it is that this scenario with a patient with terminal stage IV cancer plays out repeatedly in oncology offices, including my own. In most cases the patient is older—since cancer is more commonly a result of aging and cellular senescence—but the refusal to accept one's mortality at any age is axiomatic in our contemporary society where the mantra of TV commercials assures us that there is a pill or treatment for every malady, even death itself.

Both Hatcher and Gawande discuss the importance of courage among people who approach their mortality. Hatcher refers to Bahá'u'lláh's teaching about the elimination of fear through knowledge:

In the treasuries of the knowledge of God there lieth concealed a knowledge which, when applied, will largely, though not wholly eliminate fear. This knowledge, however, should be taught from

childhood, as it will greatly aid in its elimination. Whatever decreaseth fear increaseth courage.

(*Epistle 32*)

In his chapter about heroism, Hatcher asks if true heroism—or courage—is being unafraid in the face of danger, or if it is, instead, the will to act despite experiencing fear. Perhaps the answer lies in Bahá'u'lláh's assertion that the knowledge of the eternality of our essentially spiritual self and, thus, our continuity beyond this life, can play a major role in reducing fear. Such assurance emanates from a belief that the body is a temporary vehicle for the development of our soul; that this mortal life, while important, is primarily a period of preparation for our birth into the spiritual realm, just as our gestation in the womb is preparation for being able to function in this life. Hatcher mentions that many people do not have faith in an afterlife, and yet these people can also reduce their fear of death. This often occurs when we endanger our lives for a worthy cause, knowing that our objective in this life is to undergo psychic/emotional/spiritual growth.

A beautiful example of courage and heroism in the face of death is the documentary film *Death by Joy*. The movie begins with the preparation of the Bahá'í funeral of a woman named Mary. Instead of the funeral home staff, Mary's two daughters lovingly apply rose water to their mother's body and wrap her in a fine white shroud. The movie then goes back in

time to approximately one month earlier, when Mary receives a diagnosis of incurable glioblastoma multiforme, the most aggressive form of brain cancer.

Recognizing the finality of her disease, Mary decides to forego radiation and chemo—with their potential to prolong survival by several months—in order to focus her limited remaining time on her loved ones. What ensues is a month-long celebration in her home with her family and dear friends as constant visitors.

Mary's body gradually fails, but, amazingly, we witness no sadness or tears. Rather, the house is filled with music, delicious food, laughter, love, and invigorating energy. At one point, our hero Mary admits that she could fret about her physical death, but she chooses not to, so she can concentrate her energy on what matters most to her—love. Recognizing the spiritual purpose of her life, she allows herself to be filmed in order to demonstrate, through her own acceptance of her fate, that death need not be feared. She opts to approach her death with serenity as an example for others, to teach that this natural transition is an integral part of each of our lives.

One of the movie's highlights occurs when Mary starts to have dreams of a realm of lights, which she interprets as glimpses of the spiritual world she is destined to enter soon. She describes her visions with rapture and conviction. As a viewer, I found it impossible not to share in her joy, and for me Mary ultimately becomes a

true hero, a teacher of courage and of Bahá'u'lláh's precept that knowledge reduces fear.

The main hero in Gawande's book *Being Mortal* is clearly his father, Atmaram Gawande, who is also a physician. His story about the diagnosis, treatment, and outcome of a spinal tumor provides the framework for the book. The senior Dr. Gawande develops a shooting pain in his arm. Imaging studies show a tumor within his spinal cord. Several expert neurosurgical opinions ensue and surgical removal of the tumor is considered. Gawande Sr. ultimately decides against surgery because of uncertainty about the treatment's chances of success.

Over the course of time, the tumor grows, and Gawande Sr., who is a urologist, gradually loses use of his arm and retires from surgery two and a half years after the diagnosis. He then survives two and a half more years during which he invests himself wholeheartedly in philanthropic activity. Finally as the tumor continues to grow, he opts for a course of radiation to the tumor, but it does more harm than good. He ultimately loses use of his legs, and when the quality of his life diminishes further, he starts hospice care.

Gawande's father is awakened by his own mortality. After the diagnosis, he chooses to live his life more deliberately. His thoughts, actions, and decision-making become keener. One might say that he becomes more "alive" than he had ever been, perhaps because he realizes that we all have a

death sentence. Gawande describes his father's experience in this fashion:

Only now did I begin to recognize how understanding the finality of one's time could be a gift. After my father was given his diagnosis, he'd initially continued daily life as he always had—his clinical work, his charity projects, his thrice-weekly tennis games—but the sudden knowledge of the fragility of his life narrowed his focus and altered his desires. (209)

Detachment from extraneous, worldly matters and focus on issues of greater import is a profoundly spiritual realization. Bahá'u'lláh reveals in one of the Hidden Words, "O My Servant! Free thyself from the fetters of this world, and loose thy soul from the prison of self. Seize thy chance, for it will come to thee no more" (Arabic n. 40).

As in Hatcher's evaluation of death, Gawande's book on mortality also attempts to define courage and heroism. After acceptance of our mortality, how do we summon the strength to face it? Strength grows out of courage just as knowledge can generate and foster courage. In reference to Socrates reasoning in Plato's *Laches*, Gawande defines courage as "*strength* in the face of knowledge of what is to be feared or hoped" (232). For Gawande, his father exemplifies such courage:

When I was a child, the lessons my father taught me had

been about perseverance; never to accept limitations that stood in my way. As an adult watching him in his final years, I also saw how to come to terms with limits that couldn't simply be wished away. When to shift from pushing against limits to making the best of them is not often readily apparent. But it is clear that there are times when the cost of pushing exceeds its value. Helping my father through the struggle to define that moment was simultaneously among the most painful and the most privileged experiences of my life. (262)

The experience of watching and assisting his father through terminal illness becomes a profound lesson for Gawande. He comes to understand that his role as a physician is not only to treat and cure, but also to help individuals and our society as a whole on the journey from birth to death: "I never expected that among the most meaningful experiences I'd have as a doctor—and, really, as a human being—would come from helping others deal with what medicine cannot do as well as what it can." (260).

Physicians can work to facilitate rather than interfere with the "dying role" at the end of life. This role, Gawande points out, is crucial in one's life as well as in the lives of those left behind. It provides the opportunity to establish one's legacy, make peace with God, connect with loved ones, and ensure that the patients' stories

end “on their own terms.” At its core, *Being Mortal* is a manifesto for our society to start to address forthrightly and intelligently the topic of our own mortality:

Our most cruel failure in how we treat the sick and the aged is the failure to recognize that they have priorities beyond merely being safe and living longer; that the chance to shape one’s story is essential to sustaining meaning in life; that we have the opportunity to refashion our institutions, our culture, and our conversations in ways that transform the possibilities for the last chapters of everyone’s lives. (Gawande 243)

The book concludes as Gawande visits the Ganges with his father’s ashes. He paddles out early one morning into the mist of the river. He recites prayers in a ceremony to enable his father’s spirit to achieve Nirvana, and this process allows him to see the collective mortality that connects us through the generations. The author is transformed through the experience of his father’s death. Raised a Hindu, Gawande expressly denies a conviction in religion. Nevertheless, an awareness of the ancient cycle of birth and death creates a vision beyond the self and toward something much vaster. It is in this vein that the final chapter of *Being Mortal* ends:

After spreading my father’s ashes, we floated silently for a while,

letting the current take us. As the sun burned away the mist, it began warming our bones. Then we gave a signal to the boatman, and he picked up his oars. We headed back toward the shore.

In a beautiful metaphor, Gawande acknowledges the physician’s role as spiritual gatekeeper or boatman. The concept of the Bodhisattva is also applicable: an individual who attains Nirvana only to return to the mortal world that they might help others.

Obviously, no physician can assume that all people will share a belief in an afterlife or even the reality of the soul, but the spiritual message remains true regardless of one’s perspective. It is possible to accept death in a positive fashion because death is a natural and inevitable function of being alive. Mindfulness about our mortality can actually improve the quality of our lives. Bahá’u’lláh, and the Prophets of all the great religions of the world, emphasizes this point: life in this physical world is shorter than our minds would like to accept.

O Son of Being! Bring thyself to account each day ere thou art summoned to a reckoning; for death, unheralded, shall come upon thee and thou shall be called to give account for thy deeds.  
(Arabic Hidden Words n. 31)

## CONCLUSION

My belief as a Bahá'í and my work as an oncologist require the recognition that death is a natural and integral part of life. Not only as individuals, but as a society, we are constantly exhorted to refrain from acknowledging our mortality or from discussing it openly. But if we accede to this tendency we do so at a cost both to ourselves and to the body politic. Gawande would rightfully suggest that those costs are immense.

Furthermore, our lives are characterized by processes of change—as soon as we are born, we journey toward death, at least insofar as our mortal lives are concerned. It is my own belief that our essential reality does not stop with the cessation of our physical bodies. But regardless of whether one believes in an afterlife, we can all strive to remain mindful of mortality on a regular basis in order that we may maximize the potential of our individual lives.

Finally, my job as an oncologist mirrors my duty as a Bahá'í which is to serve people—first to do no harm, and then to assist one another as, in time, we all prepare to leave the shore of this world. So it is that after each case, I had best reflect on Bahá'u'lláh's teaching:

O Son of the Supreme! I have  
made death a messenger of joy to  
thee. Wherefore dost thou grieve?  
I made the light to shed on thee

its splendor. Why does thou veil  
thyself therefrom? (Arabic Hidden  
Words 32)

The field of oncology is inextricably linked to discussions of human mortality. Medical Bodhisattvas of sorts, oncologists, through exposure to the inevitability and necessity of death, can strive more fully to succor their patients, to connect with them spiritually and to reduce their suffering.

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