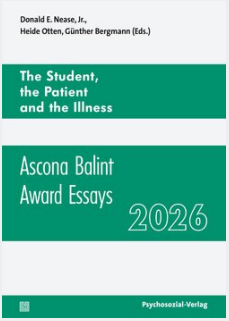
Tess Wheeler

What Prognosis Cannot Predict



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Introduction

This is the story of two weeks of a woman's life. At first glance, the case seems relatively straightforward. There was no major conflict, no tragic adverse event, no medical errors or non-compliance. You might wonder why I picked it. But as we dissect layer by layer, from outward appearance to medical reality and ethical ambiguity to find the person and relationships underneath, I hope you understand why this experience has stuck with me. I hope to demonstrate that it's not just the extraordinary and shocking that should demand our thoughtful reflection as practitioners, but the seemingly ordinary and mundane too, who so often are brushed over as they aren't a thorn in anyone's side.

The pathway I will take you through this journey differs from the uni-directional linear one we are so familiar with in the medical world. Presentation, history, exam, differentials, investigations, results, diagnosis and management. We tend to progress through these components as we tell a story about a patient, checking them off the list and moving along. And we grumble and shake our heads when those chatty patients, you know the ones, present to the emergency department and attempt to begin their history with "It all started when I went to the grocery shops 10 years ago, I met my lovely wife Betty that year! ..."

And I get why. As doctors we are investigators. We need to line up the evidence and rule out life-threatening diagnoses, create differentials and order tailored investigations to confirm or deny our hypotheses. It makes sense to cut out the fluff and get the pertinent information, put it in order and get on with it.

But when we take this linear approach and apply it to the non-medical

stuff, it gets messy. Life doesn't proceed in an orderly fashion. It ebbs and wanes, twirls and twists, crescendos and decrescendos like some sort of untrained hurricane. And when you consider that each of these lives, these hurricanes, is interacting with hundreds of other hurricanes, well, that just tells you that no human story is linear, nor predictable.

I offer an alternate approach to telling this woman's story, Jay, we'll call her. Rather than a linear case history or a moment of insight, I'll take a spiral approach. First encircling the case from the outside, the most superficial layer you could say, then dissecting one layer deeper, and deeper. I will repeatedly return to the same encounters, observations and tensions, each time attempting to delve deeper into an unexplored vantage point to accumulate meaning. This mirrors how I experienced our relationship in practice, not as a series of discrete events or chronological order of analysis, but as a layered process of noticing, misunderstanding and correcting.

Throughout this process, as I reason and feel my way through many smaller tensions, I come to several personal reflections and aspirations about myself and the broader medical field. The main reflection that flows through all of these others though, is the need to seek the complexity in even the seemingly more straightforward cases. You will always find it, and your care for the patient will improve markedly as a result.

Spiral 1: Myself and Jay

Breathing forcefully normal, eyes determinedly (but rapidly) blinking and attention 'casually' intent on reading the patient list, I trudged after the palliative care team down the hallway. We had just left a room with a woman surrounded by pictures of her family, her daughter present holding her hand as the exceptional palliative care consultant knelt at her bed and spoke gently to her, ensuring her pain was under control and firmly telling her to let the team know if she needed anything, anything at all. It was probably the 3rd or 4th patient we'd seen that morning with a similar story. Metastatic cancer, affecting the lungs, liver, bone or even the throat and signalling end of life for these people. Each of them with a lifetime of experiences, relationships and stories.

I was a wreck. Embarrassed that I seemed more out of control than the patients or their families I did my best to hide my feelings. Guilt washed over me in waves, what right did I have to witness this, and even worse, to

feel the pain. They must have it so much worse. I felt relieved it wasn't my mum, my brother, my friend, and the guilt intensified. How cruel of me.

As we walked into the next room, I felt like I was forcing my feet forwards through honey. Not again, I can't face it again. A new patient, a new life to discover and grieve in the same breath.

But this one was different.

Sunlight streamed in through the massive glass window, bathing the bed in a warm glow. In its centre, seemingly emitting the light herself, was a middle-aged woman. She was sitting up in bed, laughing at her adult daughter who stood to the side. She greeted the team warmly and she and her daughter dismissed the notion of them coming back at a better time as if it were ridiculous. The team didn't spend much time with her at all. Like, less than 2 minutes. As we left, I questioned the intern why we were involved in her care and found out she was in hospital to monitor for adverse events while on a new treatment for her refractory cancer. "She has refractory lymphoma," the intern explained, "but she's not in hospital because she's dying". They were just doing their due diligence checking in, and upholding a major principle hammered into us in the palliative care term – early involvement of the palliative care team, i. e., as soon as someone receives a terminal diagnosis, not when they're on their deathbed.

My Emotional Response

Finally.

A happy case on oncology and palliative care term. I had known I wasn't cut out for this term from the get-go. I cry in almost every movie I watch. I cry imagining sad scenarios that aren't even real. And my fear had only been realised when I had dragged myself up to ward rounds and endured tragedy after tragedy. Don't get me wrong, it was an honour to be invited into that space, and I admired the team beyond words. I knew their work was so important, and helping people die in comfort and dignity, in the place and way they want is so important. I just knew I couldn't handle it.

So Jay, the woman emitting sunshine, was a bubble of fresh air in a suffocating ocean.

I knew immediately I wanted to do her for my written assignment.

In the oncology and palliative care term, each student was required

to do a case assignment. It involved detailing their medical case (history, presentation, investigations and progress), and looking at it through a specific biomedical lens, e. g., pharmacology. I had been dreading finding a patient to do this on, as I knew it would no doubt involve lengthy discussion with that person and time writing up the report. Activities no doubt resulting in massive accumulation of time engaging with these sad topics at an intimate level and sitting with the intense feelings they evoked in me.

I resolved to go and talk to Jay privately, to obtain consent to do my case report on her, and to take a detailed history and examination. I did so that very day.

The Medical Side

Perhaps more reluctantly than eagerly, I come to the medical details. Not because they are unimportant but because they are so often allowed to eclipse the person they belong to. Still, Jay's story cannot be told without them. Her relationship with medicine, hope and uncertainty has been shaped profoundly by the sequence of diagnoses, treatments, remissions and relapses that make up her medical history.

Jay was a 64-year-old woman admitted to hospital for close monitoring at the commencement of Epcoritamab, a novel immunotherapy she was receiving as part of a Phase III clinical trial for refractory follicular lymphoma. The admission itself was precautionary not reactive. She was being monitored for cytokine release syndrome and immune effector cell–associated neurotoxicity, complications that existed only as probabilities on a consent form but which had the potential to become suddenly and frighteningly real.

Her journey with cancer had begun almost four years earlier, in a way that felt deceptively benign. Jay had a renal ultrasound as part of an investigation for a urinary tract infection with lower back pain, that revealed an incidental finding of splenomegaly with multiple hypoechoic masses. What was expected to be a routine screen for pyelonephritis rapidly escalated into a life-altering diagnosis. Further imaging demonstrated extensive lymphadenopathy both above and below the diaphragm, along with hepatic and splenic lesions. An ultrasound-guided liver core biopsy confirmed stage IV diffuse large B-cell lymphoma.

Jay underwent six cycles of R-CHOP chemotherapy. The treatment was gruelling but effective. A post-treatment PET scan showed a complete metabolic response, and she was told she was in remission. She then had two cycles of maintenance Rituximab, followed by regular four-monthly surveillance.

Jay was cancer-free for 2 and a half years.

Then, a year before I met her, the story shifted again. Jay presented to her general practitioner with a three-month history of progressive left inguinal lymphadenopathy, swelling of her proximal left leg, left hypochondrial pain, night sweats, and profound fatigue. A biopsy of the inguinal lymph node was consistent with grade 3A follicular lymphoma, and PET imaging revealed widespread lymphadenopathy above and below the diaphragm, consistent with stage III disease.

Salvage chemotherapy with R-ICE was commenced, carrying with it the hope that this would once again turn the tide. However, a post-cycle PET scan showed only a partial metabolic response. Further cycles were deemed unjustified, and Jay was confronted with a new and unfamiliar label: 'refractory disease'.

Jay was then offered participation in a Phase III clinical trial for Epcoritamab in combination with lenalidomide and rituximab. When I met her, she had just started this new treatment. It felt like Jay was at a threshold of a new chapter with her cancer, not cured but not out of options. She was in the space between promise and uncertainty that modern oncology so often inhabits. The way Jay spoke about the medication and trial conveyed the miracle of modern medicine. It was clear she felt so grateful to access this cutting-edge drug, and spoke about the remarkable efforts of her haematologist to get it to her.

I gathered all this information from Jay in one of the most welcoming clinical interactions I have ever had. I approached her, explained my role and requested if I could chat to her to further my learning. I wish I could say I was responsible for building the strong student-patient rapport that ensued but in truth she did most of the work. At times it felt like she was asking me more questions than I asked her, ever interested in my studies, relating my experiences to those of her daughter when she studied paramedicine, and delighting in my recent move to the area, giving me countless recommendations for food and activities to balance out my studious life. The first time I went and spoke to Jay I spent 2 hours with her.

My Emotional Response Revisited

I came away with a reinforced version of the impression I had walking away with the team. More informed, sure, and aware of the diagnosis and management pathway. But the way she spoke about it and the optimism she was brimming with left me even more reassured that this was in fact, finally, a happy oncology case. I felt, more than knew, that these new treatments were going to work for her, and she wasn't really a palliative case at all. I assumed hope was synonymous with survival.

Spiral 2: The Haematologist

Jay gave me permission to access her electronic medical record and read any notes and scans, as well as use her for my assignment case. I thanked her profusely, and took some time to look through her notes, hoping to learn more about the trial medication she was on. The information in the record was relatively sparse, and I decided to seek out her treating haematologist, a doctor I had been taught by previously, to ask some questions.

The second 'spiral' of this case took place in a small, cramped office. The haematologist sat facing the screen while I awkwardly brought my chair up to the side to observe the scans he was showing me. There was no family, no patient, just the two of us and the glow of her PET scans.

He scrolled in silence for a while, then began to speak. His voice was flat, not unkind, but with the practiced neutrality of someone who has had to say hard things many times. He pointed out areas of uptake, compared them to previous scans and named the pattern for what it was: refractory disease with very limited options.

When he moved on to talk about the trial, the contrast with my internal story became almost audible. I had been carrying around an unspoken assumption that this new drug was, if not a miracle, at least a strong contender. In my mind, it sat as the satisfying next step in a narrative that curved gently towards improvement.

He did not describe it that way.

He called it "a reasonable last shot." He talked about "modest response rates," about the small pool of long-term survivors in the early data, about the fact that, for many participants, the benefit was measured in months rather than years. He acknowledged that it was an important opportunity

to refine treatment options and to learn what might help the next cohorts of patients like her.

He was not dismissive of Jay as an individual. He spoke about her as a good candidate, someone whose prior treatments and current functional status made her eligible. He circled back to the importance of her values and preferences. I could hear that he wanted what was best for her. But 'best' in this context did not sound like the guaranteed certainty I had been subconsciously assuming. It sounded like informed risk in a landscape of diminishing choices.

Sitting in that chair, I felt a small but distinct snap in the narrative I had been carrying.

All along, I had treated her optimism as evidence that we were on firm therapeutic ground. I thought that medicine had pulled a rabbit out of its hat once before and was about to do it again. Hearing him describe the trial instead as a slim personal chance nested inside a broader research agenda forced me to confront how much of my comfort had been built on wishful thinking.

Nothing in that room was dramatic. No one cried. No new catastrophe was revealed. He did not say, "There is no hope." He said, "There is some hope, but it is small, and it sits alongside uncertainty and the need to learn for future patients." The change was not in her condition – she was still upstairs, chatting to the nurses, planning what snacks her daughter would bring in – but in the angle from which I was looking at the same situation.

I walked out of his office carrying two parallel stories that would not quite line up. In one, Jay was the happy case, the bright spot on a heavy ward, about to benefit from cutting-edge therapy. In the other, she was a woman taking a calculated risk at the outer edge of what we could offer. I realised her success was far from assured and that the purpose of the clinical trial extended beyond her. His motivation extended beyond her wellbeing.

The facts hadn't changed. My access to them had.

And with that, the 'straightforward' case I had clung to began unravel.

Spiral 3: Time, Illness, and the Long View

Back at my desk that evening, I opened the electronic notes again to piece together the bits of history I had not fully grasped in our earlier conversations. On the screen, Jay's life flattened into date-stamped entries. Ul-

trasound. CT. Biopsy. R-CHOP cycle 1, 2, 3. PET: complete remission. Rituximab maintenance. Discharge letters. Follow-up appointments. The paper trail of four years compressed into a list I could scroll through in under a minute.

On the ward, her story had felt like a fresh chapter. In the clinic, it had felt like a plot twist. In the notes, it was something else again. A long, looping narrative of remission and relapse, of hope rising and dipping in ways my two-week snapshot could never convey.

I traced the progression: the incidental finding on renal ultrasound, the shock of the initial lymphoma diagnosis, the harsh but curative chemotherapy; the fragile normality of those two and a half remission years. Then the slow intrusion of fatigue and night sweats, the swelling in her leg, the new biopsy results with a different histological label but an equally heavy weight. Salvage chemotherapy. Partial response. Refractory disease.

Reading it all at once, the contrast with my own time horizon was jarring. I had met Jay near the start of yet another treatment, and my feelings about her situation had been shaped almost entirely by that entry point. A neatly framed 'before' and 'after' had comforted me: before trial, after trial; before hope, after hope fulfilled. I had imagined myself catching her at the upward curve of a graph.

The notes told a less tidy story. There were months of waiting between scans, stretches of "watch and wait" that would never make it into a case summary because nothing dramatic had happened, but which must have been thick with quiet anxiety. There were routine clinic letters that summarised "stable disease" in two lines, sign-offs written in the same font as the most devastating news.

What I had labelled a happy case was, in reality, one small segment along a much longer oscillation between fear and relative safety. Her cheerfulness on the ward was not the naive relief of someone spared catastrophe, but the practised posture of someone who knew catastrophe well and had learned how to live alongside its possibility.

This disturbed me because it forced me to notice how much I preferred the version of her story that aligned with my own needs. I wanted a case that could be resolved within the timeframe of my term, preferably with a good outcome, preferably with a lesson I could write up neatly.

Yet as I scrolled through PET reports and chemotherapy protocols, it became harder to maintain the illusion that prognosis and hope occupy the same axis. Jay's optimism had outlived remission and returned along-

side relapse. It had accompanied her into salvage chemotherapy and now followed her into an experimental trial. It had been present in clinic when refractoriness was named out loud.

Hope, I began to see, was not a simple reflection of her estimated survival time. It was something more stubborn and more relational, threaded through conversations with her specialists, her family, and, somewhat to my discomfort, with me.

Spiral 4: Knowledge, trust, and agency

The more time I spent with Jay, the more it became clear that she did not fit the caricature of a 'bravely ignorant' patient clinging to denial. She knew the vocabulary of her disease. She could list her previous regimens, recall approximate dates, summarise side effects. When we talked about the trial drug, she wanted to know how it worked, where in the immune cascade it intervened, why it might succeed where others had faltered.

Her questions were not aggressive or mistrustful. They carried a practical curiosity that felt almost collaborative. When I admitted I did not know the detailed mechanism beyond what I had hastily read the night before, she laughed and said, "Well, you'll learn. You lot always do." There was no accusation in it, only a gentle expectation that knowledge would catch up to the reality already unfolding in her body.

Her daughter, a paramedic, often stood at the bedside, arms gently crossed, occasionally translating medical shorthand into the family's own vernacular. Her son-in-law and husband were frequent visitors, comfortable navigating ward routines, asking after bloods and scan results without deference or hostility. Watching them together, I was reminded that medical literacy in families is rarely evenly distributed, and that expertise circulates quietly in conversations long after the team leaves the room.

Trust sat in the middle of all this, both obvious and uneasy. Jay often said things like "I trust my team" and "They've got me this far." The successful treatment of her first lymphoma had left a deep imprint; medicine had already, in a sense, saved her life once. That history infused her current situation with a kind of residual faith, even as the language shifted from curative intent to experimental options.

From my vantage point as a student, this trust was both reassuring and unsettling. On one hand, it felt right that she did not have to bear the

entire cognitive and emotional load of each decision alone. On the other, I found myself wondering how her previous positive experiences with the system affected her sense of what was being offered now.

When the trial was discussed, I heard phrases like "another option," "promising data," "good candidate." I also knew, at least in theory, that a trial is designed to generate knowledge for future patients as much as it is to help the person in front of you. That dual purpose was invisible in the warmth of the ward interactions. It sat underneath, in protocol documents and ethics applications I would never see.

Jay did not strike me as someone misled or coerced. She was, within the constraints of her situation, choosing. Yet I could not shake the feeling that the scales on which she weighed that choice included variables that I, as a healthy outsider, could barely comprehend. She had experienced cumulative fatigue from years of treatment, fear of running out of options, gratitude for time already gained, loyalty to a team who had walked with her through multiple crises.

If anything, her agency complicated my comfort further. It would have been easier, in some ways, if she had seemed confused or doubtful, if I could point to a clear gap in consent and reassure myself that I would never allow such a thing when I was a doctor. Instead, she knew enough to ask good questions, had enough trust to say yes, and enough courage to live with the consequences.

The 'happy case' now had an edge I had not recognised at first: her optimism and trust were not simply feel-good accessories to effective treatment, but active forces shaping how she stepped into ethically fraught territory.

Spiral 5: The Edge of Care – Trial and Ethics

Beneath the surface, I knew there was another narrative running: the study protocol, with its inclusion criteria, dosing schedules, and adverse event grading scales. Somewhere, a sponsor's spreadsheet listed her as a participant number, her data points destined to join others in a statistical analysis. The same intervention that, for her, represented a last chance at controlling her disease also represented, for the trial, a contribution to knowledge whose primary beneficiaries might be strangers she would never meet.

It was surreal to think about how every single patient my eyes had glossed over reading randomised control trials for class or study, had been

another Jay, another person. Of course I had known this, but I had never been so involved in a trial participant's care, never talked to them so much.

I had learned about this duality in lectures. We had been told to distinguish clearly between clinical care and research, to avoid the "therapeutic misconception" that assumes an intervention is always primarily for the patient's individual benefit. On paper, the separation made sense. At the bedside, it did not feel separate at all. The cannula that delivered the trial drug was the same plastic we used for antibiotics. The nurses who checked her were the same ones who adjusted other patients' opioids. Her haematologist was both her clinician and a principal investigator.

When she did develop a low-grade fever and mild confusion overnight, it was, in one sense, expected. These were listed events, anticipated, graded. The team responded calmly, escalating monitoring, adjusting medications, documenting it meticulously.

It felt wrong, almost indecent, to know that somewhere this episode could later appear as a single entry in a results table: "Grade 2 CRS in X% of participants." I also knew that without such data, future patients and clinicians would be deciding almost blindly. The abstract good of knowledge was, at that moment, balanced precariously on Jay's flushed skin and restless hands.

I became uncomfortably aware of my own position in this arrangement. Unlike the haematologist, I bore no formal responsibility for the trial or its outcomes. Unlike Jay, I bore none of the physical risk. Yet I was learning a great deal from being there. I was observing, asking questions, later writing reflective notes that, in their own way, turned her experience into a kind of curriculum for me.

The teacher in this situation had never agreed to that role directly. Yes, she had consented to me speaking with her, to me being present. She had been generously open, even delighted, to share her story. But she did not choose for her suffering, her side effects, her resilience, to become the raw material from which I would carve out my professional identity. That part was simply how the system worked.

This awareness sat heavily with me. It disturbed the easy gratitude I had initially felt about 'finally finding a good case' for my assignment. What did it mean that my educational gain was entangled with her exposure to risk, with her willingness to inhabit this uncertain space at the edge of established care?

I did not find an answer. Instead, I found myself coming back to her

trust and her agency, and wondering what kind of doctor I would need to become to be worthy of both, in a context where the lines between treatment and research are never entirely clean.

Spiral 6: The Student's Hands – Doing Less, Feeling More

Throughout my time with Jay, I was acutely aware of how little I could do. I could not alter her regimen, tweak her doses, or offer alternative options. I did not sign her consent forms or interpret her scans. My role in the team was officially observational.

At first, this felt almost shameful. On other rotations, I had clung to small acts of "usefulness" – writing notes, chasing pathology, doing blood pressures, checking cannulas. With Jay, most of that work was already covered. The team was efficient, the nurses meticulous. There was no obvious gap for me to fill that would make the ward round move faster or the documentation neater.

What remained, unassigned and therefore somehow less legitimate in my mind, was time. Time to sit. Time to listen. Time to talk about things that would never make it into a discharge letter.

On the afternoons when I had no tutorials, I found myself drifting back to her room. Sometimes we talked about her disease, her past treatments, the side effects she feared most. Sometimes we did not. She told me about her daughter's first ambulance shift, about trips she had taken before she got sick, about the small rituals that made the hospital room feel less foreign – her own pillow, a particular brand of tea, a playlist she kept returning to.

There were moments when I felt a tug towards asking more, probing the depths of her understanding of the trial, checking – for my own reassurance – that she grasped the seriousness of her situation. Each time, I had to decide whether that urge was driven by genuine concern for her, or by my discomfort with sitting alongside hope that did not align neatly with prognosis.

I began to experiment, tentatively, with restraint. If she wanted to talk about the café down the road, I let the conversation stay there, resisting the impulse to steer it back to illness to prove I was "doing learning". If she wanted to revisit stories she had already told me, I listened again, noticing how different details emerged when she was more tired, or when her daughter was present, or when she had just come back from yet another scan.

None of this would have satisfied the part of me trained to measure contribution in tasks completed. Yet slowly, I started to recognise that being consistently, attentively present was not a consolation prize. It was a form of care, especially in a context where so much of what happened to her body was outside both our control.

This recognition was uncomfortable because it demanded a different metric for my own worth. Instead of asking "What did I do?", I had to ask "How did I behave in the space I was given?" Did I crowd it with my anxieties, my need for answers, my eagerness to impress? Or did I make room for her way of holding hope, even when it grated against my accumulating knowledge of survival statistics?

If anything, Jay seemed to sense this tension more clearly than I did. On one of the last days I saw her, she said almost offhandedly, "You don't always have to ask clever questions, you know. It's nice just having you here." It was such a simple comment, but it jolted me. In my head, I had been constantly assessing whether our conversations were "worthwhile" in educational terms. She was evaluating something else entirely: whether my presence made her feel more or less alone.

The happy case I had claimed at the beginning of the term had, by this point, frayed at the edges. The prognosis remained poor. The trial outcomes were unknown. She had already weathered more pain and uncertainty than I could fathom. And yet, in that small remark, I glimpsed a kind of reciprocity that did not depend on cure, or even on meaningful symptom improvement. It depended on attention.

Spiral 7: Leaving

I did not see a clear endpoint to Jay's story. There was no dramatic crash, no tidy resolution, no final "goodbye and thank you" scene. My term, however, did have an end date. On my last day, I went to the ward intending to tell her I was leaving. She was out of the room having a scan. I waited for a while, then got called away to another commitment. By the time I could return, she was sleeping, her daughter curled up in the visitor's chair scrolling through her phone. I hesitated at the doorway, did not want to wake her, and ended up slipping away with a quiet wave to her daughter and a vague promise to "visit if I'm ever back on the ward."

On the train home that evening, I realised that I had been unconsciously

expecting closure that matched the emotional weight of our interactions. A conversation that would define the relationship, some explicit acknowledgment of its significance to both of us. Instead, what I had was a half-finished goodbye and a lingering sense of incompletion.

It felt wrong, at first, to write about our relationship from that place of ambiguity. Who was I to draw conclusions when I did not even know how her trial would turn out, whether she would tolerate further cycles, whether she would live to travel again or die within the year? The temptation was to wait, to somehow seek out the ending before allowing myself to reflect.

But medicine rarely gives us neat endings. Patients move away, transfer care, die between clinics, improve unexpectedly, relapse after we have rotated off the team. The emotional arcs we imagine for them are constantly interrupted by the logistics of rosters and timetables.

Sitting with the unfinishedness of my time with Jay forced me to confront how much of my discomfort came from my own need to turn stories into lessons. The ASCONA brief asked for a narrative about a student–patient relationship and its contribution to my professional development. Part of me wanted that contribution to be clean: a defined turning point, a clarity gained, a moral resolved.

What I had instead was a tangle: hope that persisted in the face of bleak statistics; a clinical trial that was both opportunity and experiment; a relationship in which my most significant offering may have been simply not looking away.

Leaving without resolution did not negate any of that. If anything, it made it more honest. My professional identity was not forged in a single moment of insight, but in a series of imperfect encounters with her reality and my own limitations.

Spiral 8: Seeking Complexity in the "Straightforward"

When I first chose Jay for my assignment, I told myself – and a few classmates – that it was because her case was "less tragic" than the others on the ward. I framed it as a sensible act of self-preservation: pick a story that would not crush me, that I could manage emotionally while still ticking the boxes of the task.

Looking back now, that justification feels too simple. What drew me to

her was not the absence of tragedy, but the way hope sat so prominently in the room that first day. It was easy, in that moment, to see her as the exception – the bright, resilient patient in a sea of decline. It was harder, and took much longer, to notice the complexities underneath that light.

Her optimism was not naive. It had survived previous crises, been recalibrated after each relapse, stretched to accommodate the knowledge that treatments fail and bodies can only be pushed so far. Her trust in the team was not blind. It had been earned over years, tested in side effects, sustained through long waits and ambiguous scan results. Her willingness to enter a clinical trial was not a simple refusal to accept death, but a layered decision made in conversation with family, shaped by her history with medicine, and constrained by the shrinking list of alternatives.

In other words, the "straightforward" patient I had been so relieved to find was only straightforward from a distance. Up close, her story, like everyone else's on that ward, twisted and folded back on itself. The difference was that the edges were softer, the crises more spaced out, the suffering less visible at first glance.

Recognising this has altered how I think about "easy" patients more generally. It is tempting, especially when overwhelmed, to gravitate towards those who fit our preferred narrative arcs: the compliant, the grateful, the ones whose conditions respond predictably to treatment. It is also easy to treat them as emotional rest stops, brief reprieves between more dramatic cases.

Jay taught me that doing so risks missing the very tensions that could deepen our practice. The ethical friction of research-as-care. The quiet exhaustion of long-term survivorship. The subtle ways in which our need for meaning and resolution can distort how we listen.

If I had stayed at the surface – enjoyed her company, written up her case as "a good example of patient-centred hope," moved on – I might have walked away with a pleasant story and very little change. Instead, allowing myself to be unsettled by her situation, and by my reactions to it, has left a more durable mark.

The main reflection that runs through all of this is deceptively simple: even the apparently uncomplicated patients deserve, and in fact require, the same depth of attention we instinctively grant to the obviously complex ones. Complexity is not the preserve of rare diagnoses or dramatic crises. It is there in how people make sense of risk, in the stories they tell themselves and us, in the compromises they accept and the lines they refuse to cross.

For me, the shift is not in suddenly becoming able to "see everything," but in adopting a stance that assumes complexity is present, even when I do not immediately recognise it.

Progression: How I Hope to Practise

If Jay's story has changed anything concrete about how I intend to practise, it is this: I want to resist the reflex to collapse a patient's narrative into the neatest possible arc just because it makes me feel more competent or less afraid.

In practical terms, that means a few commitments I am trying, even now as a student, to cultivate.

First, I want to listen for the tension between prognosis and hope without rushing to resolve it. When a patient expresses optimism that seems "out of proportion" to what I know from the data, I would like my first question to be, "What does that hope look like for you?" rather than "How do I correct this?" Sometimes, certainly, there will be misunderstandings that require gentle clarification. But sometimes, as with Jay, hope will function less as a prediction and more as a way of inhabiting time. Learning to tell the difference feels important.

Second, I want to recognise presence, attention, and ethical restraint as real forms of care, not just placeholders until I am "useful enough" to prescribe or operate. My time with Jay showed me how easily a student can either intrude – asking for more detail than is kind, probing at raw places for the sake of curiosity – or shy away entirely, absenting themselves to avoid discomfort. I would like to occupy a middle ground more deliberately: to show up, to notice, to accept that sometimes the best thing I can offer is to stay, quietly, when there is nothing to fix.

Third, I want to keep questioning the structures that make cases like hers both possible and necessary. Trials are essential; so is honesty about whose risks underpin whose benefits. As I move further into medicine, I hope to pay attention to how recruitment is discussed, how information is framed, how we talk about "options" when there are, in truth, very few. I do not yet know what advocacy or boundary-setting will look like from inside the system, but the unease I felt watching her navigate that crossroads is something I want to hold onto rather than smooth over.

Finally, and perhaps most importantly, I want to make room for ongoing

reflection, not just episodic crises of conscience. Writing about Jay has been one such space. Participating in Balint-style groups and narrative medicine sessions during my training has shown me that sharing these stories with colleagues – not to diagnose them, but to inhabit them together – can transform private discomfort into collective learning. I hope to seek out, and when possible help create, such spaces in whatever teams I work in.

Progression: What Training Could Do Differently

My encounters with Jay did not clash with my formal education so much as expose its seams. We had been taught the science of lymphoma thoroughly, the protocols, the survival curves, the mechanisms of new drugs. We had touched, in lectures, on research ethics and consent. We had been encouraged to be empathetic, to communicate clearly, to provide "holistic care."

What I had not been prepared for was the emotional and ethical dissonance of standing at the intersection of all those domains as a student: watching someone older than my parents consent to a trial that might extend her life or might only add toxicity; feeling both privileged and uneasy to be present; realising that my need for narrative completion was, in that moment, irrelevant.

If medical training is to enhance our awareness in such situations, a few shifts seem necessary.

We need more opportunities to explore cases not because they are rare or spectacular, but because they reveal the ordinary complexities of long-term illness and relational care. Rooms like Jay's should not be relegated to side notes in teaching sessions in favour of more dramatic emergencies. They should be central texts.

We need explicit spaces where students can talk honestly about the ways their own needs – for competence, for closure, for a "good case" – influence which patients they gravitate towards and how they interpret what happens. Without that, such dynamics remain unexamined and silently shape practice.

We also need teaching on research ethics that starts from the lived bedside experience, not only from abstract principles. Seeing how consent processes play out in real time, how trust and desperation and hope intersect, should be something we are invited to reflect on with guidance, not something we stumble through alone.

And we need institutional commitment to reflective practices that are sustained, not one-off. Balint groups, narrative writing, debriefs that focus on relationships rather than only on clinical decisions – these are not luxuries. They are safeguards against the slow erosion of curiosity and compassion. They help doctors tolerate ambiguity and moral discomfort without shutting down or defaulting to cynicism.

If there is one concrete change I would wish for, it would be that every oncology and palliative care term includes protected time for students and clinicians to sit together and talk about one patient purely as a person in relationship with them, not as a problem to be solved. To ask, "What is it like to be with this person? What is it like to be ourselves with them?" and to let that conversation shape how we practise.

Closing the Spiral

I still do not know what happened to Jay. I sometimes catch myself imagining different endings: that the trial worked and she is somewhere planning another trip; that it didn't, and she died surrounded by the same photos I saw on the wall that first day; that her story followed some stranger curve entirely that I would never predict.

What I do know is that my time with her has unsettled some of the neat lines I once drew between good and bad outcomes, realistic and unrealistic hope, useful and useless roles. It has made me more wary of my own relief when a case feels "straightforward," more curious about what lies beneath an apparently simple narrative, more willing to acknowledge that my presence in a patient's story is both formative for me and potentially burdensome for them.

The spiral structure I have used to tell this story is, in a sense, the same structure by which I experienced it: circling back to the same room, the same smile, the same optimism, each time seeing something slightly different. Light and PET scans. Agency and risk. Trust and trial protocols. My own fear, and my own quiet learning.

If medicine is, as we are often told, both science and art, then relationships like the one I had with Jay are where that duality is tested. The data mattered deeply in her case. So did the stories she told herself, and me, about what those numbers could and could not dictate. My professional identity will continue to be shaped by such encounters, not as tidy morals but as ongoing questions I carry forward.

Perhaps the most honest way I can end this is not with a conclusion, but with a commitment: to keep seeking the complexity in the patients who at first appear to offer me easy comfort, and to keep carving out spaces in my training and practice where such complexity can be named, shared, and borne together.

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