

## Not on My Watch

**Arjun Gupta, MD**  
Sidney Kimmel  
Comprehensive Cancer  
Center, Johns Hopkins  
University, Baltimore,  
Maryland.

Ian is a man in his 40s, with a loving family and a fulfilling job. A few weeks of abdominal discomfort and some goading from his wife prompt a visit to his primary care physician. A computed tomographic scan reveals masses in the liver and peritoneum, with a nasty-looking colon tumor. After a colonoscopy, he arrives at the medical oncology clinic with a diagnosis of metastatic colon cancer.

He is the first patient I care for as a July first-year oncology fellow. At my institution, fellows see patients with newly diagnosed cancer in conjunction with a faculty expert. If patients agree, fellows “inherit” the patient, acting as their primary oncologist, with the attending physician following closely. Our meeting lasts an hour and a half. I leave to discuss his case with the attending physician, and we both re-enter the room to finalize recommendations.

He asks us how much time he has. I tell him that we are still awaiting some studies to inform prognosis and treatment.

“I understand. But I’m a numbers guy,” he says. He is a banker. “What is the average?”

“Approximately 3 years is the median,” I reply, adding the timeworn but crucial, “but each patient is different.” I draw out a bell curve in the notebook where his wife is carefully taking notes. I glance at the attending physician for validation. He gives me an encouraging nod.

Ian nods as well. I think he expected the answer. Perhaps he had looked it up. His face is calm, steely.

As we wrap up, I ask if I can be his oncologist. “Of course,” he replies. “But won’t you graduate soon?”

“Our fellowship is 3 years, so I’m here for awhile.”

He grins. “So I just need to outlast your fellowship then, and I would beat the median.”

I am dumbstruck, with no ready reply. He saves me. “I’m kidding. I get it. You’ll call us with the portacath date?”

“Yes.” We shake hands and say goodbye.

Walking back to the workstation, I mull over his words. Beating the median does sound good. There are several chemotherapy options available. An idea is born in my head: *Not on my watch*. I had cared for plenty of patients during residency, but had never felt such ownership. *I need to get him 3 years. Not on my watch!*

We become close over the next few weeks. He is not my only patient anymore, but he is special—the first patient always is. In caring for him, I learn about fancy-sounding clinical trials such as TRIBE and fancier-sounding chemotherapy acronyms such as FOLFOXIRI (ie, folinic acid [leucovorin], fluorouracil, oxaliplatin, and irinotecan). I explore the National Comprehensive Cancer Network guidelines and watch as Ian develops chemotherapy-induced neutropenia. I feel myself take shape as an oncologist while chemotherapy starts to

shape Ian’s path. It is minor to start: “I can’t hit as many tennis balls to my daughter.”

We carry on. Bloodwork, a visit with the genetics team, chemotherapy, a trip to the urgent care center for a blood clot—cancer is a full-time job. He finds time to take his daughter to New York for the US Open.

Two months after initiating chemotherapy, we obtain restaging computed tomographic scans. The results are crucial—they will tell us how the cancer has responded. He—we—have invested so much. I read the scan report. The word *progression* jumps out. I call the radiologist, hopeful.

“Is that not a hazy border? Could this be stable disease?” I ask.

“No, this is progression,” she replies. “I am sorry,” she adds, probably sensing my angst.

Ian is in a room down the corridor. I break the news to him. His voice quivers, then halts. He is literally speechless. He does not want to receive scan results in person again. “Email me first,” he says. “I need time to process these things.”

We plan to bolster the chemotherapy regimen. A faculty member looks over my shoulder as I enter new chemotherapy orders. She hugs me. “It is difficult, as it should be,” she says. *Not on my watch*, I think to myself.

Ian gets through chemotherapy 2.0. There is fatigue and graying hair. “My daughter asked me if I was growing old,” he says, smiling wistfully. He tells me I need to stop working so hard. “You love cricket, right? When was the last time you attended a game?” I tell him I have not been to a game since I left India, where I grew up. He tells me about his time in the United Kingdom, when some associates took him to a cricket game. “I’m a Red Sox fan, and it felt like Fenway Park. You have to go.”

Two months fly by, it is time for scans again. “Email me,” he reminds me the night before. More confident now, I look at the images myself. *Progression*. Again. I am angry, flustered. But we are rounding on the wards. There is no time to process emotion. The veteran attending physician, experienced in sniffing out distress, pauses rounds, and asks me what’s wrong. “Nothing,” I mumble. Not satisfied, he takes me to the family consultation room.

With just the 2 of us, I let my guard down. “It’s not fair,” I sob. The attending just sits there, silent. “My dad told me 20 years ago—sob—“Bill Gates said life is not fair, get used to it”—sob—“but this is just not done.” *Not so early*. A minute passes. My breathing normalizes. The attending has not said a word. He heads back to rounds, not expecting me to join. I email Ian. *Maybe on my watch*.

I confide in co-fellows. We all have similar stories. We marvel at the unfairness of the world. In some

**Corresponding Author:** Arjun Gupta, MD, Sidney Kimmel Comprehensive Cancer Center, Johns Hopkins University, 401 N Broadway, Baltimore, MD 21287 (guptaarjun90@gmail.com).

ways, our fellowship class is actually a Fellowship, like the one in *The Lord of the Rings*.<sup>1</sup> We are on a transformative journey together. It is a little bit secret and a little bit sacred. We have all traversed medical school and residency, some have additional doctorate degrees. We concur that this is the most emotionally challenging year of training.

We switch therapies again. Ian is weaker now. A palliative care consultation helps tremendously. I attend the appointment. They ask Ian what matters most to him. He starts spending more time with family, moves on to a more mentoring role at his job, and talks about leaving a legacy. I FaceTime my family in India and tell them I love them. I spontaneously book a trip to the United Kingdom for the 2019 Cricket World Cup, spending all my vacation and a quarter of my savings.

Our visits become more social. The cancer is in the background now, an irritating companion. I mention to him that another patient cannot routinely afford parking. The next day, he donates to our cancer center fund to help patients with out-of-pocket costs. He has turned me into a hugger. I hug my patients now. Some are surprised; most hug me back tightly.

We are 7 months into therapy. The disease is more extensive. We are running out of chemotherapy options. *Likely on my watch*. We explore clinical trials. Before we can enroll Ian, his wife calls one day, frantic, "Ian has severe belly pain." I meet them as he is wheeled into the emergency department. He looks awful. He has intestinal perforation. I worry he may literally die on my watch—in front of my eyes. He undergoes emergency surgery.

I visit him the next morning. He is resting, now extubated. He senses a presence, and opens his eyes. He croaks, "Arjun. Hi. Thank you." It amazes me how often he offers his thanks, even in

times of distress. I tell him about all the things I am thankful to him for: things he taught me, his trust, and for delivering Girl Scout cookies to me at 9 PM when he was at the hospital for a fundraiser.

The sun shines through the large windows in the intensive care unit room. It is peaceful, beautiful. I want to enjoy Ian's light as much as the sun's for as long as possible. I notice the drains and monitors in the room. *It is going to be on my watch*.

We chat like friends. I tell him I will be back after clinic, which is true. I also assure him that I will advocate to the surgeons to let him eat, which is a white lie.

A few days later I find myself thinking about an episode of *Scrubs*,<sup>2</sup> one of my favorite sitcoms. In the show, the brilliant if snobbish Dr Cox takes great pride in not overseeing any deaths during his shift. "Not on my watch," he declares. Ultimately, with 5 minutes to go before the end of his shift, a patient dies, and he does not get his "perfect game." But was it really him and his watch that kept those patients alive? Was it even about him at all?

I realize how foolish it is to ascribe the success (or failure) of a particular chemotherapy to an oncologist's prowess, how clinicians sometimes overreckon our contribution to an outcome. I think about how whether Ian achieved the median had very little to do with being on my watch, or me.

I realize what a privilege it is to care for patients with metastatic cancer. They entrust so much to us, often as they face a limited life expectancy. I realize how much I have grown in the past year, how much I have learned, and how I have evolved. I realize how much of this is because I met Ian.

It hits me then.

He was never under my watch. I was under his.

**Published Online:** July 11, 2019.  
doi:10.1001/jamaoncol.2019.1904

**Conflict of Interest Disclosures:** None reported.

**Additional Contributions:** I would like to thank the patient and his wife for allowing me to share this story and for their love and trust through this journey. I would also like to thank Ross C. Donehower, MD, and David H. Johnson, MD, for

providing feedback on earlier versions of this article and for their mentorship and support. They were not compensated for their work.

**Additional Information:** I have since confirmed that Bill Gates never actually said, "Life is not fair, get used to it," although it is often attributed to him. I have informed my father of this.

1. Jackson P. *The Lord of the Rings: The Fellowship of the Ring*. Burbank, CA: New Line Cinema; 2001.

2. Buckland M. *Scrubs*. Episode 12. "My Blind Date." Aired January 8, 2002 on NBC.