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Editorial

The subjunctive pluperfect syndrome

GUSTAVO D. KUSMINSKY

Hospital Universitario Austral, Buenos Aires, Argentina

E-mail: gdkusminsky@gmail.com

JC, a 71-year-old male, working as systems engineer, has been living with monoclonal lymphocytosis for the past three years. Initially, his studies determined that the lymphocyte phenotype corresponded to B chronic lymphocytic leukemia, which initially did not require treatment. Among his medical history, the only notable condition was moderate hypertension with no impact on target organs. Over the past eight weeks, there has been a dramatic increase in lymphocytes, with splenomegaly, and a decrease in hemoglobin levels, prompting the decision to start treatment. The patient was evaluated as fit from the perspective of his performance status. In two consultations, approved first-line therapies, their advantages, disadvantages, and potential adverse effects were explained. Eventually, in mutual agreement with JC, the treatment regimen of obinutuzumab (a monoclonal anti-CD20 antibody) and venetoclax (a BCL2-targeted agent) was prescribed[1].

Following the initial antibody administration, despite instituted prophylaxis, the patient developed tumor lysis syndrome, requiring rasburicase treatment. He also developed peripheral cytopenias and persistent fever. He received the febrile neutropenia empiric treatment in accordance with institutional guidelines. Red blood cell transfusion support was required. Platelet levels significantly declined, although transfusions were not deemed necessary. After a week of hospitalization, the patient was discharged with partial recovery of his blood cell counts.

During the first post-hospitalization consultation, the patient and his wife attended along with their 40-year-old son, filled with unease over the complication that had arisen. Although during the initial meetings there had been discussions regarding potential complications, including tumor lysis syndrome, it wasn't long into the consultation when questions arose, giving rise to this contemplation. *What if we had chosen a different treatment? What if we had initiated treatment earlier, when the spleen wasn't enlarged; could that have mitigated the effects of tumor lysis?* More persistently, the patient's son, who had not been present at the initial encounter, mentioned that he had conducted online research about his father's condition, and his investigations had left him with doubts about the management of the situation.

The bond between patients and the healthcare team has notably evolved in recent times. While in the past, it was grounded in a paternalistic and authoritative model, with a vertical vector that descended majestically from the doctor to the patient, nowadays, there has been an evolution towards a more cross-cutting, back-and-forth approach, with an emphasis on shared decision-making[2].

Within this bond, there are several variables that create distortions and tensions, likely stemming from a decline in the quality of communication, a lack of empathy, time constraints during consultations, and external interferences in the bidirectional relationship between patients and caregivers. As A. Agrest pointed out, the once coveted social recognition associated with being a physician, coupled with respect and compensation, has shifted towards a realm of suspicion. It has also ushered in a slew of demands and increased pressures, exacerbated further by consultations with "Dr. Google." In this way, patients exert a sort of intellectual and even moral scrutiny upon the physician[3].

Today, the word of the healthcare team is met with doubt, cross-referenced with internet searches, and weighed against the opinions of various individuals with diverse backgrounds and abilities. It is crucial, therefore, to acknowledge that there are other players in this relationship with patients, a group that can be broadly termed "the environment." This environment is characterized by its potential to be highly influential in sowing doubts or even rejecting conventional treatments. In the case of patient JC, his environment was represented by his son. While absent from the initial consultations, his words and actions towards the patient carried a significant presence, sowing the concerns that needed clarification.

It must be acknowledged that this environment can also be supportive, collaborating with the healthcare team and providing strong support in the decisions made along the way, particularly in clinical conditions that can endure for an extended period.

The context of patients, especially those facing complex health imbalances, and even more so for oncology and hematology patients, must be taken into consideration from the outset of the relationship. In the consultations that formally establish the mode of care, communication channels and action plans regarding diagnostic and treatment aspects are clearly needed also from the beginning. Patients often come accompanied, and these companions are just a sample of all the voices that surround the daily life of the afflicted. This is an echo of the reality where the disease takes center stage and permeates every layer of the affected person's thoughts.

During the phase of contractual moments, there must be a clear communication regarding plans and strategies while simultaneously establishing a framework for communication with the individuals surrounding the patients. It is of paramount importance to underscore, through insistence, that any events that occur are rooted in the present disease, irrespective of whether a particular adverse effect is caused by a drug or a combination of drugs. Every event has its origin in the presence of that specific ailment. It is not uncommon to hear the phrase, "*It's not the cancer that will kill me, but the cancer treatment*."

When undesirable effects occur, when responses do not align with expectations, it is at that juncture that questions beginning with the aforementioned tense, the past subjunctive pluperfect, come into play[4]. This verbal tense can lead to a zone of unease in communication with the patient, especially when unwelcome news must be conveyed. To prevent this, it is of vital importance to maintain a connection with the patient's caregivers, establishing lines of interaction with the environment, always with the patient's knowledge and authorization but as a form of prophylaxis against the "*what if we had done that…*" scenarios that may arise. In some sense, for critical situations, advanced illnesses, and end-of-life scenarios, it becomes evident that the survivors of this triad, the patient, the doctor, and the environment, will predominantly be the caregiver and the environment.

Recognizing and averting potential grievances can even help alleviate the discomfort that often permeates the relationship, a discomfort that, when taken to extremes, can result in legal disputes.

In the labyrinth of patients' and their companions' thoughts, the shadows of uncertainty intertwine in diverse ways, giving rise to disturbing thoughts. At times, they find themselves ensnared by a lingering question, one that persists until the panorama from the outset is clarified, perhaps like a recurring echo: "What would have happened if a different path had been chosen at that past crossroads of possible treatments? Would this present, with its mysteries and tribulations, be different, perhaps devoid of adverse effects or with better responses?"

Each past determination, with all its shades and lights, has led the patient to their current point. The choices of yesteryears are unchangeable, and thus, the possibilities of various scenarios were initially opened up, with the patient also having to trust in the guidance of the healthcare team in this model of shared decisions.

There's a popular saying that it's easy to critique Sunday's soccer results with Monday's newspaper. In the medical field, especially in situations where life is at stake, it is imperative to exercise prudence and continuously facilitate a channel of communication that prevents the

arrival of the moment when the past subjunctive pluperfect is associated with a complaint. This is particularly crucial when the results of a specific treatment are known, and reflection comes into play. Transforming unease critically depends on the necessity to reaffirm the information presented previously. It is also essential to remain vigilant because, despite being aware of its existence and consequently establishing prevention, the syndrome of the past subjunctive pluperfect tends to rear its head. What matters is reassuring the patient and strengthening the bond with the mentioned tools.

Preventing the "past subjunctive pluperfect syndrome" is not a simple task. It requires establishing effective communication from the very beginning of the relationship and considering the patient's environment to maintain a line of communication and trust even with that other sphere. It is striking that doctors have been highlighting these issues for a long time, and the difficulties persist with the same or even greater intensity. In 1972, Florencio Escardó spoke of creating an "existential unity" with the patient's family group, where efficient and affectionate communication could take place (empathy was a term not used at that time). He also cautioned about the phenomenon of the patient as a consumer in the mechanistic reality of the surrounding world[5].

Time, perhaps, gives the illusion of being circular, and issues that repeat in the medical profession's practice resurface. Names of prestigious doctors who have reflected from their professional wisdom yet refer to situations similar to those more than half a century after Escardó's publication. Or perhaps, it's worth the effort to persevere and return from the past subjunctive pluperfect to the present indicative, at least to a somewhat more auspicious tense.

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