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Editorial

How, and when, to say no

The problem with starting palliative treatment for the metastatic cancer patient is to know when to stop. When an American gets cancer he/she is outraged and thinks ‘how dare this happen to me!’ In the mind of this patient, the fault must be corrected immediately. In other cultures, conversely, getting sick is not an outrage. Rather than fighting death, their outlook is simply…first you live and then you die. The radiation oncologist in our culture, however, who concludes that radiation is ineffective for a palliative cancer patient who expects radiation is ‘spitting in his face.’ The patient, now more unhappy, then seeks a second opinion[1] of a new oncologist who, invariably, suggests that not only is radiation indicated but that it may also, in fact, result in longer survival. After all, says the second opinion oncologist, ‘miracles *do* happen.’

The majority of the articles in clinical cancer journals support the second opinion doctor and, for the most part, are enthusiastic regarding the treatment of disseminated cancer. Forty percent of patients sent to radiation oncology are treated with palliative intent.[2,3] A fact not surprising, since only about 40% of cancers are cured.[4]

There are few practical guidelines clinically defining a terminal/dying patient. Moreover, if there were, total disagreement would likely accompany them. Karnofsky said that for patients treated with nitrogen mustard for lung cancer, benefit occurred for patients with a Karnofsky above 60.[5] In contrast to this, however, many patients are irradiated with a KPS at, or under 60, often from gurneys or wheelchairs, not able to walk and/or take care of themselves. In addition, too many patients are told they are dying when they are too ill, sedated on narcotics, or not alert enough to make a will or to plan their family’s future. When does cancer treatment stop? When should a patient be told he is dying? When should hospice begin?

As radiation oncologists, we are often asked to treat terminal (6 months to live) or dying patients (3 weeks to live). As consultants, we should be able to recommend against radiation or offer hospice as an option to these patients. Offering either of these options could cause serious backlash, however, as the patient may have already been told that radiation would be given. In addition, the patient commonly misunderstands their prognosis or has not been told that he/she is dying or even terminal. In fact, in a previous study by Gattellari et al. only 75% of patients were informed that their disease was incurable and only 58% were informed about life expectancy.[6] With this is mind, it is not surprising that over 40% of patients have overly optimistic expectations of cure[7] with up to 25–30% of patients believing their palliative radiation is for cure.[8,9] Not willing to give bad news, some radiation oncologists opt to give the patient what he/she wants because they feel that if they do not, someone else will. Other radiation oncologists think that allaying anxiety of a patient who is in their office only for a 1–10 fractions course of radiation is not their job but is that of the referring physician. A common excuse for not telling a patient how short his/her life expectancy is, is to say that ‘no one can predict how long patients will live.’ However, what about offering an opinion or a discussion of the published range of median survival, with an explanation of median. The range of median survival in these patients is relatively small because though patients with carcinomatosis have a long period of preserved function, there is a precipitous drop that starts only a few months before death. This drop commonly occurs when all truly effective treatments have failed and the patients’ activity significantly diminishes, often associated with symptom progression.[10,11]

For those radiation oncologists who opt against treating dying patients and choose to discuss the reasons for their decision with the patient, I have no easy ‘explanation’ strategy, as it depends on the patient–doctor relationship. Though this was an easier task in the past era of the doctor-dominated consultation, today there exists a more balanced partnership between doctors and their patients. Some patients continue to prefer the patriarchal approach while others desire a negotiated partnership; one that has justly been forced on our profession by the growing patient consumerism and the constraints of doctors’ fear of criticism and complaints.

Three questions directed to the patient have helped me plan a strategy:

What do you know?
What do you want to know?
What have your doctors told you?

The extroverted patient will often answer in extreme detail. It is, instead, the secretive non-verbal patient who makes obtaining the answers more difficult. In the final analysis, the truth of the answers depends on how much trust the patient has in the oncologist with some patients trusting no one. With all patients, one way to draw them out is to recognise them as a person, not just as a disease. Maintain eye contact, introduce yourself slowly, shake hands and explain the purpose of the consultation. Speak up, do not speak rapidly or mumble. By doing so, one is able to recognise the patient as something more than a cancer. After the medical history, ask the patient's permission to do an examination, a request especially important for those patients requiring a rectal–vaginal examination. Discuss the reasons for your recommendations in non-medical terms, give your conscientious opinion and ask the patient to repeat what he or she understands. By doing so, the patient, whether or not he/she follows your recommendations, knows that you care, that you have a sense of duty to practice good medicine—something which includes a commitment to the patient's quality of life. The process of addressing death and dying with a patient is one of continuous learning for physicians. It is a process of win some, lose some; a process of attempting to not get discouraged and trying to remain humble and continue forwards. Many times, I have asked social workers for help and feel that their presence and participation is mandatory in situations in which many relatives are involved or the patient accepts your recommendation and the spouse does not. In medicine the only care worth having is the care that cannot be bought.

Conflict of interest statement

None declared.

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