

Acknowledging the Limitations of Treatment: Surrendering to Reality

LINDA R. DUSKA

University of Virginia Health System, Charlottesville, Virginia, USA

Disclosures of potential conflicts of interest may be found at the end of this article.

“We have two options, medically and emotionally: give up or fight like hell.” – Lance Armstrong

If cancer is a battle and treatment is the weapon, then what happens when the war ends and it is time to stop treatment? As authors Morgans and Schapira note, with many solid tumors, that time will come: when further cancer treatment is, at best, futile and, at worst, toxic and life threatening [1]. As oncologists, many of us feel that it is our job to “win” by “beating the cancer” and prolonging life, no matter what the cost. Using the war analogy, the oncologist is the opposing general, the strategist, and the one holding the secret weapons. Played to the end, it means that giving up on treatment is just that: surrendering. Our patients use this metaphor often when they ask us not to give up, to keep trying, to keep fighting.

“We cannot direct the wind but we can adjust the sails.”
– Anonymous

As physicians, we know that we cannot always win the war against an individual’s cancer. We also know that stopping cancer treatment does not mean we stop treating the patient. In fact, stopping cancer treatment can be liberating. We are no longer focusing our attention solely on the cancer, but instead are refocusing on the patient, her quality of life and symptom management, and her personal goals of care. Studies have shown that when we do this, when we focus on those aspects of palliative care medicine that encompass all domains of life, our patients live longer and better [2]. Then, why is it so hard for us as physicians to admit that the treatment is no longer working and it is time to stop active cancer treatment and segue into palliative care?

Medical oncologists are not alone facing this question. Surgical oncologists also have a difficult time with this concept. Surgeons take pride in their technical skill in fixing problems, and we spend years training to be technical experts. Gynecologic oncologists, for example, take pride in their ability to optimally cytoreduce an ovarian cancer patient with advanced disease; there is something very gratifying about having the technical expertise to successfully remove all cancer in a complex operation, thereby providing the patient a survival advantage. On the other hand, there is nothing worse than having to tell a patient and her family that the surgery was unsuccessful: the tumor could not be

removed; the bowel obstruction could not be fixed; there was nothing we could do. The inability to remove all tumor, even in the setting of exceptional surgical skill, feels like the ultimate failure.

Morgans and Schapira do an excellent job of summarizing the key points of the SPIKES (setting, perception, invitation for information, knowledge, empathy, summarize and strategize) protocol, which is a tool designed to help oncologists structure discussions with patients at the end of treatment [3]. The authors also describe how these conversations can be difficult to both initiate and conduct well, and can be significantly tainted by our own emotions. The guilt that we feel over our “failure” to cure the cancer can permeate into these discussions, make them stressful for us and the patient, and make us likely to avoid them altogether [4]. Indeed, for surgeons devoted to the care of cancer, our years of surgical training and our necessary belief in our surgical skills may contribute to our difficulty in admitting failure.

As the authors also point out, however, the end of treatment is not a failure, especially if it is managed well. If the physician is able to have an honest conversation with the patient and her family, and facilitate a successful transition to the next phase of care, then the end of treatment becomes not a failure at all, but a shift in focus from the cancer itself to the patient as a whole. As caregivers, then, we must redefine our definition of failure (or loss of the battle) both for ourselves and for our patients. The battle, if we are to call it that (and I would propose that we do not), is for life with quality and purpose and not for life at any cost.

As the treatment options for cancer grow and the expectations of our patients that medicine can cure all ills persist, it is our responsibility to our trainees to teach and model algorithms such as the SPIKES protocol. We must prepare our trainees to expect the transition to comfort care at the end of life and to not consider the end of treatment a personal failure. In the case of the surgical oncologist, this training must include the development of the judgment to know when it is time to abandon a potentially morbid cytoreductive operation because it is unlikely to be successful, when it is time to place a gastric tube instead of fix a bowel obstruction, and when it is time to advise the patient asking for a surgical option for her recurrent disease that surgery simply is not indicated and likely will make the clinical situation worse.

Correspondence: Linda R. Duska, M.D., University of Virginia Health System, P.O. Box 800712, Charlottesville, Virginia 22908, USA. Telephone: 434-924-1851; E-Mail: lrd5d@hscmail.mcc.virginia.edu Received July 1, 2015; accepted for publication July 2, 2015; published Online First on July 20, 2015. ©AlphaMed Press 1083-7159/2015/\$20.00/0 <http://dx.doi.org/10.1634/theoncologist.2015-0264>

We also need to be mindful of the risk for burnout associated with managing oncology patients, particularly at the end of life. We must, as a group, work to avoid burnout and preserve our experienced provider resources. How best to achieve this goal is peripherally addressed in the Morgans and Schapira paper, but it remains a vitally important issue for us as a society as the population ages and cancer cases increase. Burnout is common in all types of oncologists: medical, surgical, and gynecologic. Almost 45% of medical oncologists in a recent survey were burned out on the emotional exhaustion and/or depersonalization domain of the Maslach Burnout Inventory [5]. The oncologists who spent the largest amount of professional time in direct patient-care activities were at greatest risk for burnout. In a survey study of surgical oncologists, 28% qualified as being burned out, with higher percentages of burned out physicians being women (37% vs. 26%; $p = .031$) and providers under age 50 years [6]. The authors of the surgical survey study suggested that the roots of surgeon burnout may have their origin early in the training process, a process that includes years of long work hours and delayed personal gratification. Finally, a similar survey study specific to gynecologic oncologists suggested that younger gynecologic oncologists are more likely to experience work-related stress and burnout than more experienced ones, emphasizing the need to prepare for difficult clinical situations during training [7]. The work-related stress index in that study was correlated with response to the statement, "Telling a patient that they are going to die is difficult for me." Those surveyed who agreed with the statement had the highest work-related stress index scores ($r = -.19$, $p = .006$). These data suggest that the end of treatment is a time of particular stress and potential burnout for the gynecologic oncologist.

Working in groups, debriefing with colleagues, and "sharing the pain" with palliative care colleagues are options for providers with those resources. In academic surgical and gynecologic oncology, we use the tumor board setting not just to make treatment decisions, but also to discuss complex surgical cases to validate our individual assessment of whether a clinical situation can or should be managed surgically. These

tumor board settings, in which respected colleagues who are not emotionally connected to the patient provide expert opinions, may allow an individual surgeon who is emotionally involved to admit to herself that surgery is simply not a logical choice. The tumor board opinion is then communicated to the patient as not just an individual provider's opinion, taking some of the overwhelming responsibility off the shoulders of the surgeon who is saying nothing can be done, and giving the patient the reassurance that others have also reviewed her case and agree.

As oncologists, we must continue to train our residents and fellows in effective patient communication, particularly at the end of life. To accomplish this goal, we need to teach algorithms such as the SPIKES conversation presented by Morgans and Schapira [1], and expose our trainees to these difficult conversations. But we also need to change the way we think about the so-called battle against cancer. Perhaps, instead, we could consider the cancer treatment as a journey, with the care provider as the guide. The decision to end treatment, if it comes, is not a failure, either of the patient or the physician, but instead should be viewed as a natural segment of the journey and a desirable change in the focus of care. Support through this transition needs to be provided to the patient and her family, but also to the providers. Work stress related to end of treatment and subsequent burnout must be prevented if we are to preserve not only our young oncologists but also our best and most experienced. Our ultimate goal is not cancer treatment until death; it is preservation of quality of life, dignity, and individual patient goals of life whenever possible.

"'Tis not always in a physician's power to cure the sick; at times the disease is stronger than trained art." – Ovid

DISCLOSURES

Linda R. Duska: GlaxoSmithKline, Bristol-Myers Squibb, Millennium Pharmaceuticals, Aeterna Zentaris (RF), Inovio (SAB).

(C/A) Consulting/advisory relationship; (RF) Research funding; (E) Employment; (ET) Expert testimony; (H) Honoraria received; (OI) Ownership interests; (IP) Intellectual property rights/inventor/patent holder; (SAB) Scientific advisory board

REFERENCES

- Morgans AK, Schapira L. Confronting therapeutic failure: A conversation guide. *The Oncologist* 2015;20:946–951.
- Temel JS, Greer JA, Muzikansky A et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med* 2010;363:733–742.
- Baile WF, Buckman R, Lenzi R et al. SPIKES-A six-step protocol for delivering bad news: Application to the patient with cancer. *The Oncologist* 2000;5:302–311.
- Tesser A, Rosen S, Tesser M. On the reluctance to communicate undesirable messages (the MUM effect). A field study. *Psychol Rep* 1971;29:651–654.
- Shanafelt TD, Gradishar WJ, Kosty M et al. Burnout and career satisfaction among US oncologists. *J Clin Oncol* 2014;32:678–686.
- Kuerer HM, Eberlein TJ, Pollock RE et al. Career satisfaction, practice patterns and burnout among surgical oncologists: Report on the quality of life of members of the Society of Surgical Oncology. *Ann Surg Oncol* 2007;14:3043–3053.
- Ramondetta LM, Urbauer D, Brown AJ et al. Work related stress among gynecologic oncologists. *Gynecol Oncol* 2011;123:365–369.

EDITOR'S NOTE: See the related article, "Confronting Therapeutic Failure: A Conversation Guide," on page 946 of this issue.