




## Response to Martani, Tomasi, and Casanto

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Martani and colleagues have unpacked perhaps the most concerning aspect about Right-to-Try (RTT) laws: declamatory statements in the name itself proclaim a false sense of what the law is attempting to do rather than what it actually does (1)—something with which we wholeheartedly agree. RTT laws cause confusion among patients and oncologists, lead to unrealistic expectations, and can impede a healthy dialogue about cancer care (2). Private equity supported, for-profit cancer centers charging patient members for “unique access” to experimental therapeutics through RTT further complicate open and honest conversations (3). In response, Martani and colleagues call for educating oncologists about the law and all available pathways to help patients (1). By extension, we feel those efforts should also include support for shared decision making (SDM) to foster better conversations that respond to the patient’s situation whether or not that includes experimental therapies. As conversations about cancer care are challenging given the psychosocial distress on patients and the emotional burden on oncologists in delivering devastating news (4), SDM tools to improve care conversations could serve to reduce stress and anxiety and help patients and families cope through their therapeutic journey.

There are many bases for beginning experimental therapies. The primary justification should be based on whether the therapy is the most appropriate response to the medical, practical, emotional, relational, and existential situation of patients and their families. The only way to determine this is in conversation with patients. The illusions of RTT can muddy the waters, but the need for these conversations still exist whether experimental therapies are available or not.

Several considerations bear on these conversations: harms and benefits; wishes of patients and families; experience and recommendations of clinicians, which may be clear and aligned or ambiguous and conflicted; the practicalities and goals of treatments; and the integration of a momentous decision in the life story of the patients and those who love them, particularly

as that story risks coming to a close (5). RTT as a declamatory statement suggests that the patient’s desires are the only factor in play. The law introduces harms, benefits, and practicalities that further complicate matters. All of these matters require attention in decision conversations. Addressing physicians’ legal ignorance alone will not solve the greater challenge of crafting an appropriate response to the patient’s situation—what to do for this patient, here and now.

SDM can help patients and clinicians consider, reconcile, and coordinate risks, options (including palliation and experimental therapies), wants, roles, goals, practicalities, emotions, and meaning to come to well-formed decisions (6). SDM tools that promote conversation, including about experimental therapies, could assist patients, clinicians, and families. Those tools do not yet exist, and their goal should be to foster caring relationships, communicate information clearly, open space for the free expression of desires, and then facilitate problem solving, including navigating preapproval pathways, establishing goals, deliberating, and bringing dignity to a very difficult time in a person’s life (6). Such an approach extends clinician RTT education and brings experimental therapies into the regular care of patients with life-threatening cancer.

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Not applicable.

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