The Invisible Effects of Therapeutic Failure

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Disclosures: Robert Buckman: None.

The content of this article has been reviewed by independent peer reviewers to ensure that it is balanced, objective, and free from commercial bias. No financial relationships relevant to the content of this article have been disclosed by the author or independent peer reviewers.

THE ELEPHANT IN THE ROOM

To a greater or lesser extent, we all feel frustrated when our treatment does not affect the outcome or the course of our patient's cancer. The effects of the failure of therapy may feel as if there is an "an elephant in the room," a presence that markedly hampers communication between oncologist and patient, but that is rarely discussed openly or even acknowledged. In the current medicopolitical analysis of the cost of health care and public satisfaction with it, now is an appropriate time to discuss some of the factors that contribute to the more subtle effects of that "elephant," and to consider approaches that may help reduce and cope with the disappointment and frustration created when treatment is ineffective.

EFFECTS OF TREATMENT

It starts with the treatment itself. In medical oncology, treatment is often arduous and difficult to bear, compared with treatment in other specialties. In treating hypertension, for instance, a physician knows that in most cases the hypertension will respond to one or more of the available medications: if one antihypertensive is ineffective, or causes unacceptable side effects, there will be other effective options. No internist treating hypertension—unlike oncologists treating many types of solid tumors—is confronted by

the prospect of a recommended treatment being effective in only (let us say) 40% of cases and having no effect on blood pressure or survival in the other 60%. In addition, antihypertensives do not usually cause nausea and vomiting (even if controllable), fatigue, loss of concentration and memory, alopecia, and neutropenia, among other side effects. Simply having to describe these potential side effects is difficult and unpleasant for the medical team, and may even make the treatment seem to contravene the Hippocratic Oath, which stipulates that the physician should do no harm.

Furthermore, past advances in chemotherapy have set the bar very high. In the 1960s and 1970s, mechlorethamine–vincristine–procarbazine–prednisone (MOPP) and multidrug regimens totally transformed the prognosis of Hodgkin's lymphoma and acute lymphoblastic leukemia of childhood. Although there have been major advances in adjuvant and targeted therapies since [1], the "new MOPP for common solid tumors" has remained largely elusive to date.

EFFECTS OF UNPREDICTABILITY

These general problems are made worse by the fact that we usually cannot make accurate predictions of efficacy (or lack thereof) in individual cases. Furthermore, the factors mentioned above—response rates that are far short of 100%, and a

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high chance of side-effects—make the impact of unpredictability on patient and physician worse. If the treatment has many side effects, then it is even more important to know whether it will actually work in this individual case or not. If the treatment has few side effects and is inexpensive (such as most endocrine agents in receptor-positive breast cancer), this may not be a major problem. But when the therapy has major side effects, and/or is costly, then the balance between the toxicity of treatment and its impact on survival and quality of life becomes more difficult. For this reason, predictive tests—such as human epidermal growth factor receptor predicting response to trastuzumab and mutations of the *k-ras* oncogene predicting for resistance to therapy—by reducing unpredictability, will become even more valuable and important in the future.

PRODUCTIVE AND UNPRODUCTIVE OUTCOMES

Of course, many of the effects of failure of therapy act as spurs to increase our efforts to improve treatment, and are thus highly productive. Tremendous advances in the knowledge and treatment coming from clinical and from basic research, and concurrent advances in the relief of symptoms, including the development of the entire specialty of palliative medicine, have been partly fuelled by our dissatisfaction with the status quo and our urge to produce improvements. However, although there are many productive outcomes, there are also some unproductive ones.

It requires greater effort and more time to provide clinical care when the patient's disease is progressing. A patient who is receiving adjuvant therapy or is a "well follow-up" is likely to be pleased, as is the clinician, and the interview may be short [2]. However, if the disease has recurred or is progressing, the interview is inevitably more emotionally charged, and demands a greater amount of time and attention. This may, in itself, cause the clinician to feel pressured or daunted or both, and may contribute to burnout [3].

Furthermore, time constraints may themselves further increase the tension in the interview, because it is often more difficult to make effective plans for the patient's condition when one is feeling "under the gun." Even though some oncologists respond positively to that increase in demand, many do not. The resulting sense of irritation and pressure may sometimes be transferred to the patient, manifesting itself as blaming the patient: a negative outcome that originates not in the interaction between the clinician and the individual patient but in the failure of therapy.

EFFECTS ON COLLEGIALITY

The same elephant in the room may also affect our relationships with colleagues within our specialty. Although the emotional atmosphere is not measurable or quantifiable, it is likely

that treatment failure makes us more impatient and frustrated, and may sometimes cause healthy academic debates to escalate into ad hominem attacks and factionalism. Furthermore, these feelings may also prompt us to take that failure personally, even occasionally causing clinicians to feel that "if my treatment doesn't work then nobody else's can," sometimes rejecting other options when their own chosen regimens have been unsuccessful. One patient caught in that situation rather aptly termed it "the God in the manger syndrome." Even though this assessment was perhaps harsh, the outcome may be perceived in that way. The root cause of the physician's reaction may not have been a matter of professional ego, but rather a difficulty in recognizing and acknowledging the disappointment caused by the failure of therapy.

EFFECTS OF EMOTION

In general, patients' emotions pose many problems for physicians, and studies show that, although some oncologists are good at responding to them, in many instances this may not happen. A recent paper showed that oncologists respond to an emotion expressed by the patient (an empathic opportunity) in only 22% of cases [4].

This is only one finding, but there may be many reasons for it.

First, many of us were not taught (or shown) how to respond to a patient's emotions, and so we may fail to do this partly because we simply do not know how. Whereas auscultation of the heart, or examination of the abdomen, is appropriately considered as a core professional skill, responding to a patient who is crying or shocked seems almost mysterious, and is not yet universally considered a core skill. Fortunately, the required techniques are becoming better known and more widely adopted in medical schools, so that further improvement may be expected.

Second, we may instinctively avoid exploration of strong emotion because we fear opening a "can of worms" that will be difficult or even impossible to resolve. Yet, dealing with an emotion does not mean that we have to resolve the clinical problem that provoked it (such a thing is often impossible). Simply listening to the patient and acknowledging an expressed emotion is a therapeutic intervention in itself, and may be much appreciated.

Third, there are still some negative connotations attached to the word "emotion." In the past, the word emotion was often used interchangeably with "sentiment," which carries some pejorative and judgmental overtones. Even the simple acknowledgment of a patient's emotion was formerly discouraged by the medical establishment and, although rarely phrased as such, was commonly regarded as a sign of "weakness."

Fourth, discussions that focus on the patient's emotions

may be regarded as blurring the boundary between professional and personal issues. In the past, conventional wisdom regarded the physician's job as limited solely to looking after the disease, which can be assessed objectively, and did not include attention to any emotions triggered by those events that are, by definition, subjective.

Finally, the more strongly we identify features that are common to the patient and to ourselves, the more painful it becomes for us to deal with the patient's deterioration. The more we have to acknowledge that "there, but for fortune, go I," the more painful the failure of our therapy becomes.

Ultimately, interactions at difficult times are interpersonal exchanges between human beings. Just as the patient is a complex produced by the disease process as experienced by the person ("patient = disease + person"), so the physician possesses not only detailed knowledge and technical skills, but also the interpersonal potential required for their efficacy ("doctor = treatment + person"). The fact that there is a human being on both sides of the interaction means that valuable support can result.

WHAT WOULD REDUCE THE IMPACT OF THESE EFFECTS?

As with any elephant in the room, the first step is to recognize and identify it, and acknowledge its existence overtly.

The recognition of—and then the freer discussion of—the frustration and disappointment that we all may feel, will undoubtedly reduce the impact and the toll that these reactions exact.

Second, we now have the tools and practical techniques for dealing with these problems. There is ample evidence that the empathic response, the central technique for dealing with unacknowledged emotion and a relatively straightforward practical technique, can be taught and learned in communication skills courses [5] with videotaped "how-to" examples [6].

Ultimately we will come to regard the activity of dealing with these effects as a routine—and central—part of the work of the oncologist, not merely as a specialized or advanced skill that may be called upon in exceptional circumstances.

Our patients need us most during periods of major clinical change, and there is no doubt that we can be successful as physicians even when—and particularly when—the treatment fails. In fact, this can be an insightful and revealing experience for all parties. As the Stoic philosopher Epictetus put it: "difficult circumstances are the things that show us who we are" [7]—a perspective that can only encourage and support us as oncologists.

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