



## PALLIATIVE CARE CASE OF THE MONTH

“If she is dying anyway, why not give her more chemotherapy?”  
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**Case:** BP is a 65-year-old woman who was admitted to the hospital with weakness and worsening abdominal pain in the setting of known pancreatic cancer. She had received two lines of chemotherapy, both of which she tolerated well, and most recently was on a drug holiday. Palliative care was consulted for goals of care because scans showed disease progression, and her performance status had declined from PPS of 80 to 60%. From the oncologist, further chemotherapy was expected to provide only a 10-20% chance of 6-month survival. On bedside interview in the presence of her family, her husband recounted her course with cancer remarking how well she had tolerated treatment thus far. In view of disease progression, I brought up planning for the future considering that time ahead might be limited. The husband said that “if she’s dying anyway, why not give her more chemotherapy?”

**Discussion:** The question makes us really uncomfortable. It worries us because we know how much suffering can occur between dying and death. For the husband, however, nothing could be worse than death. From that point of view his question makes sense. Lastly, we worry we will have a long conversation with the family and still end up doing all possible aggressive medical intervention until her death. Given the importance of setting realistic goals and of our participation in these discussions, it would be helpful to develop a framework that allows us to be less defensive.

First, consider the question as a statement of emotion rather than a request for continued treatment. Just like the statement “she is a fighter” does not inform the patient’s value, this is also an emotional statement that hides the patient’s fear of dying and the family’s fear of losing their loved one. We often approach end-of-life discussions as being a means to determine what a person wants; whether they want chemotherapy or not, whether they want to be resuscitated or not, whether they want hospice or not. Instead, a large part of our task is actually to help people negotiate the overwhelming negative emotions they experience when talking about end of life: anxiety and fear of suffering; leaving loved ones; and financial duress.<sup>1</sup> Helpful, empathic responses can be “It must be incredibly hard to think about your \_\_\_\_\_ not getting better,” or “I can see this is incredibly difficult”, or to name how sad it must feel “I can’t even imagine how sad you must feel”.

Second, rather than working on convincing the family to choose one way over the other, we could ask the family if they want information. “Would you like to know why we typically do not do this?” If they say yes, provide information about the possible harms of the medical intervention. In this case, chemotherapy is likely to cause more side effects such as weakness, tiredness and increased risk of infection likely resulting in repeated hospitalizations and perhaps precipitating a stay in the ICU.

One way to say that would be “For patients who are in a similar stage of their disease process, chemotherapy is going to cause more harm than good. I worry that you would end up coming back to the hospital or even have to go to the ICU, decreasing the quality of life you have enjoyed until now. All of this may not be a good use of the limited time ahead.”

Third, be clear about the options. The family may be questioning the fairness of the FDA’s compassionate use policy or not understand why certain drugs are not available in the United States. As a clinician, it is not helpful to get into a discussion of the risks and benefits of this. Acknowledging that the family feels it is unfair is the most one can do. So, it would be ok to say that “Although it seems unfair, our system does not allow this.”

**Resolution of Case:** In response to the husband, I endorsed how well the patient had tolerated past chemotherapy regimens, and I said “I wish that further chemotherapy would be as helpful as it has been in the past, and I wonder whether we could talk about if things did not turn out that way”. This was met by silence, after which the patient said she was active in charity work and also had some advice she wanted to share with her children. The patient and husband recounted their travels together and the places they still wanted to visit. Toward the end of the meeting, I urged the patient and husband to make sure they share with the oncologist what they would like to focus on. In an email to the outpatient oncologist who had initiated the consult, I summarized what was important to them so that he could continue helping them with decision making.

### References:

1. Gawande A. Being Mortal; 2014.

*Personal details in the case published have been altered to protect patient privacy.*

For palliative care consultations please contact the Supportive and Palliative Care programs at PUH/MUH, 647-7243, pager # 8511, Shadyside, 647-7243, pager # 8513, Perioperative/Trauma Pain, 647-7243, pager # 7246, UPCI Cancer Pain Service, pager 644-1724, Interventional Pain 784-4000, Magee Women’s Hospital, pager 412-647-7243 pager # 8510, VA Palliative Care Program, 688-6178, pager # 296. Hillman Outpatient: 412-692-4724. For ethics consultations at UPMC Presbyterian-Montefiore and Children’s pager 958-3844.

With comments about “Case of the Month” call Dr. Robert Arnold at (412) 692-4834.