Doc, I Don’t Want Your Poison

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Mrs. A. is a bright and intense 58-year-old woman. She is married and the mother of two sons. She is a Catholic who practices meditation, has trust in natural medicine, and believes that the mind has control over the body’s physical well-being. We met her in 2003 when her mother was diagnosed with lung cancer, which eventually led to her mother’s death. During this period, although Mrs. A. clearly trusted our therapeutic approach, she also prepared some homeopathic remedies for her mother, such as Bach flowers. When her mother passed away, Mrs. A. thanked us for our work. We remained in touch, and every Christmas she sends us handmade presents.

In April 2010, Mrs. A. found a lump in her left breast. After consultation with a doctor practicing complementary and alternative medicine (CAM), Mrs. A. concluded that the lump was a sign of psychological distress and did not undergo any further diagnostic procedures. However, the lump did not disappear. Six months later, Mrs. A. finally underwent a mammogram and biopsy; breast carcinoma was diagnosed. In December 2010, Mrs. A. underwent a quadrantectomy with sentinel node excision. At the follow-up examination a few days later, we discussed the biology of her tumor, which involved a risk recurrence worthy of adjuvant therapy. We proposed a standard chemotherapy regimen including trastuzumab, radiotherapy, and hormone therapy. Mrs. A. calmly but firmly refused all the suggested treatments, saying that she did not want to be poisoned and have her immune system destroyed. We did not make any negative remarks about her decision, but we asked her to consider another meeting to further discuss treatment options. She said, “Ok, I’ll think about it.”

Most patients with cancer accept the treatments proposed by their oncologists, even when the clinical evidence is likely to be modest [1]. Most women who undergo adjuvant chemotherapy for early-stage breast cancer consider its benefits to be worthwhile, whereas only 1%–2% of patients would not repeat chemotherapy regardless of the magnitude of potential benefit [2]. Approximately 25% of patients with breast cancer prefer to be the sole decision maker about adjuvant therapy options, with the desire for decisional control increasing after medical consultation [3].

The widespread availability of web-based medical information and internet forums in which patients share experiences and opinions may complicate the oncologist’s decision-making approach [4, 5]. Moreover, CAM is a growing field in oncology, with one study reporting that 80% of patients have used these therapies at least once [6]. Patients are motivated by the perceived absence of toxicity in these approaches, even though only 37% of patients believed that they could be cured in this way. Of note, almost half of interviewed patients wanted more control over their medical care [6]. In the setting of adjuvant therapy for breast cancer, most patients use CAM as an additional therapy rather than as an alternative to the established medical practice [7]—a behavior that is usually harmless. In contrast, there are serious negative consequences in term of survival rates when the standard oncologic treatment is withheld in favor of CAM [8].

When an oncologist is faced with a mentally competent patient who makes a medically irrational choice, it is important to separate this irrational preference from the rest of the patient’s values and beliefs [9]. Although physicians propose therapies based on a set of specific measurable goals (e.g., survival, morbidity), patients’ decisions are ultimately based on a complex system of personal values, beliefs, experiences, and emotions [10–12]. Interestingly, a patient who refuses treatment often seems to assume that this choice terminates the patient’s relationship with the oncologist [13].

Studies on how patients with cancer develop trust-based relationships with their physicians are limited. The few published studies show that professional competence, honesty, and patient-centered behavior are the main enhancers of trust [14]. Addressing the emotional needs of patients is a fundamental task during the medical encounter. Emotional support
REFERENCES


