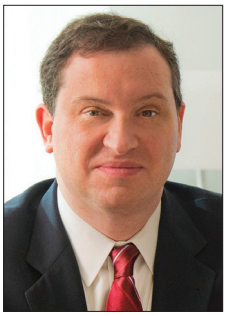
Debate, Argument, or Discussion?



At a recent debate on the treatment of CLL, I was going head-to-head with a colleague regarding whether BTK inhibitors or venetoclax should be first-line therapy. I debated vigorously, confident that my position was correct. Of course, my colleague did the same. In the end, and as expected, there was no winner; both are excellent therapies, and one is no better than the other. One could argue that debating between BTK inhibitors and venetoclax is a prime example of the ability of academicians to pontificate on anything, regardless of its significance. We were not debating chemoimmunotherapy versus novel agents, or the merits of tax breaks for corporations.

In our world of self-determination and freedom of choice, we allow patients to make their own choices, even insist that they do so, regarding treatments affecting the management of their medical conditions and their lives. (The question of choice is so ingrained that it has become a major point of contention regarding the public health measures to be taken against COVID-19.) Choices regarding cancer treatment can be extremely complicated, however. We are dealing with patients who are already struggling with their own mortality, given their diagnosis. We then present to them multiple, complicated treatment options, with long lists of differing adverse event profiles, logistical concerns, and financial hurdles. At the end of the presentation, our training tells us to ask patients what they want to do. It is almost as if we are anointing them as experts on the basis of the short course we have just provided.

Once patients understand their treatment options, along with their varying chances of success, risks, toxicities, and disruptions to quality of life, they need to decide on how much suffering they are willing to endure to attain a hoped-for best outcome. The decision may be simpler for patients who are deciding between treatment options when a cure is possible. But what about the patients for whom that is not part of the discussion? These patients are in a situation that forces them to decide on how much suffering they are willing to endure in their final years or months.

It is vital that patients be engaged in these discussions because it is their lives—both the length and the quality—that are being affected. For a physician, helping a patient to make an informed decision should count as a success, regardless of the outcome. Patients may discount our recommendations because of specific wishes or desires. They may even be driven to their decisions on the basis of fear and anxieties. But what do we do when patients discount our recommendations on the basis of "faulty" assumptions? I placed *faulty* in quotes because even though we may believe that the reasoning a patient is using is faulty, the patient certainly does not.

These decisions cannot be glossed over with a "we cannot win them all" sigh. I am not referring to a patient refusing a COVID-19 vaccine out of fear of being magnetized by the vaccine. We have all encountered this type of problem too often. I am more concerned about the patient who insists on proceeding with an allogeneic transplant for low-risk CLL because it is the only curative option. Or even the patient who has CLL with *TP53* dysfunction and wants chemoimmunotherapy instead of BTK inhibition because a friend died unexpectedly while on a BTK inhibitor. Our patients' "N of 1" experiences are all they know. We may be powerless to convince them otherwise.

What is our responsibility to such patients? Their desire for an allogeneic transplant or chemoimmunotherapy is contrary to what we believe. It is easy enough to "pass the buck" to the next physician by sending someone for a bone marrow transplant consultation. But what about having to write the chemoimmunotherapy orders? You are being made to order a potentially toxic treatment that you do not want to give. What options do you have to counter the patient's decision? Can you refuse to treat the patient? Refer the patient to another provider? Referring the patient may significantly delay the initiation of therapy and lead to other issues. Should you do what the patient requests, even if you know it is not the best option?

As physicians, we hold an esteemed place in society, not only because of the life-and-death decisions we make but also because of our insights into the nature of humankind. We see beliefs, thoughts, and behaviors that few others do. But it is also our struggle to provide the best care to our patients—in some cases, despite themselves. I am sure we have all encountered some of these scenarios. I would be interested in hearing about such cases from you. As for me, I'll let you know how treatment turns out for my complicated, opinionated patients.

Sincerely,

Richard R. Furman, MD