

## What Would You Do?

As oncologists, how many times have we had to answer the question, “What would you do?” There is always the temptation to answer it with a straight-up, “Well, in my opinion, you should ...” or dismiss it with the reply, “It’s your decision.” And yet, we all know that is not what we should do. We live in an age of shared decision making, in which we are entrusted to impart our knowledge and experience to patients so they can factor in their personal priorities and together we can decide what is best for them. Still, patients ask this question, which to me is a signal that they are not feeling comfortable with the shared decision-making process. So, how should we answer? Below are two examples of recent doctor-patient interactions that I hope will shed some light on how to handle this vexing question.

In our multidisciplinary prostate cancer clinic, all my patients with newly diagnosed disease are seen by me and by my colleagues in urology and radiation oncology. We usually discuss the cases and any unusual features that might complicate treatment with one another, but most of the time the cases are straightforward, and multiple treatment options are available. Such was the situation for a 68-year-old man with unfavorable intermediate-risk prostate cancer. Although imaging showed no evidence of metastasis, our data suggested that he had a 30% to 50% risk of recurrence after localized therapy. He had already met with my other colleagues and heard the pros and cons of surgery vs radiation therapy with a short course of hormonal therapy. After a brief discussion, he asked me the question, “So what would you do?”

I said that personal priorities play a role in this decision, which can change according to life circumstances. Then I explained the ways in which I was different from him: 10 years younger and still working, with a heavy burden of responsibilities and time commitments. So, I would be motivated not just to treat the cancer definitively but also to learn where I stand so I could plan the next 10 years of my life accordingly. Then it hit me: the real difference between him and me was that he had a new diagnosis of cancer and I did not. This is the emotional component of dealing with cancer that we shouldn’t deny. It’s the elephant in the room, and we must face it. So I asked him, “How do you feel about having cancer?”

Recognizing the emotional component of cancer is an underappreciated step, and probably the best way to connect with patients. In this case, he opened up about his

fears and let me affirm his feelings while also addressing some misconceptions. We discussed how he was not alone in this experience. I offered to connect him with our prostate cancer patient support group. By the end of our meeting, he was feeling more comfortable with a nonsurgical approach. Was that what I would have chosen? Maybe not, but without factoring in the emotional component of a new cancer diagnosis, I am not sure how complete my answer would have been.

Another situation that stuck with me came on a Zoom call last year with an 84-year-old patient who lived in the mountains of western North Carolina. This patient, who was co-managed by me and his local oncologist, presented with stage IV prostate cancer in 2021. Over the course of four years, he had been treated with a sequence of life-prolonging therapies: androgen deprivation, abiraterone acetate, radium 223, docetaxel, and lutetium 177 PSMA; while he was on the last of these his disease had progressed, with worsening liver metastases and anemia. His voice was weak, and I could see that he had lost a significant amount of weight. I knew that he was dying.

We made some small talk before transitioning to treatment options, which included palliative cabazitaxel chemotherapy and cyclical/bipolar testosterone. Then I brought up hospice as an alternative. He asked what I thought his prognosis was, and I told him about 3 months. He was not surprised. He then asked what I would do. I first told him that I really cared about him and didn’t want to see him suffer. Then I said that the treatment options had a small chance to extend his life, but without hospice, it was more likely that complications would develop that would land him back in the hospital. I then told him that hospice is a personal choice and is not so much about giving up but rather about facing mortality and being responsible for the people we love who will be hurt most by our passing. When he nodded, I knew I was speaking his language. “Well, that’s it, then,” he said. We hung up shortly thereafter. Afterward, I sat for a few minutes alone, thinking, *Is that what I would do?*

Sincerely,



Daniel J. George, MD

