

A psychological commentary on the relationship dynamics underlying cancer overtreatment in advanced cancer patients.

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Abstract

To prolong life as well as to relieve symptoms, patients with advanced or relapsed cancer are overtreated with antineoplastic agents before they die. On the other hand, prescribing anticancer treatment can be considered a substitute for a relationship that has become more and more difficult as the disease worsens. The aim of this commentary is to reflect on this theme, with particular reference to its psychological implications for oncologists and cancer patients.

Keywords: Cancer; Overtreatment; Oncologist-patient relationship; Hope

Introduction

The cancer burden in Europe is estimated to have risen to 2.7 million new cases and 1.3 million deaths in 2020[5]. When comparing data over different time periods, it can be said that about half of cancer patients die of their disease. To prolong life as well as to relieve symptoms, patients with advanced or relapsed cancer are overtreated with antineoplastic agents before they die. Despite the crucial contribution of integrating early palliative care in cancer management[14], no definitive change in the overtreatment of cancer patients with advanced disease, particularly those at the end of life, has yet been seen [9]. Hospitalisation in advanced-stage disease, given its poor prognosis, can itself be considered a form of overtreatment [4]. From 2003 to 2010, the use of chemotherapy increased by 67% in the U.K., which led to an excessive “pharmaceuticalization” in oncology. A similar phenomenon, albeit to a lesser extent, was seen in other Western countries [3]. Nevertheless, chemotherapy in cancer patients with advanced disease is often ineffective [13] and aggressive [10]. With the advent of molecular targeted therapy and immunotherapy, the drugs available to oncologists over the last 20 years have increased by 70%. No one denies the improvement, even considerable, provided by these new therapies to metastatic cancer patients’ survival. It is equally true, however, that many of these treatments do not meet the patients’ expectations in terms of prognosis, nor sometimes even correspond to the results of randomized controlled clinical trials [6]. Given that oncologists frequently avail themselves of anticancer drugs, patients’ expectations concerning their life expectancy have likewise increased. However, prescribing ineffective cancer treatment can be considered a substitute for a relationship that has become more and more difficult as the disease worsens. The aim of this commentary is to reflect on this theme, with particular reference to its psychological implications for oncologists and cancer patients.

Cancer overtreatment as therapeutic illusion

When a patient’s cancer becomes advanced, the oncologist-patient relationship changes. While aware of the fact that the only outcome possible is the patient’s death, oncologists are often reluctant to communicate prognosis. Faced with the patient’s death, the most convenient option available to the oncologist is to prescribe further anticancer agents, as if the metastatic threshold had not been crossed, with the implied objective being to maintain the status quo of living with cancer (or even to achieve complete recovery). Notably, cancer patients with advanced disease claim they do not know their prognosis

is poor nor that the treatment they are undergoing is only palliative [15]. The patient is deeply reassured, and the oncologist feels as if the disease can still be controlled. Thus, they complicitly deny death, or even the worsening of the disease; the void created by the unsaid is filled and exorcised by a multiplication of medical interventions (treatments, medical visits, diagnostic tests). When informed that their clinical situation has worsened, cancer patients often turn to another specialist for a second opinion. These patients are looking for a more complete explanation regarding how serious their disease really is, for treatments that are potentially more effective, or even only to be reassured that their oncologist is managing their case appropriately [8]. The oncologist experiences the patient’s search for a second opinion as a defeat, which is at times accompanied by the more or less explicit fear that another oncologist will not confirm the appropriateness of cancer management so far. A second opinion, as the patients’ right, should lead to a discussion of the case among colleagues and shared with the attending oncologist [11], but it often leads to overtreatment [12]. Both overtreatment and the at-times repetitive request for a second opinion cultivate the illusion that there are endless therapeutic solutions, which implies the omnipotence of medicine and the patient’s immortality. A therapeutic pseudo-alliance is formed, which is presented as ideal but which in fact only mystifies the situation on many levels. When the disease persists, and even more so when it worsens irreversibly, the patient’s mind, subject to unfamiliar emotional pressure, may cling to miraculous fantasies. As Freud reminds us [7], “At bottom, no one believes in his own death, or, to put it another way, in the unconscious every one of us is convinced of his own immortality.” Thus, at least right then and there, the patient with advanced cancer accepts the oncologist’s proposal to continue with further cancer therapies; this allows both to avoid facing the end-of-life experience.

Open and honest communication as a hope-giving process to reduce overtreatment

We strongly believe that when all effective cancer therapies have been

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exhausted, the oncologist must inform the patient openly and honestly of the prognosis; from this moment onwards the oncologist-patient relationship will necessarily evolve towards greater transparency. This change will undoubtedly be painful but is also potentially enriching for both. Further, it is useful to treatment decision-making. The oncologist must be willing to accompany a patient who is waiting for the end. This moment can be dramatic for the patient, who must not only give up any idea of surviving but also risks feeling abandoned, no longer counted among the curable, the living. The realization that the end is near may, from this point on, result in the patient's feeling condemned, as if already dead. In his article, Bustamante (2001) observes that subjects deal with critical situations according to their personality and their way of hoping. In the initial phase of facing one's disease, patients, while expecting to recover, still fantasize about the progression of their cancer and of impending death. Subsequently, when their cancer responds to treatment, they hope to avoid any recurrence, sometimes resorting to thoughts and behaviours that give them a sense of regaining that control initially lost. Should the prognosis worsen, the process of hope deepens, and the oncologist must change accordingly. Strongly reasserting the principle of residual quality of life, Bustamante emphasizes the need to understand the patient as a whole person, with all the prerogatives of a symbolic animal (conscience, emotions, inner world, belief system, need to love and be loved). Facing death, a new type of hope emerges, fully rooted in the historical and personal reality of each individual, including, but not limited to, the hope that pain will disappear, the hope of receiving the visit of a loved one, the hope of life after death, and so on. Bustamante adds that terminal patients tend to sleep a lot, as if their psychic activity were concentrated on internal processes. Accompanied and supported by the oncologist, the patient's processing can generate further hope and comfort, even to the point of achieving self-reconciliation. Thus, open, honest communication between the oncologist and patient can itself be considered a hope-giving process. In the light of these reflections, hope would ascend to an existential category of great importance at the end of life. Being able to think of a life after, and without, oneself in the here and now is a psychic process of extraordinary significance and awareness; it is not just one generic expedient among many, but a realistic point of arrival. The pain involved in the change in the relational status naturally concerns oncologists as well, who must admit that they can no longer keep their patient alive for long (a pain that is just as complex); they must find within themselves the courage, the willingness and the inventiveness to navigate end-of-life care with the utmost lucidness and closeness. Nevertheless, since this process can also activate anguish, guilt, remorse and suffering, oncologists must forestall this risk with an attitude that is as restrained and as unconventional as possible. In this sense, being exclusively in the care of a palliative team or hospice may awaken in the patient the same anguish mentioned previously: the oncologist, who can heal or make the patient feel better, no longer takes care of the patient. No matter how essential palliative care is, delegating end-of-life care exclusively to another team entails the interruption of

a relationship between the oncologist and patient that has often lasted for years. In our opinion, oncologists should not "disappear"; they should always be there to witness, with empathy and participation, their patients' end-of-life care.

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