

CONSULTATIONS IN ETHICS

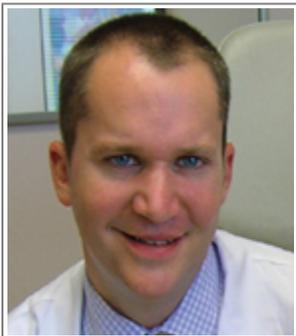
A Wife Asks for Futile Therapy for Her Husband, a Fighter: How to Respond?

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I was asked to see a patient with widely metastatic renal cell carcinoma in the ICU. He is a 47-year-old man who had a large, clear-cell primary renal cell carcinoma resected 21 months ago; had a recurrence in retroperitoneal lymph nodes, bones, and lungs; and was treated with three lines of therapy but had no response and continued to progress. In the 6 weeks prior to the current hospital admission, he became progressively more debilitated, was eventually wheelchair-bound, and became increasingly short of breath. When he was admitted, he was in florid respiratory failure from compression of his inferior vena cava and right atrium and compression of his left lower lobe bronchus. He was immediately intubated and sedated; he eventually became paralyzed because of progressive worsening of his respiratory status. I saw him as a consult and visited nearly every day for 5 days. His wife, who is his primary spokesperson, has continued to demand that I provide him with [sorafenib \(Drug information on sorafenib\)](#) (Nexavar), since she read that it works in kidney cancer and it is one of the treatments he has not tried. She says that he was always “a fighter,” competing in triathlons even after his diagnosis. Should I provide the patient with sorafenib, just to satisfy his wife, since it is unlikely to do much harm?

Dr. Helft Responds



Paul R. Helft, MD

One way of framing the ethical question in this case might be: “What are my ethical obligations to provide an anticancer therapy when I think it is unlikely to benefit the patient?” The broader clinical questions involved in this case, although more acute because of the advanced nature of the patient’s situation, are fundamentally the same in most patients, not just those who are in extremis. They have to do with the risk-benefit ratio of a given treatment, what is known about its response rate and benefits in patients similar to the patient at hand, and whether the patient is otherwise a candidate for the therapy. In this case, I would argue that neither

sorafenib—nor any anticancer therapy—has essentially any chance of providing any benefit with respect to the quantity or quality of this patient’s life. He is actively dying. Sorafenib, like all anticancer therapies, has side effects, although this particular patient may not even live long enough to experience them. This makes the risk-benefit ratio of any anticancer therapy, including oral targeted drugs, very poor. So the “simple” answer is that you are under no ethical obligation to provide a therapy that you think will do the patient more harm than good.

Several other features of this case are worthy of comment, however. First, I think it is important to emphasize that the best way of dealing with a request like this might be characterized as “compassionate refusal.” This involves listening carefully to the request, taking it seriously and not immediately dismissing it, acknowledging the place of deep pain that the request comes from on the part of the patient’s wife, and framing the refusal in terms of lack of benefit to the patient (as opposed to reminding the patient’s wife about our ethical obligations not to provide therapies that are more likely to harm than to help—since framing it that way would make it more about us than about him). Careful attention to the wife’s emotional state and needs should remain the focus of the interactions. Also, use of the words “there is nothing more we can do” should be banished. There is always more we can do to relieve suffering and help patients and families with the acute phases of dying.

Second, when the patient’s wife commented that he was a “fighter,” it is easy to jump to the conclusion that, being a “fighter,” high-risk/low-reward therapies might be considered to be consistent with his preferences, and therefore ethically acceptable. However, Robert Arnold and other scholars of cancer communication have rightly pointed out that such statements might be better interpreted as statements of strong emotion, rather than specific descriptions of patients’ authentic preferences. In this case, a good response might include invitations to say more about him and his life and what he was like, and to offer “I wish” statements, such as “I wish so much that a medicine like sorafenib would help him to fight through this, but it won’t.”

The third issue, which will be obvious to most readers, is that even though the consultation was requested specifically with regard to the issue of providing sorafenib to the patient, it seems important to me to continue to interact with the patient and family beyond the refusal to provide the therapy, as much as anything to continue to convey the message that the “fight” is not only about taking anticancer therapy.

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