**Process and Content of Decision Making by Advanced Cancer Patients**

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Patient-physician communication regarding decision making is a complex and poorly understood area of cancer medicine. One of the main reasons for our lack of knowledge in this area is the deficiency of research regarding the process and content of patient decision making and how to improve it.1 In this issue, Grunfeld et al2 provide valuable information about the way breast cancer patients perceive their decision making regarding palliative chemotherapy. One hundred two patients underwent 117 40- to 60-minute interviews a median of 20 days after their key clinical decision-making consultation regarding first-line chemotherapy (70 interviews) or a median of 13 days after a second-line chemotherapy consultation (47 interviews).

The authors did not conduct recording of the consultations, and recall bias could have had considerable impact on their results regarding the process of the consultation. However, this study provides useful information about the patients’ perceptions. The medical oncologist was seen as the most important person in influencing the patient’s decision making with regard to first-line and second-line chemotherapy. The family, partner, nurse, and general practitioner were identified as having a significantly more limited role. The relative importance of family and partner might be quite different among some minority groups and in developing countries.3 However, these findings emphasize the fact that, in the United Kingdom and North America, decisions regarding palliative chemotherapy are made overwhelmingly as a result of a discussion between the patient and the medical oncologist. Therefore, physician/patient decision aids can be helpful in these key clinical decision-making consultations.4

The authors observed that approximately 47% of the patients took a passive decision-making role, 38% took an active role, and 15% took a shared role. The decision-making style could not be predicted by age, ethnic group, education, or marital status. Other studies have found a similarly wide variation in decision-making preference among breast cancer patients undergoing their first medical oncology visit5 or among palliative care patients attending their first consultation.6 The authors also report an apparent shift toward a more active decision-making role in the consultations regarding second-line chemotherapy. Other studies have also suggested that patients’ decision-making styles are frequently unstable.7 Patients who choose a more passive role at the beginning of their treatment may be more willing to make their own decisions after they have experienced treatment failure and adverse effects. These same patients may later develop more heavy symptom burdens including fatigue, depression, and pain, and they may be more willing to adopt a more passive decision-making style. Probably, the wide variability, lack of predictive characteristics, and instability of the decision-making style explain why physicians correctly estimate the patient’s preferred decision-making style after a visit in less than 50% of cases.8 What are the practical implications of these findings? In key clinical decision-making consultations, oncologists should ask whether the patients would prefer to make the treatment decisions on their own or after hearing the physician’s opinion (active decision-making style), whether the patients would prefer to make the treatment decisions together with their physician (shared decision-making style), or whether the patients would prefer the physician to make the treatment decision after talking to them (passive decision-making style). This information will help physicians conduct the consultation in the way that is most likely to be perceived as satisfactory to their patients.8

Grunfeld et al2 found that hope as a reason for receiving chemotherapy increased dramatically from being a factor of influence in 19% of patients receiving first-line chemotherapy to becoming the single main reason for patients choosing to receive second-line chemotherapy (43%). The authors argue that patients in their study seemed to be generally well informed but may not have been aware of their prognosis or alternatives to cancer treatment. A recent systematic review of literature on the communication of prognosis in cancer care found that the overwhelming majority of the published research has been conducted in the early-stage cancer setting, and therefore, there is limited access to evidence-based recommendations for the best modality of communicating prognosis in advanced cancer.1

As the possibility of controlling the tumor decreases and hope becomes a major reason why patients opt for receiving further chemotherapy, oncologists may find collaboration with palliative care teams particularly effective. Patients and their families are familiar with the importance of having a plan B in case catastrophic events occurred in their lives (eg, car insurance, trust funds for the education of children, and so on), even though they hope these events will not happen. Therefore, it is quite possible for them to be able to effectively plan for the possibility of needing enhanced care as a result of tumor progression and increased symptom burden while, at the same time, continue to receive second- or third-line chemotherapy in the hope that tumor regression can be achieved. Therefore, palliative care can be seen as completely
complementary to the patient’s cancer care plan, rather than as an alternative to be considered after the failure of second-line chemotherapy.

REFERENCES


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