CANCER CARE CHRONICLES

When "Rocking the Boat" Saves a Life

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It was 7:30 AM on my last day of inpatient service when my intern presented a case of an overnight transfer from the surgical suite. Mr S had been admitted with a bowel perforation from an aggressive lymphoid malignant neoplasm. As surgical interventions had failed and the patient continued to decline clinically with recovery unlikely, the team recommended hospice care. The surgical team cited open wounds, fistulas, active infections, and severe malnutrition as irreversible. Regardless of the underlying cancer, the team recommended comfort care and focusing on symptom control, suggesting that the ongoing issues would prohibit any meaningful therapy. The patient was transferred to our medical oncology service to complete arrangements for end-of-life care.

Despite his due diligence in arranging for a hospice meeting, case management, and social work, the resident gave an abbreviated presentation, skipping over details of the patient's history, physical examination results, and laboratory data, contending that additional information would not alter management. I seized the teaching opportunity and asked about Mr S's lymphoma subtype and prior therapies. Disappointed by the lack of satisfying answers, I explained the complexity of lymphomas and reminded them of the potential for cure.

Entering a dimly lit room, I saw a thin man lying in bed with a flat affect. He glanced at our overwhelming team of 2 interns, 2 residents, a pharmacist, and a student, and then turned his eyes back to a family photograph on the bedside table. I introduced myself and asked Mr S whether he understood his condition and plan. He looked at me with sad eyes, saying, "I am aware; when do I go home?" I answered, "We will work out next steps with the hospice team at 11 AM." I tried to get a brief history, not wanting to irritate him with redundant questions. I inquired, "Is your family around? Do they understand the goals of hospice care?" "They do," he answered calmly as a tear traveled down his cheek, "I want to fight this, Doc. Did you try everything you could?"

Somehow, I felt uneasy answering this simple question. I assumed that the surgical team had tried, but had they? Had I? Taken by surprise, I began to doubt the validity of the plan. I was now officially in charge of Mr S's case; he was under my care. Fifteen years of practice, hundreds of patients, and many invading gray hairs had earned me the courage to challenge a decision—a stance I might have struggled with earlier in my career.

I asked my intern to postpone the hospice meeting until we could learn more about Mr S and contact his prior institution. Disgruntled at the waste of time, and at me for "rocking the boat," he contacted the social worker. I sensed that my team members saw me as representing that aggressive breed of oncologists who continue unnecessary treatments. I decided to ignore the noise.

It took 4 hours to obtain his history, review slides, and piece together his prior course. Mr S had an aggressive large B-cell lymphoma with poor molecular features. His prior treatment had likely contributed to his bowel perforation. At 62 years, Mr S had no comorbidities, was previously healthy, and had adequate family support. It troubled me that no additional therapy for his lymphoma had been considered. Armed with my new information, I entered his room again, sat down, and asked him quietly why he had decided on hospice care. "I was told that this was the proper choice, my open wounds and these infections and 'bad bugs' will not go away," he said. His eyes lit with hope when I said, "What if there was another option that we could explore?" I continued, "It won't be easy and I cannot guarantee success, but we could work on healing your bowel perforation, controlling the infection, improving your strength, and then consider more chemotherapy."

As we discussed plans for rehabilitation, total parenteral nutrition, antibiotics, and psychosocial support, my resident and intern became more engaged. I realized that as an intern, I too would have hesitated to challenge a decision made by a senior physician who has already outlined a plan. I shared with them how asking colleagues about a decision is appropriate and in essence a patient's right.[1]

I wondered whether second opinions in oncology affect outcomes. I found a systematic analysis citing that 7% to 36% of oncology patients seek a second opinion. Changes in diagnosis, treatment recommendations, or prognosis as a result of the second opinion occurred in 12% to 69% of cases.[2] In 43% to 82% of cases, the original diagnosis or treatment was verified. Patient satisfaction with second opinions was high. Overall outcomes related to second opinions were not consistently reported. Studies on second opinions in patients who are recommended hospice care were not available, but I knew there was a positive effect for Mr S.

Now, 6 months later, Mr S has almost finished chemotherapy. He drives himself to his appointments and is delightful, upbeat, and optimistic. Cured or not, at least he got a chance to fight again. I learned from this experience that there are times when rocking the boat is the best strategy to fight cancer and provide realistic hope. I would rather rock the boat any day.

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