Treatment for cancer has gotten out of hand. For almost every type of cancer, there are now dozens of potential treatments, in what are often hundreds of combinations. And, what is infinitely worse, these treatments can be lined up one after the other in a seamless row so that when one treatment fails, a doctor and patient simply step up to the next one. It's gotten so that it's almost impossible to stop treating cancer, because doing so means saying "no" to the next treatment that is ready and waiting.

If you don't believe that this is a very real problem, you need look no further than the recommendations released last week by the American Society for Clinical Oncology (ASCO). The country's leading professional organization for cancer care, ASCO thought that this endless chain of treatment was concerning enough to draft a recommendation that, they hoped, would constrain the unfettered use of chemotherapy for advanced cancer. The short summary is that we tend to continue treatment for advanced cancer long past the point at which such treatment offers benefit. Their core message? Learn to say "no."

The real message in ASCO's recommendation, though, isn't what this organization said. Instead, to get a real sense of the depth and breadth of the problem of overtreatment in advanced cancer, just take one simple sentence. Oncologists, they suggest, should not use chemotherapy for patients very near the end of life, particularly when treatment has not been proven to be effective.

Does that statement seem a little odd? Think about it. Why should the premier oncology organization in the country have to remind physicians not to use treatment that doesn't work? Has overtreatment really gotten so bad that we need a national professional organization to tell us not to use treatment that is ineffective? Apparently it has.

I could understand that a professional society would recommend against specific treatment for given diseases. This happens all the time. An organization might review the medical evidence and conclude that, based on the balance of risks and potential benefits, the use of a particular treatment for a particular condition just doesn't make sense.

But this is different. ASCO isn't suggesting that oncologists avoid one treatment regimen. No, they're recommending that we don't use treatments that aren't effective. Don't do what doesn't work.

As advice goes, that's a little like telling doctors to "do no harm." It's good advice, I suppose. It's advice that difficult to argue with, in fact. Of course they should do no harm. And of course they shouldn't use treatment that doesn't work.

The problem, though, is that this advice is almost impossible to apply in the real world. Oncologists don't need to be told to avoid ineffective treatment, they need more guidance about what is and isn't effective. Perhaps more importantly, they -- and we ourselves -- need limits. It's not enough to say that we should avoid ineffective treatment, because the pull of those treatments is often strong enough to override reason and common sense and even the most forceful guidelines.

That's especially true because "effectiveness" is almost never a simple yes/no determination. We don't usually say that a treatment is or isn't effective in advanced cancer. Or if we do, we qualify that statement with numbers. That treatment is ineffective, we might say, because only 5 percent of patients respond with a temporary remission. Another treatment might also be called ineffective because it only improves patients' quality of life but it doesn't help them to live longer.

Are these treatments "ineffective"? I'm not sure, but I know that many of my patients would want to give them a try. And I suspect many of my oncology colleagues would offer these treatments as legitimate options.
So the blanket statement that oncologists and their patients should avoid ineffective treatment in very advanced cancer is unlikely to drive a major change in the way that oncologists practice. Nor is it likely to have a meaningful effect on the sorts of treatments that patients ask for, and expect. And it won't change the conversations that I have with my patients.

Instead, we'll need something stronger. We'll need guidelines that tell physicians not merely that they should do the right thing, but also how to do the right thing. We'll need clear guidance about which treatments offer what kind of benefits to which patients. But that's a tall order, and will require much more high-quality research evidence than we have available right now.

In the meantime, we need alternatives. We need to be able to choose between treatments whose effectiveness is uncertain and... something else. As a start, we could make it routine to introduce palliative care and hospice into all discussions about treatment for advanced cancer. This wouldn't take further chemotherapy off the table, but it would offer patients and their families an alternative.

First, rather than moving on to yet another round of a new chemotherapy drug, patients could routinely be given the option of a palliative care consult. That would help to make sure that they have an adequate opportunity to talk through their goals and preferences, and to decide for themselves whether more chemotherapy is really what they want. And a palliative care consult could be valuable in managing symptoms and improving quality of life in ways that don't require chemotherapy.

Second, we can be more organized in making sure that patients know they can choose hospice as an alternative to more chemotherapy. That choice isn't between yet another round of treatment or "nothing," but between treatment that might offer some benefits or comfort care that definitely will. It's a choice between uncertain effectiveness and predictable side effects, or a chance to make the most of whatever time is left.

I can't tell my patients how to make that choice. Indeed, I'm not even very good at predicting which way they'll lean when I describe those options. But I'm often surprised by how many -- even those who have been steadfast in their requests for every possible treatment -- choose the hospice alternative when it's presented.

ASCO's admonition to avoid ineffective treatment is unlikely to constrain the use of chemotherapy in advanced cancer significantly, because although it's good advice it's difficult to put into practice. And as a society we're not ready to impose the sorts of limits that tell patients they can't have further treatment after a certain point. But we can make sure that patients know they have a choice, and that they can make an informed decision about whether more treatment is really better.

For more by David Casarett, M.D., click here.

For more on cancer, click here.

FOLLOW US

Connect with your friends
Check out stories you might like, and see what your friends are sharing!
The City Where You're Most Likely To Get A Mosquito Bite Is...

Like
1k

Surprisingly Calcium-Rich Foods That Aren't Milk

Like
1k

'Big Love' Actor Luke Askew Dies Of Lung Cancer At Age 80: How Is Age A Factor In Cancer?

Like
27

Most Prescription Painkiller Abusers Get Drugs From Friends Or Family: Study

Like
26

Gladys Knight Eliminated From 'Dancing With The Stars' 60 Pounds Lighter

Like
74

'I Want To Be All I Can Be'

Like
105

12 Processed 'Foods' With More Than 25 Ingredients

Like
1k
You Tried It: Jari Love's Revved To The Max
Like
6

Are Allergies Actually Meant To Protect Us?
Like
21

Don't Miss HuffPost Bloggers
1 of 5

Mariska Hargitay
Violence Against Women Act Helps Restore Lives

Ted Kaufman
New Gangs in Politics

You Tried It: Jari Love's Revved To The Max
Like
6

Are Allergies Actually Meant To Protect Us?
Like
21

Don't Miss HuffPost Bloggers
1 of 5

Mariska Hargitay
Violence Against Women Act Helps Restore Lives

Ted Kaufman
New Gangs in Politics

Search The Huffington Post  Submit Query