in this study. Indeed, only 66 patients with mutated-PIK3CA tumors used aspirin after a diagnosis of colorectal cancer and only 3 of them died of colorectal cancer during the follow-up period.

Assuming these findings are confirmed in large prospective studies, one may predict that the PIK3CA mutation status of colorectal tumors will become a useful biomarker that may guide adjuvant therapy. Since more than one of six primary colorectal tumors harbors PIK3CA mutations,9,10 targeted use of adjuvant aspirin could have a major effect on the treatment of colorectal cancer. Aspirin may well become one of the oldest drugs to be used as a 21st-century targeted therapy.

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Talking with Patients about Dying

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Self-deception is a valuable personal coping tool. It allows us to aspire to significance, strive for new knowledge, and yearn to make a lasting contribution to the world despite the certainty of our inevitable end. Indeed, no arduous task would ever be undertaken if we were unable to exaggerate the benefits we expect from it and underestimate the difficulty of its accomplishment. Daniel Kahneman has called this the “planning fallacy,” our tendency to overestimate benefits and underestimate costs, and thus make foolish decisions to embark on risky pathways.

People have an optimistic bias. This optimism helps us cope with the inevitability of death, which Ernest Becker has described as our “denial of death.” So if you ask a dying person what they believe will be the outcome of a treatment that they have already decided to take, what do you think they will say?

In this issue of the Journal, Weeks and colleagues did just that.3 They asked nearly 1200 patients with metastatic lung cancer or colorectal cancer whether they expected their treatment to cure them. The authors found that the majority of patients with these conditions with a poor prognosis regardless of therapy felt that their treatment course was likely to “cure” them. Perhaps the problem here is the word “cure.” To a patient with advanced disease, it may mean something very different from eradication of all disease without return. It may mean an end to pain or a hope for a better tomorrow with fewer incapacities. If patients actually have unrealistic expectations of a cure from a therapy that is administered with palliative intent, we have a serious problem of miscommunication that we need to address.

This brings up other questions. Were the patients who were surveyed not actually told that their disease was incurable? Or were they not told effectively, did they choose not to believe the message, or did they fully understand the message but respond too optimistically to the questions posed by a stranger? It is probably a com-
bination of all four possibilities. Weeks et al. were not present in the examination room, but direct-observation studies have shown that two thirds of doctors tell patients at the initial visit that they have an incurable disease, but only about a third actually state the prognosis—at any time. It is not easy to tell patients that they are going to die, and most of us choose not to do it. This may explain why 2 months before death, half of all patients with lung cancer have not heard any of their doctors use the word “hospice.”

Patients also choose not to believe. When patients are given their actual prognosis, one third or more will not admit that treatment will not cure them. It is also critically important to remember that patients with cancer have a very different perspective from those without such a diagnosis. However, patients’ inability to write the word “terminal” on a survey may not prevent them from making advance directives and using hospice.

It is possible to tell patients more effectively that they have a terminal illness, a sharing of information that would enable them to better plan their remaining life. But they need help. Oncologists can help patients understand by giving personalized information. Nearly all patients want to know whether or not they can be cured, and the majority want to know their prognosis. An essential skill for practitioners is mastering the conversation known as “ask, tell, ask,” which consists of asking patients what they want to know about their prognosis, telling them what they want to know, and then asking, “What do you now understand about your situation?”

Truthful conversations that acknowledge death help patients understand their curability, are welcomed by patients, and do not squash hope or cause depression. We need help breaking bad news. This is not one hard conversation for which we can muster our courage but a series of conversations over time from the first existential threat to life. We recommend stating the prognosis at the first visit, appointing someone in the office to ensure there is a discussion of advance directives, helping to schedule a hospice-information visit within the first three visits, and offering to discuss prognosis and coping (“What is important to you?”) at each transition. This “best practices” model has allowed one large provider to double patients’ length of participation in hospice programs, maintain rates of survival, and decrease total costs. Concurrent palliative care increases knowledge of prognosis, helps alleviate symptoms, reduces stress on caregivers, may improve survival, and lowers costs.

These are not trivial issues. Chemotherapy near the end of life is still common, does not improve survival, and is one preventable reason why 25% of all Medicare funds are spent in the last year of life. Patients need truthful information in order to make good choices. If patients are offered truthful information—repeatedly—on what is going to happen to them, they can choose wisely. Most people want to live as long as they can, with a good quality of life, and then transition to a peaceful death outside the hospital. We have the tools to help patients make these difficult decisions. We just need the gumption and incentives to use them.

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