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## Commentary: Injecting hope without making false promises

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Discussing prognosis is challenging, and for many of us, uncomfortable. Surgeons are fixers by nature and want to believe our surgical intervention will cure patients 100% of the time. In addition, many surgeons believe that cancer prognosis discussions are the job of oncologists. I disagree. As thoracic surgeons, we are frequently the first consultant for a patient with a lung mass, and unfortunately the positron emission tomography scan done along the way into the office for that first visit sometimes shows metastatic disease. It is our duty to initiate biopsy, complete staging, orchestrate referrals—this means we have to be equipped to explain the findings and ramifications, including prognosis. For early-stage thoracic cancers, we are the only specialist involved and patients rightfully want to know their chances, so yes, it is our job to have these conversations.

We are taught to first do no harm. But as Matthews<sup>1</sup> so poignantly points out, honesty in discussing cancer prognosis and outcomes can be harmful, demoralizing, exacerbate depression, and worsen the quality of what may be a short remaining life span. On the other hand, unrealistic optimism adversely affects patient decision making about aggressiveness of care and will direct patients toward heroic measures when symptom management may be more appropriate. This feels ethically wrong; furthermore, it can contribute to excessive end-of-life spending on unnecessary or ineffective services.<sup>2</sup> Finding that balance is not easy. How should we relay statistics to patients in a way that makes sense, is honest, and doesn't completely deplete patients of hope?

The 3 most common approaches to prognosis discussions are realism, optimism, and avoidance (eg, my crystal ball is broken).<sup>3,4</sup> Trying to find that perfect balance of realistic hopefulness, peaceful awareness is the ultimate goal. One approach is to focus on concrete examples, using numbers



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### CENTRAL MESSAGE

It is part of our job as thoracic surgeons to discuss prognosis with our patients. We must strive for the delicate balance of realistic hopefulness and be thoughtful about how we deliver difficult information.

not percentages: Instead of saying 5-year survival is 50%, a better explanation may be, "If 10 patients had the same diagnosis as you, 5 years from now, 5 of them would still be alive." Another strategy is to lay out best, worst, and most likely scenarios<sup>5</sup>; this is a way to digest the statistics, and give a more realistic interpretation of numbers to patients.

Regardless of what kind of concrete numbers we state to a patient, we should never forget to give hope along the way as well. Even patients with stage 4 disease can get curative treatment with the advent of new therapies such as immunotherapy, which has opened doors previously sealed shut. Finally, the job of a good thoracic surgeon is never finished. By simply asserting that you will be there for your patients whenever they need you, you are a light in the darkest of tunnels.

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