



Art of Medicine

Rethinking failure and tolerance in oncology

When I received my first chemotherapy tablets, the literature was terrifying the insert warned against touching the pills or my bodily fluids without gloves. The bag read CAUTION next to a neon yellow biohazard symbol. Shared bathrooms were discouraged. I thought: if this treatment is so dangerous, why am I supposed to ingest it?

My question showed incomplete understanding of modern oncology. Treatment is both poison and cure; toxicity is not a side-effect but the treatment mechanism itself. Precautions do more than protect others—they train patients to understand themselves. Yet, necessary as they are, these warnings create a subtle barrier, signalling that the patient requires constant surveillance and implying they are hazardous.

In clinical practice, the body can feel less like a lived experience and more like a problem—especially in the language used to describe outcomes. When my tumour progressed during a clinical trial, the physician said, “You’ve had vorasidenib failure.” I nodded, but what I heard was that my body had failed. Even when not said aloud to patients, the language of so-called failed therapy permeates charts, oncology boards, insurance approvals, and clinical decisions. Medical records routinely document that a patient has failed prior lines of therapy; that wording follows the patient into eligibility criteria and future treatment decisions. Language intended as shorthand for biological response can attach itself to a person’s identity.

Conversely, when reporting gruelling side effects, I was frequently told that my treatment was well tolerated. When I picked up my first chemotherapy dose, staff suggested that because I was young, exercised, ate well, and was otherwise healthy (other than my incurable cancer), perhaps I wouldn’t need anti-nausea drugs. I spent the first night vomiting, and the next morning blowing leftover dinner out of my sinuses.

Medically, well tolerated meant no neutropenic fever or hospitalisation. In lived terms, it meant unrelenting nausea despite anti-emetics, ongoing seizures, and cognitive decline and fatigue following radiotherapy and chemotherapy—forcing me onto disability benefits, away from a job I loved, and estranged from my body. To call this lived experience tolerated creates dissonance: safety metrics are met while daily life unravels.

Cancer is often described as a failure of immune recognition—a breakdown between self and non-self. The body becomes a site of biological misidentification. Hearing my disease described this way—cells that had escaped notice or needed immune recognition—brought a quiet internal dislocation. Because the tumour was composed of my own brain cells, part of me began to feel foreign.

Yet, malignancy is not foreign like a virus is. My cancer arose from my own cells, carrying my genome and shaped by my developmental history. Immunologically, it occupies an uneasy borderland: altered enough to provoke recognition, continuous enough to remain me. If the cancer is made up of my own cells, where does it end and where do I begin? Am I myself—or am I not?

Contemporary immunology shows that the boundary between self and non-self is porous. Trillions of microbial and genetically distinct cells inhabit our bodies, influencing immunity and health. As a mother, I still likely carry foetal cells from my son. The human body is composite, plural, and dynamic. Cancer arises within this complex cellular community—a dysregulation of growth signaling in an interdependent system, not a neatly divided one.

Recognising this complexity does not eliminate narratives of invasion and betrayal, but invites language of stewardship and containment, not only eradication.

During chemotherapy, I noticed the burning, the nausea, rather than resisting them. Not as therapy, but to stay embodied—experiencing the medication as part of my care, not as poison.

Long-term treatment demands more than just physiological endurance; it requires staying at home in one’s own body. Reintegration may mean inhabiting a changed body without experiencing it as a site of failure or hazard. Reintegration is not a luxury of the recovered; it forms the psychological ground for continuing treatment.

Clinical precision is essential for patient safety and regulatory clarity. Yet, when carried from chart to bedside, this precision can become a second, inadvertent layer of injury.

If a treatment does not control the disease as intended, clinicians should acknowledge it as a failure or limitation of the therapy, rather than of the person.

Rather than calling a medication well tolerated, clinicians should ask, “How is this medication affecting your daily life?” The answer won’t change outcomes, but it can change how patients inhabit the months between scans.

Words matter—in charts, in conversations, in a note read at home. Oncologists do not have to be therapists, but they can be stewards of language, which shapes the terrain where patients build or lose a sense of meaning amid illness. Although the yellow biohazard label serves a purpose, the person taking the medication is not hazardous. Attending to language helps preserve that distinction. Precision in oncology should extend not only to molecular targets, but also to the words used to describe the people who live with cancer.

Catherine R Shteynberg
cshteynberg@gmail.com