# Ethical Perspectives on Oncology Care

By Terri Maxwell, RN, MSN, AOCN

Medical practice will always involve ethical considerations and dilemmas. Oncology professionals face dilemmas on a daily basis related to truth telling, balancing hope, the use of high dose opioids to manage symptoms at the end of life, withholding or withdrawing therapy, DNR (do not resuscitate) decisions, and issues related to resource allocation and informed consent. Many medical and nursing curriculums now include lectures on ethics, but few clinical practitioners feel completely prepared to navigate the complicated web of ethical and legal principles that guide ethical decision-making. Fortunately, there is increasing interest in bioethics in continuing medical education and most practitioners have ethics committees at their disposal for difficult cases.

The primary goal of enhancing one's understanding of ethics is to improve care for patients and their families in clinical situations. There are often conflicting values at stake in a clinical situation, and rarely are these situations "black and white." Too often, healthcare professionals impose their personal values on others in the name of technical expertise. When a physician decides to withhold the truth regarding a patient's prognosis to prevent the patient from "losing hope," they are imposing their own values, not examining the decision from an ethical or moral perspective. Moral questions in medicine do not have a medical solution. Ethical decisions must be based upon careful consideration of the ethical principles involved.

The three key ethical principles that frame end-of-life care in oncology are those of autonomy, beneficence, and justice. The principle of autonomy supports the tenet that the patient's own values ought to be considered. This principle questions whether patients are provided sufficient information about their prognosis in order to make truly informed decisions about their care options. The use of advanced directives was founded on the principle of autonomy. Advance directives allow patients to put in writing what their preferences for medical treatment would be if they were unable to express themselves because of serious illness or injury. Unfortunately, too few people have advance directives and they are not always helpful, because clinical situations cannot always be predicted. Cultural differences also need to be taken into account when considering the principle of autonomy. Autonomy is highly regarded in Western society, but may be secondary in Asian and other cultures. Furthermore, the tendency of family surrogates to impose their own values when speaking for patients places some patients' autonomy at risk. Relying upon families as surrogates can be problematic because families often have difficulty recognizing that care in some circumstances is futile, they often have little direct understanding of what the patient would have wanted, and their perception of the patient's suffering may be quite different than what the patient is experiencing.

The principle of beneficence requires both the avoidance of harm and the seeking of the best solution possible for the patient. Beneficence is at the heart of palliative care. Not being overly aggressive with burdensome treatment that has little likelihood of success and providing pain medication to relieve suffering, even if it sedates a patient and hastens death, are two examples of care guided by the principle of beneficence. Unfortunately, physicians and nurses both report they often feel compelled to act against their conscience in prolonging burdensome treatment. Some continue to have misguided beliefs that providing opioids in a dying patient is akin to euthanasia. In oncology, the line between burdensome treatment and one that might provide a benefit is often blurred.

The third principle, justice, requires that society afford citizens a fair and decent level of healthcare services. It implies the wise use of scarce or expensive resources. Employing therapies that are high in personal and societal costs in patients with advanced cancer, where the risk of adverse effects are high and beneficial outcome is low, needs to be examined. Questioning the case where $1.2 million was spent on antifungal medications in a $35 million pharmacy budget for a patient who succumbed anyway is an example where evaluating the situation using the principle of justice would have been beneficial. In addition, important services such as hospice are underutilized and their lengths of stay are declining.

When is a clinical intervention justified and who should make the decision? Instead of a paternalistic approach, where the doctor decides everything about what is best for the patient, or complete patient autonomy, where the doctor explains, but the patient (or surrogate) decides everything, the preferred approach is one of shared decision-making. In this approach, the goals and values of both the practitioner and the patient (or surrogate) are taken into consideration along with determinations of what medical interventions (if any) can be best achieved. Disagreements about the course of action usually center on disagreements about facts (the clinical condition or prognosis), disagreement about what values should be considered (quality vs quantity of life), and disagreement about how to weigh different values (ie, what is most important to each party). Some people are more willing to push the envelope or are more hopeful than others, and oncologists as a group seem oriented towards aggressive care. An aggressive approach may be to the patient's benefit, but not always.

When situations where the chance of success is not clear, a trial of treatment should be considered. However, a physician should not try to overmaster a disease no longer responsive (Hippocrates). Patients and families have an obligation not to request treatment if it's futile, and healthcare professionals have their own moral integrity that should not be violated. The goal today is to practice preventative ethics through the establishment of a trustworthy partnership with the patient and family, and communicating early and often about the overall goals of treatment and possible endpoints. OS

*The* Oncology Spectrums *Oncology Ethics Forum is an exploration of the many ethical considerations faced by cancer medicine professionals. A rotating panel of experts discuss challenging issues in palliative and end-of-life care, policy and practice, and research and genetics. Our team of expert contributors includes: Terri Maxwell, RN, MSN, AOCN, executive director of the Center for Palliative Care at Thomas Jefferson University in Philadelphia, PA; Richard J. Boxer, MD, clinical professor of urological surgery at the University of Wisconsin Medical School in Milwaukee; and Steven Joffe, MD, MPH, instructor in pediatrics and ethicist at the Dana-Farber Cancer Institute in Boston, MA.*