Oncologists would be well advised to consider their obligations to the patient, as well as other stakeholders, and be prepared to resolve potential conflicts that go beyond the focus of their clinical training.

Clinical oncologists are trained to evaluate a patient's condition and assist the patient in choosing between available, ideally evidence-based, options to maximize quality of life and overall health. However, many situations arise that require clinicians to confront choices related to communication, resource utilization, goals of care, and other factors beyond clinical management alone. Medical ethics is concerned with evaluating the right path forward in such situations, by identifying the principles at stake, evaluating relative obligations of the clinician towards potentially competing outcomes or interests, and providing the moral justification for choosing one path or the other.

In their article in this issue of ONCOLOGY, Tenner and Helft present three cases intended to prepare practicing oncologists to confront common ethical dilemmas. First, they consider a case in which the costs of therapy may prove prohibitive for the patient, raising questions of how oncologists should integrate costs of cancer care into medical decision-making. Next, they consider a case involving a potential conflict between the patient's and the family's preferences for prognostic information, raising questions of how to guide discussions of advanced illness. Finally, they consider a case in which a critically ill patient with advanced cancer becomes unresponsive, forcing the physician to confront a family's request for aggressive care in a setting in which such care is likely to be futile and may be inconsistent with the patient's preferences and interests.

Each case involves potential conflicts between the patient's interests and the outside interests of the family and/or society. The role of oncologists in balancing these interests and meeting their primary obligation to the patient, while considering the limitations on this duty and their competing obligations to other parties, is well explored by Tenner and Helft. The dilemma surrounding the dual role of oncologists who may be asked to honor their fiduciary responsibility to the patient and simultaneously consider society's interest in resource utilization or public health, or the family's interest in information and a different view of the patient's welfare, is not new, but these issues remain complex and largely unresolved.[1,2] Oncologists may at least recognize and prepare for the inevitable tensions that will arise in such situations. At the same time, the choice of these three specific cases highlights an increasingly common and important theme in oncology: How can we best individualize care for patients with advanced cancer?[3]

Three trends converge to bring this question to the forefront of modern oncology. First, costs of healthcare, including cancer care, are high and rising.[4] Second, the inadequacy of our conversations regarding prognosis and care preferences is now well documented.[3,5] Third, there is increasing recognition of our failure both to adequately address end-of-life issues before there is a crisis and to maximize the potential benefits of palliative care.[6]

The cost of healthcare has become a major concern, both within the United States and internationally, where healthcare consumes an increasingly large portion of the budget and grows at an unsustainable rate.[4] Cancer care constitutes 5% of total healthcare spending and is characterized by high-profile expensive medications and a frequent disconnect between the costs of an intervention and its benefit to patients.[7,8] Many factors contribute to the cost of cancer care, but perhaps one of the most important among them is the oncologist's failure to communicate realistically with patients regarding their preferences and the goals of care. As noted by Tenner and Helft, failure to address these issues can lead to delivery of care that an informed patient would decline. A large percentage of spending for medical care in general, and cancer care in particular, occurs in the last months or weeks of life. In retrospect at least, much of this care is futile. In addition to financial consequences of such care for the patient and for society, aggressive care at the end of life may be associated with more toxicity and a worse
quality of life.[6] Given the heterogeneity and complexity of advanced cancer, blanket statements about the value of specific interventions in select settings can be difficult, but the American Society for Clinical Oncology has identified provision of cancer-directed therapy to patients with poor performance status, no benefit from prior therapy, and no strong evidence to support further therapy as one of the top five practices that should be eliminated in an effort to improve the quality and reduce the costs of care.[9] Besides adhering to this guidance, most oncologists can likely agree that whatever care is delivered should correspond to the informed patient’s goals and preferences. Care (and the attendant healthcare spending) that does not serve these ends, or that is not discussed adequately with the patient, should be avoided.

Potential barriers to such conversations are presented in all three cases considered by Tenner and Helft. Physicians may be concerned that discussions of the limits of care may be confused with rationing. Indeed, physicians are increasingly expected to consider the costs of care in the clinic, with unclear impact on difficult conversations regarding patient preferences and the doctor-patient relationship.[10] Patients and family members may have differing preferences for both the amount of information discussed and the decisions that follow. Desire to avoid family conflict or discussions that may upset the patient, as the authors present in the second case, are both likely contributing factors. Finally, as presented in the third case, discussions of prognosis and preferences are often addressed late in the course of illness, and a crisis may intervene before such discussions can take place.

Oncologists should be aware that data have consistently shown that patients expect and appreciate frank discussions of prognosis and goals of care.[11] They should also be aware that when such conversations occur, they often change the care that is delivered, with a shift towards greater emphasis on palliative care.[12] Realistic discussions of prognosis can be difficult, and there is a need to evaluate and respect the patient’s preferences regarding the details of these discussions. As illustrated by the third case, failure to have these discussions can result in even more difficult circumstances later in the course of care.

When discussing options with patients and/or their family members, the way in which options for ongoing care are presented is critical. We should avoid the pitfall of simply reviewing potential interventions. Such conversations must focus on the goals of care. When a patient cannot participate, the family must be reminded to consider what the patient would want in this circumstance, not what the family or the doctor may want. A realistic presentation of the prognosis, potential best and worst case scenarios, and the potential harms and benefits of any intervention, in addition to an emphasis on continued care regardless of whether the goal is disease control or control of symptoms, will help avoid the common false dichotomy between aggressive care and withdrawing care.

In the end, evaluating patients’ goals and preferences for advanced cancer care will not always lead to changes in management, cost savings, or the avoidance of potential ethical quandaries. There will still be occasions when oncologists are confronted by inability to obtain the resources to provide a patient with the care he or she needs and desires. There will still be conflicts between family members or patients and their families over how much information should be provided and how care should proceed. There will still be cases when patients with cancer cannot make decisions for themselves, and potentially futile care will be urged by well-intentioned family members. Oncologists would be well advised to consider their obligations to the patient, as well as other stakeholders, and be prepared to resolve potential conflicts that go beyond the focus of their clinical training. However, it is perhaps not coincidence that the three cases selected by Tenner and Helft point to at least one way that we can reduce, if not avoid, the ethical tensions often arising in oncology, by evaluating the goals and preferences of our patients with advanced cancer early and often throughout the course of care.

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