Ethical issues in the geriatric patient with advanced cancer ‘living to the end’

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Cancer incidence will increase as the population ages; there will be a 50% increase in new cancer cases over the next 20 years, and the biggest rates of increase will occur in the developing world. Owing to technical advances in the care of critical illness, as it is the case in elderly people with advanced cancer, physicians, patients and families are often confronted with ambiguous circumstances in which medical advances may inadvertently prolong suffering and the dying process rather than bring healing and recovery.

In this review of the ethical issues confronting physicians who care for patients with advanced life-limiting illnesses like cancer, a philosophical debate continues in the medical community regarding the rightness or wrongness of certain actions (e.g. physician-assisted death, euthanasia), while at the same time there is a strong desire to find a common ground for moral discourse that could guide medical decision-making in this difficult period in the lives of our patients. We will discuss how a good palliative care can be an alternative to these ethical dilemmas.

Although some issues (e.g. the role of physician-assisted death in addressing suffering) remain very controversial, there is much common ground based on the application of the four major principles of medical ethics, no malfeasance, beneficence, autonomy and justice.

Thus, the physician’s primary commitment must always be the patient’s welfare and best interests, whether the physician is treating illness or helping patients to cope with illness, disability and death. A key skill here is the communication of bad news and to negotiate a treatment plan that is acceptable to the patient, the family and the healthcare team.

Attention to psychosocial issues demands involvement of the patients and their families as partners. Physicians should be sensitive to the range of psychosocial distress and social disruption common to dying patients and their families. Spiritual issues often come to the fore. An interdisciplinary healthcare team can help in these areas.

The goals of this review are to raise the awareness of doctors, nurses and other members of the healthcare team to the important ethical issues that must be addressed in providing medical care to elderly patients with advanced cancer; and also to encourage members of the healthcare team to take the ethical issues seriously so that we can improve the circumstances of a vulnerable group of patients—the elderly patients with cancer.

introduction

In almost every country, the proportion of people aged over 60 years is growing faster than any other age group, as a result of both longer life expectancy and declining fertility rates. Cancer incidence will increase as the population ages; there will be a 50% increase in new cancer cases over the next 20 years, and the biggest rates of increase will occur in the developing world (Globocan, 2008).

In Lebanon, there are currently around 8250 new cases of cancer diagnosed each year; around 40% of those occur in persons ≥65 years representing 3300 cases (Lebanese National Cancer Registry)

Owing to technical advances in the care of critical illness, as it is the case in elderly people with advanced cancer, physicians, patients, and families are often confronted with ambiguous circumstances in which medical advances may inadvertently prolong suffering and the dying process rather than bring healing and recovery [1].

In this review of the ethical issues confronting physicians who care for patients with advanced life-limiting illnesses like cancer, a philosophical debate continues in the medical community regarding the rightness or wrongness of certain actions (e.g. physician-assisted death, euthanasia), while at the same time there is a strong desire to find a common ground for moral discourse that could guide medical decision making in this difficult period in the lives of our patients.

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ethical principles in end-of-life care

Ethics is a branch of philosophy that examines rights and wrongs, what should or ought to be done. Clinical ethics refer to application of the science and understanding of morality in the field of medicine and health sciences. They are defined as ‘the
Obligations of moral nature, which govern the practice of medicine. The goal of clinical ethics is to improve the quality of patient care, emphasizing the commitment to the well-being of patients [2].

Several ethical issues arise in the care of elderly patients with advanced cancer. Although some issues (e.g. the role of physician-assisted death in addressing suffering) remain very controversial, there is much common ground based for the application of the Hippocratic Oath that embraced the classical principles of medical ethics of beneficence, non-malfeasance, confidentiality, autonomy, and justice. Thus, the physician’s primary commitment must always be to the patient’s welfare and best interests, whether the physician is treating illness or helping patients to cope with illness, disability, and death [3].

The goal of palliative care is to relieve suffering. Suffering has been defined as ‘the state of severe distress associated with events that threaten the intactness of the person’ [4]. The World Health Organization has defined palliative care as ‘the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social, and spiritual problems, is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families’ [5].

Healing and alleviation of suffering, the classical duties of physicians, have been practiced throughout the history of the human society development. The patient–physician relationship is a time-honored tradition and a reward for the compassionate physician and the appreciative patient. The first code of ethics between the physician and the patient appeared in 1750 BC, when Hammurabi was commissioned in Babylon to establish laws that govern the practice of medicine [6].

Different perceptions of a patient’s suffering within the medical team (e.g. between nurses and physicians), between the medical team and family members, or within families can lead to conflict and are not infrequent reasons for ethics consultations in patients with advanced life-threatening illnesses.

This will provide the context for the application of the major principles in the Hippocratic Oath. Beneficence is the obligation of healthcare providers to help people in need (relieve their suffering). Non-malfeasance is the duty of healthcare providers to not harm their patients (exacerbate their suffering). Doing good (beneficence) and doing no harm (no malfeasance) are two complementary ethical principles that impose affirmative duties to maximize benefits and minimize risks to the patients. Autonomy is the right of a person to choose and follow his or her own plan of life and action. In recent decades, the relationship between patients and physicians has been evolving from one characterized by paternalism, in which physicians made decisions for patients according to their professional values, to a more equal relationship of shared decision making, in which physicians provide information that allows competent adult patients to make their own choices, referred to as ‘informed consent.’ Autonomy is founded in the overall desire of most human beings to control their own destiny, to have choices in life, and the right to consent to or refuse treatment [7]. Although the physician has an obligation to respect the patient’s wishes, he or she also has a duty to fully inform the patient of the probable consequences of those wishes. Justice is often regarded as being synonymous with fairness; in a general sense, people are treated justly when they receive what they deserve (Table 1). The pledge promises to respect the patient’s rights and to place his welfare above all else (Table 2).

A key skill in this situation is the communication of bad news; and then to negotiate a treatment plan that is acceptable to the patient, the family, and the healthcare team. The patient and his or her family should be able to discuss in advance their desires regarding life-sustaining treatments and personal care. Physicians should facilitate this advance care planning, and must support the dignity of all persons and respect their uniqueness [8].

### advanced directives and informed consent

With progression of an advanced illness like advanced cancer, there is increasing debility and loss of independent function that erodes a patient’s autonomy. This progressive loss of autonomy, in as much as it further threatens the integrity of the person, adds to the suffering of these patients.

That is why the practical extension of patient autonomy has been the development and use of advanced directives. Typically, advanced directives can be in the form of a living will in which treatment preferences usually related to care at or near the end of life (especially regarding attempts at resuscitation) are documented, or a durable power of attorney for healthcare, in which a surrogate decision maker is identified (often one’s spouse or other close relative) [9, 10].

In actual practice, it is almost impossible to anticipate every possible situation that might arise, especially during intensive care of a critically ill individual, in which specific decisions can be made in advance. Thus, the principle of autonomy as applied to medical decision making in the context of patient

<table>
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<tr>
<th>Table 1. Ethics and end-of-life care—major principles</th>
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<td>(i) Nonmalefence ‘first do no harm’</td>
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<td>(ii) Beneficence—a duty to do good (not just avoid harm)</td>
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<td>(iii) Autonomy—the recognition of the right of self-determination, establishing one’s own goals of care</td>
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<td>(iv) Justice—the equitable distribution of often limited healthcare resources</td>
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<th>Table 2. Patients’ rights</th>
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<td>(i) Right for a good quality care</td>
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<td>(ii) Right for a free choice</td>
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<td>(iii) Right for healthcare decision</td>
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<td>(iv) Right for clear information</td>
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<td>(v) Right for confidentiality</td>
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<td>(vi) Right for information and health education</td>
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<td>(vii) Right for human dignity</td>
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<td>(viii) Right for spiritual assistance</td>
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incapacitation is in a process of evolution depending on the
country and culture [2,7,11].

The under-treatment of pain and other symptoms is well
documented; the causes are complicated and not well
understood. Although, an improvement in pain control is noted
these last few years, due to a better health professionals education,
more public awareness and adaptation of health policies to the
international recommendations. Guidelines have been also
developed to assist physicians in controlling other symptoms,
such as nausea, vomiting, fatigue, and breathlessness [12, 13].

**withholding/withdrawing therapies vs. physician-assisted death**

There is no fundamental difference ethically between
withdrawing or stopping a treatment that is no longer
beneficial, and not starting or withholding such a
treatment [14].

Once a decision is made to withhold a ‘life-sustaining’
treatment, other ongoing treatment should be reviewed as to the
appropriateness of its continuation, as well. The decision to
withdraw life-sustaining therapy is rarely an emergency. It is
essential to take all the time necessary to resolve any conflicts
that may exist between the medical staff and family members or
that may exist within the medical team [15].

Clinicians should be aware that personal beliefs and values
often play a dominant role in their clinical decisions. All team
members (attending physician, residents, nurses, social workers,
etc.) who have a direct role in the patient’s care should have
input in the process [16].

Thus, withholding or withdrawing treatments that are no
longer beneficial or administering opioids for pain relief that
may indirectly hasten death are not euthanasia. In the ongoing
debate regarding physician-assisted death (euthanasia or
physician-assisted suicide), the most important argument in
favor of the practice relates to suffering. If suffering is the
greatest evil (which many advocates of physician-assisted death
would endorse), then all means should be available to manage
it, including intentionally causing the premature death of one’s
patients [17].

There are a number of reasons to resist embracing such a
‘solution’ to the suffering of our patients [18]:

(i) Requests for physician-assisted death are often a sign of
unaddressed issues, including inadequately treated physical
symptoms (e.g. pain), untreated clinical depression, fear of
a loss of control (autonomy), fear of being a burden, and
potential existential or spiritual distress.

(ii) Physical suffering can be relieved without prescribing a
lethal drug. Distressing symptoms can be controlled in
>95% of cases with medications, supportive, and palliative
care. Terminal or palliative sedation can be used to control
very difficult symptoms without taking a life.

(iii) The end of life is a critical time for personal growth.
During the last days and weeks of life, a number of very
important activities can occur including reconciliation and
healing of relationships, life review, and spiritual growth as
one search for meaning in one’s suffering.

(iv) Legalization of physician-assisted death would be unsafe in
communities like ours in the Middle- East. Patients with
limited or unequal access to healthcare (e.g. the poor)
would be particularly vulnerable, as physician-assisted
death would inherently be quite ‘cost effective’ [19].

(v) Physician-assisted death poses an inherent conflict of
interest for physicians. With rising healthcare costs
(particularly at the end of life), the pressure for more ‘cost
effective’ solutions (e.g. physician-assisted death) will
mount. Physician-assisted death is in direct conflict with the
Hippocratic Oath and tradition. And in most countries
in the Middle-East where people are believers and have
faith, such a solution goes against the religious
recommendations.

(vi) Although physicians may be able to address the physical
distress of the dying, they may not have the skills or
resources to address deeper, existential issues troubling
their patients. This lack of knowledge does not justify
taking a patient’s life when others who may have the skills
and patience are available to help.

(vii) Palliative care team has here its primary role and place.

**conclusions**

Patients and their physicians together face a number of
challenging ethical issues at the end of life of an elderly patient
with advanced cancer. Although some issues (e.g. the role of
physician-assisted death in addressing suffering) remain very
controversial, there is much common ground based on the
application of the four major principles of medical ethics, non-
malfeasance, beneficence, autonomy, and justice.

Thus, the physician’s primary commitment must always be
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The physician must support the dignity of all persons and
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**disclosure**

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references


