Ethical dilemma arising from new oncological treatments

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Era of success

Technological advancement in oncology treatment has brought about great improvement in the treatment outcome of cancer. New molecular agents, in particular, have made revolutionary breakthrough, eg the use of imatinib in gastrointestinal stromal tumour and gefitinib or erlotinib in non-small cell lung cancer.

Nevertheless new oncological treatments have also changed the faces of the palliative phase and brought along ethical dilemma.

The transition

In the old days, the changing from curative phase to palliative phase is a sharp transition. The treatment changes from active and aggressive to conservative. Since there are not much anticancer treatments to consider, the majority of patients are just put on symptomatic care. Nowadays, many patients are put on some kind of anticancer treatment for some period of time before they gradually step down slowly to simple symptomatic care. The transition has become a blurred protracted process.

Palliative phase becoming a treatment laden phase

The availability of new oncological treatment has changed the pattern of medical care during the palliative phase. In the old days, even when palliative chemotherapy was to be given, they were often given for more chemo-sensitive tumours like breast cancer, and more commonly only one or up to two lines of treatment were given. Now with increasing availability of palliative treatment options, patients are given multiple lines of treatment. Upon the diagnosis of incurable phase of cancer, referral to oncologists for advice and discussion on treatment options now becomes a common practice.

Once oncological treatment is started, there is a tendency for patients to exhaust all available lines of treatment even though there will be decreasing margin of benefit. More patients are on oncological treatment in the late stage of life. When to stop becomes a difficult question.

Ethical dilemma

The treatment decision process has become more complex. The treatment modalities are more sophisticated in nature and the options expanding in number. Much information has to be given and the impact need to be considered from different perspectives. The discussion and decision process has become more demanding both for patients and doctors. Apart from these, various ethical issues arise during the process.

Benefit vs burden

Every treatment delivered during the palliative phase has to be weighted carefully against the toxicities. Though new oncology drugs often have a better toxicity profile, they are not without side effects. As the patient goes down the line of treatment, changing from first to second to third line etc, the margin of benefit is expected to decrease, the toxicity issue is of increasing concern.

The clinical routines related to oncological treatment, eg the need to attend clinic follow up, performing investigations, arranging admissions etc may also be a burden for patients and carers.
Time burden

It is hoped that oncological treatment can prolong the survival of patients. However if the treatment occupies a significant proportion of the remaining life span, it becomes a dilemma to some patients that whether this is buying time or a waste of time, and whether this is worthwhile.

Financial burden

New oncological treatment are exceedingly expensive. Most of the new drugs are self financed items in the Hospital Authority, with monthly cost ranging from $10,000 to HK$ 40,000. The cost of treatment in the private setting will be even much higher. Many patients have to make a lot of sacrifices in their family budget in order to have enough money for treatment. Some patients even turn to other more drastic means in order to get the money, eg borrowing loans.

When counseling patients on treatment, the financial aspect is also an issue to consider. Doctors often have a concern that if they suggest treatment that patients cannot afford, this may induce regret and grievance for patients. On the other hand, doctors also have the responsibility to offer full information to patients and they are not in a position to do the judgment for patients.

Option vs obligation

Once when treatment options are still available, there is a natural tendency that patients will exhaust all available means before treatment is finally stopped. Patients may feel that they have not fulfilled their responsibility if they have not tried all options available. In such case, choice then becomes compulsion and option becomes obligation.

Hope

Sometimes patients may take an oncological treatment just to buy some hope. On one hand, this may buy some time for patients to cope with the reality, while on the other hand, this may have opposite effect of enhancing denial. The dividing line between hope and false hope is difficult to draw. How to maintain hope while being realistic about the disease and treatment is a big lesson for the patients and doctor.

The paradox

We have entered into an age of success and hope. It appears that we have more power and freedom to treat cancer, including incurable cancers. However this new age also brings along paradox, which we as doctors need to be aware of:

Paradox exists in which patients may have:

- More information, but less understanding
- More choices, but less freedom
- Longer survival, but less time
- More treatment, but less healing

Messages

The palliative approach should go more upstream, to be incorporated into the treatment phase instead of only applying to the terminal phase when all oncological treatments are stopped.

There should be a well informed discussion process before the decision on treatment is being made. This should take into account of the psychosocial concerns of patients and families.

Treatment should be a tool instead of being a goal itself. The real goals of treatment, apart from survival, should include peace, comfort and quality of life for patients.

Though oncological treatment may defer the time to face the reality, the time will come at last. Patients eventually need to face a time to let go. The advancement of oncological treatment cannot replace a true psychosocial care.