**[Ethical Dilemmas](http://www.geriatric.theclinics.com/article/S0749-0690(11)00081-4/abstract" \t "_blank) in**[**Advanced Cancer Patients**](https://www.medscape.com/viewarticle/780057)

Doaei S1**, Mosavi-Jarrahi A2, Nasibe Jafarnia3, Gholamalizadeh M1**

1. Student Research Committee, Cancer Research Center (CRC), Shahid Beheshti University of Medical Sciences, Tehran, Iran.
2. Dept. of Social Medicine, Medical School, Shahid Beheshti University of Medical Sciences. Tehran, Iran
3. Department of Health medicine, Guilan University of   Medical Sciences, Guilan, Iran

**Corresponding author:**

Maryam Gholamalizadeh

Student Research Committee, Cancer Research Center , Shahid Beheshti University of Medical Sciences , Tehran , Iran. [gholamalizadeh@sbmu.ac.ir](mailto:gholamalizadeh@sbmu.ac.ir)

**Abstract**

**Introduction & Purpose:** End-stage cancer is considered as one of the most refractory illnesses causing difficult conditions for patients and their relatives. The purpose of this study was to investigate the important ethical considerations related to patients with refractory cancers.

**Methodology**: In this study, using databases such as PubMed, all articles related to ethical considerations in patients with severe cancer were collected using keywords such as end-stage cancer, ethics, and advanced cancer.

**Results**: Important ethical considerations associated with advanced cancer patients include sharing information with the patient, deciding on treatment, end-of-life palliative care, supportive care environment, and euthanasia. The results showed that, in terms of medical ethics, it is necessary for the patient to be aware of the reality of his or her illness and respect his/her independence in the choice of treatment. Palliative care is also used to reduce the pain and provide necessary supportive environment to improve life satisfaction. Use of different euthanasia methods is not recommended.

**Conclusion**: Observing ethical aspects of patients in end stage of cancer can prevent violation of patients' rights and their families on the one hand, and, on the other hand, increase level of life satisfaction and improve cooperation of the patient with the treatment team.

**Keywords**: End-stage Cancer, Medical Ethics, Refractory Illness

**Introduction**

Cancer is a group of diseases which occur with uncontrolled cell growth and invasion of local tissues and systemic metastases. It is a disease at the cellular level that is characterized by its unlimited and unpredictable proliferation of cells that form malignant neoplasms (1). Cancer is the second leading cause of death in America, and more than 560,000 Americans die annually from this malignant illness. Most cancers in men include lung, prostate, colon and rectum, and in women, lung, chest, colon and rectum (2). This disease is the third most common cause of death in Iran, and more than 30,000 Iranians die each year from it (3).

Patients within the advanced stage of cancer have legal rights due to the nature of illness and its irreversibility, which should be morally practiced by a doctor and a treatment team. As long as a patient with a refractory illness is alive, one can never definitely determine his death time. Many advanced cancer patients who were believed to be dying, have lived and recovered years after the diagnosis.

Therefore, attention to ethical issues related to medical care associated with these patients is of particular importance, which is considered as an important topic in medical ethics (4). Medical ethics is a system of ethical principles and rules that apply values and judgments in the medical field. As a discipline, medical ethics has its practical applications in clinical situations combined with work on history, philosophy, theology, and sociology (5). The purpose of this article was to examine the important aspects of ethical considerations associated with patients with severe cancers.

**Sharing information with the patient**

Expressing facts of disease can help the patient to decide on the treatment process and reduce burden of medical duties. On the other hand, in a patient who is not expected to be treated, this problem can be psychologically and socially problematic. In many cases, the patient's family resists this issue and demands not to tell the facts of the disease to the patient. In different societies, in terms of social and environmental conditions, public opinion about knowing the truth of their disease and the view of physicians about telling the truth to the patients are different (6).

There is concern that disclosure of cancer to the patients will cause mental distress and hopelessness, some health care staff avoid to do that or express it in an obscure way. However, it is important to consider better ways to express cancer (7). Therefore, it is suggested that it should be done with specific sensitivity and that the health care staff receive appropriate training in this regard (8).

Research in Iran has shown that most physicians consider telling the truth to patients to be subject to issues that are largely attributable to their own diagnosis (9).

Experts believe that knowing the truth about the process of the disease is one of the patient's rights, as the patient may have an incomplete work and should take this opportunity. Also, the secret keeping of the treatment team and the right to tell the truth to others is among the patient rights. Spiritual matters often come to the mind of the patient, and spiritual and religious care teams and other interventions of this kind should be available to him. If the patient has no definitive treatment, the physician should clearly explain his or her opinion. But, he or she should never talk about the death of the patient, as death is not at the hand of the doctor. The cost of treatment should be clearly explained, because the high cost of useless treatments may not help the patient (4).

Generally speaking, the cancer disclosure in cancer patients can be positive if it is done correctly and in a proper manner and while encouraging the patient to follow the treatment by hoping for overcoming the disease, his active participation in the therapeutic program will certainly have a positive effect on the outcome of the treatment. On the other hand, today's debate about whether cancer diagnosis is focused on how to disclose cancer (7).

**Making a decision regarding treatment**

A patient with decision-making capacity may accept or reject medical advice on different treatments, usually after considering the benefits and potential risks. Respecting the patient's independence recognizes the individual's right and ability to decide for himself based on his personal values, beliefs and length of his life. It is necessary to know and take into account decision of the patient reflecting his values. For example, it has been accepted that a patient can reject certain treatment according to his religious beliefs. If the patient does not have the power to make decisions, the decision is left to his closest relatives (4).

A major challenge in this regard is the conflict between the medical staff and the patient's relatives regarding therapies that are ineffective, but the patient or his relatives are asking for them. On the other hand, there are recommendation that are considered useful by the therapeutic staff, but the patient or the patient's relatives do not accept them for the cost of the treatment (10).

In general, patients' independence in deciding about the final stage of life should be respected. This includes the patient's right to refuse treatment and ask for relief methods to reduce pain, except for cases that accelerate the patient's death. However, the physician does not have the moral right to help the patient to commit suicide, which involves prescription of any treatment that has no effect other than pain relief.

Physicians should consider the right for patients to write their therapeutic demands for the time when they are not able to express them, and to appoint a person as a successor to decide on issues that the patient has not previously referred to. Physicians should talk to patients about their demands for survival as well as palliative measures that may be used as a side effect, and if possible, the selected person as a successor should also be included in this discussions (10).

**Palliative care at the end of life**

The task of the therapist (if possible) is to reduce suffering and protect the patient's interests. There is no exception to this principle, even in the case of refractory diseases. In caring refractory diseases, the main task of the physician is helping the patient to have the best quality of life through symptom control, mental needs, and ultimately a desirable and convenient death. Physicians should inform patients of the possibility of palliative care, benefits and complications (11). Palliative care is defined as: an approach to improving the quality of life of patients and families of patients facing problems associated with life-threatening diseases by preventing and quenching their suffering through early detection, and curing and reducing pain and other physical, psychological and spiritual problems (12).

In many cases, pain management is a common but challenging need, especially in patients at the end stage of cancer. In spite of much improvement in pain management, more than half of the patients suffer from moderate to severe pain, and this phenomenon is particularly noticeable in patients at the end stage of cancer. Regarding the pathophysiological complications of pain in malignancies and lack of regular pain relief treatments, especially in metastatic patients, pain management is one of the most important ethical challenges (13). Since clinical management of pain in the refractory diseases is very important to reduce the suffering of the patient, physicians and national medical associations should share pain management information so that all physicians involved in the clinical care of the end stages of refractory illnesses use the best practices and the latest treatments and methods available. Physicians should be able to implement pain control methods without worrying about legal or regulatory consequences.

**Creating a supportive environment**

The treatment team should try to identify and consider patient psychological needs, especially in relation to his physical symptoms. Physicians must provide the necessary mental and psychological support for the patients and their families so that they can withstand the anxiety, fear and grief resulting from the end stage of disease (14).

Communication and dialogue about what the patient expects is one of the tasks of the treatment team (4). Providing spiritual care necessitates the presence of believers, gentle, good-natured nurses who are committed to professional ethics, which conducts specific tasks such as comfort, hope for the patient and family, helping with religious practices and ...; In addition, a lively environment, provision of a private room if necessary, and relaxation during the hospitalization of the patient are also considered necessary by participants (15). Therefore, the attention of management to select nurses with an appropriate spirit for providing spiritual care, providing them with educational programs in this regard, as well as reducing the workload of nurses to provide more opportunity to care about patients in all aspects, as well as paying attention to the atmosphere seem necessary for patient. Parallel to the activity of managers in this field, nurses should also strive to promote spirituality within themselves while respecting the principles of professional ethics and use it as a spiritual source available to their clients (16).

**Euthanasia**

One of the most important issues of law and jurisprudence and medical knowledge around the world is Euthanasia. Euthanasia can be divided depending on the method of doing it. If we consider physician involvement or non-involvement, we will have two types of euthanasia: 1. Active euthanasia: the physician deliberately and consciously ends the patient's life because of pity. 2. Passive euthanasia: the physician refuses to continue the treatment and attempt to keep the patient alive, at the request of the patient or his family, or his own diagnosis, knowing that this refusal accelerates the death of the patient (17).

The request and satisfaction or lack of request and satisfaction of the patient causes both active and passive euthanasia to have three conditions: 1. Voluntary: refers to cases in which a patient deliberately and explicitly requests another person to kill him or in this way, to help him. In fact, the patient himself wants death. 2. Non-volunteering: refers to cases where euthanasia is performed without the consent of the patient, by the sole discretion of doctors, family or relatives. 9. Mandatory: refers to cases in which a person has the authority to make decisions, but has no explicit request for this action, and wishes to live and loves to continue living, but he is killed.

It should be noted that the physician duty is primarily to relieve the patient pain, then to treat and prolong life, and the last to refrain from prescribing drugs that speeds up the death (4). Studies on euthanasia in Iran have shown that none of the types of euthanasia can be justified on the basis of these principles; the only action in difficult cases is caring and palliative treatments to relieve the pain and suffering of the patient. (18).

In families affiliated with religious beliefs, most parents believe that death and living are within the power of God, and if we discontinue treatments, in principle, it is an intervention in the work of God, and they never have the right to do so. Also, most families prefer hope to hopelessness and consider it religious, and consider discontinuation of treatment as disappointment (19). The physicians can, if the vital function of the patient is not reversible, provide the necessary tools to maintain organs' activities for their donation, in accordance with the ethical frameworks set forth in the Sydney Universal Declaration of the Detection of Entry into the Phase of Death and Maintenance.

**Conclusion**

Ethical considerations in patients with refractory cancers are one of the most vital areas of knowledge for the medical care teams involved in the treatment of cancer patients. Observing ethical aspects can, on the one hand, prevent violation of the rights of patients and their families and the probability of subsequent problems, and, on the other hand, increase the level of satisfaction with life and improve the patient's cooperation with the treatment team. Future research on the various types of refractory cancer can help to create more complete ethical guidelines for managing each of these types of malignancies.

**Acknowledgement:**

This work was supported by Shahid Beheshti University of Medical Sciences, Tehran, Iran.

**Refrences:**

1. American Cancer Society. Cancer facts & figures. The Society; 2008.
2. Schottenfeld D, Fraumeni Jr JF, editors. Cancer epidemiology and prevention. Oxford University Press; 2006 Aug 24.
3. Mousavi SM, Montazeri A, Mohagheghi MA, Jarrahi AM, Harirchi I, Najafi M, Ebrahimi M. Breast cancer in Iran: an epidemiological review. The breast journal. 2007 Jul 1;13(4):383-91.
4. Jalaee kho H, Keyhani M, Shegarf F. Ethical Consideration Related to Patients with Refractory Disease. Iranian Journal of Surgery. 2016; 24(2): 97-102.
5. Miron NB. The primary ethical consideration. Psychiatric Services. 1968 Jul;19(7):226-8.
6. Robert J Sullivan, Lawrana W Mena Pace, Royce M White; Truth Telling to patient diagnosis, Journal of Medical Ethics 2001; 27:192-197.
7. Surbone A. Telling the truth to patients with cancer: what is the truth? The lancet oncology 2006;7(11):944-50.
8. Pang M. Protective truthfulness: the Chinese way of safeguarding patients in informed treatment decisions. Journal of Medical Ethics 1999;25(3):247-253.
9. Kazeminan A, Parsapoor A. Evaluation of Physicians Ethics About Truth Telling to Terminal Ill Patients. Iranian Journal of Ethics in Science and Technology. 2007; 1(1): 61-67.
10. Hjermstad MJ, Gibbins J, Haugen DF, Caraceni A, Loge JH, Kaasa S, EPCRC, European Palliative Care Research Collaborative. Pain assessment tools in palliative care: an urgent need for consensus. Palliative Medicine. 2008 Dec;22(8):895-903.
11. National Consensus Project for Quality Palliative Care. Clinical practice guidelines for quality palliative care. The Kansas Nurse. 2004 Oct;79(9):16.
12. Sepúlveda C, Marlin A, Yoshida T, Ullrich A. Palliative care: the World Health Organization's global perspective. Journal of pain and symptom management. 2002 Aug 31;24(2):91-6.
13. Newshan G, Sherman DW. Palliative care: pain and symptom management in persons with HIV/AIDS. The Nursing Clinics of North America. 1999 Mar;34(1):131-45.
14. Rahnama M, Fallahi Khoshknab M, Seyed Bagher Madah S, Ahmadi F. Cancer patients’ perception of spiritual care. Iranian Journal of Medical Ethics and History of Medicine. 2012 Jun 15;5(3):64-80.
15. Mueller PS, Plevak DJ, Rummans TA. Religious involvement, spirituality, and medicine: implications for clinical practice. Mayo Clin Proc 2001; 76(12): 1225-35.
16. Daaleman TP, Usher BM, Williams SW, Rawlings J, Hanson LC. An exploratory study of spiritual care at the end of life. Ann Fam Med 2008; 6(5): 406-11.
17. Van der Maas PJ, Van Delden JJ, Pijnenborg L, Looman CW, of Statistics CB, Hague T. Euthanasia and other medical decisions concerning the end of life. The Lancet. 1991 Sep 14;338(8768):669-74.
18. Movahedi MJ, Tavacoly G. Euthanasia in religion based deontology. Medical Ethics Journal. 2016 Jun 8;10(34):165-86.
19. Moulton BE, Hill TD, Burdette A. Religion and trends in euthanasia attitudes among US adults, 1977–2004. InSociological Forum 2006 Jun 1 (Vol. 21, No. 2, pp. 249-272). Springer US.