

Ethical Dilemmas in Gynecologic Oncology— Practice Points for the Oncology Practitioner

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Abstract

Gynecologic oncology is a unique field in which physicians frequently become engaged in, and manage, ethical dilemmas. Understanding the features of patients who receive ethics consults is crucial for maintaining continuity of care and identifying areas for physician education. A review of the MD Anderson Cancer Center clinical ethics database and institutional medical record was performed for gynecologic oncology patients receiving ethics consults from 1993 to 2008. Data abstracted included patient demographic and clinical information, clinical case types, and key underlying issues. Information on all gynecologic oncology patients seen during the study interval was also obtained to define a base population. Summary statistics were generated, and comparisons between consult and base populations were performed. Forty-one consults were conducted. Six (15.4 %) patients had established medical power of attorney, and seven (17.1 %) had a living will. The distribution of disease sites in consult patients was similar to the base population, except for gestational trophoblastic neoplasia, which was overrepresented (7.9 versus 0.8 %, $p < 0.0001$). Compared with the base population, there was a greater proportion of consult patients who were African-American (33.3 versus 10.9 %, $p < 0.0001$), had Medicaid (15.4 versus 4.8 %, $p = 0.002$), or were self-pay (15.4 versus 5.4 %, $p = 0.009$). The most common clinical ethics case types involved identifying levels of appropriate treatment. Common underlying issues included family dynamics and patient coping mechanisms. Ethics consultation provides a substantial resource in identifying relevant psychosocial issues experienced by gynecologic oncology patients, on which physician educational initiatives may be based.

Keywords

Gynecology, clinical ethics, ethics consultation, oncology, advance directives, end-of-life decisions

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Gynecologic oncologists play a crucial role not only in the physical treatment of their patients, but also in the emotional and psychological adjustments to their cancer diagnoses. Frequently, this involves addressing ethical issues, including end-of-life decision-making and mediating family disagreements about treatment goals. We recently reported on a review of the ethics consults for gynecologic oncology patients at MD Anderson Cancer Center.¹ The five most common primary clinical ethics concerns were cited (see *Table 1*). Several cases in particular stood out as good teaching examples that highlighted themes commonly encountered by our patients. Here we address those cases and suggest points for practitioners to consider when they experience similar situations.

Case #1—Coping Strategies in a Patient with Advanced Carcinoma (Level of Appropriate Treatment—Code Status)

Mrs Smith is a 53-year-old white female with progressive primary peritoneal carcinoma. She had previously undergone extensive surgical

resection and chemotherapy, and was noted to have metastases to her femur, ribs, and vertebrae. The patient was admitted to the hospital because of spinal cord compression due to vertebral metastases and underwent palliative radiation. Mrs Smith's oncologist had discussed do-not-resuscitate (DNR) status with her, and the patient was reluctant to agree to such status. She noted that she did not want to 'quit' her fiancé and that she did not want to give up if "God puts his hand down and cures me." An ethics consult was requested to discuss the futility of further medical intervention and assess the patient's hesitancy to proceed with palliative measures. The patient's coping strategy was subsequently identified as the primary underlying issue.

Discussion

Coping strategies are significant underlying issues for many patients. For Mrs Smith, managing her relationship and reconciling religious beliefs with medical realities posed challenges both spiritually and psychologically. A patient's success in coping with disease is often

associated with psychological distress and psychiatric symptoms, the degree of which vary from person to person.² In 2006, de Faye et al.³ reported that perspective-taking, seeking support, and resignation/acceptance are frequently utilized coping strategies in persons with cancer, and that patients may employ different strategies when faced with specific stressors. For example, patients with social concerns are more likely to employ ‘hope’ and ‘spiritual support’ compared with women with physical ailments, who more commonly engage in direct action to address concerns.³ In a review of women with breast cancer, Classen et al.⁴ reported that patients who described their coping styles as having a ‘fighting spirit’ or demonstrating more emotional control had better psychological adjustment to their diagnoses than those women lacking such styles. It is important to recognize that the experience of cancer is different from woman to woman and perceived stressors are often not uniform between patients.³ Similarly, it is important for the physician to identify maladaptive coping strategies and to seek assistance when the severity of the perceived stressors exceeds what the patient’s coping mechanisms are able to handle.

Outcome

In this case, a conference was held between Mrs Smith, her physician, and the clinical ethicist. A discussion about prognosis, the patient’s understanding of DNR, and her hopes for the next phase of her life was initiated. The patient expressed her wishes to die a dignified death, but she was unable to accept the recommendation for DNR. A second medical opinion was requested and the consultant agreed with the medical inappropriateness of aggressive resuscitative efforts. A DNR order was written and the patient was informed of the decision. She was discharged to inpatient hospice and passed away two weeks later. Prior to her discharge, the patient’s primary physician noted: “I think we are all comfortable with the way in which things were accomplished and in the end result... we still all ended up on the same team.”

Case #2—Surrogate Decision-making at End of Life and Managing Family Dynamics (Withhold or Withdraw Procedure from Incompetent Patient—Life-sustaining, Surrogacy)

Ms Brown is a 45-year-old African-American patient with recurrent endometrial carcinoma who was admitted to the hospital and underwent multiple abdominal explorations due to an infected pelvic mass and sepsis. The patient’s condition deteriorated and she required intubation for acute respiratory insufficiency. The patient’s terminal condition was discussed with her father and four siblings, and the attending surgeon recommended discontinuation of mechanical ventilation and comfort care. No advance directive or identified surrogate was in place. The family was divided about accepting this recommendation and an ethics consult was requested.

Discussion

Identification of a surrogate decision-maker is an important component in the care of cancer patients because it maintains patient autonomy, a key tenet in medical ethics.⁵ Unfortunately, only a minority of patients identify surrogates and outline their wishes for decision-making should they become incapacitated. In a survey of more than 30,000 patients, it was noted that only 11–15 % of patients had advance directives;⁶ similar studies have reported that fewer than 10 % of patients with chronic

Table 1: Most Common Clinical Case Ethics Concerns—Primary

1	Level of appropriate treatment—code status
2	Level of appropriate treatment—shift from curative to palliative
3	Withhold or withdraw procedure from incompetent patient—life-sustaining
4	Obligations to non-compliant patient
5	Discharge

diseases have living wills.⁷ Demographically, living wills are used less frequently among persons who are non-white, have lower educational attainment, are uninsured, or are women.⁷

In 2009, Kierner et al.⁸ surveyed attitudes toward advance directives in cancer patients. Only 5 % of patients had an advance directive in place. Of those who did not have advance directives, only 11 % expressed interest in wanting them.⁸ The primary reasons for not drafting advance directives included lack of full trust in physicians, the feeling that it was not an important topic at the moment, and fear about making the wrong decision.⁸ Given that surrogacy and levels of appropriate treatment were common clinical case types noted in our previously reported series, it is important for physicians to increase awareness about advance directives and provide education on the maintenance of patient autonomy. Proactively engaging the patient in decision-making processes clarifies patient desires and significantly reduces stress felt by family members and surrogates later in the disease process.

Ms Brown’s case highlights how interactions between family members can be affected by a cancer diagnosis. Understanding the potential changes that may occur within a family can provide the physician with insight that is later useful in effectively counseling patients and their families. Lifestyle interruptions and shifts in previously defined roles can have a significant impact on the wellbeing of the family unit, especially when the patient’s role is maternal.⁹ Up to 33 % of family members who act as patient caregivers may themselves experience psychiatric morbidity, especially toward the end of a relative’s illness.¹⁰ Marital dissatisfaction may more fully manifest in certain relationships, and a caregiver’s avoidance in accepting the diagnosis may affect the patient’s ability to herself adjust.⁹ Family members may also have a difficult time reconciling their own medical needs with those of the cancer patient.¹¹ With the potential for alterations in family relationships, the physician must be aware of increased psychological vulnerability of both patients and their caregivers and how such vulnerability may influence dynamics within the family. Consistent interaction between the treating oncologist and the family caregiver can provide support and help manage the inevitable stress associated with caring for a loved one.¹¹

Outcome

In this case, the ethicist supported trying to achieve a consensus among family members. It was, however, affirmed that, in the absence of a medical power of attorney, the father was the patient’s legal surrogate and could make decisions regarding care of the patient, regardless of whether there was a family consensus. Once this was established, the attending surgeon had another discussion with the patient’s father, and the decision was made to proceed with comfort care. The patient was removed from the ventilator and she died shortly thereafter.

Case #3—Addressing the Level of Appropriate Care, the Shift from Curative to Palliative Care, and Patient Spirituality

Ms Jones is a 43-year-old Caucasian woman with advanced cervical cancer. She had been previously discharged to hospice after an admission for pain management and acute renal failure. The patient had declined palliative chemotherapy for seven months. While at hospice she changed her mind about DNR status and made her boyfriend promise to obtain everything possible to give God a chance to save her. She presented to the emergency center with acute shortness of breath requesting that all interventions be performed. The attending physician strongly recommended against intubation, and the patient's boyfriend, who was her designated medical power of attorney, agreed. Because the patient had full decision-making capacity at her time of presentation, clinical ethics was consulted to assist in this case, addressing the level of appropriate care.

Discussion

The ethicist is of utmost importance in such situations, where patients and physicians may markedly disagree about the treatment plan. In 2009, Winkler et al.¹² surveyed a cohort of patients with end-stage cancer regarding involvement in their decisions to limit treatment. They reported that only 47 % of patients felt involved in decision-making, and the strongest predictor of whether or not the patient's desires were respected was whether or not such desires were consistent with the physician's treatment goals.¹² Additionally, the greatest incongruity in treatment goals was noted when the physician supported comfort care and the patient requested further life-sustaining measures.¹² Decisions regarding appropriate treatment are weighty and require a frank discussion between the care team and patient about the risks and benefits of ongoing treatment, as well as maintenance of quality of life. Mismatched end objectives ultimately require a mutually agreeable resolution, and facilitating such a resolution is a prime opportunity for the involvement of an ethics consultant.

Ms Jones also presented an issue that is very common in end-of-life discussions, namely, spirituality and the role of God. Brett and Jersild¹³ recently described four main categories of religious reasons that patients

may use to justify continued treatment: hope for a miracle, refusal to give up on the God of faith, a conviction to preserve life at all costs, and the redemptive value of suffering. While not all spiritually influenced reasons to continue treatment may fit snugly into one of these categories, they at least provide the physician with a framework for understanding a patient's decision-making. Religious immersion may be a coping mechanism for patient and family, and can represent unresolved conflicts or feelings of guilt.¹³ In such situations, consulting a clinical ethicist, and perhaps a chaplain, to mediate the sometimes difficult emotional waters encountered at the end of life can be a beneficial step in finding common ground between the healthcare team and the patient or her family.

Outcome

A second medical opinion was obtained and it was deemed inappropriate to perform aggressive resuscitation on the patient. The patient's boyfriend was in agreement with this plan. Ms Jones was transferred to a hospital floor where she received medication for pain and air hunger, and was given supplemental oxygen. Arrangements were made for her family to visit her and she expired less than 24 hours later.

Conclusion

Awareness of the issues underlying a patient's response to her disease is crucial for the oncologist. We have briefly described several commonly encountered ethical dilemmas in gynecologic oncology patients that reflect the realizations of such issues, but these dilemmas and their resolutions should not be considered unique to the gynecologic patient. The crucial point elucidated from the cases is a simple, yet important, one—that open communication should be initiated early and maintained throughout the entirety of a patient's disease course. Addressing end-of-life decision-making and encouraging patients to identify surrogates while explicitly stating their treatment wishes can more easily facilitate a smooth transition from aggressive interventions to palliative comfort care. Efforts should be made by the medical team to understand a patient's religious preferences and social stressors to gain insight into the rationale behind her desires for treatment. Ultimately, an open dialogue between patient and caregiver remains a key component in optimizing healthcare delivery and should be emphasized by all practitioners. ■

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