



The University of Sydney



Concord Hospital



Sydney Cancer Centre

CURING, CARING, CREATING BREAKTHROUGHS

# CLINICAL DECISION MAKING IN ADVANCED CANCER

## *Asian Oncology Summit 2010*

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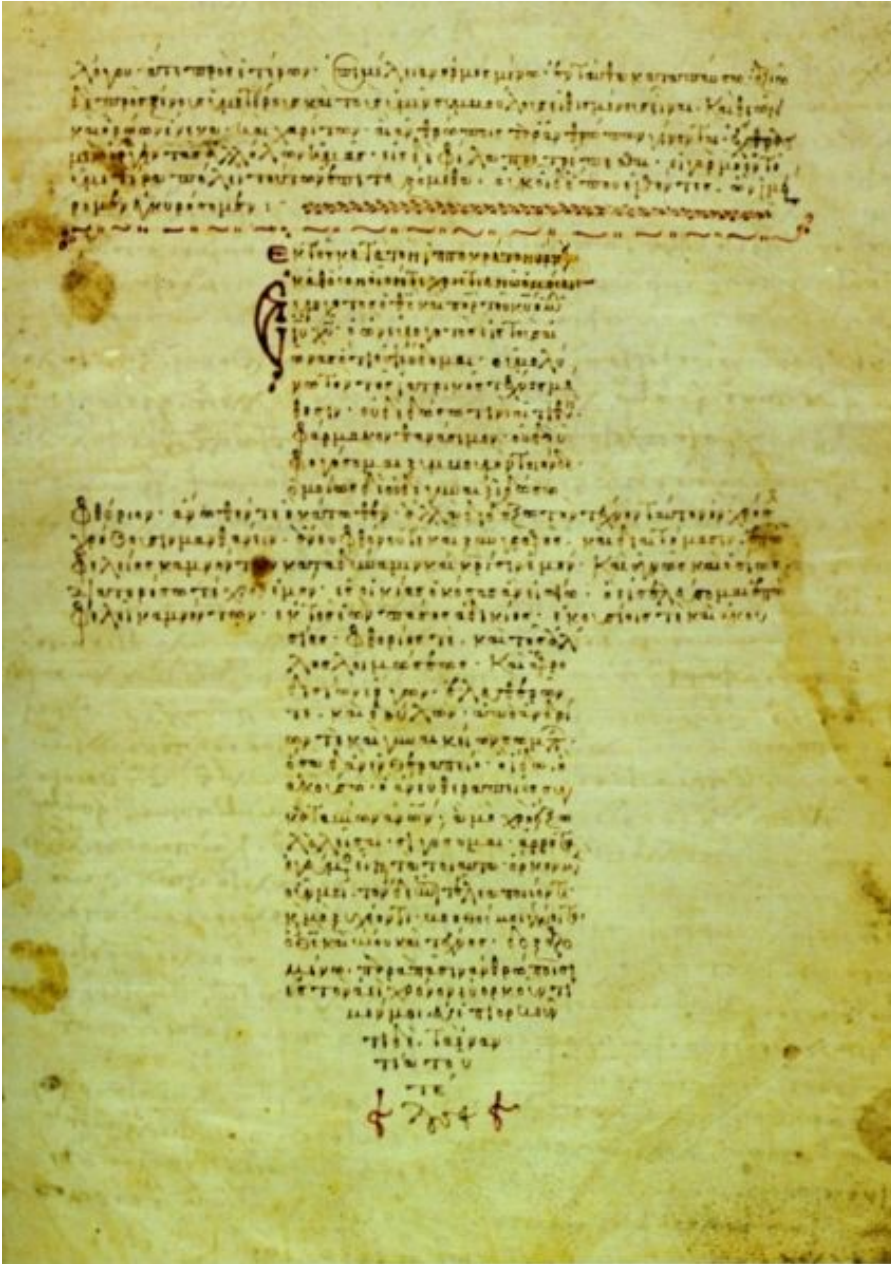
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## History revisited

- Ancient Greek understanding and the sacred oath of service to the sick
- Christian cleric-physician and link to divine authority and service to the sick / God
- Enlightenment: concepts of the self and freedoms
- Loss of link with health
- Liberal concepts of self in healthcare
- Legal support of patient's right of self-determination



## HIPPOCRATIC OATH

I swear by [Apollo](#), [Æsculapius](#), [Hygieia](#), and [Panacea](#), and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgment, the following Oath. ....

... for the good of my patients according to my ability and my judgement...To please no one will I prescribe a deadly drug nor give advice which may cause his death.....never do harm to anyone.....

The **Declaration of Helsinki**, developed by the [World Medical Association](#), is a set of ethical principles for the medical community regarding [human experimentation](#). It was originally adopted in June [1964](#) in [Helsinki, Finland](#), and has since undergone eight revisions, most recently in the year 2000. The Declaration expands upon the principles first stated in the [Nuremberg Code](#) and applies these ideas specifically to clinical research.

# Current reflections

- Cure and saving lives can be realised
- People are living longer
- Longer with chronic diseases (breast, prostate cancer)
- Technological advances
  - ▣ Prolong life
  - ▣ Postpone death
  - ▣ (palliate symptoms)
- Healthcare costs
- Scarce resources
- Ethical issues and conflicts

# General Ethical Principles



- Morality governs behaviour that affects others
- Behaviour that reduces or avoids the amount of harm suffered
- Character traits that help us
- Moral assumption of the duty of respect for the autonomy of others
- Professional duty of care for our patients

# Ethical Issues in Cancer Management

- Investigation and diagnosis
- Disclosure
- Treatment options and informed consent
- Multi-centre trials and new drugs
- Prognostication
- End of life care
- Futility and Medical care
- Resuscitation
- Euthanasia

# Ethical Principles

*Four principles useful in medicine*

- Autonomy (freedom of self - determination)
- Beneficence (doing good)
- Non - Maleficence (doing no harm)
- Justice (fairness)

■ Beauchamp TL: Principles of Biomedical Ethics

# Autonomy

- Freedom of self determination
- As the capacity to think and decide and to act on the basis of such thought and decision freely and independently and without let or hindrance
- Basic moral obligation to respect each person's autonomy
- Principle on which the debate on Informed Consent has hinged

# Beneficence

- Limits must be set of a person's duty to do good to another person
- No guidelines but morality may play a part

## Non Maleficence

- Duty of not doing harm
- May have clearer definitions and boundaries

# Justice

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- Fair distribution of resources
- Relates to the macro-allocation of resources (health spending versus defense spending) and to micro-allocation of a resource such as the physician's time

# Bioethics in clinical practice

‘Recently, a trend has emerged in bioethics in which the focus for ethical decision making is less on the application of abstract principles and more on the meaning of particular facts of specific cases as interpreted and experienced by the participants’

Slomka 1992

# People: Patient and Doctor

## Complex ecological matrix

*(JN Lickiss)*

ENVIRONMENT  
PERSON

H  
I  
S  
T  
O  
R  
Y

INHERITANCE

• BIOLOGICAL • CULTURAL

# Virtue Ethics

- Transcends legalistic rule and blind application of principles
- Honors the humanity of patients
- Honors the high standard of the profession
- Moral decision-making
- Compare: care-based ethics, duty-based ethics

# How do we learn ?

- Guiding principles
- Internalisation of Ethics
  - ▣ core integrity and honesty
  - ▣ reasons for doing medicine
- Experiential model
  - ▣ case based
  - ▣ clinical based
  - ▣ Mentorship
- Principle based bioethics
  - ▣ need for the above
  - ▣ but influenced by morality, inner integrity and honesty



# In practice

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## □ Pause and wait

- Clarify the issue
- Medical restraint

# Cancer Patients Approaching End of Life

- Very sick / Changing clinical situation
- Approaching death - fear / anxiety / preparation
- Short time for therapeutic maneuvers
- Different Personalities / needs
- Family VS Patient - varying needs
- Staff concerns and needs

# 5 domains of quality end-of-life care

*(Singer, 126 patients)*

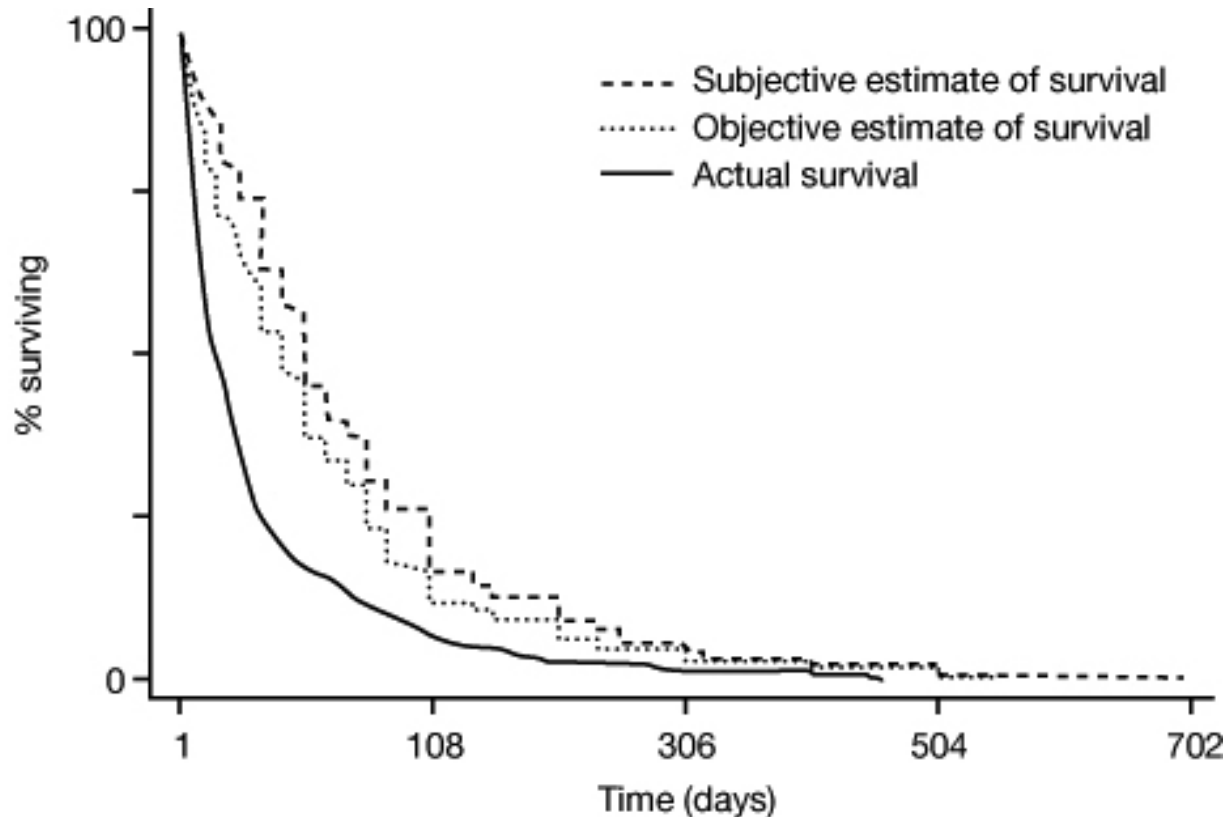
- Adequate pain and symptom management
- Avoiding inappropriate prolongation of dying
- Achieving a sense of control
- Relieving the physical and emotional burden that their dying would impose
- Strengthening relationships with loved ones

# Diagnosing Dying

- Prognostication
- Training in diagnosing 'active dying'
- Withdrawal of medically futile treatment
- Minimising observations and interventions
- Institution of appropriate end of life care
  - ▣ Medications, mouth and pressure care
- Discussion of end of life care with patient and family
- Documentation of DNR / NFR

# CLINICIAN ESTIMATES OF PROGNOSIS

- Generally inaccurate
- Systematically overoptimistic
- Christakis (2001)
  - ▣ Communicated survival median 90 days
  - ▣ Private 'formulated' survival median 75 days
  - ▣ Median 'actual' survival 24 days



Relationship between subjective, objective, and actual survival. The graph illustrates the differences between actual survival, formulated 'objective' survival (told to the investigators), and communicated 'subjective' survival (that would be told to patients) in 300 terminally ill cancer patients. The median actual survival was 24 days, the median objective prognosis was 75 days, and the median survival disclosed to the patient was 90 days. Source: Lamont and Christakis, 2001.

# WHAT EVIDENCE SHOWS:

- Experience improves prognostication
- Stronger the doctor-patient relationship, the lower their prognostic accuracy
- Importance of the second opinion
- Palliative Care consult

# CLINICIAN ESTIMATES OF PROGNOSIS

- The clinical estimate of survival is a powerful independent prognostic indicator
- Performance status
- Symptoms like anorexia, breathlessness, and confusion are important predictors
- QOL scores may be more powerful than KPS scores or symptom reports in predicting survival

# MEDICAL ETHICS

## □ MEDICAL FUTILITY

- ▣ Treatment that will not produce the benefits sought by the patient
- ▣ Therapy that results in temporary and fleeting benefits that do not improve conditions
- ▣ Treatment which prolongs the dying process and offers no realistic chance of improvement

# Medical Futility

- "Medical futility" refers to interventions that are unlikely to produce any significant benefit for the patient. Two kinds of medical futility are often distinguished:
- *quantitative futility*, where the likelihood that an intervention will benefit the patient is exceedingly poor, and
- *qualitative futility*, where the quality of benefit an intervention will produce is exceedingly poor.

# Medical Futility

- Quality of life
  - ▣ Never should be a value judgement about the worth of a person or their lifestyle
  - ▣ 'good' or 'bad' based on a patient's prognosis or medical outcome
  - ▣ Determined by the patient
- Good and basic medical care is never futile
- Assessment of the intervention
- There is a difference in treatment that prolongs life compared to treatment that prolongs the dying process
  - ▣ Eg; the ICU patient

# Medical Futility

- Distinct difference between the stopping of futile treatment and euthanasia
- Principle of Double Effect
  - ▣ My personal experience: uncommon
- Clinicians are not required to provide futile treatments
- Withholding and or withdrawing treatments that are futile is good medical practice

# Basic rules in scenarios of difficult discussions

- Physical setting
- Personal preparation
- What does the patient/family already know
- Empathy
- Active listening
- Maintenance of realistic hope
- Follow up

# Acceptance and Maintenance of Hope

- Supportive environment when bad news is broken
- Allow emotions to occur as it happens
- Provide realistic estimates of treatment options, outcomes and prognosis
  - ▣ Doctors feelings of failure
- Allow patient to grieve in a safe environment
- Explore patient's goals
- Maintain realistic hope
- Change the goal posts
- Help prioritise

# Acceptance and Maintenance of Hope cont'd

- Don't provide false hope
- Walk the journey alongside the patient
- Demonstrate sensitivity to religious and cultural beliefs
- Don't say 'we can't do anything'
  - ▣ There is always support and comfort

# Realistic estimates of treatment options

- The way information is given and their bias
- Disclosure and informed consent
- Treatment with false hope
- Prolonging life at all cost
- New drugs and availability in drug trials only
- Expensive drugs and justice / equity
- Even in palliative care globally: more expensive slow release preparations rather than the cheapest morphine preparations

# CPR

- What percentage of people survive a cardiac arrest?
- Whose responsibility is it?
- Is our duty of care to the patient or family?
- Do we have to do everything to preserve life?

# EFFICACY OF CPR

- **What do most patients believe?**
  - ▣ Optimistic expectation about the outcome of CPR
  - ▣ Review of fictional portrayal of CPR on TV
    - **nearly 67% of “patients” survived**

# EFFICACY OF CPR

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- Study of 71 elderly patients
  - ▣ 29 (41%) successfully resuscitated
  - ▣ 9 died within 24 hours
  - ▣ 6 remained comatosed until death

# EFFICACY OF CPR



- In hospital CPR - low survival rate of 6% to 24%
- Nearly 44% of survivors of in-hospital CPR had a significant decline in functional status

# EFFICACY OF CPR


- Age
  - >70yr - 3.4%
  - <70yr - 19.2%
- Metastatic disease 0%
- Cancer 0-7%
- Sepsis 0-2.5%
- Renal failure 0-4.4%
- Pneumonia 0-6.9%

# Discussions on CPR

- CPR is a medical intervention
  - As is antibiotic therapy
- It is a medical decision to institute it or not
- Determination of Medical futility
- End of life discussion with patients including the dying process (how does one die?)
- Do not ask the patient or relative if they want CPR
- Often they do not have the understanding to make that decision
- If you choose to get informed consent then you need to present full information as is required for IC
  - Including statistics, outcomes
- Bereavement experience

# Fear and Death Anxiety

- Fear of death
- Manner in which they will die
- Physical symptoms
- Pain at the end
- Loss of control, independence
- Loss of dignity
- Aloneness
- Prior witness of dying / death



Don't be afraid to discuss issues even if it makes people sad, upset and emotional.....

Address their concerns openly.

Acknowledge your own distress.....

# Summary

- Early discussions about end of life care with patient and families
- Communicate end of life care plans to your colleagues
- Good documentation
- Prognosticate
- Diagnose dying
- Continue good medical care
- Withdraw and withhold futile treatment
- Governed by morals, ethical principles and clinical experience