
Editorial

Is there a better way? Bioethical reflections on palliative cytotoxic drug use

Some of the most significant advances in cancer treatment over the past 20 years have resulted from the use of cytotoxic chemotherapy in patients with disseminated cancers such as choriocarcinoma, non-Hodgkin's lymphoma, Hodgkin's disease, germ cell tumours and various childhood malignancies. Many of these patients are now cured, and protocols for curative treatment are well established. However, most patients receiving chemotherapy are being treated with palliative, rather than curative, intent and there is no consensus on 'best documented practice' for this larger group of patients.

Thousands of scientific papers have now been published in the oncology literature, attesting to the poor response rates of many human solid tumours with the use of chemotherapy; examples include metastatic non-small cell lung cancer, malignant melanoma, thyroid carcinoma, renal cell carcinoma, hepatocellular and hepatobiliary carcinomas, soft tissue sarcoma, gastric carcinoma, endometrial and cervical carcinomas, cerebral astrocytoma, and prostatic carcinoma. However, despite the plethora of clinical papers that document relatively poor 'response rates' for these tumours, cytotoxic drugs are often used in clinical settings in which there is only meagre evidence of benefit. Furthermore, despite significant recent interest in developing valid quality of life instruments, we still know very little about the quality of life of patients receiving palliative chemotherapy, compared with those patients receiving 'best supportive care'. Even in patients who do receive chemotherapy for symptomatic control of their malignancy, we do not know which cancer-related symptoms are alleviated, and which are not.

A number of clinicians have called for the development of evidence-based minimum guidelines for treatment of metastatic cancers by cytotoxic chemotherapy.^{1–3} It has been suggested that the benefits of the development of guidelines and their implementation would include a reduction in financial costs to the health care system and to society in general, the maximization of health outcomes for patients who *do* receive chemotherapy, and an increase in the vocational satisfaction of cancer specialists who prescribe chemotherapy.

Patients with advanced cancer (or their relatives) will often become depressed and resentful when told that nothing more can be done to prolong life; in many instances, oncologists may feel under pressure to 'do something' by using cytotoxic chemotherapy. Some oncologists still believe that to offer cytotoxic treatments in the face of almost certain therapeutic failure can be justified on the basis of providing patients with 'hope'.

Frustration, anger and despair are all natural and authentic emotions associated with coming to terms with a diagnosis of incurable malignancy. However, it may well be that skilled emotional support, rather than cytotoxic drugs, is a more appropriate professional response to a patient and family faced with the shattering realization that the cancer is now beyond cure. In analysing the attitudes of patients to chemotherapy, Slevin *et al.* have concluded that 'faced with the reality of the diagnosis as to the purely theoretical possibility, patients are likely to accept any treatment that offers them some possible benefit and hope, however slight'.⁴

One could rightly make the case that it is in

neither the oncologist's nor the patient's interest for cytotoxic drugs to be prescribed when a response is unlikely, when the potential for toxicity is so great, and when false hopes are so readily aroused in patients and their families. Ill-worded phrases such as 'you have failed to respond to treatment' compound the patient's disappointment at therapeutic failure, suggesting, as they do, that the 'failure' is in some way the patient's fault. For many patients with incurable malignancy, chemotherapy represents an intrusive treatment option, which hinders the ability of patients and family to come to terms with the reality of dying.

Is there, then, a better way? First, it would seem appropriate to support further research and/or evidence-based consensus initiatives to determine which group of patients with metastatic cancers receive little or no benefit from chemotherapy compared with 'best supportive care'. It is conceivable that a prospective randomized trial to test this critical hypothesis could be mounted, using appropriate quality of life instruments and important input from health economists. The essential goal in managing patients with incurable cancer is to improve the quality of remaining life in a cost-efficient manner; cytotoxic chemotherapy is only one of the many ways in which quality of life can be improved, but it is a poor choice for many patients.

Secondly, more data are clearly required concerning patient and carer needs, and the essential determinants of a good quality of life for patients with life-threatening illness. While the alleviation of cancer related physical symptoms is critical to the success of palliative care measures, other issues inherent to an improved quality of life include a restoration of personal control, enhancement of self-esteem, the implementation of strategic coping skills, and attention to existential concerns. At a time when some health care professionals claim that the provision of psychosocial and psychospiritual support not only improves well-being but may contribute to a prolongation of life,⁵ important research questions related to the provision of psychosocial interventions need to be formulated and funded if palliative medicine is to accept the challenge of responding creatively to the pressure to treat with cytotoxic drugs. Therefore, sufficient funding is urgently needed to research and develop the use

of a wider range of holistic support services, so that options other than cytotoxic chemotherapy can be recommended as a valid means by which the lot of patients with metastatic cancer can be improved.

Finally, those patients (or their families) who still insist on receiving chemotherapy create a particularly difficult clinical dilemma in balancing the concepts of beneficence by the physician with the patient's right for self-determinism. In perhaps no other field of medicine are interpersonal and communication skills (especially in the breaking of bad news) so important to patients, their families and the collective health care system. It will often be important to spend time with families to elicit the driving factors behind their demand for cytotoxic drugs in the face of near certain failure. Sensitive and realistic discussions regarding the relative ineffectiveness of cytotoxic chemotherapy for many common solid tumours will need to be linked to the provision of those supportive measures with proven benefit in maximizing quality of life. On other occasions, a second opinion from a suitably qualified colleague will be offered. For many patients who are otherwise asymptomatic, patients and families will see that a decision not to offer cytotoxic chemotherapy is often in their best interests.

If the medical profession is to demonstrate its ethical and clinical competence, it must accept the challenge of developing clear guidelines for anticancer drug usage in patients with metastatic cancers. A further challenge to develop collaborative randomized clinical trials for a range of emotional, social and spiritual supportive interventions should also be obvious to health care workers devoted to improving the quality of life of their patients. Such challenges are not new, for, to quote Aristotle, 'in medicine, it is easy to know what honey, wine and hellebore, cautery and sugary are, but to know how and to whom to apply them; that is truly to be a physician!'

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References

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