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Ethical aspects in managing patients diagnosed with digestive cancers; a review of literature

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All authors had an equal scientific contribution and shared the first authorship.

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Review

Ethical aspects in managing patients diagnosed with digestive cancers; a review of literature

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Abstract

Numerous bioethical recommendations are now available in the complex process of communication with cancer patients. In this review, we have focused on the complex process of managing patients with different types of oncologic digestive diseases, immediately after the diagnosis is made.

We have analyzed the literature data on the topic. MEDSCAPE and PubMed databases have been studied. Issues such as telling the truth to patients with digestive cancer, the physician's responsibility in the psychological management of patients and their relatives, the nurses' duties, the consented death, the practice of euthanasia and physician-assisted suicide (PAS) as well as the clinical research have been the main targets of our study.

Keywords

: ethics, management, digestive cancers

Highlights

- ✓ Communication with the cancer patient about the development of the disease and the oncologic management is the key to a successful oncologic therapy.
- ✓ Cultural statements, laws and ethical rules have been largely developed and standardized lately to create models of behavior for physicians, nurses and patient's family members, to maximize the comfort and the life quality of cancer patients.

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Introduction

Bioethical rules should guide physicians in the communication process with cancer patients. In this review, we have focused on the complex process of communication with patients suffering from different types of oncologic digestive diseases, immediately after diagnosis. Communicating the information about diagnosis, treatment and prognosis to patients with gastrointestinal cancer is the main issue concerning the ethical aspect of the studied pathology (1). For more than 25 years, different committees composed of experts in psychology, researchers in the field of oncology, patient's advocates and physicians have been preoccupied and made efforts in creating a guideline to follow when it comes to cancer patients. Throughout time, the central ethical aspects studied have been the following: telling the truth to the patient, the physician's responsibility for the psychological management of patients and their relatives, the nurses' duties, the consent to death (2), the practice of euthanasia, the physician-assisted suicide (PAS) (3) and the clinical research (4).

The present review relates to the available data in the literature regarding the ethics in oncologic digestive diseases. MEDSCAPE and PubMed databases have been studied, and terms such as ethics and gastrointestinal cancer have been the search engines. From the entire database, thirteen studies have been selected. Issues such as: telling the truth to the patient, the physician's responsibility for the psychological management of patients and their relatives, the nurses' duties, the consent to death, the practice of euthanasia, the physician-assisted suicide (PAS) and the clinical research have been the main topics studied.

Discussions

- *Telling the truth to patients with digestive cancers*

Attitudes and practices of truth-telling to patients diagnosed with digestive cancer have changed substantially in the past decades (5). In clinical practice, dilemmas of whether, when and how to tell the truth to patients are sometimes very difficult to solve. Cultural and individual differences interfere and these aspects have magnified the difficulties in the communication with digestive cancer patients. The prognosis of the disease can influence the anxiety of patients when coping with digestive cancer (6). The main approved approach related to these patients is unitary but it is influenced by digestive cancer location and stage. Patients playing an active role in the diagnosis of digestive cancer are nowadays the first target of screening programs. Making people aware of the

importance of detecting digestive cancer in the early stages is the concern of our current society. Spreading the information regarding the screening procedure for colorectal, esophageal or stomach cancer can lead in the following decades not only to a better communication with the cancer patient but also to a decrease in the incidence of oncologic digestive diseases. The willingness of patients to participate in screening programs makes it easier for the physician to communicate the subsequent diagnosis. Patients concerned about their health are more focused on "what to do next" than on the gravity of the moment. They can play an active role in the diagnosis and treatment management. However, the majority of patients are discovered beyond the screening programs. To better cope with the diagnosis, people need to preserve hope. The means of treatment, the evolutionary and the prognostic data should be correctly presented to patients to ensure that the accurate information is given and the right choice is made by the patient. However, ethnical origins, religious beliefs, cultural differences and legal regulations should be also respected.

- *The physician's responsibility in the psychological management of patients and their relatives*

Advances in the psychological research have changed the way of thinking about health and illness. The biopsychosocial model relates to health and disease as the product of a multitude of factors including biological characteristics (such as genetic predisposition), behavioral factors (such as lifestyle, stress, health beliefs) and social conditions (such as cultural influences, family relationships and social support) (7). This conceptualization of health and illness has many scientific and practical benefits. Following this concept, a lot of patients can reduce their risk of developing major medical problems, receive adequate treatment and reduce health-related costs when asking for the treatment to an interdisciplinary team including behavioral healthcare providers (8-10). However, in the field of oncology, things are more complicated. Facing the diagnosis of cancer causes severe distress. Like the patient, the family also feels the emotional discomfort of the patient. Patients feel distressed during the onset, the course and the outcome of the disease. The psychological support for the patient and family members could minimize the impact of the illness and can also contribute to an improved life quality for both patients and relatives involved in caregiving.

Physicians are focused on improving collaboration and the illness perception among the family members, patients and other healthcare professionals. In all this

period, it is essential to support the patient and the family throughout the course of the disease and the cancer treatment. The therapeutic alliance with the family that should be informed about all aspects of the digestive cancer patient is a powerful tool to improve. Besides the life quality of the patient, the psychological distress of the family members who are involved in the patient's support should be improved. The physicians' goal is to help the patient's family face the anxiety and fears for patients with digestive cancers and also, the capacity to meet everyday problems (11). The impossibility of self-feeding in esophageal cancers, the presence of stomata for easier feeding, the presence of stomata for intestinal evacuation are challenging for patients. One should plan meetings to inform patients and home-care providers to accept the new disability and to monitor the functionality of the devices used. Special communication skills are required to meet the family's expectations during the discussions regarding the aspects of the patient's everyday life (12). Before meeting the family, it is essential to know the details regarding the patient's family, such as composition, residence, the living standards, the lifestyle and the social life and, whenever possible, the aspects about culture, values and spiritual beliefs. These aspects will make it easier to cooperate when it comes to the material and psychological resources throughout the disease and what expectations they have from doctors and medicine altogether (13). Planning whom to invite to a meeting and the preparation of the meeting along with the proper environment for it are issues that should be solved beforehand. The physician should then investigate with empathy all the emotions and beliefs that run in the family and try to support the positive feelings of pain sharing. Moreover, the physician should allow time to express the negative feelings of anxiety and to advise the patient and the family to deal with them in everyday life and the change in habits required by the illness. However, the patient should remain the core of the conversation. The physician should emphasize the suffering, the communication difficulties, the commitment to active participation to treatment and the influence of emotional distress on relatives. Counseling experience proved that physicians should always be aware of the patient's constant shifts, from the expectation of endless support from the family members to the effort of being autonomous and independent in the management of the disease, and act consequently (12).

- *Nurses' responsibilities*

The management of cancer patients required specialized healthcare providers. An innovative class of

nurses to attend patients with gastrointestinal cancer is now available in some specialized centers. The nurse's role in caring for digestive cancer patients includes knowledge on the oncologic disease pathophysiology, risk factors identification, detection methods, clinical features, available treatments, conventional and integrative holistic nursing interventions and community resources. For digestive cancer patients, nurses should be skilled in monitoring and restoring the damaged functionality of the devices used. They should inform patients and family members on everyday use of tools and their cleaning and should also tell them about possible side effects (13, 14).

- *The consent to death, the practice of euthanasia and physician-assisted suicide (PAS)*

Physician-assisted suicide (PAS) is the most exciting issue of present times (3, 15). Religious condemnation and sometimes moral disapproval of suicide by the society were associated with its criminalization in most societies before the beginning of modern times (16, 17). However, opinions regarding suicide have changed during the 19th and the 20th century, which coincide with the development of modern psychiatry, as an autonomous discipline. In this field, the practitioners could investigate, diagnose and treat anxiety, depression and other ailments leading to suicide. The achievements in the psychiatric field referred to mental illness opposite to the hypothesis that consenting to death in end-stage diseases is related to a psychiatric disorder or is determined by social or psychological forces. These issues once contributed to the decriminalization of suicide (18). In 1967, the wave of accepting the idea of end-of-life choice appeared, even if dominated by skepticism among the society and the medical authority (19).

Along with the specialist's evaluation of the medical reasons for the patient's end-of-life decision, an exhaustive psychiatric evaluation is required when confronted with a request for PAS. Another concern of the authorities, besides the elimination of possible mental illness, was the idea that PAS can become a practice, especially in vulnerable populations. Targets such as increasing the patient's autonomy and adhering to professional liabilities, as well as promoting for additional research that focuses more directly on the patient-centered perspective, are still imposed. Nowadays, PAS is legal in 4 states of the US and also in the Nederland. Even though legitimate, the issue is not without discomfort for physicians. Even the phrase itself "physician-assisted suicide" is controversial. For example, Oregon's "Death with Dignity Act" clearly states the physicians' role as the primary gatekeepers of assisted suicide. The physicians'

duties are the insurance of the fact that the disease is terminal, with a prognosis of maximum six months and only if the patient requesting PAS acts voluntarily, being capable of making decisions and being well informed about his medical condition. Even under such conditions, physicians may feel uncomfortable to assist PAS. Besides the communication with the patient's physician regarding all aspects of treatment and behavior when facing digestive cancer, the psychiatrist's role as an expert includes the evaluation of his decision-making capacity and the clarification of discussions among treatment participants (the physician, the family and, last but not least, the patient) to minimize the possibility of undue influence on a patient's ultimate decision (20).

- *Clinical research*

The newest oncologic therapies have led to an increase of the mean survival time for patients with advanced digestive cancer, for example almost fourfold longer than expected with the best supportive care in CRC. This good evolution was accomplished due to the combination of chemotherapy and targeted biologic agents. However, the identification of KRAS mutations proved that the newest agents are targeting epidermal growth factor receptors, such as cetuximab and panitumumab, and therefore are not beneficial to patients with mutations. This process of understanding what is of maximum interest for the targeted therapy in colorectal cancer has taken years (21). The time spent from the presentation and publication of small, retrospective phase II studies to widespread acceptance of the KRAS predictive value and changes in oncologic guidelines was lengthy enough. The process of data disclosure regarding KRAS status and the treatment of advanced CRC patients was effective in permitting timely decisions regarding the ongoing publicly funded clinical trials and, whether or not such decisions were rational and ethical is still controversial (22).

Conclusions

The ethical aspects of the oncologic digestive diseases are fundamental in managing patients. The ability of physicians involved in diagnosis and treatment, the support of psychiatrists, the interaction and communication with family members, the support of nurses and the law regulations in terms of allowing assisted death are the pillars of an excellent ethical attitude. The differences in culture, religious beliefs and socioeconomic status make it very hard to have a global approach. However, ethical rules should guide the

physician's decisions in attending digestive cancer patients.

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Conflict of interest disclosure

There are no known conflicts of interest in the publication of this article. The manuscript was read and approved by all authors.

Compliance with ethical standards

Any aspect of the work covered in this manuscript has been conducted with the ethical approval of all relevant bodies and that such approvals are acknowledged within the manuscript.

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