Ethics of palliative care in late-stage cancer management and end-of-life issues in a depressed economy

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Abstract

The Hippocratic Oath has often been referred to as the ethical foundation of medical practice with the key restriction “cause no harm” which is also the principle of benevolence in bioethics. In medical profession, the Oath still exemplifies the key virtues of a doctor in its emphasis on the obligations toward the well-being of the individual patient. In management of end-stage cancer in a depressed economy such as Nigeria, we frequently encounter a wide range of ethical issues that arise in the provision of palliative care mostly due to the prevailing economic situation and cultural setting. Since most of these patients came from a lower economic class of the society, with little or no formal education and lived at a subsistence level, they often find it difficult to provide the medications needed. In a poor setting where health inequity is rife, and ignorance and poverty are commonplace, a good understanding of medical ethics with a good model of health care system will contribute to the health professional’s decision-making that will be in the best interest of the patients. Physicians must protect the lives of their patients and should never hasten their death. In end-stage cancer management, we have to relieve suffering and pains, promote palliative care, and give psychological support but never abandoning the patient or initiate terminating their life. This presentation is a clinical analysis of the ethical issues regarding the management of end-stage cancer patients in a poor economy with a critical overview of end-of-life issues in African perspective.

Key words: Depressed economy, end-of-life issues, ethics, palliative care

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Introduction

Worldwide, cancer constitutes serious health morbidity and mortality with its incidence varying widely according to geographical location and site of the body characterized by age, sex, or race. Estimated prevalence rate of cancer worldwide shows there were 14.1 million new cancer cases, 8.2 million cancer deaths, and 32.6 million people living with cancer within 5 years of diagnosis in 2012. Of these, 57% (8 million) of new cancer cases, 65% (5.3 million) of the cancer deaths, and 48% (15.6 million) of the 5-year prevalent cancer cases occurred in the less developed countries. In developing countries, most patients present late due
to a chain reaction of event viz.: Improper health seeking behavior, poverty and ignorance of the disease, treatment by quacks and unorthodox medication, nonavailability of medical personnel, superstitious belief, and family decisions. End-stage cancer has often been associated with having one of the worst effects on the quality of life among affected patients. The most patients on clinical management have often demonstrated their concern and priorities on adequate pain and symptom relief, avoidance of prolongation of painful death, and relief of both financial and social burden on relations.\[3\] The management of end-stage cancer patients involves palliative care since most patients are often faced with uncertain prognosis and treatment outcome. The World Health Organization (WHO) defined palliative care as an approach that improves the quality of life of patients, and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification, impeccable, assessment, and treatment of pain and other problems, physical, psychosocial, and spiritual.\[1\] Palliative care improves patient’s treatment outcomes, including family satisfaction with care and symptom management.\[4,6\] It also promotes patient well-being and dignity, communication with healthcare providers, emotional and spiritual support for the patient and the family, and access to community support services.\[5\] Palliative care is often aimed at improving the quality of life and supporting patients, and the families of patients with serious and complex chronic illnesses in whom prognosis is uncertain or may not be measured in years. There is much difference between euthanasia and palliative care. Palliative care is not euthanasia nor is it physician-assisted suicide. Fundamental differences in each one of these make them distinctly separate. Euthanasia is defined as the act of a third party, usually a physician, ending a patient’s life in response to severe pain or suffering. In contrast to euthanasia, the intent of palliative care is not to cause death but to relieve suffering. Palliative care is long-term care to make the end-of-life stage as comfortable as possibly, euthanasia is simply putting the patient out of his or her misery in a humane manner. However, the focus in this paper is on palliative care. The management of end-stage cancer patients involves relieving suffering through a multidisciplinary and holistic approach that addresses patients’ and caregivers’ physical, emotional, spiritual, and logistical needs. In Nigeria, as its often the case with other developing countries palliative care is a newly emerging field of health care with little or no documentation of its services.\[8\] Consequently, palliative medicine and hospices have been neglected despite the increasing occurrence of cancer in the environment.\[9\] In Africa, health inequality is rife, and most of these cancer patients more often do not have financial backings to receive palliative care treatment and psychological support until they die naturally. In certain situation, some of the patients are abandoned to their fate in the hospital because the relations do not have the means to fund their treatment. About 70% of cancer cases present at the advanced stage when the only option available becomes the palliative care because of limited access to health facilities and treatment options.\[10\] There is no doubt that culture and poor economy among others are limiting factors to palliative care in our environment in comparison to developed countries. In the developed countries such as USA, UK, and Canada palliative care has remained the hallmark of end-of-life care because they practice the core principle of palliative care which involves open disclosure of ailments to the patient, autonomy and patients participation in decision-making concerning their health, and a workable health system in contrast to what we have here.

### Cancer and Palliative Care in Nigeria - An Overview

Cancer incidence in Africa is on the increase and according to the WHO report 12.5% of all deaths worldwide are attributable to cancer and if the trend continues unchecked, it is estimated that by 2020, 16 million new cases will be diagnosed per annum out of which 70% will be in the developing countries.\[11\] Literature review shows the occurrence of cancers in Africans is getting higher,\[1\] an ailment which was once believed to be rare due to the high prevalence of communicable diseases.\[7\] According to Parkin et al.\[12\] about 650,000 indigenous African population of the estimated 965 million are diagnosed with cancer annually. While breast cancer is the most common cancer among women in Nigeria with increasing incidence,\[13,14\] the prostate cancer in men is equally on the increase. Cervical cancer is the second most common cancer among women worldwide, with an estimated 529,409 new cases and 274,883 deaths in 2008 with about 86% of the cases occurring in developing countries.\[15\] Orofacial cancer, on the other hand, is becoming a new epidemic as several new cases are being reported with increasing mortality rate.\[16\] Cancers of the oral cavity make up 3–4% of all cancers, being in eighth place in men and eleventh in women when the cancer is caused by smoking and alcohol misuse\[17\] with 5-year prevalence level of 4.2% for all cancers cases affecting the lip, oral cavity, and the nasopharynx. \[11\] The increasing incidence of oral cancer and the associated mortality rate emphasizes the need for preventive measure.\[18\] The most of the patients often come from a lower economic class of the society, with little or no formal education and lived at a subsistence level. Approximately, 100,000 new cases of cancer occur in Nigeria annually.\[19\] In Nigeria, these patients often present at an advanced stage of the lesion when the only treatment options remain the palliative care.\[16\] Palliative care in most African countries is rudimentary, and most health practitioners have poor knowledge of palliative care. It has been shown that established care, support/pain control exists only in few countries such as South Africa, Zimbabwe, Uganda, Kenya, Tanzania, and Egypt. Therefore, individualistic approach
to the management of terminal cancer patients is what obtains.[20] The University College Hospital, Ibadan was the first to have structured Palliative Care Services in Nigeria. Palliative Care Services commenced in 2007 as a collaborative effort between the Hospital and the Centre for Palliative Care in Nigeria established in 2003.[21]

Ethics of Managing End-stage Cancer in a Depressed Economy

While individual doctors have their own personal beliefs and values, there are certain professional values on which all doctors are expected to base their practice. Doctors have a duty to make the care of patients, their first concern and to practice medicine safely and effectively. They must be ethical and trustworthy. Patients trust their doctors because they believe that, in addition to being competent, their doctor will not take advantage of them and will display qualities such as integrity, truthfulness, dependability, and compassion. Good professional judgment and conduct in clinical practice should be patient-centered. It involves doctors understanding that each patient at the end-stage of his or her ailment is unique, and working in partnership with their patients to address the needs and reasonable expectations of each patient. The philosophical dictum as postulated by Plato and Aristotle emphasized the role of reason both in perceiving what is just and in allowing us to act justly rather than give in to contrary impulses of desires and emotions. In the same ethical maxim, the Hippocratic Oath has often been referred to as the ethical foundation of medical practice with the key restriction “cause no harm” which is also the principle of benevolence in bioethics. In medical profession, the Oath exemplifies the key virtues of a doctor in its emphasis on the obligations toward the well-being of the individual patient.[22] This is the principle on which the professional conduct of physicians and surgeons is centered.[23]

Ethics is about duties and obligations: To whom we have duties, how extensive they are, how best they may be discharged, and how we deal with conflicting duties and obligations. Patients have duties and obligations too and should be respected as moral agents and be seen as an end but not as a means to an end. Situations where as a clinician, you consider you have a duty to people other than your patient; a key issue is how best you discharge these duties in the best interest of both parties. A duty of care is, therefore, paramount in the relationship between clinician and patient, especially in a depressed economy such as ours.[24] Ethics is not just a set of rules, nor is it a formula that must be followed blindly or rigidly. Each case should be treated on its merits and specific circumstances. One rule fits approach might be unethical as it fails to consider the specific interests of the prevailing situation. The moral conduct and responsibility of medical professionals in the clinical management of terminally ill patients such as in end-stage cancer in a developing society with depressed economy should be centered on giving the patients the best palliative care available to relieve their pains and give them psychological support.

As clinicians, our obligation to duty is to ensure the well-being of our patients and not sacrificing one to make other people happy. Physicians must protect the lives of their patients and should never hasten their death. When we cannot cure an ailment what we have to do is to relieve suffering but never abandoning the patient or initiate terminating their life. We must promote palliative care and give psychological support, so they can find the meaning of life until they die naturally. In clinical management of terminal diseases, distinction should be made between optional and obligatory treatment. Extraordinary treatment can legitimately be forgone but not ordinary treatment, especially in a depressed economy like ours. The principle of deontology as postulated by Immanuel Kant and utilitarianism should come into play if we apply proper clinical judgment in the management of terminal ailments with the watchword “cause no harm.” Extraordinary treatment in this context means using high-tech costly equipment such as life support machines while ordinary treatment is the common pain relieving drugs used in palliative care such as morphine.

The national health policy of African countries should as a matter of needs institute health insurance policy to help patients under palliative care treatment obtained proper care. The terminally ill patients, rich and poor should have right to obtain treatment and be free from pain and discomfort, share quality time with family and friends and put their affairs in order as they set for their last journey on earth.[25] A denial of such duty of care should be seen as an infringement on the human right of the individual. Because of the economic predicaments of most African countries, and the fact that palliative care management and hospices required funding, the health policy makers in Africa countries should, therefore, institute policies of palliative care beyond the conventional method obtained in developed countries with the view of making palliative care in the African context affordable and achievable. Hospice and palliative care team can offer the required comfort and peace of mind as people get near to the end of life’s journey.[13]

End-of-Life Issues and Euthanasia in African Perspective

In most African countries, the concept of life begins from the time of conception to the last breath of life and any human efforts aimed at truncating this natural process of life is often seen as an abomination. In as much as one may not rationalize the homogeneity of African culture because we
live in a pluralistic and complex society, but all traditional African people believe that the soul of an individual lives after death. Most Africans, especially the Igbo and Yorubas of Nigeria believe that people do not die in actual sense, but transit to join their ancestors at the time the ancestors’ beckon on such an individual. Therefore, it will be a taboo to institute terminating the life of an individual even in the state of hopelessness and terminal disease because the ancestors will be angry and visit the community with plaque.

The Igbo of Nigeria and indeed some other African societies believe in reincarnation. People are believed to reincarnate into families that they were part of while alive. Before a relative dies, it is said that the soon to be deceased relative sometimes give clues of who they will reincarnate as in the family. Once a child is born, he or she is believed to give signs of who they have reincarnated from. This can be through behavior, physical traits, and statements by the child. A diviner can also help in detecting who the child has reincarnated from.[26] These beliefs also extended to their understanding of health matters. In the traditional African society most ailments are known to be spiritually oriented so more often, they resort to a diviner for intervention or witch doctors, with the belief that most often patients with incurable diseases are suffering from vengeance from an offended god for their sins committed in their past life. Therefore, it will be improper to terminate the life of such a person in the face of the terminal and incurable disease.

Extended families are still the norm and, in fact, remain the backbone of the social system in Africa. Grandparents, cousins, aunts, uncles, sisters, brothers, and in-laws all work as a unit through life. Family relationships are guided by hierarchy and seniority (Familismo). Individuals turn to members of the extended family for financial aid and guidance, and the family is expected to provide for the welfare of every member even in time of ill health. Therefore, individual that benefited from the family structure is expected to owe allegiance to the system in return and in a certain situation, do not have autonomy to decide on his or her health matters without the family input.

Cultural factors strongly influence patients’ reactions to serious illness and decisions about end-of-life care.[27] However, the emerging global health care has placed the Africans on the precipice of being concerned about some basic questions about life and human values such as the rights to life and healthy living, euthanasia, healthcare policy and management, health inequity, and life technology. The extent to which cultural beliefs should be permitted to influence health care policy in Africa should be of concern to policy makers, clinicians, ethicist, and medical experts in the face of increasing incurable cancer cases and terminally ill patients in our society.

Conclusion

The management of end-stage cancer in a depressed economy as seen in most African countries such as Nigeria should be centered on palliative care. We frequently encounter a wide range of ethical issues that arise in the provision of palliative care mostly due to the prevailing economic situation, limited option of treatment, and cultural setting. In a poor setting where health inequity is rife, and ignorance and poverty are commonplace, a good understanding of medical ethics with a good model of health care system will contribute to the health professional’s decision-making that will be in the best interest of the terminally ill patients. As clinicians, our behaviors, actions, and attitudes must be in tandem with the services we render to the public regarding their health. We should be responsible enough to recognize ethical issues involve in palliative care and make choices that will be in the best interest of the patients. Clinicians should, therefore, be accountable to meeting the standards of care in their practice as required to enhance the public’s trust. We should adequately be informed that patients have fundamental right no matter how bad their health condition may be and are entitled to make choices regarding their health. We must protect the lives of our patients and should never hasten their death. When a clinician cannot cure a terminal ailment such as end-stage cancer, what should be done is to relieve suffering and pains but never abandoning the patient or initiate terminating their life. We should promote palliative care and give them moral and psychological support until they die naturally.

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References