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ETHICAL ISSUES OF DIAGNOSIS IN GYNECOLOGICAL MALIGNANCY

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Abstract

Objectives: The research focused on identifying ethical conflicts faced by gynecologist in communicating cancer diagnosis and understanding patient's expectations regarding communication and taking therapeutic decision.

Material and methods: It was a prospective study realized in the 1st Clinic of Gynecology Iasi which used a questionnaire for all patients admitted in our clinic

Results: 90 patients with mean age 47.7±5.2 years (range 18-76 years) were analyzed. 93.3% of women wanted to be informed if they have cancer, 92.3% in a directly manner and only 13% didn't want as relatives to find out the diagnosis. 88.9% of patient request to be informed about chances of surviving and not about mortality. 86.7% of them wanted to know how the disease will affect the quality of life. Only 53.3% of patients wished that the diagnosis to be communicated in the presence of a closed person. 61% of cases appreciate

more a doctor which tells them straight and honest the diagnosis. Even the paternalistic relationship regarding treatment it isn't actual, in case of malignancy 72% of patients considered that the decision of management must be taken by the doctor totally.
Conclusions: By increasing the autonomy of the patient and the degree of education, appears the necessity of knowing the own disease. The way of communication of bad news is important for our patients and most of them want honesty and realism. The resolution of physician's dilemmas regarding communication of cancer diagnosis achieved with a focus on respecting the preferences of the patient.

Key words: neoplasm, ethics, physician patient relationship, communication

Introduction

Patient's information about cancer diagnosis and prognosis has been an ethical challenge from immemorial time. The physician assessed the communication as a difficult task due to lack of investments for the development of communication skills in medical school, the symbolism of cancer, the presence of unreality to the patient's knowledge of the diagnosis and the difficulties in dealing with death.

It is considered pertinent to assume, that in oncology difficult news are constantly transmitted, both in the initial and in the terminal stage of the disease, demanding that doctors develop skills focused on the communication of difficult diagnostics and prognostics. The physician is concerned about the way of communication of bad news which must be approach, because the impact on the patient is very strong. Those who feel insufficiently trained in communication skills experience significantly higher levels of distress when faced with patient suffering (Farhat, Othman, el Baba & Kattan, 2015). Another concern is how the bad news will affect the patient. Physicians also consider breaking bad news to be an unpleasant task, because they do not wish to take hope away from their patients. They might be fearful of the patient's or family's reaction to the news, or uncertain about how to deal with an intense emotional response. Other reasons that physicians tend to avoid disclosing the truth to cancer patients include lack of time and desire to avoid painful discussions.

Gynecological cancers account for a significant amount of all cancers among women. In 2018, cervical-, uterine-, and ovarian- cancers accounted for 13.7% of all cancers among women worldwide (GCO, n.d.). Given the difficult treatment course and poor prognosis for many women with a gynecological cancer diagnosis, it is not surprising that rates of psychological distress are high. It seams that between 30% and 42% of women with gynecological cancer report moderate to severe anxiety (Bodurka-Bevers et al., 2000; Goncalves, Jayson & Tarrier, 2010) and up to one third report moderate to severe levels of depressive symptoms (Bodurka-Bevers et al., 2000; Clevenger et al., 2013; Norton et al., 2004; Hipkins, Whtworth, Tarrier & Jayson 2004).

The incentive to conceal the truth and the lie, considered mild by the intention of not causing harm to the patient, was present in traditional codes of nineteenth-century medical ethics. Changes in society, with the development of new information technologies, and in the biomedical field, with the rapid improvement of medical science and the emergence of bioethics, may be contributing to reformulating paradigms in the field of health, in which are highlighted new moral values and rules associated with autonomy and recovery of the patient in achieving their desires and exercising their rights. Rise of patient self-determination and differing values between healthcare workers and patients are among the many factors contributing to the frequency and complexity of ethical issues in healthcare (Ong, Yee, Lee, 2012).

Objective

The research focused on identifying ethical conflicts faced by gynecologist in communicating cancer diagnosis. The aim was improving of patient's communication with healthcare professionals. The objective of clarifying the current available knowledge of patient preferences was taking into account when we decided to start this study. We want to provide an overview of not one specific but all gynecological cancers with an emphasis on patients' perceptions of quality of care and expectations regarding communication and taking therapeutic decision.

Material and Methods

A 15-item questionnaire was developed: 12 questions to measure oncology patients' communication preferences regarding communication of malignant gynecological disease and 3 questions were demographic. Demographic variables were age, place of living and, education level. Questions were clearly formulated, taking into account a good understanding for patients with all levels of education. Data collection took place for a single month (October 2019) in the 1st Clinic of Gynecology Iasi. The nature and purpose of the study were explained to all participants. It was emphasized that participation was voluntary. Verbal consent was obtained before adult participants were interviewed, respecting their autonomy and anonymity.

Results

90 patients with mean age 47.7±5.2 years (range 18-76 years) were analyzed. We must mention that only 9 of them have been diagnosed with gynecological malignancy (cervical cancer, ovarian cancer, endometrial cancer or breast cancer) and the other 81 women were admitted in the hospital for different diagnosis. Most of them live in a city (60%). A total of 32 (35.55%) had college or higher education, 45 (50%) graduated high-school, 9 (10%) gymnasium, and 4 (4.45%) graduated primary school (fig. 1). One of generally accepted principle of biomedical ethics is veracity (to tell the truth and not to deceive others). So we started the questionnaire with the question: If you would have cancer, do you want to know the diagnosis. 93.3% of women wanted to be informed if they have cancer and 92.3% preferred communication in a directly manner. Most patients want doctors to be realistic when discussing prognosis and be given the opportunity to ask questions. The preference in favour of revealing the diagnosis wasn't influenced by the age and the level of education.

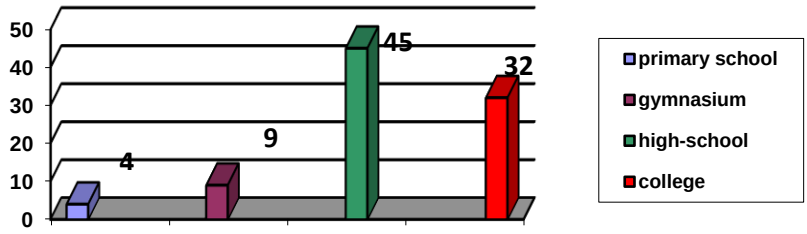

Fig. 1 The level of education of the participants

Regarding confidentiality (not to disclose information shared in an intimate and trusted manner), only 13% didn't want as relatives to find out the diagnosis. When we refer to another principal of biomedical ethics, privacy (respect for limited access to a person), only 53.3% of patients wished that the diagnosis should be communicated in the presence of a closed person.

We want to know if patients want to discuss about life expectancy. 61/90 patients (67.78%) would like to know how much they have to live. When we asked about this subject

that 9 women with the diagnosis of cancer established, 7 of them wanted to be informed about their survival interval. Older patients are less likely to want prognostic information about life expectancy – in our study women had more than 48 years old. On the other hand, when we asked a qualitative question we found out that patients did not want to be told a bad prognosis. We asked them about the mode of communication optimistic vs. pessimistic and 62 patients indicated that they want to be informed about chances of cure not about mortality. Many patients stated that they would like to be given more reassurance and hope. An increased number of women (77 cases – 85.56%) wanted to know the effect of cancer on their quality of life (fig. 2). Patients wanted information on the expected impact of the illness on their daily lives (e.g. functional status, pain).

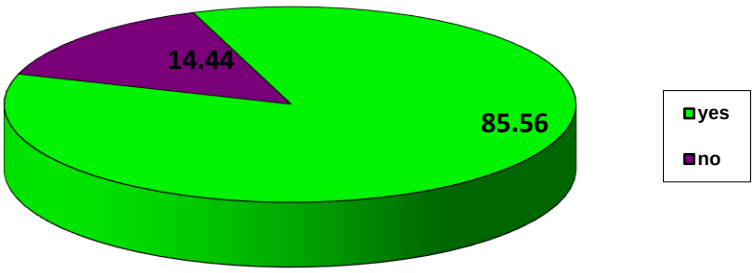

Fig.2 Option of participants for knowing the effect of cancer on their quality of life

Message content was rated as most important by participants. Most patients (63.33%) stated that they appreciated more if the physician is honest and directly and the rest of them wanted a communication in mild terms, with sensitivity to their emotional response. When we talk about the respect for autonomy of the patient (respect for individual liberty, values, beliefs and choices), even the paternalistic relationship regarding treatment it isn't actual, in case of malignancy 72% of patients considered that the decision of management must be taken by the doctor totally. We also asked patients about talking with a psychologist after being informed of the diagnosis of malignancy and 68 women – 75.56% considered that such a discussion would be useful.

Discussions

Many patients would like the specialist to check with them first if they want prognostic information and what type of information they would prefer, such as the probabilities of cure, survival rates, general expected outcome of the disease (Lobb, Butow, Kenny & Tattersall, 1999; Kaplowitz, Campo & Chui, 2002). For example, Kaplowitz et al. asked 352 patients whether they would like to be given a 'qualitative prognosis' (i.e. patient will/will not die from the disease/ probably live a long time) or a 'quantitative prognosis' (i.e. an estimate of their expected survival). They found that 80% wanted a qualitative prognosis but only half wanted a quantitative estimate (Kaplowitz et al., 2002). It is better to communicate an average and longest survival times, emphasising a range rather than a single time point. Another qualitative study found that patients preferred written prognostic information to be presented using positively framed language in terms of survival probabilities as opposed to chances of mortality (Davey, Butow & Armstrong, 2003).

Information about genetic risks and possible side effects of treatment were ranked second; and how cancer affects life was ranked as third priority in a swedish study (Wallberg et al., 2000). In our study patients presented a high interest for genetic risks – 94.44% and how cancer affects life – 85.56%. In Wallberg study higher preferences for information about cure and genetic risk was associated with lower education levels in contrast with ours. In the present study these information didn't depends of education level

Mannea et al. suggests that brief supportive counseling, which is the prevailing treatment model in oncology settings, did not impact psychological distress. This finding has important clinical implications for oncology mental health care delivery. To truly deliver benefits to newly-diagnosed gynecological cancer patients, training mental health professionals in structured, cognitive-behavioral approaches may be appropriate. They had a relatively low rate of psychological intervention acceptance, particularly among older patients and patients diagnosed with ovarian cancers (Mannea et al., 2017). In our study patients which considered psychological intervention useless were not old. Only 3 of them were older than 70 years and the majority of them younger than 55 years.

Parker found that expertise of the physician, information provision and being given bad news in a clear and honest manner was most highly valued by the participants in his study. In our study we came at same conclusions. Factors influencing patient hope were: physician willingness to talk, answer questions and provide information. Perceived poor communication could decrease hope (Parker et al., 2001). For this reason we consider that gynecologist must participate at some workshops for improving the skills for bad news communication.

Clinically, the challenge has been to balance these concerns with the complexities of making prognostic estimates (Mackillop & Quirt, 1997; Llobera et al., 2000; Christakis, Lamont, Smith & Parkes, 2000) while complying with legal requirements to provide patients with all necessary information (Goldberg, 1984). Despite these issues, there is a lack of guidance for clinicians on the best way of approaching prognostic discussions. But there is evidence that ethics protocol, guidelines and programmes may help reduce ethical conflicts. Multidisciplinary meetings provide a forum for the airing and discussion of such dilemmas.

Our study has a limitation, the small number of patients with diagnosis of cancer and perhaps this is the reason we didn't know really what is in the mind of a woman with gynecological malignancy. But even in this situation we can have an opinion about expectations of our patients regarding communication of bad news.

Conclusions

By increasing the autonomy of the patient and the degree of education, appears the necessity of knowing the own disease. The way of communicating bad news is important for our patients and most of them want honesty and realism. The majority of cancer patients wanted all the information including the chances of cure and possible side effects. Patients with diagnosis of gynecological cancer wanted to be given some prognostic information but prefer a quantitative prediction. The resolution of physician's dilemmas regarding communication of cancer diagnosis achieved focusing on respecting the preferences of the patient.

References

1. Bodurka-Bevers, D., Basen-Engquist, K., Carmack, C. L., Fitzgerald, M. A., Wolf, J. K., Moor, C. D., & Gershenson, D. M. (2000). Depression, Anxiety, and Quality of Life in Patients with Epithelial Ovarian Cancer. *Gynecologic Oncology*, *78*(3), 302–308. doi: 10.1006/gyno.2000.5908.
2. Christakis, N.A., Lamont, E.B., Smith, J.L., & Parkes, C.M. (2000).Extent and determinants of error in doctors' prognoses in terminally ill patients: prospective cohort study. *Br Med J*, 320, 469–473.
3. Clevenger, L., Schrepf, A., DeGeest, K. et al. (2013).Seep disturbance, distress and quality of life in ovarian cancer patients during the first year postdiagnosis. *Cancer*,119, 3234–3241.

4. Davey, H.M., Butow, P.N., & Armstrong, B.K.(2003).Patient preferences for written prognostic information. *Br J Cancer*, 89, 1450–1456.
5. Farhat, F., Othman, A., el Baba, G., & Kattan, J. (2015). Revealing a cancer diagnosis to patients: attitudes of patients, families, friends, nurses, and physicians in Lebanon—results of a cross-sectional study. *Curr Oncol* , 22(4), e264-e272
6. GCO.(n.d.). Cancer today. Retrieved from http:// gco. iarc. fr/ today/ home.
7. Goldberg, R.J.(1984). Disclosure of information to adult cancer patients: issues and update. *J Clin Oncol*, 2, 948–955.
8. Goncalves, V., Jayson, G., & Tarrier, N. (2010). A longitudinal investigation of psychological disorders in patients prior and subsequent to a diagnosis of ovarian cancer. *Journal of Clinical Psychology in Medical Settings*, 17, 167–173.
9. Hipkins, J., Whtworth, M., Tarrier, N., & Jayson, G. (2004).Social support, anxiety and depression after chemotherapy for ovarian cancer: a prospective study. *British Journal of Health Psychology*, 9, 569–581.
10. Kaplowitz, S.A., Campo, S., & Chui, W.T. (2002).Cancer patients' desire for communication of prognosis information. *Health Comm*, 14, 221–241.
11. Lobb, E.A., Butow, P.N., Kenny, D.T., & Tattersall, M.H. (1999).Communicating prognosis in early breast cancer: do women understand the language used? *Med J Australia*, 171, 290–294.
12. Llobera, J., Esteva, M., Rifa, J. et al.(2000).Terminal cancer: duration and prediction of survival time. *Euro J Cancer*, 36, 2036–2043.
13. Mackillop, W.J., & Quirt, C.F.(1997). Measuring the accuracy of prognostic judgments in oncology. *J Clin Epidemiol*, 50, 21–29.
14. Mannea, S.L., Virtuea, S.M., Ozgab, M. et al. (2017). A Comparison of Two Psychological Interventions for Newly-diagnosed Gynecological Cancer Patients. *Gynecol Oncol*, 144(2), 354–362
15. Norton, T.R., Manne, S.L., Rubin, S. et al. (2004) Prevalence and predictors of psychological distress among women with ovarian cancer. *Journal of Clinical Oncology*, 22, 919–926.
16. Ong, W.Y., Yee, C.M., Lee, A. (2012).Ethical dilemmas in the care of cancer patients near the end of life. *Singapore Med J*, 53(1),11-16
17. Parker, P.A., Baile, W.F., de Moor. C., Lenzi, R., Kudelka, A.P., & Cohen, L. (2001). Breaking bad news about cancer: patients' preferences for communication. *J Clin Oncol*, 19, 2049–2056.
18. Wallberg, B., Michelson, H., Nystedt, M., Bolund, C., Degner, L.F., & Wilking, N. (2000). Information needs and preferences for participation in treatment decisions among Swedish breast cancer patients. *Acta Oncol*, 39, 467–476.