Stage III-B Cervical-cancer of Young Age in Medical, Bioethics and Clinical Ethics Perspectives

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Abstract

Background: The incidence of cervical-cancer in Indonesia is mostly obtained at the age of 40-50 years. But now many are found at the age of 25-40 years. **Method**: Case-report. **Findings**: Female, 25 years old with a diagnosis of cervical-cancer stage 3B planned for chemotherapy. Patients complain of vaginal bleeding. Married 2 times, at the age of 16 years and 19 years with infertility. The central dilemma: a young woman with advanced stage cervical-cancer was planned for chemotherapy as a gold standard, in terms of patient-autonomy and family refusal. Informed concent was required in the delivery of bad-news and human approaches based on Kubler-Ross's theory (denial, anger, bargaining, depression, acceptance) with the concept of SPIKES (Settings, Listening-Skills, Patient's Perception, Invitation to share Information, Knowledge transmission "bad-news", Explore Emotions and Empathize, Summarize and Strategize). Both medical indication and quality of life were appropriated but in terms of patient preference and contextual feature were refused by patient and families. Resolving this case was not enough with medical-aspects, it also required a bioethical and clinical ethics approach. **Conclusion**: Medical, bioethical and clinical ethics approaches are methods of resolving a case with an ethical dilemma.

***Keywords**: cervical-cancer, perspective of medical, bioethics and clinical-ethics*

Introduction

According to WHO (2012), around 8.2 million deaths were caused by cancer. Ministry of Health reported the number of cancer sufferers in Indonesia reaches 6%. Based on data from the Ministry of Health, the Indonesian Cancer Foundation, and the Indonesian Association of Pathologists, 64.4% of cancer suffered by women.[1,2]

The high mortality rate because most of cervical-cancer sufferers were awared of the disease after being in an advanced stage, because in the early stages the patient did not feel any complaints or symptoms. If it was at an advanced stage, cervical-cancer would cause more physical complications and death. Cervical-cancer is a type of cancer that is caused 99.7% by oncogenic human-papilloma-virus, which attacks the cervix (Indonesian Journal of Cancer, 2009). In Indonesia, only 5% patients did the screening for cervical-cancer, while 76.6% of patients had entered an advanced stage (III-B and above) when detected because cervical-cancer is usually asymptomatic at its initial stage.[2,3]

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Method

The method of this study was case-report.

Findings

A 25-year-old woman escorted to Wahidin Sudirohusodo Hospital by her sister for chemotherapy. Patients diagnosed with stage III-B cervical-cancer with complaints of vaginal bleeding for 3 months that had not

stopped, she also had a history of post-coital bleeding 6 months ago. Two times marriage history at the age of 16 years with a 3-year old marriage, divorced and has no children, the second husband last 1.5 years, has no children as well. No history of contraception. She worked as a cafe/waitress assistant, her husband is still alive and works as a driver.

The physical examination: vital-signs=normal, good general condition, compos mentis, BP=100/60 mmHg, pulse=82x/minute, RR=18x/minute, T=36.5^{0}C, height=149 cm, weight=51 kg, BMI=22.97 kg/m^2. Gynecological examination: high palpabled uterine fundus, tumor mass and pain were absent, blood flux was present. Speculum examination found no vulva abnormalities, the vagina looked bumpy at 1/3 proximal, the portion was lumpy, fragile, easily bleed, blood flux was present. The results of examination in the vagina, obtained 1/3 proximal palpabled mass with fragile bumps, easily bleed mass on the entire surface of the portio and parametrium.

Ultrasound examination: mass in the lower segment of the uterus measuring 4x5 cm, uterine size slightly enlarged 7x6x5 cm in size, both adnexal normal, no free fluid appeared in the Douglasii cavity, the kidney appeared hydronephrosis bilaterally. The diagnosis of this patient was Stage III-B Cervical-cancer Pro Chemotherapy.

Discussion

Medical-Analysis

The quality of palliative-care focuses on client-choice, collaboration, interdisciplinary and holistic approach and orientation to the client and family. During the recovery-period, support for the client and family is a focus in curative and non-curative services, this is known as supportive care. Supportive care services for the physical and psychosocial can be provided in the form of education, research and promotion of clinical services and improving the quality of life of clients with cancer.[4,5]

Based on 30 analyzed literature, concluded that changes occur in an end-stage cancer causes changes in quality of life because quality of life consists of four dimensions namely physical, psychological, social relationships and environmental dimensions that are not only dealt with curatively but need a more personal approach so that it can be concluded that palliative-care plays a role in achieving maximum quality of life in stage IV cancer thereby reducing pain or preparing for death. Good palliative-care can change the life quality of cancer-sufferers for the better. However, palliative-care are still rarely performed in hospitals in Indonesia, because focuses are still on curative, while physical, social and spiritual changes cannot be intervened entirely with curative. In order to make the life quality of cancer patients remain high, there are several things that need to be done, among them is by implementing a comprehensive and integrated palliative-care from the palliative team.[6]

Kubler-Ross state that there are five stages of emotional reaction that are associated with chronic-diseases: denial, anger, bargaining, depression, and acceptance.[7]

a) Denial

Denial is a defense system that makes a person try to avoid the effects of illness.

b) Anger

The patient tries to question "Why do I have to suffer from a chronic illness?" Analysis: the patient is in this stage because the patient feels that she still has a lot of hope that she wants to do in the future, for instance having children, enthusiasm in finding fortune, but this disease makes her hopes disappear.

c) Bargaining

The cancer-sufferer divert anger better with different strategies.

d) Depression

Depression as a lack of control is a realization of the worsening of symptom as a condition of a disease that does not improve.

The cancer-sufferer will feel fed up, tightness, fatigue, difficulty eating, difficulty controlling herself, difficult to focus attention, avoid pain and feeling uncomfortable.

e) Self-acceptance

The cancer sufferer is no longer angry and has familiarized herself with the idea of death which makes her depressed and also faces unpleasant thoughts.

This patient was in the anger stage, it was evident in every time we provide education related to the disease, the patient had difficulty concentrating and unstable emotions, there was an acceptance stage to start chemotherapy due to coercive factors from parents.

KODEKI (Indonesian Medical Code of Ethics) states that "Any doctor's actions or advice that might weaken psychic or physical endurance, must obtain the patient's/family's approval and are only given for the benefit and good of the patient". To reduce drastic emotional changes of patients, the delivery of information about their illnesses is carried out with the "SPIKES":

1. Setting, Listening-Skills

Before delivering bad-news to patients, it is necessary to prepare ensuring the smooth delivery of information to patients before delivering bad-news, you should prepare the ability to 'hear', include: silence, repetition, availability.

2. Patient's Perception

Before delivering bad-news, the doctor should know the patient's perceptions of: her own medical condition and her expectations of the results of the medication she was taking, ask the patient's estimate of the results of the medication

3. Invitation to share Information

Ask whether the patient wants to know the developments regarding her situation or not. If the patient claims not to be ready, consider delivering at a more appropriate time and ask the patient to prepare in advance. If the patient states that she wants to know the progress of the situation, ask the extent to which she wants to know.

4. Knowledge transmission "Delivering bad-news"

Before delivering bad-news, do a 'warning shot' as an opening to tell the patient that there is 'bad-news' to be delivered to the patient so that the patient is not surprised.

5. Explore Emotions and Empathize

Always observe the patient's expression and emotion as well as what underlies changes in her emotion, examine the patient's emotional state.

6. Summarize and Strategize

At the end of the talk, review the entire conversation again: conclude the 'bad-news' that was delivered in stages (piecemeal). Conclude the response given by the patient during the bad-news delivered, show that the doctor listens and understands what the patient is delivering, gives the patient the opportunity to ask questions, gives feedback, and discusses plans to follow up on the bad-news that has been conveyed to the patient.[8,9]

Bioethics Analysis

As stated in the Geneva Declaration the doctor stated: "Patient health will always be my first consideration" and the International Medical Ethics-code states: "Doctors must give their patients full loyalty and all the knowledge they have". The doctor must tell the patient the consequences of the decision taken. Patient must understand clearly what the goals of a test or treatment are, what results will be obtained, and what the impact would happen if they delay the decision.[10]

The rules of bioethics are an absolute law for doctors. The Indonesian Medical Council, by adopting the principles of western medical ethics, stipulates that the practice of Indonesian medicine refers to 4 basic moral principles which are often also called the basic principles of medical ethics or bioethics, namely:[11,12]

1. Beneficence

It's a principle that a doctor is doing good, respecting human dignity, the doctor has to make every effort so that the patient remains in good health. The principle of beneficence emphasizes the role of the doctor to provide convenience and pleasure for patients in taking positive steps to maximize the good results rather than the bad things. The principles contained in this rule are: prioritizing altruism, guaranteeing the basic values of human dignity, looking at a patient or family is not an action that only benefits the doctor, trying to have more good or benefit compared to a bad one, paternalism is responsible/compassion, ensuring the good and minimal life of humans, maximizing the rights of patients as a whole, implementing the Golden Rule Principle, giving an efficacy but inexpensive prescription, developing the profession continuously, and minimizing bad consequences.

Analysis: the doctor has done the best for the

patient in the treatment effort by doing chemotherapy in accordance with the procedures of medical-treatment in hospital which all costs are borne by the Government (BPJS).

2. Non-Malficence

Non-maleficence is a principle in which a doctor does not perform actions that aggravate the patient and choose the treatment with the most minimal risk for the patient who is treated by him. The ancient statement, first, do no harm, still applies and must be followed. Non-maleficence has the following characteristics: helping emergency patients, treating injured patients, not killing patients, not looking at patients as objects, not insulting/abusing/utilizing patients, protecting patients from attacks, patient benefits outweigh the doctor's losses, no endangering patients because of negligence, avoiding misrepresentation, giving life spirit, not committing white collar crime.

The principle applied to this patient is that when chemotherapy is performed, the patient is given premedication drugs so that in the process of chemotherapy the side effects are minimized.

3. Autonomy

Every individual must be treated as a human who has the right to self-determination. The Autonomy rule has the following principles: respect the right to self-determination, honestly respect privacy, maintain patient secrets, respect patient rationality, carry out informed consent, allow adult and competent patients to make their own decisions, not intervene or impede patient-autonomy, prevent others from interfering with patients in making decisions-including the patient's own family, patiently waiting for decisions to be taken by patients in non-emergency cases, not lying to patients even for the patient's benefit, and maintaining relationships or contracts.

Analysis: After receiving counseling, information and education about the disease related to complications and prognosis, the patient chose to undergo chemotherapy. Autonomy requires that patients must first receive and understand accurate information about their condition, the type of proposed medical-treatment, the risks, and also the benefits of the medical action.

4. Justice

Justice has the following characteristics: applying everything universally, taking the last portion of the process of sharing that he has done, providing equal opportunity to individuals in the same position, respecting the health rights of patients, respecting the legal rights of patients, respecting the rights of others, maintaining the rights of others vulnerable groups, do not differentiate services to patients on the basis of SARA, social status, etc., do not abuse, make contributions that are relatively equal to the needs of patients, request patient participation in accordance with their abilities, return rights to their owners at the right time and competent, not giving a heavy burden unevenly without valid or appropriate reasons, respecting the rights of the population with the same vulnerable to disease or health problems, and wise in macroalocation.

Analysis: doctors provide the same treatment of chemotherapy services to all patients who need these services for the benefit of patients without looking at the economic, social-status, elements of SARA and so forth.

Clinical-Ethics Analysis

Jonsen, Siegler and Winslade (2002) develop ethical-theories that use 4 essential topics in clinical services, namely:[13,14]

MEDICAL-INDICATION Diagnosis Nature of disease Condition of patient Prognosis Treatment options	PATIENT-PREFERRENCES Advance directive Previous spoken Previous choices
QUALITY OF LIFE Who decides? What standar? Suffering Relationships	CONTEXTUAL-FEATURES Social Culture Legal Financial Institutional

(Source: Mappaware NA. Bioethics, Medical Law, and Human Rights. Umitoha: Makassar; 2010)

Figure 1. The essential topics in clinical-services

1. Medical-Indication

All relevant diagnostic and therapeutic procedures are included to evaluate the patient's condition and treat it. Ethical questions on this topic are similar to all information that should be conveyed to patients in the doctrine of informed-consent.

After answering all the above medical indication questions using the principle of beneficence and non-malificence, it is determined the choice of advanced chemotherapy to prevent further complications of metastasis to the surrounding organs.

2. Patient-Preferrences

The ethical questions include questions about the patient's competence, volunteer nature, attitudes and decisions, understanding of information, who makes the decision if the patient is incompetent, the values and beliefs held by the patient, and others.

In this case it is more the autonomy principle where the patient is mentally capable and legally competent in realizing and understanding her current clinical condition so that she agrees to do further chemotherapy. Previously the patient had understood the advantages and disadvantages of this chemotherapy procedure through informed-consent.

3. Quality of Life

This is the actualization of one of the goals of medicine, which is to improve, maintain or increase the quality of human life. What, who and how to assess quality of life are ethical questions around prognosis.

According to WHOQOL (1996), that there are some things that need to be considered when assessing life quality, where life-quality is closely related to the domain being assessed, namely: 1) physical-health, 2) psychological, 3) degree of independence, 4) social-relations, 5) environment, 6) spirituality/religion/individual beliefs. To find out how one's quality of life can be measured by considering the physical, psychological, social and disease conditions.[15]

According to Ferrell et al. in Zeng (2010), there are 4 domains in measuring life quality of cancer patients: 1) physical-control or relief of symptoms and maintenance of function and independence, 2) psychological (efforts to maintain life control over threatening diseases marked with emotional disturbances, changes in life priorities, fear and positive life changes), 3) social (efforts to deal with the impact of cancer on individuals, their roles and relationships), 4) spiritual (ability to maintain the hopes and meaning of a cancer experience which marked by uncertainty).[16]

4. Contextual-Features

The principle in Contextual Features is Loyalty and Fairness. Here ethics questions are discussed around non-medical-aspects that influence decisions, such as family, economic, religious, cultural, confidentiality, resource allocation and legal factors.

The patient's own motivation to run chemotherapy is still lacking. There are no obstacles in making good decisions from the family, all support her in undergoing treatment. There are no religious, cultural or belief factors that conflict with decision-making.

Conclusion

Medical-treatment has been carried out in accordance with medical-aspects, bioethics and clinical-ethics.

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Conflict of Interest-No

Ethical Clearance- Yes

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