Numerous complex and emotive life choices punctuate the cancer journey. Difficult decisions are unavoidable. Practitioners have an important role in providing information and support to help patients and families make decisions. They also contribute to decisions in terms of care and treatment and make decisions that determine their actions and omissions. The process and impact of decision-making that stems from the ethical aspects of care and treatment can be challenging and practitioners may have to negotiate differences of values and perspectives. In practice and educational contexts it can be helpful to construct complex practice situations as ‘ethics cases’ and to use an ethical framework to analyse the concerns that arise.

Here we introduce one framework for the analysis of ethics cases – the four-quadrant approach – and apply this to one practice situation.

**An Ethics Case**

When we discuss examples or cases from practice it is not possible to present all of the detail. Therefore, we are selective in including and excluding aspects. This is particularly so when we use cases in discussion of ethical aspects of cancer care. The term ‘case’ can have a broad definition as, for example, ‘a person, a family or a group… a short description of a situation, an event or a piece of work.’ An ‘ethics case’ such as those presented in professional education or in clinical ethics committees is likely to have particular features. Such cases are constructed in a particular way and generally have the following components.

**Action**
The case outline is driven by plot, that is, what is done and what happens. There is usually little information about character or context.

**Tempo**
The action usually takes place over a short period of time but there may be a summary in terms of what happened over a longer time. There is generally little information about what happens before or afterwards.

**Closure**
The case often ends with a question, e.g. ‘what should the practitioner do?’ Sometimes the ending is given and the reader is invited to say how the practitioner ‘should have acted’.

Crucially, for our purposes here, the practitioner’s actions are based on a decision.
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Table 1: The Four-quadrant Approach

<table>
<thead>
<tr>
<th>Medical Indications</th>
<th>Patient Preferences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s medical problem, prognosis, goals of treatment, probabilities of success, treatment options, patient benefits.</td>
<td>Does the patient have capacity? If so, what does he/she want? If not, has he/she expressed prior preferences? What is in his/her best interests?</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>Contextual Features</td>
</tr>
<tr>
<td>What impairment/distress is the patient experiencing? Will the quality of life post-intervention be acceptable to the patient? Are there plans for palliative care?</td>
<td>Are there family factors that may influence decision-making? Are there religious, cultural or legal matters that need to be taken into account? Are there conflicts of interest?</td>
</tr>
</tbody>
</table>

Adapted from Jonsen et al., 2006. Also see McCarthy et al., 2010 and Sokol, 2008.

Consistency with the four-quadrant approach to make it impossible to adequately assess what are the best options for that patient in an urgent situation.

- When resources are inadequate and it is not possible to give patients and families what they want or need. This may be a hospice bed, equipment or staff.
- When a patient lacks capacity and family and professionals have different views in terms of what is in his/her best interests. A person lacks capacity for a specific decision if they are unable to express an informed view on that issue within the required timeframe, as a result of persisting impaired cognition. To have capacity for a decision, a person must understand and retain the relevant information, in order to make and communicate a balanced decision.
- When a patient has capacity but communication barriers prevent adequate open discussion, for example, language barriers that lead to professionals becoming overly dependent on family members for giving information to the patient and in describing the patient’s wishes.
- When patients refuse to share information with family members regarding their diagnosis or prognosis.
- When patients or families request interventions that are illegal or considered unethical by professionals.
- When patients and their families do not agree on the best course of action when facing decisions around life-prolonging treatments, particularly once capacity is lost or where patients have consistently left most decisions to their family members.
- When professionals disagree about the right course of action in relation to patient treatment and care.

There are different approaches to the ethical analysis of practice situations that can help practitioners consider the pertinent concerns that help to make a reasoned decision. One such is the four-quadrant approach (see Table 1).

Each quadrant needs to be considered in relation to the case to help practitioners make ethical decisions. In terms of the values that underpin each quadrant or box, it has been suggested that the four quadrants can be supported by the four principles of biomedical ethics: respect for autonomy, beneficence, non-maleficence and justice. The medical indications category, for example, is underpinned by beneficence (do good) and non-maleficence (do no harm); patient preferences is underpinned by the principle of respect for autonomy; quality of life captures three principles of beneficence, non-maleficence and justice; and contextual features is underpinned by the principle of justice or fairness.

Other approaches to healthcare ethics are also relevant to case analysis, for example, a virtue-based approach. The focus of this approach is on the question “how should we live?” and “what ethical dispositions or virtues are required to be an ethical practitioner?” In ethical decision-making in cancer care it can be agreed that practitioners require a range of virtues, for example: professional wisdom to consider the salient points of a situation and to deliberate well, for example, balancing patient autonomy against distributive justice considerations when resources are scarce; moral courage to, for example, defend patient rights or to take a course of action that may be unpopular; compassion to respond appropriately to patient and family suffering; and, perhaps, respectfulness to demonstrate the value or worth of the person regardless of age, mental capacity status or any other factor. An important point to bear in mind is that a virtue ethics approach can accommodate different decisions, that is, two virtuous practitioners may come to different conclusions in terms of what to do in particular circumstances.

The following case represented a series of difficult decisions for practitioners but also for a neighbour and family member. Here we focus on one difficult decision that had to be made regarding the response of a hospice team. The case has been anonymised and included here with family consent.

Mrs Jackson – Overview of an Ethics Case

Mrs Jackson is 92 years of age. She lives alone and has recently been diagnosed with breast cancer. Prior to her diagnosis, she had been independent and had enjoyed the company of friends and neighbours. She has no family in the UK and her son lives in Canada. She now appears low in mood and says that she does not wish to live any longer. She has refused all medical interventions and visits from professionals, including her GP who has known her for many years. She is eating little and relies on an elderly neighbour who visits her twice daily. Her neighbour, Mrs Brown, and her GP are aware that Mrs Jackson has a “living will” saying she does not want hospital admission. One morning, Mrs Brown finds Mrs Jackson on the sofa. She is still fully dressed from the previous evening and incoherent. There are packets of soluble paracetamol around her. A copy of her living will is on the table beside her. Mrs Brown phones the GP and says that “something has to be done”. The GP is unable to visit as he has a morning surgery but phones the local hospice. He gives the details to one of the senior nurses who is to attend the morning admissions meeting. The nurse attends the meeting and has to decide whether and how she can make a case for Mrs Jackson’s admission to the hospice.

Using the four-quadrant approach as a framework, what aspects of the case does the hospice team need to consider? Should they offer her a hospice bed?

Medical Indications

The patient’s medical problem, prognosis, goals of treatment, probabilities of success, treatment options and patient benefits, etc. should all be considered.

The hospice team will require a good deal more information about Mrs Jackson’s diagnosis, prognosis and what might benefit her. For example, the label “breast cancer” is unclear and they would want to know the staging, treatment options and current impact. Is it early or end-stage disease? Is it easily treatable (oral hormones) or not treatable? And is it currently asymptomatic or disabling?
Conversely, additional medication or alcohol could have been taken consequently an overdose could easily have been accidental. Paracetamol overdose, she could be acutely unwell or intoxicated. Incoherent? As this would not be an expected result of a recent incoherence, it may be to treat – if it is established that Mrs Jackson has taken an overdose. If this is so, it is potentially fatal but can be reversible at presentation. The amount and timing of any overdose is crucial. Regardless, the default position is urgent referral to hospital for immediate medical attention as an overdose is potentially fatal with irreversible damage if not urgently treated. It is necessary to fully consider the relative merits of any healthcare intervention. The main choice to make is between:

- some form of terminal care; that is supportive care alone, with a second-level decision of either remaining at home or admitting to the hospice. This course presumes that he/she will die over a number of days, with additional distressing symptoms – if he/she has taken an overdose – or liver failure, by which point the option to pursue antitodes will have passed should she change her mind. The less likely outcome would be a subfatal overdose resulting in a proportionate degree of liver failure from none to severe without any impact on survival; or
- life-saving active care: send the patient to hospital to treat the overdose predicting that she would fully recover and return home (assuming that she could still get to hospital within the timeframe needed to reverse the overdose).

**Patient Preferences**

Does the patient have capacity? If so, what does he/she want? If not, has he/she expressed prior preferences? What is in his or her best interests?

The case outline states that Mrs Jackson is “incoherent” suggesting she may lack capacity and not be in a position to express a preference. If Mrs Jackson is not competent to decide for herself then a decision may need to be made in her best interests as set out in the Mental Capacity Act (MCA) 2005 checklist. The team would ask if there is an underlying cause to explain the confusion and clarify if this is a temporary or permanent loss of capacity. The default position may be to treat – if it is established that Mrs Jackson has taken an overdose – in case capacity could be established later. Why is she incoherent? As this would not be an expected result of a recent paracetamol overdose, she could be acutely unwell or intoxicated. Consequently, an overdose could easily have been accidental. Conversely, additional medication or alcohol could have been taken after a capacitous act of overdosing. The team might also ask if there is a suicide note in addition to the living will requesting that she not be sent to hospital. Without it we cannot presume the overdose was deliberate despite her low mood and the fact that she had said she did not wish to live any longer.

Although competence could return, one view is that there is no option to defer hospital admission and treatment to wait until competence returns.

In terms of Mrs Jackson’s prior wishes, there was no prior refusal of treatment for the paracetamol overdose; however, this was potentially a deliberate attempt to end her life. This is supported by her refusal of hospital care and all medical interventions, visits from professionals and her statement that she did not want to live any longer. A living will saying that she does not want hospital admission has no legal weight while she has capacity, yet it can still distract from discussions around decision-making when capacity is retained. Moreover, even if valid such an advance decision is unlikely to be applicable when capacity is lost. A blanket “no” to hospital without parameters may not be specific enough to count. This was a predictable shortfall – a living will needs to clearly meet the MCA 2005 requirements and thus must be sufficiently fleshed out and widely shared (i.e. within advance decision-making/planning) to ensure it will be accepted at point of need.

The statement on the living will or advance directive “does not want hospital admission” appears to add little, but cannot be ignored. Many people with advanced illness will be vocal in not wanting to go to hospital again when feeling relatively fit and well. However, when the time comes that they need to go to hospital, many will change their mind, particularly if a short stay with straightforward treatment appears to offer them a better quality and quantity of life. Additionally, as discussed, the legal weight of an unspecified blanket statement is extremely limited.

Ideally, the GP would have visited Mrs Jackson and conducted an assessment, however, this was not possible. In the community, the “lead clinician” is the GP – the hospice nurse’s role is to contribute to the GP’s best interests decision-making – not to make a decision. Similarly, the hospice’s morning admissions meeting carries no weight in deciding best interests. The team decides if they are willing and able to provide the course of action confirmed as ‘best interests’ by the GP with or without adding to the GP’s decision-making process. Moreover, healthcare professionals never decide what to do to with patients, they merely estimate as best they can what the patient would want in the circumstances. Healthcare professionals clarify the clinical scenario and the treatment options. It can be argued that there is no “decision” as there is no choice. The patient’s condition dictates the necessary treatments and the available resources clarify what the real world choices are at that time. The patient’s wishes determine the course of action (or inaction).

However, in this case Mrs Jackson does not appear to be able to participate in decision-making apart from her living will statement. There did not appear to be any legally designated decision-makers to involve. Her only relative, her son, is in Canada and the urgency of the situation meant it was not practicable to consult him. Indeed, it is not clear how well placed or informed a view of his mother’s wishes he could offer. The only other relevant views to take into account are those of her neighbour who telephoned the GP and said “something...
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has to be done’. This would appear to suggest more should be done rather than do less.

It is important that best interests would not be determined merely on the basis of, or following unjustified assumptions around, irrelevant factors such as her age or malignancy.

Quality of Life
Questions that need to be considered include: what impairment/distress is the patient experiencing? Will the quality of life post-intervention be acceptable to the patient? Are there plans for palliative care?

Mrs Jackson had been independent and enjoyed the company of friends and neighbours. Before this situation arose, her quality of life was unclear, although presumably it was poor. Crucially, the team might ask if her independence has already been lost forever. While eating little and relying on visits from an elderly neighbour it is unclear if this level of quality of life could be improved to become more acceptable. Successful treatment of any overdose would not affect her quality of life positively or negatively. Although treatment would provide an opportunity to try and improve her quality of life. Without treatment she would most likely die, where no quality of life can be demonstrated. There is no evidence that her current/best potential condition was such that continued life might be judged undesirable. However, if her preference was not to continue to live no quality of life may be acceptable to her.

Contextual Features
Are there family factors that might influence decision-making? Are there religious, cultural or legal concerns that need to be taken into account? Are there conflicts of interest?

Mrs Jackson’s son is in Canada and it seems that her neighbour, Mrs Brown, has taken on a key carer role. The hospice team will require more information about her family in Canada and about any religious and, perhaps, cultural matters that may influence her care. The team may also wish to speak with Mrs Brown and with Mrs Jackson’s consent, if possible, with her son in Canada. Crucially, the hospice team have to weigh Mrs Jackson’s healthcare requirements against other claims for a hospice place, which is a scarce resource, and the team may have to decide which of a number of patients will get the hospice bed.

Repercussions
Mrs Jackson was offered a hospice bed and was transferred by ambulance. After some hours her confusion resolved and she appeared to regain capacity to make decisions about her care. She made it clear that she was unhappy with the decisions of her neighbour and GP. She agreed to stay overnight in the hospice and to have a discussion with a consultant the next morning. During this discussion she disclosed that she had taken an overdose of paracetamol at home. She was advised that, in these circumstances, she would normally be moved to hospital. Mrs Jackson agreed to be moved to the hospital, which was closer to home, and agreed for her son to be contacted. Her son made arrangements to travel to the UK and during his stay visited her daily in hospital. Her experience in hospital was not a happy one. Her son felt that staff members were uncaring and communication about his mother’s care and treatment was almost impossible. It was his belief that her suicide attempt had influenced the decision to withdraw medical treatment. After 10 days, Mrs Jackson encouraged her son to return to Canada. He was at Heathrow Airport when he received a phone call from the hospital to say his mother had died peacefully. He said he decided not to complain about his mother’s care because it would not have done any good.

Conclusion

Ethics cases are rarely tidy or unidimensional. They require practitioners to engage with the ‘swampy lowlands’ of everyday practice. There is no panacea but frameworks can help to structure thinking and discussion. There is also value in considering difficult decisions from different perspectives. An understanding of ethics and professional codes is essential for professional accountability.

Everyday ethics in cancer care can be challenging and there are many more difficult decisions than we could address in this article. However, the case of Mrs Jackson does challenge us to engage with multiple perspectives and complexity. It is difficult for practitioners to respond to those who refuse treatment and who appear not to value their own lives. However, practitioners can seek advice from trusted colleagues or from a Clinical Ethics Committee (see, for example, UK Clinical Ethics Network) if their organisation has one. However, what we should not forget is the consequences of our decisions for patients and families. The GP’s decision to opt for hospice admission is likely to have been influenced by his knowledge of Mrs Jackson and by her expression of her wishes in a living will. He had no way of knowing if at some point in the period following her overdose she changed her mind. Although the living will may not have had legal status, it had ethical weight. Therefore, the GP’s response may be described as being wise, compassionate and respectful in the case of Mrs Jackson. He did not go against her wishes as expressed in the living will and he did not abandon her. The challenge for professionals is to determine what constitutes an ethical response in these particular circumstances. It is possible that members of the hospice team could have interpreted the GP’s request for hospice admission as well-meaning but perhaps reflecting the path of least resistance rather than the product of best interests decision-making. Declining admission and supporting hospital admission may have represented professional virtues of wisdom, respectfulness for life and justice. The hospice team are acutely aware that beds are scarce and may have taken the view that the preservation of life outweighed any previous wishes. To reiterate the point made above, two virtuous practitioners may come to different conclusions in terms of what is the most appropriate ethical response in the same situation. Of course, what professionals think is an ethical approach is not always what patients and families think is best and we must take this seriously. We leave the final words to Mrs Jackson’s son. He said:

“Mother was nearly 92. She had loved life but no longer had the health to continue. She was depressed, unwell, lonely and most of all, bored. What could anyone have done to help her when she was ready to make up her mind to end it all? In regard to her final weeks, I’d say frank and open discussion between the patient and family by the professionals would have been critical to provide the basis for an appropriate and agreed treatment regime and proper planning for the last days. Instead we were faced with the opposite and given the mushroom treatment (meaning they are kept in the dark and not given information).

I’m not sure if any of this is of value but, in summary, I felt powerless to deal with my mother’s position. I’m known as a fixer but the system
completely defeated me and I felt that my mother had been cheated of a dignified passing. She also knew she was powerless and just an old ‘bed occupier’ and when that became obvious, I’m sure she said goodbye on her own terms. The pity was that she did not or could not stay at the hospice. That was the proper location to deal with her condition.” (Personal communication.)