Ethics Forum

Madhu Midathada, MD, Jason Mehta, BA, Rangaswamy Govindarajan, MD, A. Mazin Safar, MD, D. Micah Hester, PhD, M. Jameel Kyasa, MD, and Paulette Mehta, MD

When Substance Abuse Interferes with Cancer Treatment

There are many challenges inherent in the treatment of cancer, and these are compounded by complex physical, emotional, and psychosocial issues when the patient is addicted to alcohol.[1] Alcohol may play a pathogenic role in the development of cancer, and insufficiently treated alcoholism may predispose patients to second cancers and early relapse of primary cancers. Alcoholism can impair patients' ability to deal with their illness emotionally, to make informed medical decisions, and to use their end-of-life time productively. It also can create rifts in their relationships with family members and health care providers, just when these relationships are most important to the patients' health and well-being.

In such cases, both health care providers and caregivers often encounter ethical dilemmas. How should a provider react when a patient's alcoholism fosters a fatalistic attitude toward the cancer diagnosis, resulting in nonadherence to preventive care or therapeutic regimens? Must a provider continue to treat the acute symptoms that arise as a consequence of the patient's continued alcohol abuse, thus enabling this destructive behavior? Does such behavior indicate that the patient is incapable of making informed medical decisions and that the family members should be entrusted to make these decisions for the patient? And finally, is hospice care appropriate for patients with unresolved substance abuse issues?

The following case illustrates these difficult issues and provides a springboard for discussion of the impact of substance abuse on cancer care.

THE CASE

A 50-year-old man with a history of alcohol dependence and drug abuse presented to the emergency department (ED) in October 2004 with weakness, fatigue, and dizziness. Blood tests performed in the ED revealed severe anemia, with a hemoglobin level of 1.6 g/dL. As a result, the patient was given a transfusion of blood products and was admitted to the hospital for further workup.

There, an esophagogastroduodenoscopy and a colonoscopy showed that the patient had gastritis, a colon polyp, and rectal prolapse. He also tested positive for hepatitis C. A computerized tomography scan revealed multiple liver lesions, and a liver biopsy showed hepatocellular carcinoma.

The patient refused to undergo a bone marrow biopsy for evaluation of his anemia, and he was subsequently discharged and referred to the oncology clinic for follow-up. He did not keep his appointments with that clinic, however, stating that he did not want to be treated for his liver cancer. He continued to refuse any further workup of anemia and he rebuffed the staff's multiple attempts to help him enter a detoxification program. He told providers that he just wanted to go on as he had been, living with his sister (his current caregiver), drinking, and watching television. Because of his unwillingness to undergo further testing or treatment, it was impossible to determine the extent of his cancer or whether curative treatment was a possibility.

Over the next year, the patient returned to the hospital several times with weakness and shortness of breath arising from anemia, and he received transfusions that resolved his symptoms. On one occasion, he was brought to the ED in an unresponsive state and was found to be hypoglycemic and anemic (hemoglobin level, 1.8 g/dL). Once again, admission and transfusion improved his mental status.

When the patient's family members expressed frustration about the difficulty of caring for him, they were told about the option of hospice care. The providers brought up a concern with the family, however, regarding the fact that blood transfusions would not be available to the patient in a hospice setting. The lack of such treatment could shorten his survival significantly, irrespective of the effects of his cancer. Following a meeting of the health care team, which involved extensive discussion with the patient and his family, the patient refused hospice services and went home with his sister.

EFFECTS OF ALCOHOL ABUSE ON PATIENTS WITH CANCER

Substance abuse disorders have been stigmatized, and they are underdiagnosed and undertreated in patients with cancer.[2–5] This case illustrates some of the ways in which unresolved substance abuse—specifically alcoholism—can eclipse a patient's medical problems, impeding appropriate management of these conditions. This effect is particularly distressing in patients with cancer, given the serious-

At the time of this writing, **Dr. Midathada** was a hematology/oncology fellow at the University of Arkansas for Medical Sciences (UAMS) and a staff physician at the Central Arkansas Veterans Healthcare System (CAVHS), both in Little Rock. She is now in private practice in Lincoln, NE. **Mr. Mehta** is a third year law student at Harvard Law School, Cambridge, MA. **Drs. Govindarajan** and **Safar** are both associate professors in the division of hematology/oncology, **Dr. Hester** is an assistant professor of biomedical ethics in the division of medical humanities, **Dr. Kyasa** is an assistant professor in the division of hematology/oncology, and **Dr. Mehta** is a professor of hematology/oncology in the departments of internal medicine and pediatrics, all at the UAMS. In addition, Drs. Safar, Kyasa, and Mehta are staff physicians in hematology/oncology at the CAVHS.

ness of the disease and the exacerbating effects alcohol is believed to have on the malignancy and on related physical manifestations. Alcoholism is particularly common, and may be a pathogenic factor, in patients with head and neck cancer, pancreatic cancer, or hepatocellular carcinoma.[1]

All too often, however, substance abuse treatment takes a backseat to cancer treatment. Many oncologists struggle to treat patients who are or have been substance abusers without fully understanding the conceptual and practical issues of substance abuse treatment. The management of addiction can be time consuming and difficult, and relapses are common (but not necessarily indicative of treatment failure). Some clinicians believe that, in patients with advanced cancer, undergoing this laborious process is not worth the effort. Usually, this view stems from common misconceptions, such as the notion that treating substance abuse deprives a dying patient of a source of pleasure, that addiction is an intractable condition, or that substance abuse doesn't have much impact on the effectiveness of palliative care.[6]

The case described here clearly debunks the latter of these myths. This patient's drinking seems to have been a crutch that he used to avoid facing his health problems or taking action to improve them. If he had permitted his providers to perform the diagnostic studies necessary to pinpoint the cause of his anemia, it's likely that this cause (probably nutritional deficiencies) could have been treated successfully. If he had kept his clinic appointments and followed instructions for primary preventive care, he may have been able to break out of the destructive cycle that brought him to the ED, on the brink of disaster, again and again—a pattern seen commonly in patients with alcoholism.[7] The patient's alcoholism also compromised his relationship with his sister and interfered with his ability to use his end-of-life time productively.

CONFRONTING THE PROBLEM

An ethical question raised by this case was whether the patient's alcoholism had impaired his ability to make informed medical decisions to the extent that it would be appropriate to empower his sister to make these decisions for him. By ethical and legal standards, substance abuse alone does not necessarily negate an individual's capacity to make medical decisions. The question of a patient's competency in this regard can be resolved only through a complete psychiatric evaluation. If this evaluation results in the official declaration of incompetence, decision making authority may be transferred legally to a designated individual, such as a spouse or family member serving as caregiver.

Assuming that a psychiatric evaluation of the patient in this case would conclude that he was still able to make his own medical decisions, the challenge would be to help him realize the destructiveness of his ongoing behavior. How might a provider approach this challenge? It seems clear that continuing to treat the patient's acute anemic crises had become a way of rescuing the patient from the consequences of his alcoholism, thereby feeding his denial and reducing his chances of getting the rehabilitative treatment he needed. Is it appropriate in this setting for providers to "take a stand" and deny treatment the next time he presents to the ED?

While physicians cannot ethically withhold life saving treatment (such as blood transfusions), they are not required to provide futile therapies. In other settings, providers require patients to undergo detoxification and rehabilitative treatment before receiving elective surgery or expensive medical treatment. The choice to treat cancer usually requires that patients agree to treatment, sign informed consent documents voluntarily, adhere to therapy, and be declared healthy enough to undergo toxic therapy. Physicians have a duty to weigh benefit and harm in all decision making and to use toxic therapy only when the benefits prevail. When patients cannot adhere to treatment recommendations, the risk of doing more harm than good is evident, and a physician therefore could not be faulted ethically for not treating such a patient.

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From a legal perspective, a patient's continued use of alcohol, even when that use causes him harm and prevents him from receiving effective treatment for other conditions, does not alone impose liability on the physician. In a prominent Florida case from 1966, several physicians were excused from a medical malpractice lawsuit when the physicians convinced the court that the patient's death was the result of alcohol, and not their action or inaction.[8]

Continued on page 42

Continued from page 40

The court noted that patients have a duty to conform reasonably to the necessary prescriptions and treatment and follow reasonable and proper instructions given. This case established that the failure of a patient to act reasonably and responsibly precludes the patient from suing for medical malpractice.

Of particular note in the Florida case is the court's ruling that it was irrelevant whether or not the physicians warned the patient to not drink. Instead, the court allowed the jury to assume that a reasonable person would know not to consume alcohol while being treated for medical illness. This case, therefore, suggests that the responsibility of ensuring that patients act reasonably rests solely with the patients themselves.

To be sure, physicians still may feel an ethical—if not a legal—obligation to work with the patients and encourage them not to consume alcohol. Proactive intervention with alcoholic patients is not only the compassionate course of action but also the best method of thwarting any claims of malpractice. Such intervention may take the form of referral to an addiction service, prescription of medications for alcohol dependence (such as disulfiram, naltrexone, or acamprosate), or referral to Alcoholics Anonymous or other local resources. The National Institute on Alcohol Abuse and Alcoholism has published an excellent resource for diagnosing and treating patients with alcohol dependency, which is available online (pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/guide.pdf).[9]

THE ROLE OF DEPRESSION

In patients with substance abuse disorders, depression and other psychiatric conditions may underlie or contribute to the problem. It has been shown that, among patients with cancer, those at highest risk for depression are those with a history of affective disorder or alcoholism, advanced stages of cancer, and poorly controlled pain.[10]

Although no psychiatric disorder was documented in this case, it's possible that depression may have accounted for the patient's apparent inattention to his health, his nonadherence to treatment, and his unwillingness to work toward lengthening or improving the quality of his life.[11] If depression had been diagnosed, treatment might have helped him gain a better perspective on his life and health, clarify his goals for managing his cancer, and communicate these goals to the health care team. Thus, a psychiatric consultation to establish or rule out depression would have been appropriate for this patient.

BUILDING TRUST AND ESTABLISHING COMMUNICATION

A discussion of the goals of therapy is a critical component of care for any patient with cancer. Although the patient in this case clearly was not ready for a discussion of goals when he was first admitted to the hospital and diagnosed with his cancer, such a discussion would have been necessary at some point. Effective communication with a patient takes time and effort, and it cannot be achieved during regular hospital rounds or a routine psychiatric evaluation. It requires regular interaction with the patient to establish trust and, when the time is right, a special session in which the patient is honestly confronted and the provider and patient are able to talk openly and sincerely.

If a provider had built a strong relationship with the patient described here, this individual might have been able to help him recognize the negative effects his alcohol consumption was having on his health and on his relationship with his sister. This type of patient-provider communication also might have enabled him to consider the full implications of his advanced cancer, which shortened his life expectancy severely. With the assistance of a trusted health care professional, perhaps the patient could have identified goals—such as repairing damaged relationships—that he wanted to achieve before his death.

CONSIDERING HOSPICE CARE

After assessing the patient's present situation, the next step is to discuss strategies for future care. An ethical concern raised in this case was whether hospice care would be appropriate for this patient, who had been relying on blood transfusions to alleviate his anemia.[12] Given that transfusions would not be available in the hospice setting, would placing him in this setting shorten his life unnecessarily?

Since it is likely that this patient's anemia could have been be treated through nutritional interventions, once a constructive relationship with providers was established and he allowed diagnostic studies and agreed to follow preventive care recommendations, this issue should no longer have presented an obstacle to hospice care. Furthermore, when patients decide to enter hospice care, they generally have accepted that their expected lifespan is short, and it is common for the immediate cause of their death to be complications of their illness (such as anemia or infections) rather than the illness itself.

CAREGIVER CONCERNS

Another important aspect of this case was the caregiver fatigue the patient's sister was experiencing. Caregiver fatigue is common, greatly underappreciated, and not well researched.[13] All too often, there is an underlying cause of stress for the caregiver that, unchecked, rises to the point of burnout and may even cause physical or psychological illness in the caregiver. One way providers can help ease caregiver fatigue is to help the caregiver

Continued on page 51

Continued from page 42

arrange for respite care. This might be accomplished by rotating care of the patient with other family members or obtaining the assistance of a nurse. In the case of this particular patient, it might have been necessary for the sister to tell her brother that she could no longer care for him. Faced with that situation, the patient might have realized his responsibility and modified his behavior or agreed to placement in a nursing home or hospice center.

CONCLUSION

When a patient with advanced cancer has a substance abuse disorder, management of this disorder is an essential part of palliative care.[1,6,14,15] Goals for treating such patients should include controlling the dependency; providing effective and compassionate palliative care that alleviates suffering; and decreasing the psychological, physical, and economic burdens placed on the patients' family and caregivers.

Abstinence from alcohol or drugs is a primary goal of substance abuse treatment, since full recovery is unlikely without abstinence. Other goals include detoxification, medical evaluation, stabilization of life threatening psychological issues, education, identification of barriers to recovery, readjustment of behavior toward recovery, and orientation and membership in a support group.

Family support and involvement can make the difference between success or failure of these treatment goals. As such, it's important to consider the family's needs when managing the patient's condition and to include them in educational efforts and treatment planning. Keep in mind that the physical, emotional, and spiritual effects of alcoholism or other substance abuse can be just as profound for family members as for the patient. ●

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