Aims and reasons: ethical questions about palliative systemic anticancer therapy

de Kort, S.J.

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CHAPTER 7

GENERAL DISCUSSION

The aim of this research was to gain insight in what good use of palliative systemic anticancer therapy might be. In order to do so, I studied the aims of palliative systemic therapy (PST); the way they are shaped within different oncology practices and how those who are involved with PST deal with these aims. These empirical findings on the aims of PST are used to develop a more substantial ethical theory about the good use of PST.

This general discussion will first answer the two main research questions: 1) what are the aims of palliative systemic anticancer therapy for patients with metastatic cancer and which role do these aims play in practice? 2) how can these aims be morally interpreted? And how do these interpretations contribute to good use of PST? In the second part of this chapter I will make some methodological reflections.

7.1 Aims of palliative systemic therapy

In this thesis, the good use of PST has been studied in terms of the aims of palliative systemic therapy for patients with metastatic cancer.

7.1.1 Types of aims

To understand the various aims that may be involved, different practices were studied in which researchers, guideline developers, physicians and patients were involved in palliative systemic therapy. With regard to the first research question the following conclusions were drawn.

In research concerning palliative systemic therapy (Chap. 2), treatment aims take the form of quantifiable outcomes and particularly of life prolongation related outcome measures, such as OS (overall survival), PFS (progression-free survival), FFS (failure-free survival), and TTP (time to disease progression). Contrary to what might be expected with regard to palliative therapies, quality of life-related outcome measures (determined with different health related quality of life instruments), and symptom-focused outcome measures (different symptom monitors) are
rarely the main aim of research papers. This might be because life-prolongation-related outcome measures are easier to quantify and interpret.

Guideline development (Chap. 3), even though based on scientific evidence, displays many aims and values. Systemic anticancer therapies in the palliative phase of cancer may be recommended because of their life-prolonging effects, but also because prescribing therapies means that there is ‘at least something to offer’. The role of the cost of treatment in guideline development is unclear (Chap. 4). Some guideline developers who did not consider cost to be a decisive issue felt that only the best possible treatment should be included in a guideline. Other guideline developers, however, felt that a guideline should be realistic and applicable in practice and should therefore take costs into account.

Clinical practice shows the greatest variety of treatment aims: they are different between individual patients and may alter during the course of treatment of a patient (Chap. 5). One patient may want to live as long as possible while another aims for a palliative phase without hospital visits. Over the course of treatment, life prolongation may be replaced with the aim of a symptom-poor last phase of life.

Probably the most striking, and maybe the most disquieting, conclusion from our qualitative study of clinical practice, is that sometimes treatment aims seemed to lose importance (Chap. 6). Usually treatment is given as a means to reach an end, but sometimes in the palliative phase of cancer, forms of treatment that are very probably ineffective on any outcome measure are pursued by patients and prescribed by physicians. Such treatment does not clearly serve any aim at all, but is wanted by patients nonetheless. For example, patients may want to ‘have tried everything’ or ‘do something’. Because patients have reasons to want such treatment that are not related to any aim, I speak about reasons for treatment and not treatment aims.

Is it possible to categorize the aims we found in these practices? The various practices have different aims that can be described as either general or personal; moreover, at least in clinical practice, providing treatment sometimes seems to become an aim in itself - this is when we speak of reasons. I distinguish three categories:

1. General aims are cast in a quantifiable form. These aims are called ‘general’ because they leave special cases aside and are true of a population
in its entirety. Examples are life-prolongation-related outcomes such as OS and TTP, but also quality of life improvement and symptom reduction.

2. **Personal aims** are aims that may change over time and are related to what individual patients consider important. For example, one patient may want to live long enough to experience the birth of a grandchild, another may have the wish to maintain their personal appearance, and therefore particularly want to keep their hair. Personal aims may also be subject to change: primary aims such as wanting to experience the birth of a grandchild may change into the aim of no longer experiencing pain and shortness of breath.

3. **Reasons** are specific motives given by the patient for wanting a therapy strongly, even if it has virtually no chance of reaching a specific general or personal aim. This means that instead of being a means to an end, treatment becomes the end itself.

### 7.1.2 Good use

After defining these three categories of aims, we now come to the second research question: how can the aims be interpreted morally? And how do these interpretations contribute to good use of PST? In order to answer these questions, the value of each category of aims for specific practices has to be established. The guiding idea is that within a practice, PST is used in a good way when it may be expected to contribute to an aim that is relevant to that practice. To a certain extent, the three categories of aims given were found in all three types of practice we studied (research, guideline and clinic). Now we will see how the three categories of aims work out in each type of practice, and whether or not they are related to good use of PST.

**General aims**

General aims stem from research practice and fit in well with quantitative research. Good use of PST within research leads to clear general aims.

In guideline practice too, general aims are mainly used and these often fit in well. It is with good reason that guidelines are developed to overcome variation in clinical practice and personal preferences of clinicians. General aims are useful in this. However, guidelines often try to formulate the best treatment option (standard of care) on the basis of just one general aim which is almost always life prolongation. This is problematic with regard to palliative treatment and its many possibly relevant outcomes. In order to make a good recommendation, the guideline text
needs to be explicit about the weighing of different outcomes (for instance, is priority given to prolongation of life or to quality of life), or at the very least the guideline should offer different treatment options to meet different general aims.

In clinical practice the use of a general aim is more complicated. In the curative phase there is one overriding aim - the aim of survival - which makes a particular form of treatment good if it is effective on survival. In the palliative phase, there are by definition no anticancer therapies that lead to survival. And as I argued in relation to guidelines, in the palliative phase not just one, but many general aims of PST might be relevant: the aims might be to prolong life and/or improve quality of life and/or reduce symptoms. All these possibly relevant general aims need to be translated into patient-dependent and changeable personal aims in clinical practice.

**Personal aims**

In clinical palliative oncology practice personal aims, that describe what patients consider important and what they want from the life that still remains for them, are always at least as important as general aims. One could say that in systemic anticancer therapy in the palliative phase, general scientifically-proven treatment possibilities are always subordinate to personal aims. A translation of general aims into personal aims is needed in order to use PST well in clinical practice. PST can have been said to have been used well if personal aims are achieved. For instance, this means that the burden of side-effects can only be justified if they do not interfere with reaching these personal aims. If a patient wants to be present at her grandson’s baptism, a life-prolonging treatment in itself is not good enough; it also should avoid her being hospitalized.

In clinical practice good use of PST also demands flexibility which allows for trying out, evaluating and adjusting various forms of treatment. In this process, personal aims must match the means. The use of PST needs extra attention in cases of changing personal aims. Changing aims always demands an evaluation to see which treatment is the best in meeting the changed aims. For example, if palliative systemic therapy was given with the intention of prolonging life and then the aim was changed to symptom reduction, results from scientific studies (from the area of general aims) will be used to see whether the chosen palliative systemic therapy is still the best means of reaching this new aim. If it is not, then systemic therapy has not been used properly.
Although in clinical practice personal aims are what it is all about, personal aims do not fit in well with quantitative research. Aims of research should not become patient-dependent and therefore it is good practice that inclusion and exclusion criteria and research protocols are very strict. Neither should aims be allowed to change. Therefore, studies on palliative systemic therapy in which the primary endpoints are changed during data collection (for instance from duration to quality of life), are bad studies. Here the conflict is that personal aims are very important in palliative oncology and within research only general aims are advisable. We will come back to conflict when we make recommendations for new research in the second part of this general discussion.

In the practice of guideline development personal aims cannot be avoided. General aims need to be put into a personal perspective because scientifically proven statistically significant effects also need to be given clinical meaning (which outcome is actually clinically significant). General knowledge about personal aims (the various things patients consider to be important) helps to weigh the possible outcomes.

**Reasons**

The third category of ‘aims’ that we distinguished was that of reasons. In particular we encountered reason-based treatments. These raise a specific ethical issue: it could be felt that accepting ‘aimless’ palliative systemic therapy means that clinical practice would unavoidably slide down the proverbial slippery slope at the bottom of which every therapy is accepted and any form of justification is missing.

Would a physician be justified in refusing to prescribe toxic drugs that are very much wanted by a patient if it is highly improbable that they will have any effect on the tumour? Of course such refusals are justifiable, but the reverse may not be true: that does not mean that accommodating the wish of a competent patient for an ‘aimless’ treatment would be unjustifiable in all cases. Even though it may seem a completely irrational wish, patients have a right to be irrational and sometimes such treatments might be justified.

In Chapter 6 we suggested that probably ineffective treatments could be justified by referring to the ‘suitability’ of the treatment, inspired by ideas about eudemonia (the good life). A treatment may be suitable if it fits into the patient’s life story and into the end of this story. In order to flesh out the idea of suitability, we introduced the concept of ‘narrative coherence’. The narrative (life story) helps to provide insight into what is important for that person. Within this concept of narrative coherence,
an important assumption is that the rounding off of someone’s life is an essential part of their life story as a whole. A treatment (which is probably ineffective with regard to general and personal aims) might be justified if the treatment contributes to narrative coherence.

What type of treatment could be justified by narrative coherence? Should it be a drug that is usually given as anticancer therapy? In order to avoid the slippery slope, probably ineffective treatments that are justified because they fit into the narrative of a patient’s life, of course require limitations. In clinical practice we found indications for limitations, such as using forms of treatment with only minor and easily reversible side effects and giving treatment that needs to be evaluated quickly after every course of palliative systemic therapy.

In research and guideline practice this third category of ‘aims’ was rarely encountered. Within the guideline setting we found that therapies are sometimes recommended in order to be able to prescribe ‘at least something’. This kind of reasoning does not fit well to the practice of guideline development. The use of such reasons at least should have been made explicit by guideline developers but furthermore needs a justification by the narrative coherence of a patient’s life, while the perspective of the individual patient is virtually absent when guidelines are set.

We conclude that ‘good use’ of palliative systemic therapy is different in each individual practice. Categories of aims are related to good use. However, the practices in which the aims are used are decisive. Good use of PST in research practice is related to clear general aims. Good use of PST within clinical practice translates those general aims into patient-dependent and changeable personal aims. This translation requires continuous adjustments. Guidelines are meant to help with the translation of general aims into personal aims. Currently guidelines do this inappropriately because they are implicit about the aims and value judgements they involve. In some situations, ‘reasons’ may lead to PST being used well in clinical practice. However, ‘reasons’ must be invoked very carefully as basis for possibly toxic treatments.

7.1.3 Checklist
Now that we have determined what the various good uses of PST are, only the question about how these uses can be translated into practice is left. In what follows, the focus will be on clinical practice. The following checklist may help clinicians and their patients by clarifying aims and reasons for treatment and by reflecting upon their use of palliative sys-
temic anticancer therapy. Besides use in clinical practice this checklist could also be included in oncology guidelines to support physicians in complicated treatment decisions related to PST.

1. For what aim am I prescribing this treatment?

This question is intended to help the physician to reflect upon the use of palliative systemic therapy. Why am I carrying out this treatment? Which general aims do I consider important? How do these aims fit in with the personal aims formulated by the patient? It may be hard to distinguish an aim at all; then I realize that treatment may become an end in itself.

How can the treatment aim or reason for treatment be formulated as precisely as possible, even if only provisionally? Palliative systemic therapy may start with general treatment aims, but these are always of a temporary nature. Sooner or later the treatment will no longer be effective in terms of a primary aim, still personal aims might justify certain treatments, and even reasons for treatment may gain the upper hand in the justification. What if no more treatment aims can be distinguished and the patient wants the treatment for a specific reason? In this thesis, it is argued that giving a probably ineffective treatment may sometimes be justified by pointing to its fit with the patient’s life story.

2. Am I shaping the treatment in a flexible way?

How is the treatment actually shaped? The second question of the checklist serves as reflection on the treatment in so far as it is a trajectory (erratic process in which treatments are continually being tested, evaluated and adjusted). A question that might be helpful is this - Is palliative systemic anticancer treatment being ‘tried out’ or ‘started’? If a treatment is ‘started’ it prima facie suggests that it should also be completed. If treatment is only ‘tried out’ it suggests a much more open treatment course. In such cases, a treatment trajectory consists of many possibilities that may change and are rarely closed. To try out a treatment allows the treatment fit in with the patient’s life in which aims may shift or sometimes even disappear.

This open, flexible way of shaping treatment also fits in better with the uncertainties in evidence-based knowledge. For example, comorbidity is a reality but is hard to deal with in quantitative research. There are also many matters that should really be researched but about which so far little evidence has been generated. For example this pertains to questions such as: What is more effective: To ‘step up’ (begin carefully (sequentially), just irritate the tumour as it were), or ‘step down’ (begin
aggressively with combinations, as is usual in the curative setting). Should it be started when the patient is asymptomatic or should one wait until tumour-related signs and symptoms occur? Which agent should be used and in which treatment line should it be applied? By which route should the agent be administered? Or should the whole idea of courses of treatment be discarded? Which treatment allows the patient the most freedom to go on holiday and have a life outside hospital? New treatment modalities only make these matters more complicated.

The physician may realize that trajectories in which treatments are continuously tried out, evaluated and adapted may conflict with strictly following up some research/treatment protocols.

3. Will treatment affect ways of dying?

There is another consideration that may help the doctor to cope with diverse treatment aims and to ultimately arrive at the good use of palliative systemic therapy for patients with metastatic cancer. What does treatment mean in the last stage of the patient’s life? Treatment such as palliative chemotherapy is rarely viewed as the type of treatment that should be carried out at the end of life. But to a certain extent this treatment is certainly part of the end of life. All the more since once they have started, patients tend to want to continue. Treatment imposes a burden that is heavy to carry at the end of life but in some cases it is the last hope of an effect unlikely to occur that patients cling to. Also, treatment can reinforce the idea of ‘having tried everything’ and can thus contribute towards a fitting end of life.

PST partly determines the nature of death itself. There are several possible ways of dying of an incurable disease. Continuing treatment of the disease means that causes of death may shift. For example, in simple terms, without continuing treatment a patient might die from liver metastases, but if he/she continues to be treated with PST then he/she is more likely to die from brain metastases. In the latter case it is more likely that the patient’s psychological well-being or awareness will be more affected and for a longer period than if he/she had died from liver metastases. This may have implications, for example for being able to say farewell. Certainly no less important in this connection is the place of death. The longer treatment is continued, the greater the risk of complications and the chance that the patient will die in the hospital.
7.1.4 Scope of checklist

In order to study clinical practice we focused on two cases, i.e. patients with colorectal cancer and patients with pancreatic cancer. An appropriate question is if the checklist presented above would also be useful for patients with other types of tumour. I think it would. Although we chose these cases particularly because they were very different in regard of the number of treatment options and in the possible complexity of the question about good use of PST, I did not find many differences. In both cases, three categories of treatment aims could be distinguished. Therefore, it is reasonable to believe that my findings also apply to other metastasized tumours in which palliative systemic therapy might be an option. Hence the checklist might be of use in complicated treatments for other tumours. Brain tumours (primary or secondary) may form an exception to this. In these cases it is the disease that interferes with the patient's ability to determine and adjust personal aims, and to shape the end of their life. This may complicate reflections of both physician and patient on the three checklist questions.

The checklist is clearly meant for clinical practice and its physicians. Here reflective decisions are to be made. What do I want to offer the physician and how is he/she stimulated to use of PST wisely? What may help physicians and their patients with metastasized cancer in their search for the best form of treatment? This research project made clear that practice should not be guided by single theories or norms. The checklist offers three questions concerning the aims, the flexibility and the effect on dying, that need to be answered by the physician in order to promote good use.

I agree with Harbers, Mol and Stollmeyer when they say that practices are more likely to be improved by changing the way of looking at something rather than recommending behavioural changes. I agree with them because firstly, I do not identify myself as an ethicist with a ‘warning finger’. And secondly, it is more attractive to start viewing things from different perspectives and sharing that experience with others. Of course it still remains to be seen whether it is easy to convince headstrong physicians to take a different view.

Besides the fact that it is impossible to give one single definition of good use of PST, this motivational aspect was the other reason for designing a checklist in the form of three reflective questions instead of concrete recommendations.

The last consideration on the checklist is about ways of dying and does not originate from our empirical studies. This consideration is inspired by Randall and Downie’s statement that ‘life-prolonging treatments should
not be offered if worse ways of dying are likely to ensue'. For methodological reasons (due to our open approach we did not explicitly include this subject in our topic list) or because of a possible lack of attention to this subject, in practice we did not come up with this matter. However, I believe that the way of dying is something that we could have discussed in interviews with relatives for example, or if we had just explicitly asked about it. Even though not based on our empirical material, this consideration touches on a matter that in retrospect seemed to be important: the way patients die has an important impact on the value of their last days of life and on the last memories their family will have of them.

7.2 Methodological reflections
This second part of the general discussion chapter will give some insight into what occurred ‘backstage’ in the phases of data collection and analysis of this empirical ethical research project. In addition I will make some recommendations for new research.

7.2.1 Behind the results
By means of two identifiable, but at the same time overlapping, research phases, namely the data collection and the analysis, I will now illustrate some of the methodological considerations and decisions that finally determined the end product of this study. This view ‘behind the results’ is important, because the interpretations, considerations and decisions made by the qualitative researcher are a determining part of the results in qualitative research. Therefore these at least deserve some attention.

Data collection
A researcher has an important role in data collection for qualitative research. Because the characteristics of a research instrument, such as a questionnaire, at least partly determine the data collection in quantitative research, it is said that the qualitative researcher is, in fact, the research instrument.

The introduction of the subject of research to patients, e.g. the formulation of an information letter on the basis of which patients decide whether or not to participate in a study, is important for the selection of patients and thus for data collection. This means that the researcher needs to reflect on decisions concerning the approach to the participants. In the information letter, we wrote that our study was on ‘Decisions about chemotherapy for people with pancreatic or bowel cancer’. In doing
so we left out terms like ‘palliative’, ‘metastatic’, and ‘advanced’, because it is clear from the literature that patients with incurable metastatic disease may still be hoping for a cure even if they have been told about their illness and prognosis. To avoid an inappropriate selection of patients we did not want to exclude these patients beforehand. Did we mislead the participants? We do not think so. What we told them was true. Moreover, the alternative would have been worse, because it may have confronted some patients with prognostic knowledge they might have received from their doctor but not taken in. Changing prognostic knowledge is the task not of researchers but of treating physicians.

However, for reasons of informed consent the information letter stated that the study included three interviews and that there were several months between interviews, even though it was clear beforehand that, due to the average life expectancy, it would not be possible to carry out three interviews with every patient. Of course we could have added to the information ‘disease permitting’. Again, that would probably have caused confusion or trouble in a sensitive and emotionally charged area. But there was a risk that patients could indirectly get a misleading picture of their potential life expectancy (namely that they would survive the coming 4-6 months) and that the study was intervening in their hopes. However, we thought it was important to inform patients about the effort involved in participating.

Besides deliberative decisions about approaching participants, things that just happened were at least as important for my data collection. A patient with bowel cancer who had completed the interview process, telephoned a few days before he died. He was wondering if my research had delivered any results yet. He was especially curious to know if my discussions with him had contributed towards the results. This made it clear that this study could have contributed to a meaningful closure for some patients. Such events made me extra aware of the delicate area at the end of life in which I was gathering data and how necessary it was to reflect on my own role as researcher. Such reflections influenced the data collection: death needed to be one of the interview topics but discussed in a careful way.

Even though I tried to be careful, one patient gave me serious feedback the second time we met. He told me he didn’t like the fact that during our first interview I only had looked at his wife while I was asking if they wanted to receive my thesis some years in the future. Even though all his physicians had given him the message that he was going to die, he wanted to leave things open because he didn’t want to give up hope. As
well as trying to be even more open and careful in my approach during interviews, I gave this event meaning by interpreting it as result. I had learned that ‘acceptance of having a terminal disease’ was not such a clear phenomenon and in particular not necessarily related to treatment decisions (this patient at least for the time being did not want a PST).

Just as it was not my intention to be seen by patients as a carer, I also did not intend to be viewed as a moralist by physicians. However, the following example shows that research sometimes begins to lead a life of its own. After an interview with a medical oncologist had finished and the recorder had been turned off, she said: ‘You’re probably thinking: they make it up as they go along.’ Apparently she had interpreted my interview as a moral judgement and therefore she expressed her uncertainty about her way of working and making moral decisions. Interestingly, it was this interview that taught me quite a lot about good use of palliative systemic therapy, for instance that it seems better to have no immediate answers about what to do in difficult cases. This medical oncologist tried to assess the best use of treatment in every individual patient and situation. The alternative would be being highly, but possibly incorrectly organized and working according to one overriding standard.

Of course the fact that participants may have perceived me as a moralist could have influenced the data collection. Uncertainties, doubtful cases or even examples of bad practices may have been hidden to me. However, the interview described above was one of the few situations in which I noticed that I was not only seen as a researcher but also as outsider who judged.

Analysis
The analyzing process distinguishes important results from unimportant ones. Not only during data collection but also in the analysing process, the role of the researcher as research instrument is important. I will illustrate this by describing how the results from studying clinical practice were analysed.

During the first data collection in which I tried to find value judgements that determined treatment decisions, it became apparent that although ‘decision making’ was an established term, it did not do justice to many of my perceptions. In particular the fact that more than half of the patients interviewed told me that they had ‘no choice’ could not be ignored. I decided to extend my data collection and analysis further by addressing a much more open research question i.e. how treatments actually take shape.

Interpreting the shaping of treatments as ‘trajectories’ (erratic pro-
cesses in which treatments were continually being tested, evaluated and adjusted), I felt I needed moral perspectives to further analyse my findings. I found there was common ground with the ethics of care. Trajectories were rarely shaped on the basis of general aims alone. Personal aims which are individually determined and changeable, and sometimes reasons lead the trajectories. The ethics of care can do more with the idea of care as a process without a leading external aim than principle-based ethics, because it allows for an interpretation of the ‘trajectory’ not only as a means but also as an end in itself. Although she places more emphasis on relational aspects than on processes, Margaret Urban Walker describes the idea that a means can be an end at the same time as follows: ‘What one values is not only the actual outcomes of others’ (and one’s own) actions, but also the nature and significance of those relationships, and of the specific kinds of trust, appreciation, enjoyment, esteem, and security that those relationships bring to one’s life.’ Treatment trajectories involve more than the means to achieve a certain aim, for example, a trajectory may be shaped by the importance of not abandoning a patient, which makes it important that physician and patient keep on working on something.

7.2.2 Recommendations for new research
There are two areas of research that this study was unable to address in depth. The first relates to clinical oncological research. I have studied research mainly by analyzing published papers that reported clinical trials. This only gives a limited view because it gives insight into the result of the research practice instead of the research practice itself. It would be interesting to focus on the performance of research and its relation with clinical practice. Doing research in oncology patients is an interesting area in which different tensions appear when good use of palliative systemic therapy is concerned. On the one hand treatment given within a research protocol is often one of the few promising options for patients, on the other hand protocols may be quite strict and not very kind to or flexible with patients. For example, a potential new research project could be one that studied the development of research design. How is the patient taken into account and which potential circumstances are included and which are not? It could also compare patients getting standard treatment but are not included in research protocols with patients who are being treated within research protocols. Such research questions allow for an interesting exploration of research practice with its potential conflict between general and personal aims.

The scope of this study did not allow for further exploration of the phe-
nomenon of hope and all its appearances. Hope is not something patients and physicians aim for or something that belongs to the categories of aims and reasons we distinguished in this study. However, hope can certainly go hand in hand with aims and reasons. William Ruddick distinguishes possibility-hopes (which are often patients’ hopes) and probability-hopes that are more fact-sensitive and more supported by physicians. Both types of hope accompany an intended outcome. Hopelessness, desperation and being hopeful: what do these concepts mean to patient and physician? This would be an interesting new area of research to gain insight into situations in which no treatment aims can be recognized and only reasons for treatment remain. What are the beliefs and attitudes of patients and physicians about hope that contribute to patients sometimes strongly wanting to ‘do something’ or to ‘have tried everything’ and sometimes displaying the opposite reaction: patients who refuse a treatment with considerable potential effects?

7.3 Conclusion

This thesis is about the good use of palliative systemic anticancer therapy. It offers a more substantial moral theory about good use than can be found in the literature. The difference between practices and their related treatment aims is of overriding importance in defining good use. For example, in research practice patient-dependent and changeable personal aims do not fit and therefore may point to bad use; on the other hand in some clinical situations clear general and personal aims may have become useless and only reasons may remain to be able to speak about good use of PST.

One of the trends I mentioned in the general introduction was that the use of palliative systemic anticancer therapy seems to be increasing, especially at the end of life. If this development continues, in the near future PST will become an important part of the end of life for people with cancer. One way to interpret and judge this development is to depart from our aim-means way of thinking for a while and to see that PST is not only a means but also often an end in itself. Prescribing and receiving PST might also mean that something is still being done and that one is not giving in to the disease. When patients are facing death, their wish for PST at the end of life may be understandable. However, whether we want this to lead to the increasing use of probably ineffective PST, should be part of a public discussion on how we in modern society want to cope with the end of life.
Reference List


