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# Advanced cancer and COVID-19 comorbidity: medical oncology-palliative medicine ethics meetings in a comprehensive cancer centre

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## ABSTRACT

**Objectives** In managing patients with cancer in the COVID-19 era, clinical oncologists and palliative care practitioners had to face new, disrupting and complex medical situations, challenging the quality of the shared decision-making process. During the first lockdown in France, we developed an onco-palliative ethics meeting to enhance the quality of the decision-making process for patients with advanced cancer treated for COVID-19.

**Methods** A least one of the institutional ethics committee members was present along with oncologists, palliative care teams, psycho-oncologists, radiologists and intensive care specialists. Specific medical parameters were systematically collected to form a standardised framework for the discussions.

**Results** The main raised issues were the definition of new criteria for the implementation of invasive resuscitation techniques, optimal ways to adapt or delay anticancer treatment and best procedures to address terminal respiratory failure and end-of-life care. The main clinical and ethical guidelines that emerged during these debates are presented. The palliative care team played a major role in assessing and reporting patients' awareness of cancer-related prognosis and their wishes concerning invasive therapies or transfer to intensive care units, enabling an individualised benefit–risk balance assessment. The ethics committee members ensured continuous monitoring during the discussions. Their function was to recall the main ethical principles including dignity, which is conferred on people when there are treated as having equal status.

**Conclusions** The onco-palliative ethics meeting provided a powerful avenue for improvement of collegiality and reinforcement of teamwork, which could be a major protection against burnout for healthcare professionals facing an epidemic onslaught.

### Key messages

**What was already known?**
- During the first wave of the COVID-19 pandemic, clinical oncologists practitioners had to face with medical uncertainty and pressure in intensive care unit beds availability.
- Our institution set up an onco-palliative ethics meeting to enhance the quality of the decision-making process.

**What are the new findings?**
- Main issues discussed were resuscitation status, COVID-19 disease management, anticancer treatment changes, sedation and end-of-life care.
- The palliative care team and ethics committee members helped highlight the patient's information and support needs and recall the principle of dignity conferred on people when they are treated as having equal.

**What is their significance?**
- The lack of knowledge on COVID-19 risks highlighted the paramount importance to include the patient with advanced cancer and his relatives' point of view in the decision-making process.
- Further studies are needed to assess the impact of these onco-palliative ethics meetings in the decision-making process.

## INTRODUCTION

Cancer is a confirmed risk factor for incidence and/or severe forms or death

from COVID-19.[1] Patients with cancer who develop COVID-19 have a 20%–30% likelihood of death.[2 3] Haematological malignancies, advanced cancer, lung cancer and a poor performance status are confirmed factors increasing the mortality rate.[3 4] A severe form of COVID-19 can compromise the feasibility of anti-tumour treatment for a long time, with potential harmful consequences on cancer prognosis.[3] As health systems were stretched to the limit at the height of the COVID-19 pandemic, oversolicited oncologists had to make demanding medical decisions concerning patients with advanced cancer.[5] The usual criteria for the implementation of invasive resuscitation techniques among oncology patients were rapidly challenged by the occurrence of COVID-19.[6 7] International guidelines were rapidly published, setting out recommendations for surgical, radiotherapeutic and oncological management for cancer patients, highlighting the need to limit visits to hospital and to address the risks related to immunosuppression.[8] However, in the context of uncertainty due to the scarce available data, emerging, complex and disrupting medical situations for advanced cancer patients with COVID-19 proved to be highly challenging for clinical oncologists and palliative care teams.

Multidisciplinary boards are recognised as the gold standard for cancer patient management. Defined as '*a group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients*', these meetings are intended to provide a collaborative decision-making process relying on evidence-based medicine and the assessment of individual parameters.[9 10] However, insufficient specialist participation, lack of collegiality and suboptimal information sharing can reduce their performance.[10 11] In integrated palliative care practice, the multidisciplinary and multiprofessional approach allows cross-assessment by doctors, nurses, psychologists and social workers to maximise care aiming to relieve suffering and improve quality of life.[12] This comprehensive assessment is pivotal in providing an efficient collaborative decision-making process and a shared palliative care project.[13]

Before the COVID-19 pandemic, our hospital was holding weekly multidisciplinary team meetings for each specialty, and a palliative meeting involving palliative care team and healthcare professionals from each medical ward. This earlier experience helped us to innovate in structuring the onco-palliative ethics meeting during the first lockdown between 27 March and 7 June 2020. In this process, we responded to the French National Advisory Ethics Committee request, which was established during the first pandemic wave.[14] In this paper, we report the organisation of this onco-palliative ethics meeting for hospitalised patients with advanced cancer and COVID-19. We successively present the framework of the discussions to ensure a high-quality decision-making process, the medicoethical issues discussed and the guidance applied. Finally, we highlight the specific role of the palliative care team and the Ethics Committee members, bringing them together with oncologists in the same meeting for the first time.

## FINDINGS

### Organisation of care for inpatients with COVID-19

Most countries recommended that patients with advanced cancer should be treated as outpatients as far as possible, while patients with cancer and COVID-19 who needed to be hospitalised were to be isolated in dedicated wards.[15] The medical management of COVID-19 followed published recommendations.[8] The clinical and radiological features and the management of COVID-19 among patients with cancer treated at Institut Curie have been previously reported.[16] The palliative care referral criteria included the management of severe symptoms and terminal respiratory distress, as well as the need for discussion in the setting of serious illness and advance care planning.[17 18] To reduce the risk of infection for healthcare professionals, inpatient palliative care consultations needed to be shortened as much as possible, with separate consultations with the physician and the nurse, avoiding their simultaneous presence. Dietitians, social workers and psycho-oncologists mainly intervened by phone. Visiting conditions for patients with cancer hospitalised with COVID-19 were severely restricted. To limit the spread of the virus, strict visitor restrictions were implemented, prohibiting family and friends from visiting their hospitalised loved ones. This rule immediately had a large psychological impact, generating feelings of loneliness and isolation for cancer inpatients, sadness and guilt for their relatives, and distress for both.[19] Caregivers developed many dynamic initiatives to reduce the potential consequences of isolation as far as possible. Electronic tablets could be provided in all wards promoting the exchange of information between caregivers and relatives or between patients and their families.

If necessary, the patients were transferred to a dedicated ward in our eight-bed intensive care unit. At the peak of the first wave, non-urgent carcinological interventions were suspended; six additional intensive care beds were added in the operating room, so that COVID-19 free and COVID-19 positive patients were clearly separated.

### The ethics committee

Most of the ethics committee members are caregivers open-minded for ethical issues, and some of them also have certified degree in ethics. The group is composed of five oncologists and two oncology nurses, two physicians and one nurse from the palliative care team, one intensive care physician, two psychiatrists. The other ethics committee members are a chief financial officer, a jurist and a sociologist. The members are elected

**Table 1** Characteristics of onco-palliative ethics meetings for patients with advanced cancer and COVID-19

| | |
|---|---|
| Members | Nurses and physicians from the ward |
| | Treating oncologist and other oncologists |
| | Radiologists |
| | Intensive care physician |
| | Psycho-oncologists |
| | Palliative care team |
| | At least one ethics committee member |
| Process | Virtual |
| | Daily basis |
| | Report in medical chart |
| Type of case | Advanced cancer inpatient treated for COVID-19 disease |
| Data presented | Age, performance status, nutritional status and albuminaemia |
| | Type of primitive cancer and metastasis |
| | Comorbidities |
| | Number of prior lines of anticancer treatments |
| | Prognosis (before COVID-19 infection) |
| | Cognitive status and ability to communicate |
| | Family environment |
| | Prognosis or end-of life discussions |
| | Clinical course of COVID-19 infection |
| Types of medical decision | Resuscitation status |
| | COVID-19 disease management |
| | Anticancer treatment changes or discontinuation |
| | Sedation and end-of-life care |
| | Information to be delivered to patients and relatives |
| Information to the patient | Patient's bedside |
| Information to relatives | Patient's bedside, phone contact and individual meeting |
| Traceability | Minutes of the debate systematically included in the medical file |

for 2 years. First mission of the ethic committee is to participate to multidisciplinary meetings for complex medical situations. Prior to the COVID-19 health crisis, this participation took place approximately three times a year, in our institute with 300 beds. Other missions were to organise 2-hour meetings three times a year for a theoretical debate about one ethical question and to conduct a yearly 2-day training.

### The new onco-palliative ethics meeting

During the first lockdown in France between 27 March and 7 June 2020, the usual onco-palliative meeting evolved into the onco-palliative ethics meeting in several ways: from a face-to-face meeting to a virtual meeting, from a weekly to a daily basis, and with a composition enlarged to more oncologists, to one intensive care physician and to at least one ethics committee member (table 1). The daily occurrence of the meetings enabled immediate discussion when a quick medical decision was needed. It was organised virtually to respect the mandatory distancing measures, and two to five cases were discussed daily.

The cases were selected by the primary team (junior oncologists, ward physicians and residents) when there were facing complex and disrupting medical situations concerning advanced cancer patients with COVID-19. We did not previously set any defined criteria in order to let spontaneously emerge new and unknown medical challenges. The meeting operates as follows: junior oncologists present the patient medical history describing the oncological setting and the COVID-19 disease characteristics. The issues that were discussed during the meeting were grouped into five main themes: resuscitation status; COVID-19 disease management; cancer treatment changes or discontinuation; sedation and end-of-life care; and information to be delivered to the patients and their family. To ensure that the decision-making process was as reproducible and fair as possible, we set a rational framework for case presentation, with the parameters to be systematically described by the primary team (table 1). None of these parameters was considered as predominant, and no combined score was calculated. Prognosis of cancer disease was documented by the treating oncologist. Patients and their family's knowledge and understanding of life-threatening risks, as well as wishes for potential transfer to an intensive care unit was assessed by psycho-oncologists and/or palliative care team. The member of the ethics committee was responsible for ensuring the smooth running of discussions. The minutes of the meetings were systematically included in the patient's medical chart. A clinical case presentation and discussion is described in table 2.

### Medicoethical dilemmas and selected guidelines

Over time, we identified some major medicoethical issues, which were regularly discussed, leading to the emergence of relevant ethical principles (table 3).

Resuscitation status was systematically discussed at admission of the patient and was regularly evaluated when new medical events occurred. Two main situations were to be avoided. Because conventional or intensive care hospital beds were overloaded, there was considerable risk of making the decision to limit treatments too readily for patients with advanced cancer and severe COVID-19 pneumonia. Conversely, in the context of rapid-onset respiratory distress, there was a risk of deciding on active resuscitation without taking time to explore the patient's wishes. Whatever their age, patients with preserved autonomy and a life expectancy of more than 1 year before COVID-19 disease had a resuscitation order status, unless they expressed their opposition.

A paradigm shift occurred in the benefit–risk balance of cancer treatment, affected by the new unknown COVID-19 risk. Healthcare professionals were often required to make critical decisions on the basis of inadequate data and incomplete knowledge.[20 21]

**Table 2** Example of a clinical case discussed in one onco-palliative ethics meeting

| Onco-palliative | | 31 March 2020 | 2 April 2020 |
|---|---|---|---|
| Information collected | Age | 53 years | |
| | Performance status | 2 | |
| | Nutritional status | Severe malnutrition | |
| | Albuminaemia | 26 | |
| | Type of primitive cancer | Anal cancer | |
| | Metastasis | Lung and liver | |
| | Comorbidities | Asthma with long-term therapy | |
| | Number of prior lines of anticancer | 1 | |
| | Prognosis before COVID-19 | Rapid recurrence after surgery | |
| | | Estimated life expectancy <1 year | |
| | Family environment | Good family support | |
| | Cognitive status and ability to communicate | Correct | Correct |
| | COVID-19 clinical course | Mild respiratory distress | Severe respiratory distress |
| Issues discussed | Resuscitation status | No transfer in ICU | No transfer in ICU |
| | COVID-19 management | Symptomatic treatment | Addition of an antiviral drug |
| | Cancer treatment | Cancer therapeutic suspension | Cancer therapeutic stop |
| | Sedation | No need | Anticipated prescription |
| | Information to deliver | Bad cancer prognosis | Vital risk in short-term |
| Evolution | | | Hospice, death in 17 May |

ICU, intensive care unit.

The management of patients with acute respiratory failure caused by COVID-19 pneumonia was particularly challenging. First, effective treatment to reduce a pleuro-pulmonary tumour could facilitate the cure of COVID-19 pneumonia. Second, the occurrence of febrile neutropaenia could increase the risk of lung infection. Finally, delaying treatment of metastatic cancer could in turn expose the patient to tumour progression. Oncologists had to deal with these threats of different types and timing, the combination of which made the choice of the best treatment option particularly difficult. Most of the time, cancer treatments were delayed until COVID-19 pneumonia was cured. They were only considered on a case-by-case basis for patients with pleuropulmonary tumour invasion, which could contribute to respiratory failure, or any other threatening tumour localisation such as meningeal carcinomatosis. The clinical elements

**Table 3** Ethical dilemmas encountered and selected guidelines during onco-palliative ethics meetings for patients with advanced cancer and COVID-19

| Ethical dilemmas | Selected guidance |
|---|---|
| Resuscitation status<br>► Risk of limiting treatments too readily<br>► Risk of deciding on active resuscitation without exploring the patient's wishes | ► Systematic assessment of information needs and collection of patient's and relatives' opinions,<br>► Discussion at patient admission.<br>Reassessment according to new medical events.<br>► Resuscitation order if life expectancy longer than 1 year and patient's and relatives' agreement.<br>► Clear statement to resist utilitarian choices. |
| Benefit–risk balance of cancer treatment<br>► Risk of tumour progression in case of delayed anticancer treatment<br>► Risk of neutropaenia and pulmonary infection in case of chemotherapy | ► Systematic assessment of information needs and collection of patient's and relatives' opinions.<br>► Postponement of cancer treatment until COVID-19 disease cure.<br>► Exception possible if pleuropulmonary tumour, or other life-threatening tumour, with required conditions<br>– Preserved autonomy.<br>– Available treatment with no haematological or pulmonary toxicity. |
| Terminal acute respiratory failure management<br>► Risk of asphyxia<br>► Risk of relatives' distress if not allowed to visit dying loved ones | ► Systematic assessment of information needs and collection of patient's and relatives' opinions.<br>► Application of French law allowing<br>'deep, continuous sedation until death'.<br>► Visiting authorisations with strict respect for local safety measures. |

favouring decisions were a good general condition with preserved autonomy and an effective anticancer treatment available with low haematological or lung toxicity. For one patient included in a double-blind therapeutic trial presenting severe respiratory failure, collegiate discussion led to the decision to lift the blinding, because of the possible lung toxicity of the treatment studied.

For patients with terminal respiratory failure, palliative sedation was systematically discussed. A recent French law on rights of end-of-life patients enabled them to receive 'deep, continuous sedation until death'.[22] This treatment is to be prescribed at the patient request, when facing an incurable disease, refractory suffering and a short life expectancy (a few days). It can be requested by the person of trust or relatives if the patient is no longer conscious or able to communicate. Collegiate validation in a specific meeting is mandatory before starting this sedation. Visiting authorisations for relatives of a terminally ill patient were also frequently discussed in the onco-palliative meeting. We observed that relatives who could not visit their loved one before their death suffered an intense psychological trauma. For this reason, visiting authorisations with strict respect of local safety measures were granted to one or two relatives per day, to avoid patients with terminal disease dying without their loved ones by their side, or relatives not being able to say goodbye or undertake traditional grieving rituals.[23]

## DISCUSSION

The onco-palliative ethics meeting promoted a concerted decision-making process for resuscitation or life-sustaining treatment limitations, cancer treatment adaptation and management of end-of-life distress for patients or bereaved relatives. Uncertainty caused by the scarcity of data concerning COVID-19 disease, alongside the work overload and the shortness of supplies or manpower, could have led to premature or inappropriate decisions. In this context, it was more than ever necessary to carefully and timely analyse each case on an individual basis.[5] It offered dedicated time slots to discuss these sensitive medical issues in the management of advanced cancer patients with COVID-19 in a holistic way.

### Instrumental role of the supportive and palliative care team

The palliative care and psycho-oncologist team members played a major role during these onco-palliative ethics meetings by promoting multidisciplinary discussions.[21 24] The contribution of the palliative care team was needed to assess the patients and their family's knowledge and understanding of prognosis and life-threatening risks, to help delivering bad news and to support the ability of patients and their families to make informed decisions.[25] Advanced care planning discussions were initiated whenever possible, as they have a profound influence on the decision-making process.[13 25] Being aware of a patient wishes to avoid purposeless therapeutic obstinacy facilitates the decision not to transfer him or her to intensive care unit, or the decision to discontinue anticancer treatment. Both the palliative care team and psycho-oncologists had an active responsibility in reporting patients' wishes towards active treatment and end-of-life care, as well as the viewpoints of the families.[25] Surprisingly, the lack of knowledge on COVID-19 risks had an unexpected positive impact: it further highlighted the paramount importance to include the patient and his or her relatives' point of view in the decision-making process in the context of advanced metastatic cancer.

### Theoretical input by ethics committee members

The ethics committee members also provided an essential input by analysing the ethical consequences of each therapeutic alternative and guiding treatment decisions. The four historical principles in medical ethics are respect for autonomy, non-maleficence, beneficence and justice. We also consider the principle of dignity, which is conferred on people when there are treated as having equal status.[26] When the issue of transfer to intensive care arose, we considered the patient wishes if known and the appropriateness of resuscitation to enrich the collegiate decision-making process. There was a clear statement of the will to resist utilitarian choices, which could lead to refusal to transfer to intensive care unit because of the perceived lack of social utility of a patient.[5] The ethics committee members could also ensure that the formal discussion occurred and check the presence of the key caregivers knowing the patients and the patient's wishes assessment.

### Positive impact on team spirit

The psychological state of oncologists and palliative care team members could be stretched by oversolicitation, the high risk of COVID-19 among healthcare professionals, the infection risk for their relatives and their responsibility towards their patients.[27] However, the team-building setting provided by the collegiate decision-making experience during the onco-palliative ethics meeting may well have improved their sense of professional satisfaction and personal accomplishment. A sense of teamwork could be the main protection against burnout for healthcare professionals facing an epidemic onslaught.

### Perspectives

In the future, pressure to alleviate lockdown measures, combined with a risk of faltering public compliance with long-term social distancing requirements, could cause new outbreaks. This positive experience of an onco-palliative ethics meeting will help in possible future waves in Europe or elsewhere, which could put healthcare capacities under higher pressure again. Prospective studies are needed to assess the quality of the decision-making process, caregiver or patient and family satisfaction with the decision, the relative weight of different medical parameters and the influence of pressures on

hospitalisation. Finally, the benefit to caregivers and their quality of life should be assessed. All these results could promote the spread of these onco-palliative ethics meetings within every oncology department, extending them to all complex medical situations, even outside the COVID-19 epidemic period.

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