

Case Report

An Analytical Paper on Healthcare Providers' Divided Loyalties

Uzma Bibi,¹ Kashif Khan,² Ainan Arshad¹¹Aga Khan University, School of Nursing and Midwifery, ²HIMS CON, Peshawar**Abstract**

This paper explores the ethical challenges in pediatric oncology, focusing on a case where a 10-year-old girl diagnosed with a rare and aggressive cancer is recommended chemotherapy, which her parents oppose in favor of alternative treatments. It scrutinizes the conflict between medical best practices and parental autonomy, incorporating beneficence and patient advocacy principles. Utilizing data from global cancer registries and studies on treatment-related mortality, the paper underscores the critical role of evidence-based treatment in increasing survival rates. Ethical theories such as beneficence and virtue ethics are examined to guide healthcare professionals in advocating for optimal patient outcomes while respecting cultural and religious beliefs. Recommendations are provided to enhance cultural competency, patient education, and legislative support for evidence-based treatments. This case study highlights the intricate balance required to support medical ethics and patient autonomy in pediatric cancer care.

Keywords: Pediatric Oncology, Ethical Dilemmas, Evidence-based Treatment, Parental Autonomy, Beneficence

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The World Health Organization (WHO) reports 400,000 children annually diagnosed with cancer, with 328,000 submitting to it, including undiagnosed cases. Between 2020 and 2050, a projection estimates 13.7 million new childhood cancer cases. Without improved access, 44.9% may go undiagnosed, resulting in 11.1 million deaths, with 84.1% in low- and middle-income countries (LMICs).¹ It was revealed in an article by Sohail et.al that the Karachi Cancer Registry shows leukemia (31%) and lymphomas (20%) as significant childhood cancers, while Punjab's registry notes higher lymphoma (31%) prevalence. In Pakistan, 150,000 cases report 60-80% mortality.²

A cancer registry is crucial for evidence-based strategies, patient care, and research. It underpins informed decision-making and resource allocation in the fight against cancer. Prioritizing establishing and maintaining such registries is imperative in addressing Pakistan's cancer challenges.² Accurate childhood cancer incidence data is crucial for policymaking, but many countries lack registries, revealing a critical knowledge gap requiring urgent attention.³

Infections pose a significant threat to pediatric cancer patients, particularly in chemotherapy-induced neutro-

penia. A Children's Hospital Lahore study identified prevalent healthcare-associated infections, notably gram-negative bloodstream infections with 25.74% pan-resistance, raising antibiotic concerns.² In childhood cancer cases, immediate causes of death include infections (39.6%). This underscores the critical need to monitor and address treatment-related complications in pediatric oncology.⁴

Case Scenario

Sarah, a hypothetical 10-year-old girl diagnosed with a rare and aggressive form of cancer, along with a post-cancerous infection, has been admitted to a tertiary care hospital. Despite the medical team's confidence that chemotherapy offers the best chance of saving Sarah's life, her parents have advocated for alternative treatments, including herbal remedies and faith-based healing, which they believe will cure their child. In light of their beliefs, Sarah's parents have requested to discontinue chemotherapy and have her discharged from the hospital. As a team of healthcare providers, we were not in favor of the parent's decision because it could lead to lethal effects for Sarah.

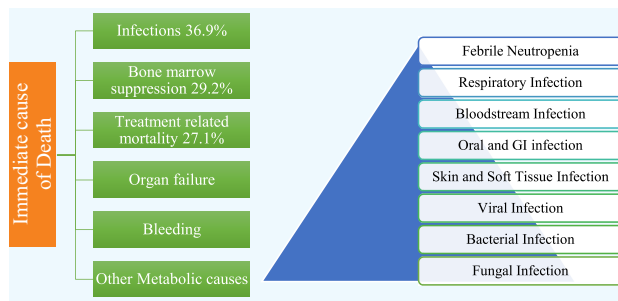


Figure 1 Causes of Mortality in Pediatric Oncology and Most Ordinary Kinds of Infections

Children with cancer in Pakistan and globally face life-threatening infectious complications, including fungal infections that contribute to mortality, especially in those undergoing intensive chemotherapy or bone marrow transplants.³ Figure 1.0 shows the most typical cause of mortality in pediatric oncology and is related to common infection among cancerous patients. In high-risk cancer patients, infection control measures like isolation, antibiotics, and hand hygiene reduce 30-day mortality.⁶ In LMICs, pediatric oncology faces infectious complications due to limited resources, disease factors, and poor infrastructure.⁷

Discussion

The healthcare providers' primary duty is to deliver the most likely care for Sarah, aligning with the principle of beneficence. Beneficence is an ethical principle encompassing the moral responsibility of doing well to others.⁸ In Sarah's case, advocate for evidence-based treatments like chemotherapy to enhance recovery chances. Given her aggressive cancer and post-cancer infection, beneficence involves admitting her for optimal care instead of discharge. Healthcare providers have the responsibility to advocate for Sarah's better care. According to an article, patient advocacy, as defined by registered healthcare providers, involves promoting safety and quality care and speaking up for patients like Sarah.⁹ Healthcare providers educate, protect, and voice professional views, considering overall well-being and treatment effectiveness.

Healthcare providers should foster cooperative decision-making, engaging Sarah's guardians to understand concerns and prioritize her health. Virtue ethics, rooted in philosophers like Aristotle, emphasizes developing virtues for superior morality.¹⁰ Virtue ethics guides healthcare providers to cultivate virtues like compassion, integrity, and accountability in supporting evidence-based therapies for patients like Sarah. It emphasizes practical wisdom in moral decision-making.¹¹ Healthcare providers navigate complex situations involving patient autonomy, cultural beliefs, and evidence-based practices. They educate Sarah's family, providing clear, unbiased information for informed decision-making about disease,

treatments, risks, and benefits.

On the other hand, Respecting Sarah's guardians' autonomy is crucial. The healthcare provider ensures open communication, informing them about treatment options. Patient autonomy, a cornerstone of medical ethics, grants individuals the freedom to make decisions about their health.¹² It is the responsibility of healthcare professionals to uphold and support patient autonomy. When patients lack the mental capacity to decide, a trained surrogate may act in their best interests. While Iranian law requires medical procedures to be approved by patients, parents, guardians, or legal representatives while complying with technical, scientific, and governmental standards, Islamic Fiqh recognizes individual autonomy in saving human life.¹² A counterargument may assert that cultural and religious views should override medical judgment, citing ethical relativism. This perspective holds that morality varies based on cultural and individual beliefs, potentially influencing Sarah's parents' preference for alternative therapies.¹³

Positionality as a Healthcare Provider

We advocate for Sarah's well-being, aligning with beneficence and emphasizing the need for her to stay in the hospital. In-hospital care is crucial for optimizing her quality of life, ensuring effective medical regimens, and minimizing pain. Going home raises the risk of disease aggression and infection, potentially leading to increased suffering rather than the comfort provided by proper medical care. Sarah's stay in the hospital offers advantages such as continuous surveillance for immediate medical interventions and optimal administration of evidence-based treatments like chemotherapy, improving recovery rates. Conversely, releasing her against medical advice poses serious risks, allowing aggressive cancer to spread unchecked, increasing vulnerability to infections, and potentially lowering overall quality of life. The decision balances the benefits of in-hospital care against the potential hazards of premature discharge.

Recommendations

- Ensuring that healthcare providers receive thorough cultural competency training.
- Prioritize patient and family education on evidence-based treatments, like chemotherapy, and the drawbacks of non-evidence-based care.
- Implement frameworks for moral decision-making, considering religious and cultural factors.
- Foster frequent communication between families and healthcare professionals.
- Support research on the intersection of medical, cultural, and religious factors in pediatric oncology.
- Advocate for laws emphasizing the value of evidence-based treatment in pediatric oncology.

Conclusion

In conclusion, combating childhood cancer worldwide requires a comprehensive strategy incorporating ethical, cultural, and medical factors. Sarah's story serves as a reminder of the difficult balancing act healthcare providers must do while supporting evidence-based care and honoring patient autonomy. Recommendations strongly emphasize interdisciplinary teamwork, patient education, cultural competency, ethical decision-making, and supporting legislation to improve pediatric oncology outcomes worldwide.

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