Title:
End-of-Life Care in Oncology: Ethical and Clinical Dilemmas

Full Name:
Sakthi Vignesh D

Name of the Institution:
Government Kilpauk Medical College (GKMC), Chennai

State:
Tamil Nadu

Objective of your solution: (Briefly define the primary outcome of your solution to this challenge):
Key objective is to provide effective end of life care, navigate the profound loss of autonomy, navigate the ethical conflict between medical futility and patient & family expectation, mainly by keeping in mind the problems in different socioeconomic statuses.
In low socioeconomic status group - many palliative interventions which could essentially improve QoL have to be bypassed due to financial constraints of the family. In some cases, the family members, liquidate all their entire life savings or sell of all their assets to undergo unnecessary treatment, with the only hope and desperation of saving their loved ones.
In high socioeconomic group - attenders are ready to spend to any extent and demand for aggressive care for their dying loved ones, where medical interventions become futile, such a way that, that treatment only increases the patients sufferings in their end of life, with no proven benefit.
Main objective is to make the attenders realise that "quality of life lived is way more important than the "quantity of life lived with no quality. Care should be taken to mitigate financial toxicity and medical futility and guide the patient and attenders in their cancer journey with dignity and self-respect.

Describe your solution / proposal: Provide a detailed account of your solution/ proposal to this challenge. You could type your solution/ proposal here. (Disclaimer: Solution/proposal should not exceed more than 300 words.):
Effective end of life care requires a quality-of-life centered management, which starts at the time of diagnosis of metastatic recurrence or diagnosis of Denovo metastasis - associated with shared decision making - keeping the patient in the forefront - respecting their values and opinions.
Effective counselling and psychological sessions can be organised to make the patient to accept the fate and undergo their journey with utmost confidence and positivity. Futuristic planning can be initiated when the patient is in a conscious and stable condition - discussing about writing their will, wealth distribution, stage of DNR and stage at which cancer treatment can be stopped, for effective transition to comfort care, according to patient will.
Patient and attenders can be made to enrol and communicate with patient support groups, who can discuss with them, their past experiences and help them navigate in tough periods. Periodic counselling and total information transparency from the beginning and implementing SPIKES protocol can help to eliminate attender and doctor conflicts at the end.
If a deadlock occurs between medical advice and patients' family demands, dedicated End of Life care committees (comprising of experts and volunteers and attenders of previous end of life care patients - who experienced the same situation) can help to resolve the conflict and help to take realistic decisions and give relatable emotional guidance and validation.
Periodic education, creating awareness, psychological support and structured communication can reduce care giver anxiety and helps to maintain the fact that patients comfort remains the absolute priority at any point of time.
For low SES families - physicians have an ethical duty to prevent financial toxicity at all cost, protecting caretakers from subsequent poverty and depression in future. Conversely for high SES patients, the focus shifts to promoting home based comfort care to preserve dignity.

Full Name:
Dr. Chilamkurty Maitreyi

Name of the Institution:
Stanley Medical College, Chennai

State:
Tamil Nadu

Objective of your solution: (Briefly define the primary outcome of your solution to this challenge):
To develop a compassionate, ethically sound, and patient centered end of life care framework that supports timely clinical decision making, effective communication, symptom relief, and dignity focused care while minimizing futile interventions, emotional distress, and financial burden for patients and families.

Describe your solution / proposal: Provide a detailed account of your solution/ proposal to this challenge. You could type your solution/ proposal here. (Disclaimer: Solution/proposal should not exceed more than 300 words.):
Problem Statement
A 64-year-old man with chronic hepatitis B–related hepatocellular carcinoma presents to our government institution with multifocal liver lesions, portal vein thrombosis, tense ascites, jaundice, severe fatigue, and ECOG performance status 3. He has already progressed after first-line systemic therapy and now has Child-Pugh C liver dysfunction.
The family requests further chemotherapy because they believe stopping treatment means abandoning care. The patient is repeatedly admitted with pain, hepatic encephalopathy, poor oral intake, and recurrent infections. ICU transfer is considered despite an extremely poor prognosis and minimal chance of meaningful recovery.
Our oncology team faces a major dilemma:

- Continue futile anti-cancer therapy with toxicity and financial burden versus
- Transition to best supportive care focused on comfort, dignity, and quality of life.

In many limited-resource and government settings, delayed end-of-life discussions result in unnecessary investigations, prolonged hospitalization, emotional distress, and avoidable financial catastrophe.
Solution: “CARE Pathway”
Compassionate Assessment, Realistic Communication, Ethical Decision-Making, and Supportive End-of-Life Care
Patient with aadvanced/terminal cancer:
↓
Clinical Deterioration or Disease Progression
↓
Step C – Compassionate Assessment
Identify poor prognostic indicators:

- ECOG 3–4
- Progressive metastatic disease
- Organ dysfunction
- Recurrent hospital admissions
- Failure of standard therapies

↓
Trigger Palliative Care Referral
↓

Step A – Authentic & Realistic Communication
Conduct structured family meeting:

- Explain prognosis honestly
- Clarify goals of care
- Address fears and misconceptions
- Identify patient's wishes

↓
Step R – Responsible Ethical Decision-Making
Ask four key questions:

- Will treatment improve survival?
- Will it improve quality of life?
- What does the patient want?
- Does harm outweigh benefit?

Meaningful benefit exists → Continue selected therapy
No meaningful benefit → Shift to Best Supportive Care
↓
Step E – End-of-Life Supportive Care

- Pain and symptom control
- Psychological support
- Nutritional support
- Spiritual counselling
- Home-based care planning
- Avoid futile ICU/CPR

↓
Document Advance Care Plan
↓
DIGNIFIED, PATIENT-CENTERED CARE
↓
Better Quality of Life + Reduced Suffering
Role of Prestigious Companies like Roche
Prestigious companies like Roche can focus on patient support, ethical care delivery, education, and access improvement.
1. Supportive Care Access Programs: Improving availability of:

- Opioids
- Antiemetics
- Nutrition supplements
- Palliative injectables
- Creating low-cost supportive-care kits for government hospitals
- Supporting uninterrupted rural drug supply chains

2. Funding Home-Based Palliative Care Models:
Many terminal patients repeatedly occupy hospital beds because home support is absent.

- Community nurse programs
- Tele-palliative care services
- Home symptom-monitoring systems
- Caregiver education modules

This reduces unnecessary ICU admissions and improves quality of life.
3. Education and Communication Training:
A major barrier in end-of-life oncology is poor communication.

- Workshops on breaking bad news
- Ethical decision-making training
- Communication skill certification for oncology residents
- Simulation-based palliative care teaching

4. Data and Research Collaboration
Ethically support:

- Real-world symptom burden registries
- Quality-of-life studies
- End-of-life outcome audits
- Cost-of-care analysis

This helps improve healthcare planning and evidence generation.
5. Patient Assistance Programs:
For selected patients with meaningful benefit:

- Subsidized targeted therapy
- Compassionate use pathways
- Financial navigation support
- Clinical appropriateness
- Quality-of-life benefit
- Ethical review

6. Infrastructure Support in Government Hospitals:

- Palliative day-care units
- Counselling rooms
- Hospice beds
- Tele-palliative care
- Digital symptom-tracking system

“Better quality of living and dying” should be given to the patient.

Full Name:
Foram Joshi

Name of the Institution:
Kidwai Memorial Institute of Oncology, Bangalore

State:
Karnataka

Objective of your solution: (Briefly define the primary outcome of your solution to this challenge):
We must realise that death is an inseparable truth of temporary human existence. By the time we truly understand this concept, it is often too late. Everyone is afraid of death, but we must accept that it is a reality of life. If asked how we would wish to die, most people would choose a peaceful death during sleep rather than struggling for the last breath on an ICU ventilator. This is why the concept of end-of-life care is important. It focuses on improving the quality of life in terminally ill patients where the outcome is already destined. This concept is important not only in oncology but also in other chronic illnesses.
As oncologists, we must understand when enough is enough. We should know when to stop aggressive treatment, define clear boundaries, and encourage timely involvement of palliative care services.

Describe your solution / proposal: Provide a detailed account of your solution/ proposal to this challenge. You could type your solution/ proposal here. (Disclaimer: Solution/proposal should not exceed more than 300 words.):
We must understand that the experience of dying can still contain deep meaning, comfort, love, and emotional peace, which are often ignored medically. Therefore, when a decision for palliative care in an unfit patient is appropriate, the main priority should be maintaining the best possible quality of life until the last breath. Mere prolongation of illness is not always the correct solution. There should be well-defined guidelines for end-of-life care and euthanasia in situations where suffering outweighs survival. This decision should always be a shared decision between the patient and caregiver.

One of the biggest challenges in this setting is convincing caregivers and family members to accept palliative care. Families are often reluctant to understand and accept the transition from active cancer treatment to hospice and supportive care. At times, starting cancer-specific treatment is easier than counselling the patient's family regarding hospice and palliative care. Therefore, quality counselling becomes the strongest pillar and most important step toward hospice care.

Once caregivers understand and accept the situation, the environment they create around the patient becomes the greatest medicine in palliative care. The more love, care, and emotional support surrounding the patient, the better the quality of life of cancer survivors.

In resource-limited countries, spending adequate time on counselling is a major challenge.

In addition, counselling often becomes difficult in the present era of artificial intelligence and digital medicine, where patients and caregivers have already searched extensively about the disease before meeting the doctor. Many patients quote information from AI platforms and internet sources, making counselling and decision-making more difficult. This often leads to doctor shopping and multiple medical opinions, leaving families confused and emotionally exhausted.

Another major problem is the lack of structured consensus regarding the boundary between initiating active treatment and shifting toward palliative care. Such important decisions should never be made by a single physician alone but should involve a multidisciplinary team discussion.

In resource-limited countries and overcrowded public-funded Regional Cancer Centers with poor doctor-patient ratios, even maintaining eye contact with the patient can become difficult. In such settings, decisions regarding cancer treatment or palliative care are often made by a single physician within a few seconds, which is unfair to the patient and family.

We must also understand that not every patient on a wheelchair or stretcher is automatically ECOG 3 or 4. The art of clinical examination is slowly disappearing in today's digital and AI-driven era. As physicians, we must remember that we are treating patients and not only reports.

Palliative care units remain among the least visited outpatient departments and wards by doctors. Very few physicians choose palliative care as a career because of emotional stress, limited work satisfaction, and the constant involvement in care of terminally ill patients. Years ago, oncology itself faced similar challenges. This becomes a major barrier to developing structured palliative care departments in cancer centers.

Therefore, there is a strong need for well-structured palliative care units equipped with pain specialists, psychological counsellors, physiotherapists, dieticians, trained nurses, and support staff. These units should not only exist within cancer centers but should also reach patients at community and district levels. Only then can palliative care programmes truly become successful. Establishing hospice care services should be a joint effort between government and non-government organizations. In addition, the enrollment process in such centers should be simple and accessible to encourage active participation.

Another major challenge in this setting is the financial burden on caregivers. Financial difficulties often limit the ability to provide quality end-of-life care and increase emotional stress on families. Therefore, clear healthcare policies addressing financial support for palliative care are also necessary. Many early-stage cancer patients discontinue potentially curative treatment because of financial toxicity and instead choose palliative care.

Euthanasia continues to remain a debated topic because of ethical and legal concerns. In my view, every person deserves a peaceful death, and euthanasia may be considered when it aligns with the patient's wishes. In severely debilitated patients where obtaining consent may be difficult, decisions should involve close family members and caregivers.

The highest priority of a quality palliative care setup should be creating a peaceful and supportive environment where cancer survivors are pain-free, surrounded by loved ones, connected with other survivors for emotional support, involved in their Favorite hobbies, and given freedom to fulfil their personal wishes and bucket-list goals.

We must also understand that a happy caregiver creates a happier patient. This highlights the importance of quality counselling and support services. One of the hardest realities to explain is that more treatment does not always mean cure. Sometimes, less treatment may provide greater comfort, dignity, and peace.

Full Name:
Habeeb K A

Name of the Institution:
VPS Lakeshore Hospital, Kochi

State:
Kerala

Objective of your solution: (Briefly define the primary outcome of your solution to this challenge):

- Ensure dignified, patient-centered end-of-life care focused on comfort, wishes, and quality of life
- Improve clear communication and ethical decision-making using structured approaches (truth-telling, advance care planning, DNR discussions)
- Balance symptom relief with safety, ensuring effective pain control without fear of hastening death
- Reduce futile aggressive interventions and promote appropriate palliative care over intensive ICU-based care
- Strengthen access to holistic and equitable EOL care in India through tele-palliative services, community support, and caregiver involvement

Describe your solution / proposal: Provide a detailed account of your solution/ proposal to this challenge. You could type your solution/ proposal here. (Disclaimer: Solution/proposal should not exceed more than 300 words.)

Good end-of-life (EOL) care is not "doing less"-it is doing what matters most: relieving suffering, preserving dignity, and honoring patient wishes.

Ten core dilemmas must be navigated:

1. Truth-telling vs hope - Use structured communication (SPIKES); shift hope toward comfort and meaningful time.
2. Aggressive treatment vs quality of life - Avoid futile ICU care or chemotherapy; focus on symptom control.
3. Patient autonomy vs family wishes - Respect competent patient decisions; ensure shared decision-making.
4. Pain relief vs fear of hastening death - Use proportional opioids; intent is symptom relief, not life-shortening.
5. DNR decisions - Explain poor CPR outcomes in advanced cancer; DNR means no futile resuscitation, while active care continues.
6. Artificial nutrition and hydration - Often non-beneficial in terminal stages; prioritize comfort.
7. Palliative sedation vs euthanasia - Reserved for refractory symptoms with consent; ethically distinct.
8. Financial burden and cultural factors - Avoid low-value care; integrate culturally sensitive and spiritual support.
9. Caregiver support - Provide counseling, respite care, and bereavement services.
10. Key enablers - Early palliative integration, advance care planning (living wills-legally recognized in India), and holistic symptom control (pain, dyspnea, delirium).

    Additional India-focused strategies:

    Tele-palliative care enables remote follow-up and reduces hospital visits. Mobile morphine access through trained PHC teams improves pain relief. Community education using local media can normalize discussions on death and advance directives.

    The reality in India is that many patients still die in ICUs without honest conversations, driven by fear and misinformation. This must change.

    Conclusion: No patient should die in pain, and no family should feel abandoned. Good EOL care is not giving up-it is the highest form of compassionate, patient-centered medicine.

Full Name:
Reshma Abraham

Name of the Institution:
Manipal hospital, Bangalore

State:
Karnataka

Objective of your solution: (Briefly define the primary outcome of your solution to this challenge):
What are the major ethical and clinical dilemmas encountered in end-of-life care, and how can these complex challenges be addressed compassionately and effectively in routine clinical practice?

Describe your solution / proposal: Provide a detailed account of your solution/ proposal to this challenge. You could type your solution/ proposal here. (Disclaimer: Solution/proposal should not exceed more than 300 words.):
End-of-life (EOL) oncology is rarely a clean choice between right and wrong. It always remains in a grey zone

1. Disclosure vs. collusion. Dilemma: Families may withhold the diagnosis from the patient out of love and a desire to protect them; consequently, the patient may perceive the treatment itself as the enemy rather than the disease. On the other hand, patients going into depression and even suicide attempts!.

Solution

a. Move beyond the binary of "always disclose versus "respect the family" toward a graded, staged truth-telling approach tailored to the patient's wishes, emotional readiness, and coping capacity.
b. Families should be conveyed that an informed patient is often better able to cooperate with treatment and decision-making
c. A brief documentation in the medical record regarding what the patient has been told and how much they wish to know can help maintain clarity and continuity. In this model, disclosure becomes an ongoing, compassionate process rather than a single moment of revelation.

2. The next line vs. honest prognosis. Dilemma: After repeated treatment failure, offering another regimen is easier than saying nothing more will help - and "more" feels like loyalty to a family but it could be at cost of draining their savings.

Solution: Goals-of-care discussion is mandatory at diagnosis of advanced disease, revisited at every disease progression and while patient progressing through each line, the physician and team should slowing starting talking about shifted goals of treatment; preparation of end of life care should be slowly introduced when the lines of treatment are ending. This enables acceptance in family and patient

3. Withholding/withdrawing life support. Dilemma: Clinicians fear that withdrawing ventilation or a feeding tube will be seen as killing.

Solution: Adopt and circulate the existing national withdrawal protocols (ISCCM-IAPC) with NCG integrated amendments, institutionally framing withdrawal as removal of futile escalation, not of care; document the principle of double effect in hospital policy so that terminal sedation and de-escalation are understood as relief of suffering, not hastening of death.

4. Futility, abandonment and ICU rationing. Dilemma: "Metastatic" becomes one word that flattens the prostate cancer with treatable pneumonia and the dying glioblastoma into a single triage category - and writing a patient off early is as easy, and as defensible-sounding, as overtreating.

Solution: Prognosis-based admission-triage criteria (NCG-led, adapted for resource-limited centres) that assess the current problem, not the staging label; a brief palliative multidisciplinary review to confirm options are genuinely exhausted before withdrawal.

5. DNR perceived as abandonment. Dilemma: Families hear "Do Not Resuscitate" as "the doctor will stop caring," so escalation wins by default, the ventilator proceeds without a conversation; de-escalation requires the hardest discussion in medicine.
Solution: Explanation of this option as continued palliative supportive care with no futile escalation; make goals-of-care conversations routine graded event, not a crisis event; Effective utilization of team members for the same, a trained nurse, residents in the team, and psycho-oncologists where available, all being in the same page as the treating oncologist.
6. Defensive medicine and the fear of blame. Dilemma: Where families have responded to death-after-costly-care with violence, escalation becomes defensive; and so, can withdrawal also be. The clinician's safety silently enters a decision that should belong to the patient. Solution: A documented palliative multidisciplinary note -oncologist, palliative physician, nursing, family; recording consensus that further treatment is futile; enforce protections for clinicians who follow due process, so the correct decision is also the safe one.

Full Name:
Monish Balaji S

Name of the Institution:
Kilpauk Medical College, Chennai

State:
Tamil Nadu

Objective of your solution: (Briefly define the primary outcome of your solution to this challenge):
Dignified end: smart hospice homes, VR memory rooms, advance-care planning, tele-palliative hubs and financial safeguards to comfort families and democratize end-of-life care.

Describe your solution / proposal: Provide a detailed account of your solution/ proposal to this challenge. You could type your solution/ proposal here. (Disclaimer: Solution/proposal should not exceed more than 300 words.):
Dilemma: Hospital vs Home death
Solution: Smart Hospice Homes equipped with telemedicine, automated pain dispensers, and remote doctor monitoring so patients can spend final days with dignity among loved ones in a familiar and comfortable environment thereby combining the best of both worlds.
Dilemma: Caregiver burden
Innovative Solution: Virtual reality and digital memory rooms where patients can revisit meaningful life experiences and family moments thereby avoiding loneliness even in absence of attenders. Also periodic assessment of caregiver burden and counselling as needed must be offered to all attenders
Dilemma: Families Hide Diagnosis from patient "He/she might not be able to take it”
Solution: Psychooncological research towards algorithms to analyze if the individual patient would be better served by revealing the diagnosis or benefit from blissful ignorance
Dilemma: Aggressive Treatment vs Dignified Death
Solution: Patients should be counselled regarding advance directives and Living will early in treatment for palliative setting.
Dilemma: Unequal Access to Palliative Care
Solution: Build a nationwide tele-palliative network where oncologists guide trained village ASHA or ANM workers through a hub and spoke model

Dilemma: Financial Toxicity of End-of-Life Care
Solution: Promote greater insurance coverage and higher reimbursement rates for palliative end of life care through financial advisors and incentivizing insurance companies along with fostering government run hospice units.
Dilemma: Lack of Holistic Support
Solution: Integrate psychologists, music therapists, and storytellers into standard cancer care through community hospice hubs.

Full Name:
Dr Mohamed Thanish

Name of the Institution:
Stanley Medical College, Chennai

State:
Tamil Nadu

Objective of your solution: (Briefly define the primary outcome of your solution to this challenge):
To address the most consequential and least openly discussed dilemma in Indian oncology end of life care the systematic exclusion of patients from decisions about their own death by proposing a structured advance care planning framework grounded in the legal recognition of living wills under the 2018 Supreme Court judgment, with specific clinical guidance on the ethical flashpoints of truth disclosure, treatment futility, and palliative sedation.

Describe your solution / proposal: Provide a detailed account of your solution/ proposal to this challenge. You could type your solution/ proposal here. (Disclaimer: Solution/proposal should not exceed more than 300 words.):
In most Indian cancer centres, the family is told the diagnosis first. The patient is told later, softened, or sometimes not told at all. The family decides what the patient will know, what treatment will be pursued, and when enough is enough. This arrangement is defended as culturally sensitive. In practice, it systematically denies patients the ability to make any meaningful decision about the end of their own life, and it produces the pattern every Indian oncologist recognises aggressive treatment continued into the last two weeks of life because no conversation about goals of care was ever had with the person most affected.
This is the central ethical dilemma in Indian end of life oncology, and it is reinforced by institutional silence rather than cultural inevitability. Most families, when given structured, compassionate guidance on how to involve the patient in proportion to their expressed preferences, do not choose total non disclosure. They choose graduated, honest communication. The difference between the two outcomes is almost entirely a function of whether the oncologist initiates the conversation or avoids it.
The legal framework now supports a different approach. The Supreme Court in Common Cause versus Union of India 2018 formally recognised passive euthanasia and the validity of advance directives living wills under Article 21. This judgment has been operationally clarified by subsequent notifications, and a patient with decision making capacity can now legally document their wishes regarding withdrawal of life sustaining treatment in India. The majority of oncologists remain unaware of this, and the majority of patients are never told such a document can exist.
The specific clinical dilemmas that follow from this structural failure include the question of when to transition from active treatment to palliative intent a decision that in Indian practice frequently defaults to treatment continuation because the goals of care conversation never happened. Futile treatment in the last four weeks of life is both costly and harmful to patient dignity, and it is not driven by patient choice when patients have never been asked.

Palliative sedation for refractory symptoms at end of life is a separate dilemma that requires institutional protocol and ethics committee guidance, because the line between appropriate sedation for suffering and hastening death is genuinely contested and needs to be navigated with explicit documentation rather than informal clinical judgment made under time pressure at 3 am.
The solutions are structural. Every cancer centre should have a documented advance care planning protocol that includes an offer of advance directive discussion to all patients with incurable disease. Palliative care should be involved from diagnosis in patients with stage IV disease, not at the point of treatment failure. And disclosure practices should be guided by patient preference about what and how much they wish to know, not by default family authority over information that belongs to the patient.

Full Name:
Jarfin I M

Name of the Institution:
Gleneagles Health City, Chennai

State:
Tamil Nadu

Objective of your solution: (Briefly define the primary outcome of your solution to this challenge):
To provide end-of-life cancer care that preserves dignity, honesty and comfort while helping families and clinicians make ethically balanced decisions.

Describe your solution / proposal: Provide a detailed account of your solution/ proposal to this challenge. You could type your solution/ proposal here. (Disclaimer: Solution/proposal should not exceed more than 300 words.):
End-of-life oncology is filled with difficult dilemmas: when to stop active treatment, whether ICU escalation is meaningful, how much truth to disclose, balancing hope with realism, managing family expectations, financial devastation, opioid fears and respecting patient autonomy in cultures where families often dominate decisions.
One of the greatest ethical challenges is continuing toxic treatment with little realistic benefit. Many patients receive chemotherapy or ICU care in the final weeks of life because stopping treatment is emotionally harder than escalating it. Yet aggressive futile care can increase suffering, isolation and financial collapse.
The solution is early goals-of-care discussion, not last-minute crisis conversations. Prognosis should be communicated honestly but compassionately. Patients should be asked what matters most to them: more time, symptom relief, staying at home, avoiding machines, or family presence. Good oncology is not abandoning treatment-it is aligning treatment with the patient's values.
Palliative care must be integrated early alongside active oncology care. In Tamil Nadu, home-based palliative services, district opioid access, caregiver education and tele-support can prevent unnecessary terminal hospitalizations.
Clinicians also need emotional support and training in communication, because burnout and moral distress affect decision-making. Standardized pathways for DNR discussions, symptom control and hospice referral can reduce confusion and conflict.
Roche can support through communication training, palliative-care education and quality-of-life initiatives.
The final responsibility of an oncologist is not simply to fight death endlessly, but to ensure that when cure is no longer possible, suffering, fear and loneliness are not allowed to dominate the patient's remaining time.

Full Name:
Dr Rajdeep Bose

Name of the Institution:
Dr. B Borooah Cancer Institute, Guwahati

State:
Assam

Objective of your solution: (Briefly define the primary outcome of your solution to this challenge):
The primary outcome of my solution is to ensure that patients and their families clearly understand the current clinical situation, prognosis, and limitations of treatment, while also addressing the emotional, social, spiritual, and financial challenges faced by the patient and his/her family members. The solution aims to reduce anxiety, confusion, denial, and repeated distress by promoting compassionate communication, shared decision-making, and psychological support. Ultimately, it seeks to provide a smoother, more dignified, and humane transition from active treatment to end-of-life care and peaceful death, while preserving the patient's comfort, autonomy, and quality of life.

Describe your solution / proposal: Provide a detailed account of your solution/ proposal to this challenge. You could type your solution/ proposal here. (Disclaimer: Solution/proposal should not exceed more than 300 words.):
End-of-life care in oncology is not only a medical challenge but also an emotional, ethical, social, and financial dilemma. My proposal focuses on individualized, compassionate communication and holistic support for patients and caregivers.
Scenario A involves a 5-year-old child with relapsed high-risk ALL who has progressed on multiple chemotherapies and cannot afford newer therapies. Here, repeated counseling sessions with the parents, especially the mother, are essential to explain the prognosis gently and honestly. Psychological support, pain relief, nutritional support, and spiritual counseling should be integrated, while allowing the family to spend meaningful time with the child in a comfortable environment.
Scenario B involves an 86-year-old male with metastatic carcinoma prostate progressing on multiple lines of therapy. In such patients, cognitive status, personal wishes, religious beliefs, and expectations from life must be assessed. Family meetings involving children and grandchildren should focus on goals of care, symptom relief, dignity, and avoidance of futile ICU admissions or invasive interventions.
Scenario C involves a 32-year-old female with metastatic triple-negative breast cancer who has progressed on multiple therapies and cannot afford immunotherapy. Along with symptom management, fertility concerns, fear of death, unfinished family responsibilities, and emotional distress should be addressed empathetically. Counseling, financial guidance, home-based palliative care, and psychosocial support for young caregivers are crucial.
Overall, my solution emphasizes multidisciplinary palliative care, transparent communication, emotional support, and dignity-centered care to ensure a peaceful and humane end-of-life journey.

Full Name:
Ananda NS

Name of the Institution:
Kidwai Memorial Institute of Oncology, Bengaluru

State:
Karnataka

Objective of your solution: (Briefly define the primary outcome of your solution to this challenge):
To identify ethical and clinical dilemmas in end-of-life oncology care that place emotional and decision-making burden on patients, families, and doctors, and to propose practical solutions to address them.

Describe your solution / proposal: Provide a detailed account of your solution/ proposal to this challenge. You could type your solution/ proposal here. (Disclaimer: Solution/proposal should not exceed more than 300 words.):
Dilemmas & Solutions:

1. Patients' Autonomy vs. Beneficence:
    a. Patients/care givers can request continuing or discontinuing life-sustaining treatment and physicians may feel to act in the patient's best interest.
    b. Advance care planning (ACP), Living Wills, and shared decision-making with patients, families, oncologists, palliative care teams may assist doctors to deal with the problem.
2. Withholding or Withdrawing Life-Sustaining Treatment:
    c. Stopping ventilation, dialysis, feeding tubes, or ICU care in a terminal illness is also emotionally challenging.
    d. Doctors should apply the Principle of Double Effect, use terminal sedation for refractory symptoms, and review difficult cases through multidisciplinary discussions to guide decisions on withholding or sustaining treatment.
3. Pain Management, Sedation & Euthanasia Concerns:
    e. Opioids, sedatives should be used ethically for symptom relief, while addressing patients' psychological and spiritual distress.
    f. While euthanasia is not widely practiced in India, recent Supreme Court support for passive euthanasia in selected terminal cases, including the Harish Rana case, further emphasizes dignity in end-of-life care
4. Futility of Care & Resource Allocation:
    g. Expensive ICU care or chemotherapy without significant survival gain imposes ethical and economic costs specially in Indian settings.
    h. Early integration of palliative care and institutional futility guidelines can prevent unnecessary suffering and misallocation of resources.
5. Family Disagreements & Emotional Burden:
    i. Families may disagree about treatment goals and end-of-life choices.
    j. Structured family meetings among doctors, nurses, social workers, psychologists, chaplains, and ethics boards help the resolution of conflicts and the provision of emotional support.
6. DNR Orders & Communication Challenges.
    k. Many families confuse DNR orders with 'giving up on care.'
    l. Doctors should guide DNR decisions compassionately and talk through care goals early, rather than at last in a crisis.

Conclusions:
Open communication, advance care planning, teamwork, and early palliative care are essential for compassionate and dignified end-of-life oncology care.

Full Name:
Mohamed Farook M

Name of the Institution:
Madurai Medical College

State:
Tamil Nadu

Objective of your solution: (Briefly define the primary outcome of your solution to this challenge):
End-of-life care dilemmas in oncology should follow three important approaches:
1.Patient-centered approach - focuses on preserving the patient's dignity, autonomy, and personal choices.
2.Physician- or surgeon-centered approach - emphasizes quality of life, symptom control, and effective pain management.
3.Shared decision-making approach - involves patients, families, and healthcare professionals working together to decide whether to continue, limit, or stop treatment.

Describe your solution / proposal: Provide a detailed account of your solution/ proposal to this challenge. You could type your solution/ proposal here. (Disclaimer: Solution/proposal should not exceed more than 300 words.):
End-of-life care in oncology involves patient-centered care, physician-centered care, and shared decision-making. These approaches help healthcare teams manage difficult ethical and clinical situations with compassion and professionalism.
1.Scenario: A terminally ill patient wants to stop chemotherapy to spend quality time with family.
Solution: Through patient-centered care, doctors should respect the patient's autonomy and provide supportive palliative care.
2.Scenario: A patient refuses artificial ventilation even though family members request it.
Solution: Healthcare providers should prioritize the patient's informed decision while counseling the family empathetically.
3.Scenario: A patient feels their opinions are ignored during treatment planning.
Solution: Doctors should involve the patient in all discussions and encourage active participation in care decisions.
4.Scenario: A cancer patient experiences unbearable pain despite ongoing treatment.
Solution: Physician-centered care should focus on stronger pain management and specialized palliative support.
5.Scenario: An elderly patient suffers severe side effects from aggressive chemotherapy with little chance of recovery.
Solution: Physicians should reassess treatment goals and prioritize quality of life over unnecessary interventions.
6.Scenario: An oncologist feels emotionally exhausted after caring for multiple dying patients.
Solution: Hospitals should provide mental health counseling and stress-management support for healthcare staff.
7.Scenario: Family members insist on continuing treatment, while the patient wishes to stop it.
Solution: Shared decision-making meetings can help balance emotional concerns and respect the patient's wishes.
8.Scenario: Doctors are uncertain about the right time to shift from curative care to palliative care.
Solution: Honest discussions with patients and families can help establish realistic goals of care early.
9.Scenario: Religious beliefs prevent a patient from accepting certain medical interventions.
Solution: Care teams should respect cultural and spiritual beliefs while explaining available treatment options.
10.Scenario: Limited ICU beds create difficulty in providing intensive care to terminal cancer patients.
Solution: Ethical guidelines and fair allocation policies should guide medical resource distribution.
In conclusion, ethical dilemmas in oncology end-of-life care can be effectively managed through respect for patient autonomy, physician responsibility, and shared decision-making. These approaches promote dignity, comfort, and compassionate care during the final stages of life.

Full Name:
Livin T

Name of the Institution:
Madurai Medical College, Kanyakumari

State:
Tamil Nadu

Objective of your solution: (Briefly define the primary outcome of your solution to this challenge):
It is simply dragging out the dying process. We have to put the patient's dignity above our own surgical egos.

Describe your solution / proposal: Provide a detailed account of your solution/ proposal to this challenge. You could type your solution/ proposal here. (Disclaimer: Solution/proposal should not exceed more than 300 words.):
Being on the surgical ward when a patient with advanced disease crashes is a massive ethical maze. As surgeons, our brains are hardwired to cut. The gut reaction is to wheel them straight into the OR for a last-ditch salvage job. You usually have terrified relatives crowding the corridor, pleading for you to do anything. But putting a frail patient through a massive resection ignores what their biology is doing. It just tacks on brutal physical suffering to the few days they have left.
And this causes a genuinely awful clinical dilemma for us on the ground. The cultural expectation to push aggressive treatments is heavy. Families frequently scheme to hide the terminal reality from the patient. You end up in this highly unethical space where the person in the bed has no idea they are dying. We sometimes find ourselves pumping late-line systemic therapies into them just to absorb the family's guilt.
But following strict NCCN or ESMO salvage pathways in a terminal scenario is morally bankrupt. We absolutely must draw a line. We have to stop treating a palliative consult like a personal surgical defeat. Getting the palliative team into the tumor board from day one totally changes the dynamic. It forces the room to stop obsessing over a clean R0 margin when the tumor biology has already won.
And leaning on objective clinical scores is the only real way to smash through family denial. When a patient's ECOG score plummets, you have to pull the relatives aside and be transparent. We must make them see that pushing interventions isn't fighting the cancer anymore. It is simply dragging out the dying process. We have to put the patient's dignity above our own surgical egos.

Full Name:
Rishika Goyal

Name of the Institution:
Kidwai Memorial Institute, Bengalore

State:
Karnataka

Objective of your solution: (Briefly define the primary outcome of your solution to this challenge):

Objective

The main objective is to make sure that one's decision of end of life care remains to be in unison with patient's values, his and family's preferences and one's quality of life objective mediated via proper communication

This approach decreases the chance of unnecessary interventions which thereby prevent unnecessary suffering on the part of patient and his caregivers.

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Describe your solution / proposal: Provide a detailed account of your solution/ proposal to this challenge. You could type your solution/ proposal here. (Disclaimer: Solution/proposal should not exceed more than 300 words.):

Gaps existing

There are multiple challenges on ethical and clinical ground which frequently arises in the end-of-life oncology practice as crucial conversations are often delayed.

The major discussions about disease prognostication, one's expectations from the treatment and end of life wishes often postponed till a crisis breaks down and patient continued to remain under aggressive clinical treatment which anyhow offer limited benefit. This delay leads to family disputes, financial crises, loss of patient autonomy apart from ineffective chemotherapy and unwanted ICU admissions

Solution

There should be integration of trigger-based goals of care pathway into modern oncology

This model consists of structured goal of care discussion which gets initiated automatically once predefined clinical triggers prevail like

Disease progression after second line therapy

Severe functional decline

Multiple hospitalizations which are unplanned

Exhaustion of meaningful disease-modifying options

This discussion should focus on disease prognosis, realistic treatment outcomes, patient priorities, symptom management, future hospitalization preferences, and preferred care settings.

It incorporates the patient and his family members along with treating specialist and members of palliative care team

It is important to document the discussion and revisit periodically as the disease progresses

This approach not only takes care of ethical and clinical hurdles by ensuring informed decision making but also preserves patient's autonomy, facilitate timely palliative care referrals and ensures providing the care which align with what aspects are most important to the patient per se.

Full Name:
Dr.Chilamkurty Maitreyi

Name of the Institution:
Stanley Medical College, Chennai

State:
Tamil Nadu

Objective of your solution: (Briefly define the primary outcome of your solution to this challenge):

To implement a compassionate, ethical and patient centered end of life oncology care pathway that improves quality of life, reduce unnecessary interventions and financial burden and ensures dignified care aligned with patient values and preferences.

Problem statement: A 64-year-old mam diagnosed with chronic hepatitis B related Hepatocellular carcinoma , presented to a Government cancer center with multifocal liver lesions, terminal stage portal vein thrombosis, tense ascites, recurrent hepatic encephalopathy, repeated infections, poor performance status (ECOG PS 3). patient progressed after standard systemic therapy and developed now child pugh C liver dysfunction, now extremely poor prognosis. Despite which his family requesting to continue systemic chemotherapy because they believe stopping treatment means giving up hope. Such situations are common across resource constrained oncology settings where delayed discussions about prognosis and goals of care lead to unnecessary over treatment, emotional distress, catastrophic financial burden, compromising patients comfort and dignity. We as oncologists face ethical dilemmas between extending treatment or ensuring quality end of life care.

Describe your solution / proposal: Provide a detailed account of your solution/ proposal to this challenge. You could type your solution/ proposal here. (Disclaimer: Solution/proposal should not exceed more than 300 words.):

Solution: A structured approach is needed to support timely, compassionate and evidence-based decision making. CARE pathway is a practical patient centered framework designed to guide oncologists, patients and families through difficult end of life decisions

C-Compassionate assessment systematically evaluates for poor prognostic indicators including ECOG PS 3-4, progressive metastatic disease, organ failure, recurrent admissions and failure of standard therapies. Identification of these triggers leads to early palliative care involvement

A- Authentic and realistic structured family/care giver meeting to explain prognosis honestly and compassionately so that focus shifts from 'what more treatment can we give?' to 'what matters most to the patient? ‘False beliefs regarding palliative care should be discussed and consider patients preferences, values and goals.

R- Responsible ethical Decision making by 4 key questions: will further treatment improve survival? Will it improve quality of life? What does the patient want? Does potential harm outweigh expected benefit? If meaningful benefit exists selected therapy to continue or switch to comfort based end of life care.

E- End of life supportive care includes comprehensively pain relief, symptom management, psychological counselling, nutritional support, spiritual care, caregiver education, home based care planning, avoid Prolonged ICU care and CPR after taking consent. These will help in fulfilling patient’s wishes.

CARE pathway can be strengthened through Partnerships with companies like Roche by supporting with low-cost supportive care kits, tele palliative services, arranging community nurse networks, caregiver training, symptom monitoring platforms and end of life research registries.

"When cure is no longer possible, care becomes the most powerful treatment. Ultimate goal is no longer survival but better living and better dying by giving ethically responsible care at the end of life.

Full Name:
Dr. Chirag Gajera

Name of the Institution:
JNMC, Belagavi

State:
Karnataka

Objective of your solution: (Briefly define the primary outcome of your solution to this challenge):
To establish an ethical, compassionate, and patient-centered approach to end-of-life care in oncology by balancing clinical decisions, patient autonomy, quality of life, and appropriate use of medical interventions.

Describe your solution / proposal: Provide a detailed account of your solution/ proposal to this challenge. You could type your solution/ proposal here. (Disclaimer: Solution/proposal should not exceed more than 300 words.):

End-of-life care in oncology involves complex ethical and clinical dilemmas, including decisions regarding continuation or withdrawal of anti-cancer therapy, use of intensive care interventions, resuscitation decisions, symptom control, patient autonomy, and communication of prognosis. Challenges may arise due to differences between patient wishes, family expectations, and medical recommendations.

Key ethical principles include respect for patient autonomy, beneficence, non-maleficence, and justice. Treatment decisions should focus on realistic goals of care, balancing potential benefits against treatment burden, toxicity, and quality of life. Advance care planning and early discussions about goals, preferences, and expectations can help avoid crisis-driven decisions.

Effective communication is essential. Healthcare teams should provide clear, empathetic information regarding prognosis, available options, and supportive care choices. Shared decision-making involving patients, caregivers, oncologists, and palliative care specialists helps align treatment with patient values.

Solutions include early integration of palliative care, establishment of institutional end-of-life care protocols, ethics consultation services, advance directives, symptom management pathways, and training programs for healthcare professionals in communication skills.

A multidisciplinary approach ensures that patients receive appropriate care focused on comfort, dignity, and quality of life while avoiding unnecessary interventions that may not provide meaningful benefit.