ABSTRACT:

The purpose of this study is to analyze the decision-making practices of cancer doctors, including how those decisions impact the identity construction and sensemaking practices of patients. I look at how doctors make ethical decisions regarding patient interaction and treatment by examining processes of decision-making. More specifically, I study how doctors navigate personal motivation and institutional structures when making their decisions. I also examine how doctors make decisions regarding the type and amount of treatment to provide to patients, as well as how doctors negotiate the risks associated with treating cancer patients.

The project examines the ethical issues that exist within the medical field, including the ethical principles which govern doctor-patient interaction. It studies why ethics is important to the medical field, how doctors confront ethical dilemmas, and how their decisions may impact patient health. In addition to this focus on ethics, the project considers how patients are impacted by doctor decisions and interaction, and whether or not patient identity and sensemaking practices are affected by the ethical decisions of doctors. I will focus specifically on end-of-life scenarios involving cancer diagnoses.

INTRODUCTION:

Every year, millions of people are effected by cancer. Cancer does not discriminate; it does not care where you are from, what color your skin is, or what nationality you claim. Cancer affects different people around the world and it kills indiscriminately and without cause or remorse. Many people have dedicated their lives to helping people with cancer, to researching a cure, and to looking for new and innovate ways of preventing the occurrence of cancer. Unfortunately, not every form or stage of cancer can be treated and not everyone who is diagnosed with cancer will survive. It is estimated that approximately 14.5 million people are presently living with cancer in the United States alone. In 2015, roughly 1.7 million new cancer diagnoses were expected to be made and 589,430 people were projected to die of cancer; that is roughly 1,620 people every day. With so many people being impacted by cancer it is important to have an understanding of what the disease really means and how it impacts people.

Broadly speaking, cancer refers to the growth and spread of abnormal cells at an uncontrollable rate ("Cancer Facts," 2015). While normal cells grow, divide and die in a systematic process, cancer cells are able to grow, form new cells, and invade healthy tissue without dying. This enables cancer cells to grow out of control and spread to other areas of the body. However, it is also important to remember that the word "cancer" is a general term encompassing over 100 different diseases, with each having the potential to cause serious illness or even death ("What is Cancer?" 2014). Medical professionals such as doctors dedicate their time to saving patients and fighting invisible enemies such as cancer, and their decisions can have life-or-death consequences for patients. Due to this potential for end-of-life outcomes, it is important to analyze how doctors make ethical decisions about patient treatment and if/how those decisions work to impact patients' experience and understanding of cancer.

STATEMENT OF THE PROBLEM:

The type of ethical decision-making practices used by cancer doctors when interacting with patients and deciding on a treatment may have unforeseen consequences. If patients are strongly impacted by doctor decisions, as is expected, then the ethical decisions of doctors could very well influence patient health. Furthermore, it is necessary to see whether or not cancer doctors are making decisions in an ethical manner because they are handling end-of-life situations. If doctors struggle with ethical decision-making, then the doctors' treatments and interactions may be less effective, and both patient health and the doctors' professional success may suffer as a result. Some of the ethical dilemmas facing doctors include: withholding the truth about a diagnosis in order to protect the patient from emotional turmoil (Swaminath, 2008); deciding whether the side effects of a treatment are justified by the outcome (Rosser & Maguire, 1982); balancing competing loyalties and responsibilities; balancing competing interests among patients and their families; and deciding the best use for limited medical resources.

RATIONALE:

Before further explanation and overview of the study is provided, I would first like to explain my own reasons for researching this topic. Let me begin by saying that, regardless of my personal interest or feelings on the matter, I will always strive to be objective in how I evaluate and illustrate research findings. Though I do acknowledge that I have a personal connection to the subject which has the potential to bias my perception of some of the studies being reviewed, I have yet to form a solid opinion on the matter and I remain open to any results from this study. That being said, I have had a great deal of personal involvement with cancer over the years. When I was young, around 8 or so, my mother was diagnosed with melanoma skin cancer. Being

as young as I was this news did not truly affect me and it all became irrelevant after my mother

went into remission. However, when I was 14 my father was diagnosed with stage four terminal

lung cancer. This time around I was older and therefore more aware of the impact cancer was

having on my family. I was also more involved, making the effort to go to treatments with my

dad and helping to take care of him. As time passed, I watched him become sicker and sicker,

slowly becoming a shell of who he once was until he eventually passed away a year later.

Yet, this was not the last time I had a personal encounter with cancer, as my mother's

cancer came out of remission when I was 19 and she continues to battle cancer to this day. All in

all, I have experienced what it is like for families who are forced to deal with cancer. I have seen

doctors deal with patients and patient treatment in a variety of ways, and I've come to realize

how differently doctors seem to go about their work, almost as if they have their own unique

style for handling patients and end-of-life scenarios. It is this family history of cancer and illness

that initiated my interest in how doctors make ethical decisions regarding patient interaction and

treatment, but it is my own personal experiences which lead me to include how patients are

impacted by these decisions.

Unfortunately, experiences such as mine are all too common. In fact, it is partially this

prevalence which makes my research important, as cancer impacts a wide range of people and,

as a result, is relevant to numerous individuals. However, this is not the only rationale for my

study, because the process doctors use to make ethical decisions and the impact of those

decisions on patients is equally important. This study focuses on cancer because the impact of

decision-making is most obvious within end-of-life scenarios where the decision-making

practices of cancer doctors can have life or death consequences for their patients. If doctors are

not thorough in their consideration of potential patient treatments, if they do not think of the

appropriate ways to interact with their patients, or if they utilize a flawed method of decision-making, then their decisions will not necessarily be well-informed or effective.

Similarly, the decision-making practices of doctors can impact the sensemaking and identity construction of their patients. Since their patients are already in a precarious state due to their cancer diagnosis and the potential end-of-life outcome, cancer doctors may have a large impact on how patients view themselves. Since studies show that optimistic patients have greater chances of survival, the self-perception and personal disposition of patients is important to patient health (Scheier & Carver, 1992). Therefore, it is important to understand how doctors' decisions and doctor-patient interactions might impact patient sensemaking and identity construction. Not knowing this information may cause unnecessary amounts of emotional distress in patient populations, which may hurt patient well-being and health (Scheier & Carver, 1992). Patient death may be unnecessarily high due to a lack of understanding regarding how doctors make ethical decisions about patient treatment and interaction, and how patients are impacted by these decisions.

This study seeks to show how cancer doctors make ethical decisions regarding patient treatment and interaction and, as a result, it has the potential to suggest methods of decision-making that may be more effective or beneficial to doctors. In that respect, this study seeks to highlight existing flaws within current decision-making practices. Once these flaws are brought to light, it may then be possible to address them and perhaps even eliminate them altogether. In general, then, this study has the potential to create new and more effective decision-making practices for doctors, as well as improve on the current methods of decision-making and interaction already in practice.

Additionally, the study should increase our understanding of how patients' sensemaking and identity construction are impacted by doctors' decisions regarding patient treatment and interaction. Such new knowledge could help improve doctors' bedside manner, thereby enabling them to make the patients more at ease and increase their morale. Because increased morale and optimism have been positively correlated with an increase in patient health (Scheier & Carver, 1992), the findings of this study could ultimately improve patient happiness and health.

BACKGROUND:

Ethical Dilemmas, Decision-Making, and Communication:

Ethical dilemmas are conflicts between moral imperatives in which obeying one ultimately results in the transgression of another; they are also a common occurrence in the medical profession (McConnell, 2014). Doctors must navigate a variety of conflicts both when treating patients and when navigating the institutional structure of their workplace. The most common ethical dilemmas experienced by doctors as a whole include decisions made near-the-end-of life (such as when patients are elderly), conflicts over patient autonomy, truth-telling or justice, conflict between stakeholders, and issues over professional conduct, religion and culture (Sorta-Bilajac et al., 2011). However, some ethical dilemmas are more prevalent within specialized fields of medicine, such as the field of Oncology which treats people with cancer or tumors.

To date, there are many studies that have investigated the ethics of doctors and the medical field (Ahmed & Ali, 2013; Oberle & Hughes, 2000; Rodwin, 1993; Rosser & Maguire, 1982; Veatch, 1977). Most studies agree that doctors with cancer patients experience difficulty when trying to make individual treatment decisions and that various external factors influence

the decision that is ultimately made. For scholars interested in this field of inquiry, medical ethics offers a place where doctor-patient relationships can be analyzed and doctors' decisions can be looked at through a lens of ethics. Medical ethics has always been in practice because the actions of doctors carry ethical implications and moral training has long been a part of medical training.

In the past, individual associations were responsible for ensuring an ethical relationship between the medical professional and the patient. For example, the American Medical Association was in charge of safeguarding ethical conduct between doctors and patients, whereas the American Dental Association was in charge of dentists. However, this soon changed. The standardized ethical practices that exist today started with religious and philosophical systems which facilitated the creation of a set of moral norms (Veatch, 2012). The Hippocratic Oath is a universal document for the ethical conduct of physicians which is often considered to be the original source of these moral norms and medical ethics (Antiel, Curlin, Hook, & Tilburt, 2011; Imran et al., 2013; Veatch, 2012). Yet, while modern medical oaths and guidelines may have been partly inspired by the Hippocratic Oath, it is by no means the sole source of professional ethics, nor is it the primary tool for modern ethical decision-making and conduct. Instead, medical professionals receive ethical guidance and regulation from numerous sources, some of which may be specific to a medical profession and others which are universally practiced and enforced (Veatch, 2012).

As time progressed and ethical abuses became known, the need for standard ethical guidelines was acknowledged and protective safeguards such as Institutional Review Boards (IRBs) were created to protect human subjects. Over time, more and more policies were implemented to protect patients, and eventually ethics became regulated and procedures were

developed to help doctors and researchers manage moral decisions and make more ethically sound decisions (Zussman, 1997). Yet, these procedures do not always offer solutions to the ethical dilemmas that doctors face.

Many doctors will experience ethical dilemmas when their personal values clash with their medical training or their perceptions of how patients should be treated. For instance, health cuts make it difficult for doctors to provide the best care possible to patients and advanced technology and pharmaceuticals provide medical breakthroughs that are too expensive to be used as commonplace treatment options. This means that doctors must choose which patients receive a particular treatment and when, leading to ethical dilemmas centered on how, when, and for whom a treatment option should be utilized. Given the complexity of doctors' work environment and the existence of conflicting and external interests, there are eleven themes that summarize the types and causes of ethical dilemmas faced by doctors (Gaudine, LeFort, Lamb, & Thorne, 2011):

1. There is a disagreement about treatment options;

2. Others are not respecting the wishes of the patients;

3. Patients are not receiving quality end-of-life care;

4. Quality care is being prevented by the patient's or family's behavior;

5. Informed consent or full disclosure has not been provided to relevant parties;

6. Doctors do not know the "right things to do";

7. Uncontrollable factors are preventing quality care from being provided;

8. Doctors values are conflicting with the values or choices of the patient;

9. The ability and skill of the doctor to provide care is being questioned;

10. The doctor disagrees with established guidelines;

11. Doctors must estimate a patient's odds of survival or the potential futility of treatment.

Those studies that have examined ethics in end-of-life scenarios have largely chosen to analyze whether particular decisions could be deemed ethical. For example, Robert Veatch (1997) examined medical ethics and reflected on the moral intuitions and choices that people must make within the discipline of medicine. Veatch described how ethical dilemmas are becoming an increasingly common problem in the medical field, arising for a multitude of reasons, including but not limited to uncertainty regarding patient diagnosis and treatment, conflicts in personal or normative principles, conflicts between personal or professional relationships, conflicting priorities, and conflicting goals. These dilemmas are often solved in a variety of ways; some doctors solve them using established institutional guidelines, some use personal or professional values, and others use techniques that have been individually adapted to suit their needs.

The ethical dilemmas facing medical practitioners were made clearer by Marc Rodwin (1993) when he conducted a study about the conflicts of interest doctors face. Rodwin explained how conflicts of interest have become an increasing problem within the medical field, with doctors having to balance financial incentives and their responsibilities to patients. Johansen (2012) and his colleagues identified how ethical dilemmas can affect doctors in a variety of ways, including when loyalty to patients conflicts with other loyalties, such as those to the medical field or medical associates. If this is the case and doctors are facing an increasing number of ethical dilemmas, such as those presented by financial conflicts of interest, then it is possible that such conflicts may result in doctors making less effective decisions regarding

patient treatment. Since less effective treatment for cancer patients can result in decreased health or well-being, it is important that this connection be analyzed in greater detail.

Yet, the ethical decision-making of doctors is not the only practice with the potential to impact patient health outcomes, as doctor-patient interactions can also impact the outcomes of chronic disease such as cancer (Kaplan, Greenfield, & Ware 1989). Kaplan et al. found that the relationship between doctors and patients may have an important influence on patients' health outcomes. Higher levels of patient involvement during doctor-patient interactions were shown to relate to better health during follow ups, while some behaviors by doctors towards patients were shown to decrease patient health. The authors of the study concluded that emotional expressions between doctors and patients were significantly related to patients' health status, and that a relationship exists between how doctors and patients interact and the patients' resulting health (Kaplan et al., 1989). This means that doctor-patient interactions have very real consequences for patient health and treatment success.

Another study by Richard Street Jr. (2009) showed similar results. Choosing to focus on doctor-patient communication and how it was linked to health outcomes, Street found that health could be improved through communication. Street cites communication as contributing to better patient health for a number of reasons. For one, Street shows how doctor-patient communication can have a therapeutic effect which helps improve psychological well-being and, by association, patient health. He then goes on to explain how communication can affect patient health through both direct and indirect methods by creating causal pathways between doctor-patient communication and patient health (Street, Makoul, Arora, & Epstein, 2009).

Sensemaking and Identity Construction:

Additionally, doctors' decisions also have the potential to impact the sensemaking and identity construction of patients. However, in order to understand how this occurs, one must first understand what sensemaking entails and how identity is constructed. Sensemaking examines issues of organizational behavior and looks at how meaning is created. It occurs as a result of the complexity that exists within organizations and situations, and can be initiated due to an interruption in the established norm which creates feelings of unfamiliarity. In essence, sensemaking is the process through which people make sense of their experiences and move through everyday life. Sensemaking is also important for the construction of individual identity (Ojha, 2005).

The construction of identity is an individual process that often takes place gradually and at varying speeds. To begin, an individual will often explore and examine his/her identity. Following this examination of the self, an individual may conform to the values and beliefs associated with his/her established identity, or resist and begin to question the identity he/she has formed. Eventually, it is assumed that an individual will develop a strong sense of who they are and what their identity means. It is this process of understanding the self where sensemaking comes into play, because identity is centered on the meaning created during processes of sensemaking among individual experiences. Put simply, sensemaking is the process through which individuals try to comprehend the unfamiliar and identity construction is how an individual articulates and forms his/her sense of self. For both sensemaking and identity construction, individuals make sense of themselves and who they are in everyday life by a comparison to that which is unfamiliar (Ojha, 2005).

If it is assumed that the sensemaking and identity construction of cancer patients is tied to their perceptions of health and well-being, then quality-of-life becomes an important factor influencing patients. Research by Muldoon, Barger, and Flory (1998) shows that the burdens of illness cannot be fully described through simplistic categories; psychological factors, such as quality-of-life, also play a part. Their study describes how subjective perceptions of health and the resounding conceptualization of quality of life is important for patients. However, they also describe how this mode of inquiry has largely been overlooked by the medical community and has consequently constrained doctors' ability to interpret important medical literature.

Catherine Riessman's (2003) investigation into illness narratives showed how patients construct a preferred sense of self in order to cope with illness. Because the construction of identity is an ongoing process and the self is under constant revision, illness narratives enable patients to cope with the disruption of illness and manage the resulting change in their relationships and social world. Through an analysis of different illness narratives, Riessman suggests that a medical diagnosis is central to the identity construction of patients. This is because a diagnosis changes expectations of performance surrounding the self, leading patients to seek coherence and develop new identities that can then be performed in order to solidify the new sense of self which has been developed. The new identities then help patients to make sense of their new position as individuals with a cancer diagnosis.

Another researcher, Lisa Wenger (2013), discussed how illness can complicate identity by disrupting taken-for-granted assumptions about gender. People, particularly men, seek to preserve their sense of self during illness. However, the changes brought on through illness and the treatment of illness complicate patients' ability to perform their identity and preserve their sense of self. During this time of turbulence and ambiguity, patients look to their doctors for

guidance and assistance in navigating their new social reality. Doctors then become providers of information and support, and the decision doctors make in regards to how they provide this service has the potential to reduce the disruption faced by patients (Arora, 2003). Thus, the manner in which doctors communicate with patients, including how they explain treatment options, has a significant impact on the patient's quality of life and health.

Based on this body of past research, in this thesis I will produce an adapted literature review which will explore the methods cancer doctors use to make ethical decisions concerning patient treatment and interaction, and the resulting impact those decisions have on patient sensemaking and identity construction. After analyzing the literature centered around the ethical decision-making of doctors and the sensemaking practices of patients, respectively, I will offer an educated hypothesis on how doctors' ethical decision-making practices can be improved. It is my hope that my recommendations can be used in order to reduce the ethical dilemmas in the medical profession and improve the quality of decisions made by doctors.

RESEARCH QUESTIONS:

This study is divided into two parts based on research which supports the notion that the ethical decision-making practices of cancer doctors, and doctor-patient interactions, impacts patient treatment and influences patient identity and sensemaking. The following research questions guide this study:

Part I: Doctors' Ethical Decision-Making Practices

1. How do doctors make ethical decisions about cancer patient interaction and treatment?

    a. What are the main ethical principles that govern doctor-patient interaction and treatment?

        b.   What is the process for deciding cancer patient treatment?

  2. How do doctors decide on the type and amount of treatment to provide cancer patients?

        a.   To what degree are doctor's decisions influenced by their professions, hospitals, colleagues, and other outside perspectives?

  3. How do doctors decide whether a new form of cancer treatment would benefit or harm a patient? How do they measure the risk?

Part II: Patient Sensemaking and Identity Construction

  4. How do cancer patients make sense of their new identity as "patient"?

  5. How do doctors help form the new identity of cancer patients?

  6. How do doctors make sense of their impact on cancer patients' lives?

LITERATURE REVIEW:

As previously stated, the purpose of this study is to analyze the decision-making practices of cancer doctors, including how those decisions impact the identity construction and sensemaking practices of patients. In order to properly examine this topic, I will begin by looking at the ethical dilemmas most prevalent within the medical field. In later sections, I will apply this knowledge in order to investigate the processes of ethical decision-making employed by doctors and examine how doctors navigate personal motivation and institutional structures when making their decisions. However, while reading this section, it is important to keep in mind that not all of the ethical dilemmas facing doctors will be discussed. Although I will do my best to be as thorough and comprehensive as possible in my analysis, the conflicts which doctors must navigate are sometimes personal in nature and so not all possibilities will be covered. Furthermore, I will be focusing on those ethical dilemmas that are the most pertinent for

answering my research questions, so some ethical dilemmas will be disregarded out of necessity; however, I will strive to include all dilemmas that are worth noting regardless of my focus.

In general, ethical dilemmas are prevalent within the medical professions. Individuals who have frequent personal interactions with patients, such as doctors or nurses, may be more susceptible to experiencing such dilemmas due to the hands-on nature of their work, as they are the ones who are responsible for the patients' health and well-being. Ethical dilemmas, specifically those centered around end-of-life care, often arise due to concerns about how much or what type of treatment to provide to patients who have a limited life expectancy (Ahmed & Ali, 2013). These dilemmas represent obstacles for doctors who are seeking to treat cancer patients, as they have the potential to obscure or challenge doctors' opinions of what is in the patients' best interest (Daugherty, 2004). Various research has been conducted in order to study the occurrence of ethical dilemmas in the medical profession, and it is this research that I review.

To begin, Ahmed and Ali (2013) explained why ethical dilemmas occur, what their impact is, and how they can potentially be resolved. They begin by listing some of the most common ethical dilemmas that are experienced by doctors treating patients with cancer. Their list includes: truth-telling; issues about cancer prognosis and the communication of those prognoses; conflict over the management of plans and treatment options; concern regarding the effective communication of a cancer prognosis while still managing to maintain the hope of patients and their families; and conflicts of interest for doctors. However, while these dilemmas were listed, they were not discussed in much further detail and they were not the main focus of the discussion. Rather, Ahmed and Ali chose to focus the majority of their efforts on explaining the causes of ethical dilemmas, using the specific ethical dilemmas listed more as examples and descriptive tools than anything else (Ahmed & Ali, 2013).

In terms of the causes of ethical dilemmas, they listed two particular factors as grounds for conflict. First, they discussed the conflicts that stem from an increase in options combined with limited resources. Although advances in medicine have expanded the range of options available to doctors as treatment for patients and the opportunities accessible to cancer patients have consequently increased as well, doctors are still faced with limited resources that act as obstacles to treatment. In fact, ethical dilemmas stemming from these causal factors may become more common or restrictive with medicinal and technological advances because, while the treatment options have increased, the resources available for use have not. This means that there are more treatments available than there are resources to implement them and doctors must decide which treatments would be a waste of valuable resources and, as a result, should be saved for another patient, and which treatments are a practical option (Ahmed & Ali, 2013).

It is through this factor that ethical dilemmas centered on management plans often arise. While the expertise of doctors ensure that they are acutely aware of limited resources and are knowledgeable on what these limitations mean for treatment options, patients do not have this same understanding. This leads to conflicts regarding treatment decisions, as doctors may prefer one method of treatment while patients prefer another. Additionally, this may also lead to conflicts over the perceived futility of certain treatments, as futility becomes more important when scarce resources are involved (Ahmed & Ali, 2013). Futility refers to any effort to achieve a highly improbable result; it is anything that cannot achieve the goals of the action. In medical decision analysis, futility is defined as the expected gain from a treatment after taking into consideration both the probability of success and the expected utility of the outcome (Schneiderman, Jecker, & Jonsen, 1990). Ahmed and Ali explain how perceptions of futility could lead to conflict, as doctors and patients may have differing opinions of the treatments cost,

probability of success, or utility. While doctors may consider a treatment futile due to its high cost and low relative utility, patients may not share this sentiment if they are unprepared to accept their terminal prognosis and the treatment is their last hope. This disparity could then lead to ethical dilemmas in which doctors must choose between their professional recommendations for treatment and the wishes of their patients (Ahmed & Ali, 2013).

The second factor for conflict discussed centered on changes in norms and the subsequent conflicting values that result from those changes. This section focused on changing norms for collusion, which is when family members request that the truth of a diagnosis be kept from the patient. Ahmed and Ali (2013) pointed out that, while it was once the norm that bad news and the truth be kept from patients, in recent years doctors have focused on patient autonomy and, by association, increased disclosure to patients. However, although this shift has occurred within the medical field, it is still common for families to seek collusion. This then creates a truth-telling ethical dilemma for doctors, because doctors must choose between full patient disclosure and complying with the family's desires for secrecy.

Yet, even though full disclosure shows respect for patient autonomy and self-determination and is an important part of the doctor-patient relationship, it can also lead to stress and conflict. According to Ahmed and Ali, this is one of the key consequences of ethical dilemmas, since such conflicts lead to doctors' moral distress. Here, moral distress refers to constraints, both internal and external, that incapacitated a moral agent's ability to act according to their own core values and apparent responsibilities. While it can stem from ethical dilemmas, it might also compound the strength of the conflict being experienced by relevant parties; moral distress was found to lead to feelings of anger, frustration and guilt and might limit ones' ability to evaluate or think clearly (Ahmed & Ali, 2013).

However, there are also limitations to Ahmed and Ali's analysis of ethical dilemmas. For one, while the authors list common ethical dilemmas and briefly touch on them throughout their discussion, there is no detailed analysis of the dilemmas themselves. Rather, the ethical dilemmas are used to support claims regarding the causes and consequences of ethical dilemmas in medicine. Even when the ethical dilemmas are explained, such as truth-telling, those dilemmas are not explicitly named; rather, they are inferred through discussion. They also do not explicitly acknowledge that there are other factors that produce ethical dilemmas in addition to those that they mention. While they do hint at individual characteristics and context being important for whether or not an ethical dilemma will occur and how that dilemma will be subsequently resolved, there is no real mention of this possibility.

Smith and Bodurtha (1995) provide a similarly useful analysis of ethical dilemmas in their research as well. Unlike Ahmed and Ali, Smith and Bodurtha go into greater detail regarding the specific ethical dilemmas that are common to doctors who are treating cancer patients. They also use specific case studies to support their claims and show common ethical dilemmas in practice. However, it is also important to keep in mind that the main purpose of their research was not just to elaborate on ethical dilemmas in oncology, but also to explain why a sound understanding of ethics is important for dealing with and resolving conflict. This means that their research findings were strongly tied to principles of ethics, with an emphasis on four areas in particular, although only three are relevant to my thesis and will be discussed (Smith & Bodurtha, 1995).

First, they looked at general principles of ethics that were strongly tied to medical decision-making and conflict resolution but were rarely articulated in practice. These general principles focused heavily on the idea of beneficence, or doing something good. They also

included ethical notions of minimizing harm, optimizing good and benefits, respecting patient autonomy and self-determination, and protecting confidentiality. Smith and Bodurtha tied these general principles to multiple ethical dilemmas, which, for my purposes, are called medical futility vs. slight chance and justice dilemmas.

The ethical dilemma of medical futility vs. slight chance dealt with the notion of futility which was likewise discussed in Ahmed and Ali's research. However, Smith and Bodurtha use futility to describe a different ethical dilemma faced by doctors. Although the definition of medical futility was the same, it was contrasted with issues relating to what they called "slight chance." This ethical dilemma stems from conflict between doctors' perceptions of a treatment's futility and opposing beliefs that there may be a slight chance in the treatment's success. The authors explain how the boundary between futility and slight chance can sometimes be unclear but the distinction between the two is still important because doctors may sometimes make choices about the futility of a treatment based on their own perceptions rather than those of their patients.

Justice was likewise an important dilemma, as questions of justice were considered to be a potential cause of conflict for doctors. Smith and Bodurtha stated that problems of justice and public health maximization has been at the center of ethical and legal battles for a long time, but declined to go into greater detail because such a topic was beyond the scope of their report. However, justice dilemmas were still considered important, even though they were analyzed on a broad social level rather than on the personal level of individual doctors. Here, Smith and Bodurtha explained how broad social issues of justice could impact individual doctors but could not be explained on an individual level (Smith & Bodurtha, 1995). Rather, they occur as a result of common "implicit or de facto empiric exclusions" that operate according to societal norms

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(Smith & Bodurtha, 1995, p. 2465). They imply that these exclusions lead doctors to experience ethical dilemmas of justice; these are dilemmas that are out of the doctors' control but which, nonetheless, lead to conflict and impact treatment decisions. For example, doctors may face an ethical dilemma of whether to prescribe a particular pain medication to a patient even though the patient cannot afford it or whether an uninsured patient should get a lifesaving transplant. (Smith & Bodurtha, 1995).

Second, Smith and Bodurtha look at issues centered on conflicts of interest. Ethical dilemmas that deal with conflicts of interest are an inherent part of all professions which involve money transfers, but here they were considered especially relevant. This is because selling drugs is lucrative; depending on the doctor's practice, pharmaceuticals can consist of over half of his/her income (Smith & Bodurtha, 1995, p.2466). This means that doctors face a financial ethical dilemma in which they must decide between financial self-interest and doing what it considered to be "medically proper." By medically proper, the authors refer to treatment decisions made by a physician which is in the best interest of the patient and not informed by the doctor's own financial benefit. In financial dilemmas, doctors must make a decision that allows them to make a living, yet also refrains from making a decision based on financial considerations. While this may not seem too difficult a task upon first inspection, there are things such as drug company incentive programs that create conflict between finances and what is medically proper, creating an ethical dilemma in which doctors must choose one or the other (Smith & Bodurtha, 1995).

The third point raised by Smith and Bodurtha is based on risk management. Risk management is considered to be related to ethical dilemmas because fear of litigation is a strong influence on doctors' decisions. The threat of litigation is very real within the medical

profession. Fortunately, risk management based on litigation fears have largely been a nonissue for doctors dealing with cancer patients. This is because there is little point in arguing for a case in which the patients' outcome would have been the same no matter what type of action was taken; the terminally ill cancer patient would have died regardless. Most of the risk management dilemmas center on the use of certain treatments. For instance, one might sue in order to gain access to a specific treatment that provides only a marginal benefit but may be the best option available in a particular context. This is not to say that doctors do not face litigation for other reasons as well. Doctors have also been sued for failing to disclose information or neglecting to tell the truth about a diagnosis or the futility of treatment. This potential for litigation leads doctors to face a risk management dilemma where they must balance doing the right thing and providing the best care for patients with protecting their professional reputation (Smith & Bodurtha, 1995).

Nevertheless, although Smith and Bodurtha were more detailed in their discussion of ethical dilemmas for doctors treating cancer patients, they still failed to explicitly name ethical dilemmas. Like Ahmed and Ali, the ethical dilemmas were heavily implied but never openly labeled as distinctive ethical dilemmas. However, unlike Ahmed and Ali, obvious attempts were made to find practical solutions to the specific ethical dilemmas which were described. Smith and Bodurtha also described the limitations of their study, showing that they were aware that certain restrictions on their research existed and that more research into those topics was needed before a truly informed resolution to ethical dilemmas could be created. Although their research of ethics can be applied to some ethical dilemmas and help lead to potential resolutions, there are other dilemmas in which the application of ethics would not be so beneficial due to the social nature of the problem which could not be addressed on an individual level (Smith & Bodurtha,

1995). For example, dilemmas dealing with issues of justice or fair distribution of health care are outside of the doctors' power to influence.

Rosser and Maguire (1982) expand on this understanding of ethical dilemmas by explaining how doctors are impacted by the conceptual and structural framework of their work. More specifically, they looked at how experiences and understandings of cancer impacts the acknowledgement of ethical dilemmas and shapes how they are experienced. Although Rosser and Maguire looked at general practitioners rather than oncologists, they asserted that their findings could nonetheless be applied to cancer specialists and I will continue with this assumption in mind (Rosser & Maguire, 1982).

Acknowledging the importance of the experience and understanding of cancer is an integral part of Rosser and Maguire's research. They argue that medical knowledge can be used by physicians to actively intervene over natural processes of the body, which provides an important means of power for them. The uncertainties in the medical knowledge pertaining to cancer has led cancer to become "a powerful symbol of the inexplicable" because it is a disease that defies understanding and classification (Rosser & Maguire, 1982, p. 316). Cancer represents the limitations of social control and knowledge, making it a threat because it is unpredictable and uncontrollable. This view of cancer as a form of uncertainty informs experiences of cancer, leading to pessimism following cancer diagnoses (Rosser & Maguire, 1982).

One ethical dilemma that stems from individual experiences of cancer is the involvement vs. survival dilemma. This dilemma largely refers to the ability of the doctors to create a balance between professional and personal involvement with patients. For example, how do doctors balance their emotional attachment to cancer patients and their need to give objective and truthful recommendations and treatment? Cancer is a disease that is related to strong emotions of

fear, hope, regret and more. Such emotionally charged situations make it easy for doctors to become emotionally vulnerable. They may become attached to their patients or become emotionally impacted as a result of caring for cancer patients (Rosser & Maguire, 1982). The impact of emotional stress on doctors may support Ahmed and Ali's belief in moral distress, since doctors would be emotionally charged and invested in the doctor-patient relationship. Such emotions may produce a dilemma when this relationship is threatened by doctors' need to maintain professional distance in order to remain objective during decision-making and diagnosis.

Doctors may face a dilemma where they have to decide how to balance their own emotional needs and vulnerability with those of their patients. Do they let their guard down and show sympathy for patients in an effort to soothe their patients' fear, even though they are making themselves vulnerable in the process? Such vulnerability may even be considered unprofessional in some situations, making emotional vulnerability an even bigger dilemma for certain doctors. Too much emotional involvement can also lead to burn out in doctors, so the dilemma of involvement vs. survival is a very real issue for many doctors treating patients with cancer. Essentially, the ethical dilemma of involvement vs. survival is also one of professional vs. personal involvement, as survival typically depends on doctors' ability to distance their emotions from their professional situation, thereby limiting their emotional vulnerability (Rosser & Maguire, 1982).

Rosser and Maguire's research provides a sound basis for understanding how experiences of cancer shape acknowledgement of ethical dilemmas. However, they assume that emotional distance on the part of doctors leads to an inability to identify and meet the needs of their patients. Although they admit that this shortcoming is not the result of lack of interest, they do

not acknowledge the fact that doctors may still be able to properly care for their patients even without becoming emotionally invested (Rosser & Maguire, 1982). While the limitations of medical knowledge are undoubtedly an issue which can create or help facilitate ethical dilemmas, lack of knowledge itself cannot be the sole cause of dilemmas. A more in-depth explanation for why the unknown leads to adverse experiences of cancer is needed. Additionally, the report does not acknowledge that ethical dilemmas can also stem from the uncertainties of cancer. Instead, it chooses to focus on how uncertainties form experiences rather than dilemmas and does not go into detail on how uncertainties may complicate doctors' decision-making by creating an abundance of potential options.

Daugherty (2004) elaborated further on how a doctors' inability to meet the needs of their cancer patients can sometimes lead to ethical dilemmas. He explained how cancer doctors deal almost entirely with patients facing life threatening or end-of-life illness, and that many obstacles exist which restrict doctors' ability to properly care for their patients to the fullest extent possible. These challenges often have the effect of obscuring a doctor's perception about which treatment would be in the best interest of their patients. He also lists the most relevant dilemmas as: conflicts regarding prognosis determination and communication; conflicts centered on effectively communicating a terminal prognosis while also maintaining the hope of patients and their families; and conflicts of interest for doctors (Daugherty, 2004). Additional ethical dilemmas were also mentioned by Daugherty, but those dilemmas were not relevant to my thesis and will not be included in my discussion.

The first dilemma investigated by Daugherty was that of conflicts regarding prognosis determination and communication. This dilemma partially stems from the fact that it is often difficult for doctors to accurately predict if their patients will die or how long they have left to

live. This uncertainty is not necessarily the result of a lack of knowledge regarding the illness in question, but rather results from existing difficulties that are compounded by the perceptions and attitudes of doctors (Daugherty, 2004). This would appear to conflict with Rosser and Maguire's analysis, which held that lack of knowledge was the inherent cause of doctor dilemmas (Rosser & Maguire, 1982). By contrast, Daugherty reported that the attitudes and perceptions of doctors can obscure the facts, making it difficult to accurately predict life expectancy or decide how and when to communicate the prognosis to the patient. Essentially, the ethical dilemma is one in which doctors must decide between methods of determining and communicating a terminal diagnosis to a patient. Do doctors inform their patients of their diagnosis immediately or do they wait until they are able to provide more information regarding life expectancy and the intensity of the cancer? (Daugherty, 2004).

Given the short survival time of cancer patients, doctors must be careful in how they communicate a diagnosis, as they do not want to remove a patient's hope for recovery and survival. Similarly, given the variability and uncertainty of cancer, doctors must be careful in formulating a diagnosis because neither the path of cancer nor the patient outcome can be definitively predicted. Rather, doctors must balance their uncertainty in determining a diagnosis with their responsibility to communicate that diagnosis to their cancer patients (Daugherty, 2004).

Linked to this conflict of communication is the dilemma in which doctors must balance effectively communicating a terminal prognosis while also maintaining the hope of cancer patients and their families. While Ahmed and Ali hinted at this ethical dilemma in their own report of the truth-telling dilemma, they did not elaborate on it further; fortunately, Daugherty did. Many cancer doctors believe that effectively communicating a terminal illness involves

being severely honest and thorough in their explanation, and equate such thorough honesty to essentially destroying a patient's hope for being cured. This means that doctors must balance their responsibility for disclosure with their need to provide support to patients in their time of need. The majority of doctors do not want to remove their patients' hope for overcoming cancer; rather, they want to foster their patients hope while being honest about the odds of survival so that patients can properly prepare themselves for what is to come. However, since the truth about a terminal cancer diagnosis has the potential to diminish patient's sense of hope, doctors are faced with an ethical dilemma when trying to make a decision about how to resolve this conflict (Daugherty, 2004).

This ethical dilemma likely results from the inability of doctors to redirect patients' and family members' hopes. If doctors were able to redirect these hopes toward a more achievable and realistic outcome, patients would likely not feel as hopeless about their diagnosis. This ability to redirect hope is especially important because, without a purpose or hope, a patient's confidence is severely limited. However, it is also acknowledged that, in order for patients to accept a terminal illness, they must likewise relinquish hope in the only outcome they view as meaningful--survival.

The last ethical dilemma discussed by Daugherty centered on conflicts of interest for doctors. Unlike Smith and Bodurtha's emphasis on this dilemma, which centered on financial conflicts of interest, Daugherty looked at the emotional and psychological conflicts of interest that doctors may experience. Although he did acknowledge that doctors might experience a dilemma due to the potential for loss of revenue from patient referral to hospice programs, this was not Daugherty's focus. Rather, Daugherty explained how cancer doctors may develop emotional attachments with their patients which may make it difficult for doctors to refer patients

to palliative care and hospice programs. Palliative care and hospice programs are alternatives for specialized care for serious illness and the terminally ill. They focus on providing patients with relief from pain and stress; the goal of such programs is to provide patients with comfortable and pain free living during their last days of life after life-prolonging therapy is no longer an option (Daugherty, 2004, p.123-4). However, for doctors who have become emotionally attached to their cancer patients, such a recommendation represents an ethical dilemma (Daugherty, 2004).

Doctor's willingness to refer cancer patients to hospice programs can be a conflict of interest dilemma because doctors must balance their psychological attachments to a patient with their medical responsibility to provide the best care possible. It can be difficult for doctors to make this referral because doing so would be equated with accepting their patients' approaching death, and such acceptance would require that the doctor communicate the terminal diagnosis to their patients. Daugherty had already shown that a dilemma can likewise exist around doctors' hesitance to communicate terminal diagnoses, so this requirement for doctors to communicate such a diagnosis may compound the conflict (Daugherty, 2004).

In fact, the emotional turmoil experienced by doctors during this decisive moment may be likened to the moral distress described by Ahmed and Ali (2013) in which doctors' experience of dilemmas leads to feelings of anger, frustration and guilt that limit the ability to evaluate or think clearly. Such an evaluation of moral distress may be relevant to Daugherty's discussion of conflict dilemmas because doctors would be experiencing psychological turmoil during this time. Because doctors may be emotionally attached to their patients, they may feel moral distress if the time comes to refer cancer patients to alternative care. In effect, doctors would be breaking whatever doctor-patient relationship that they may have formed with the patient (Daugherty, 2004). This would likewise appear to substantiate Rosser and Maguire's explanation of the

involvement vs. survival dilemma, because doctors would need to balance being emotionally invested in their patient relationship with their need to remain professionally distant in order to provide objective medical recommendations. When applied to Daugherty's analysis, this would mean that doctors experience a dilemma between maintaining their emotional attachment to their patients and ensuring that they are objective when making a decision regarding alternative treatment programs for terminally ill patients.

All in all, Daugherty provides a new perspective on the ethical dilemmas experienced by doctors who treat cancer patients. While doctors must navigate numerous dilemmas in order to properly treat their patients, many of these dilemmas also stem from the perceptions and beliefs of doctors themselves. Unfortunately, though Daugherty is relatively thorough in his explanation of how doctors' perceptions and beliefs are obscured by dilemmas, he does not really describe these perceptions and beliefs. Rather, he refers to them more as an umbrella term and does not specify which perceptions and beliefs are tied to which dilemma, nor does he elaborate on how they become obscured. Similarly, while Daugherty explains that doctors may experience psychological confusion or turmoil at the prospect of breaking the doctor-patient relationship with a referral, he does not explain what makes this relationship so strong or why the prospect of breaking this relationship would cause something similar to moral distress (Daugherty, 2004). Although this lack of information may be due to the fact that such factors would vary depending on the doctor and context, an excerpt should nonetheless have been provided to acknowledge this fact.

A study conducted in Croatia also supported the findings that were presented in these various reports. The Croatia study assessed doctors' experiences of different ethical dilemmas in practice. Though conducted in Croatia and involving Croatian doctors, the study concluded that

their findings could likewise be applied to American doctors. The study surveyed a total of 140

doctors and looked at how competing worldviews and perspectives might impact the decision-

making of doctors when presented with complex and ethically difficult cases (Sorta-Bilajac et

al., 2011, p.342). They found that truth-telling was one of the most common ethical dilemmas

experienced by cancer doctors, although dilemmas relating to end-of-life decision-making,

professional conduct and issues of justice were also dilemmas that doctors admitted to having

recently experienced (Sorta-Bilajac et al., 2011).

These findings in Croatia support the results reported by many different researchers of

ethical dilemmas. For instance, the existence of the collusion dilemma presented by Ahmed and

Ali was substantiated by the truth-telling theme of the Croatia study because it showed how

doctors struggle with balancing the needs of multiple affiliated parties with the need for full

patient disclosure. Furthermore, Daugherty's report of doctors struggling to effectively

communicate diagnoses while also maintaining the hope of patients and their families was also

validated. More specifically, Daugherty maintained that doctors struggled with the need to

effectively communicate terminal diagnoses in order to provide full disclosure with patients and

this conflict was shown to be a common dilemma by the Croatia study, as well.

The existence of ethical dilemmas relating to end-of-life decision-making was also

supported. This acts as verification for Ahmed and Ali's position that conflict arises over

disagreements between doctors' and patients' perception of the medical futility of certain

treatments. Smith and Bodurtha's assessment of the futility vs slight chance dilemma was also

supported, as doctors had to decide between whether or not a treatment would be appropriate

given the terminal diagnosis of their patients. The study supported Daugherty's dilemma of

prognosis determination and communication for similar reasons, since their dilemma dealt with

the difficulty doctors' experience when making a decision about terminal diagnoses. The involvement vs. survival dilemma of Rosser and Maguire was equally reinforced, with doctors needing to make a decision about their relationship with patients given an end-of-life context. This dilemma by Rosser and Maguire can also be likened to the theme of professional conduct, with doctors needing to decide which approach to patients would be more appropriate and professional.

The dilemma expressed by Ahmed and Ali is likewise applicable to the professional conduct theme, as doctors must choose between their professional recommendations and the wishes of their patient. Likewise, Smith and Bodurtha's findings could fall into this category of a professional conduct dilemma, as they found that there were dilemmas pertaining to financial conflicts of interest and risk management issues. These dilemmas could be included here because the financial self-interest of doctors and tactics employed during risk management could conflict with expectations of professional conduct. Lastly, the emotional conflict of interest described by Daugherty would also be substantiated by the Croatia study and included in this theme because it expressed an issue in which doctors' experience of emotion conflicted with their professional requirements for effectively treating patients.

Similarly, dilemmas relating to issues of justice were also found, providing supportive evidence for Smith and Bodurtha's conclusion that broach social issues impact individual doctors and lead to the creation of justice dilemmas. More specifically, doctors could be financially self-interested and engage in tactics that are less ethically sound according to principles of justice, or they could fear litigation and, as a result, practice risk management that also conflicts with common justice principles.

However, although the Croatia study provided substantial support for the other reports described in this thesis, it also had limitations that may limit its generalizability. For one, it did not explain the cause of specific ethical dilemmas, nor did it provide detail into how the ethical dilemmas were navigated or resolved by doctors. This means that, although the ethical dilemmas identified in the study supported past research, we cannot know for sure what the Croatian researchers meant when they listed these themes. Therefore, we cannot know for certain whether or not these themes are truly applicable to the other dilemmas discussed in this thesis. Additionally, while the study stated that it could be applied to doctors in America, we do not know the extent to which doctors in Croatia differ from those in America and so cannot say for certain that the findings can be applied to other populations. However, the ethical dilemmas identified by the Croatia study did correspond with those reported by American and European doctors, so there is reason to believe that the findings are indeed relevant (Sorta-Bilajac et al., 2011).

Another study was conducted by Steinberg, Yarborough, and Chen which shows that the existence of ethical dilemmas is important. The study surveyed the current ethical attitudes of doctors and found that seventy-three percent of participants reported ethical dilemmas in their practice. Inquiring further, it was discovered that eighty-four percent of doctors believed that ethical dilemmas and ethics research was "very" or "somewhat important." The study also identified numerous examples of ethical dilemmas within the medical field, the majority of which are discussed in some manner above. Although this report was short and limited in its explanation, it did conclude that research on the ethical decision-making of doctors is important, especially within fields pertaining to cancer treatment (Hess, Steinberg, Yarborough, & Chen, 2014).

This review of the literature suggests that it is not easy to differentiate between the numerous ethical dilemmas experienced by doctors. Because ethical dilemmas tend to operate simultaneously—and thus complicate the decision-making of cancer doctors--learning to differentiate between them can be difficult. Furthermore, many of these ethical dilemmas may stem from the same origin and, therefore, may add to the confusion experienced during an analysis of the different dilemmas. However, while it may be difficult to distinguish between distinctive dilemmas, there is substantial evidence to suggest that these different dilemmas do indeed exist. Unfortunately, an understanding of the common ethical dilemmas which cancer doctors face is only the tip of the iceberg, as these dilemmas have significant implications for how doctors make ethical decisions regarding patient treatment and how those decisions then impact patient sensemaking and identity construction.

DECISION-MAKING:

Although ethical dilemmas have important implications in their own right, they also have the potential to impact how doctors navigate personal motivation and institutional structures when making their decisions. In the following section, I will examine how doctors make ethical decisions regarding patient interaction and treatment by examining the processes of ethical decision-making employed by doctors. I will also examine how doctors make decisions regarding the type and amount of treatment to provide to patients, as well as how doctors negotiate the risks associated with treating cancer patients. All in all, this section will be devoted to an analysis of why ethics is important to the medical field and how doctors make decisions when confronted with ethical dilemmas.

As research into ethical dilemmas seems to be tied to doctors' decision-making, many of the researchers who published reports on ethical dilemmas also provided insight into how cancer doctors make ethical decisions and resolve ethical dilemmas. Research shows that, although the majority of doctors have access to ethics committees and consultation services, most ethical dilemmas are not reported or referred to these programs. In spite of this fact, the majority of research regarding the resolution of ethical dilemmas has focused on the experience of these services and the reports that they provide (Hurst, Hull, DuVal, & Danis 2005). This misplaced focus means that there are not enough studies that examine the values or actual strategies employed by doctors when seeking to resolve an ethical dilemma, although studies such as this do exist. However, before going into more detail regarding the specific processes of decision-making employed by doctors, I would first like to discuss how doctors react when they are faced with an ethical dilemma. Hurst, Hull, DuVal and Danis (2005) published a report which looked at the strategies doctors employ when they experience ethical dilemmas.

According to their report, when faced with an ethical dilemma, doctors tend to first attempt to avoid the conflict and look for assistance. This allows doctors to protect the integrity of their conscience, their reputation, and the reputation of the other people who were involved in the decision-making process. Such efforts sometimes reinforce the doctor's goals and values, but sometimes it also conflicts with them as well (Hurst et al., 2005). However, regardless of the outcome, doctors did react a certain way and use specific pre-decision-making techniques when dealing with the dilemma, which I will discuss in greater detail below.

In their study, Hurst et al. began with an acknowledgement that situational factors had the potential to influence ethical decisions, although these factors were hard to control for and, as a result, were not always included in decision analysis. In spite of this difficulty, their study sought

to examine certain situational elements in their analysis. In their study, they found that there were six reasons why doctors sought assistance when faced with an ethical dilemma: to get help deciding what to do; to identify a practical way to implement the decision that had been made; to employ a pragmatic solution; to acquire reassurance that they were making the correct decision; to face others who might otherwise challenge the appropriateness of the decision; and to seek consensus on the decision (Hurst et al., 2005, p.9). Such assistance can come from multiple sources, although people involved with the cancer patient and other such trusted persons were found to be the most likely source of support. For example, doctors commonly turn to colleagues they are familiar with or other doctors in their field, members of management, ethics consultants, the patient's family, or their family members (Hurst et al., 2005).

Unfortunately, situational factors made it too difficult to examine, in depth, why doctors sought assistance because doctors' reasoning tended to vary depending on the context of each case. However, doctors' reactions to ethical dilemmas were also examined. For example, Hurst et al. described how conflict avoidance is a common goal of doctors. This goal of avoiding conflict often takes priority over other goals, even those related to fulfilling medical responsibility, making it an important influence on how doctors react to dilemmas. Five different strategies for avoiding conflict were presented: addressing a potential conflict before it develops; refusing to face the conflict altogether; removing oneself from the case where the conflict resides; separating oneself from the potential conflict; and conceding in order to remove discord (Hurst et al., 2005, p.10-11). While such avoidance techniques impact how doctors make ethical decisions about patient treatment, they were also often employed as a method of circumventing the decision-making process altogether (Hurst et al., 2005).

The first strategy was used not only to avoid conflict, but to prevent it completely. By addressing a conflict before it emerges, doctors are able to identify the conflict that is occurring and work to prevent it. This is contrasted with the second and third strategy in which the doctors refuse to face the conflict or withdraw from the situation. Refusing to face the conflict may also involve deception. For example, doctors may do what they personally believe to be right but simultaneously lead the patient and their family to believe that they have done what they desired; this often occurs when these desires and beliefs did not coincide. Similarly, doctors also report withdrawing from cases where conflict occurred, regardless of where the conflict originated. For instance, doctors may withdraw from conflict with the patients' family over patient care and they may also withdraw from similar conflicts with other medical personnel, although this latter withdrawal would be more difficult due to continued proximity during work hours. This withdrawal could stem from feelings of restriction or discomfort, but the decision to withdraw was typically done because it was thought to be the best option for providing quality care to the patient (Hurst et al., 2005).

Doctors can also detach themselves from the potential conflict. This separation from the conflict varies depending on the context, but the main reason for detachment is almost always based on personal beliefs that make separation from the conflict the best option for the doctors. For example, doctors may believe that separation would result in the best health outcomes for patients or feel that it is the most ethically sound solution. They may also believe it is the best option because of personal reasons, such as a need to protect their integrity and preserve their emotions or core values. In essence, doctors typically feel that separation is the best course of action if continued involvement in the conflict would threaten their end goals or compromise their beliefs and values (Hurst et al., 2005).

The last strategy for avoiding conflict is conceding in order to remove disagreement. This method can sometimes involve doctors going against the wishes of their patients in order to make the most appropriate medical decision. For instance, doctors may have a patient who requires machine support in order to survive but, while the family is in favor of this, the patient was explicitly against such an outcome. After a couple of days on the machine, the doctor may decide to take the patient off of machine support, thereby conceding to the wishes of the patient. Although the patient's wishes may be initially disobeyed, this period of disparity allows time for the patient's and the family's wishes to align, thereby avoiding conflict (Ahmed & Ali, 2013).

The next topic discussed by Hurst et al., integrity, was not used to avoid decision-making and conflict but was instead a motivation behind certain decision-making processes used by doctors. The study found that doctors often seek to protect the integrity of their conscience and reputation, as well as the integrity of other individuals who are involved in the decision-making process. During the decision-making process, doctors may have to work with other individuals and, therefore, struggle to integrate the competing principles and perspectives held by others. This struggle can be compounded by doctors' need to adhere to their patients' wishes and provide the best care possible. In order to come to a decision, doctors must find a way to navigate and integrate these competing aspects (Hurst et al., 2005). Basically, they must find a way to overcome the dilemmas that are being presented to them.

For example, a doctor with a traditional approach to medicine may find him/herself involved in shared decision-making with a patient who prefers a more holistic approach. This would likely create disparity between the doctor and patient, as each would have a different perspective of medicine and so have different ideas about how care should be provided. In order to successfully treat this patient, the doctor would have to find a way to integrate their competing

principles and perspectives. The doctor would need to provide the best care possible to the patient while also ensuring that he/she respected the patient's wishes. Although this is not easy, it is possible.

During decision-making, the goals of protecting integrity may appear to be incompatible with principles of ethics and individual doctor and patient goals. For instance, doctors may believe that integrity means conceding and integrating, or they may believe that it means standing firm on one's opinions and commitments. Doctors must come to a decision regardless of whether or not these needs for concession and standing firm conflict. Unfortunately, when this incompatibility does occur, doctors often refuse to explain their views, so there is not much information regarding how doctors resolve these conflicts (Hurst et al., 2005). What we do know is that, although doctors may be faced with multiple goals, doctors also accept that not all of these goals will be successfully achieved during decision-making. Rather, doctors may sometimes engage in a decision-making process that values certain aspects over others; the preservation of integrity and the avoidance of conflict are sometimes deemed more important goals to achieve and are valued above certain other alternatives (Hurst et al., 2005).

However, this study by Hurst et al. also had many limitations that may make it less useful. The main limitation of this study is that it doesn't go into detail regarding which situational factors are important to doctors' decision-making. Although it states that the situational context influences how and which ethical decisions are made and how doctors react to ethical dilemmas, no further information is provided. We do not know what factors are the most common or the most important, nor do we know why those factors are so influential. Given that situational elements were implied to be one of the basic motivations behind the majority of doctors' decisions, a more in-depth explanation should have been provided. Furthermore, the

study states that it allowed participants to use their own definition of "ethically difficult" when responding to questions. This means that the appropriateness of the respondents' decisions cannot be evaluated, although it does offer greater insight into which issues are considered more salient for doctors (Hurst et al., 2005).

Now that an understanding of how doctors react to decisive moments for decision-making has been provided and the common motivations for decision-making are known, we can move onto a description of the decision-making process itself. A study by McCullough, McKinlay, Barthow, Moss and Wise (2010) on ethical decision-making expands this understanding of what influences doctors during the decision-making process and how they make ethical decisions given the various dilemmas that they face. This study revealed how complex the decision-making process is when dealing with terminal illness. They found that, although the process for decision-making is complex, there is nonetheless a distinct model for decision-making employed by doctors (McCullough, McKinlay, Barthow, Moss & Wise, 2010). However, a description of the roles of each professional in the decision-making process will be given before the process itself is explained.

The study began by explaining how, over the years, treatment for cancer has evolved and is now almost constantly changing. Doctors must now collaborate with one another to come to a decision about treatment, meaning that different medical disciplines for cancer treatment services frequently overlap and coexist. This overlap likewise requires that doctors share in the decision-making, leading to a more complex process with both distinct and intersecting roles of involvement. McCullough et al. also mentioned how the treatment of advanced cancer patients, when combined with this professional overlap and its corresponding confusion, can lead to ethical dilemmas which create stress and tension in the workplace (McCullough et al., 2010).

McCullough et al. went on to discuss who is involved in the decision-making process. They found that, although the involvement of doctors is most notable during diagnosis and treatment, nurses are the ones who most often mediate between doctor and patient. Nurses often interpret the doctor's diagnosis for the patient and explain information about the illness and its related treatment options. Essentially, although doctors play a prominent role in decision-making, other individuals such as nurses, patients, and the patients' family are also involved. However, even given the involvement of external parties in the decision-making process, there is still a model that both doctors and nurses tend to follow when making decisions. This model tends to be a cyclical process with fairly defined stages, even though there are some variations depending on the doctor's discipline (McCullough et al., 2010).

The decision-making process described by McCullough et al. occurs in five stages: (1) the contemplation stage; (2) treatment options are presented to the patient; (3) patient makes a choice regarding treatment; (4) the treatment is applied to the patient; and (5) the patient responds to the treatment (McCullough et al., 2010). The existence of this cyclical model is supported by Ahmed and Ali, who report the presence of a similar model in their own research. Ahmed and Ali explain how doctors use this model in order to create a systematic approach to ethical decision-making because it minimizes the moral distress that is experienced as a result of ethical dilemmas (Ahmed & Ali, 2013).

Stage one of the decision-making process is characterized by the doctor's contemplation of the treatment options. Given the array of treatment alternatives available due to the advancement of medical technology and science, doctors must deduce which treatments would be most beneficial and in the best interest of the patient. This stage also involves a large degree of variation, as the process employed by doctors when considering treatments usually differs

individually (McCullough et al., 2010). Some factors considered by doctors during this process include: the preferences, attitudes, beliefs, and values of the doctor; the stage of the cancer and the type of its malignancy; evidence for the effectiveness of different treatments; input from patients and other experts; patient preferences; knowledge of evidence and its applicability as a treatment; restrictions on resources weighed against the treatment's ability to benefit the patient; and the type of relationship which exists between the doctor and the patient. The individual characteristics of the doctors themselves, such as their professional experience and personal beliefs, also come into play and influence the type of contemplation that is engaged in by the doctor (McCullough et al., 2010).

According to Ahmed and Ali, this stage is also where doctors identify the ethical dilemmas and try to define the guiding principles which should be utilized in the situation (2013). These guiding principles are typically principles of ethics, involving things such as autonomy (respect for individuals), non-maleficence (to do no harm), beneficence (to do good and prevent harm), justice, veracity (to tell the truth and not deceive), confidentiality, and privacy. In order to successfully complete this contemplation stage, doctors much engage these principles of ethics and find a way to detach their emotional responses from the situation so that they can become objective. Once doctors achieve this separation, ideally they are able to clearly define the ethical dilemma and take on a more objective point of view which will allow for more effective decision-making (Ahmed & Ali, 2013).

Stage two is where the treatment options are presented to the patient. Depending on the outcome of the contemplation process, this may involve the presentation of a single treatment or multiple options. In some cases, there may not even be treatment options offered to the patient because the doctor may decide that all treatments would be futile (McCullough et al., 2010).

During this stage, the doctor must also consider and clarify his/her personal and professional values. Ahmed and Ali explain how understanding values is essential in the medical profession, since they can to lead to confusion, inconsistency, and indecision if they are not accounted for (2013). It is therefore important that doctors be aware of their own values and the values of others because such an oversight might complicate the decision-making process and make it harder for doctors to narrow down the treatment options available to patients (Ahmed & Ali, 2013).

Stage three is where the patient decides on a path for treatment. This can involve the patient choosing a particular treatment or deciding to forgo treatment altogether. Essentially, this is the stage where the patients "accept, decline or defer" the treatment options that were presented to them in stage two (McCullough et al., 2010, p.486). If no treatment is decided upon or the patient declines all of the options that were presented, the doctors will return to the contemplation stage in order to re-think alternative options. It is also during stage three that doctors take on more of a supporting role in the decision-making process. Here, their role is to provide additional information and clarify, as needed, helping to facilitate the patients' decision and provide encouragement and emotional support (McCullough et al., 2010).

This stage is where doctors are expected to clarify any influential factors and describe potential barriers to treatment. Influential factors may include individual characteristics of patients such as their values and culture, or medical facts such as patients' medical history and diagnostic results. It may also include barriers such as conflicts of interest and differing professional perspectives. These are all factors that, when considered, should help the doctor to engage in more effective communication with the patient and help their patient come to a more sound decision regarding which treatment they would like to pursue (Ahmed & Ali, 2013).

How doctors go about completing their role in stage three is largely up to them, as there are many different techniques employed. For example, some doctors focus on ensuring that patients do not feel pressured and have enough time to fully absorb and consider their treatment options. All things considered, stage three provides doctors with an opportunity to weigh their expertise and use their skills in order to clarify information and assist patients in their own decision-making process (McCullough et al., 2010).

Stage four is where the patient undergoes the treatment. In this stage, both the doctor and the patient play a prominent role because each is partly responsible for deciding whether or not a treatment is working. The doctor and the patient must also negotiate their individual prospects for success. Doctors are therefore required to consider whether to put emphasis on quality of life or length of life, and must make decisions about whether or not they should initiate discussions about withdrawing treatment should it become apparent that the treatment's effects are too strong. The role for the doctor in this stage is one of support, although they also take on a more deciding role when it comes to expressing their professional opinions to the patient (McCullough et al., 2010).

Essentially, stage four is where a decision is made and acted on. Regardless of the ethical dilemma facing doctors at this time, a resolution to the issue can only occur through action. In an ideal situation, the values of the involved parties would coincide, but this is not always the case. However, even if a discrepancy does exist, it should be relatively easy for doctors to overcome if the dilemma has already been systematically evaluated and the best course of action decided upon. In making such a decision, there are common strategies that are employed when resolving dilemmas. These strategies include collaboration, compromise, and accommodation. As a whole, doctors must be prepared to collaborate with involved parties when evaluating information and

options, to compromise in order to decide on an acceptable trade-off, and to accommodate for others' position. Such action on the part of doctors can help avoid disputes that result from ethical dilemmas and lead to more efficient decision-making processes (Ahmed & Ali, 2013).

The last stage is where the patient's response to the treatment is evaluated and the outcome is assessed. This is where the doctors must make a decision about whether or not the treatment has been effective or if the cancer has advanced. It is at this point that the process may become cyclical, as even a favorable response to a treatment may only be temporary. For example, if the cancer begins to progress or further treatment is recommended, then the doctor must initiate the decision-making process anew. Although the patient may decline further treatment or choose a non-treatment oriented option, such as those offered by hospice programs, doctors may still reinitiate the decision-making process in order to provide the patient with program recommendations or alternative options for treatment (McCullough et al., 2010).

Furthermore, stage four involves post-action reflections which are useful during the evaluation process. It is during this stage that doctors pay attention to specific details, looking at any unanticipated consequences of the treatment, overall satisfaction with the results, and whether the treatment used was indeed the best course of action. Such evaluation and reflection helps doctors to minimize and avert future conflicts, allowing them to improve their methods of handling future dilemmas when they inevitably occur (Ahmed & Ali, 2013).

Overall, the study by McCullough et al. is informative and provides a solid basis for understanding the decision-making processes of doctors treating cancer patients. However, it also has limitations in that it was often too broad; it refrained from mentioning specifics about how the doctors navigated each stage or what went into making a decision at the conclusion of each stage. Furthermore, the study included both doctors and nurses and it did not always

distinguish which action was done by which profession. Some decisions were specifically

applied to doctors and other to nurses, and even more were associated with both professions.

However, there were some actions and decisions that were not specified either way, leaving the

readers to make their own assumptions about to which profession it belonged (McCullough et al.,

2010). Fortunately, the report by Ahmed and Ali supplemented the shortcoming of this study,

allowing for a more informative analysis of doctors' ethical decision-making practices.

   In addition, there are also many other factors that must be taken into consideration during

decision-making; these factors do not necessarily fit within a specific stage of the decision-

making process, but they do influence the ultimate outcome. Inexperience is one such factor to

be considered, as medical professions often overlap during the decision-making process and

having diverse levels of expertise and experience may complicate the process or obscure

assigned roles. Likewise, inequity regarding the resources available may make it difficult for

doctors to properly care for their patients. Although the rule of rescue dictates that resources be

allocated to present patients, this may create a resource shortage in the future which confounds

treatment for future patients, creating a fallacy of distribution that doctors must learn to navigate

(Smith & Bodurth, 1995, p.2465). These factors are all important considerations in decision-

making because they have the potential to make resolving ethical dilemmas more difficult;

contemplating these factors and accounting for them in decision-making will enable doctors to

make more ethical decisions in regards to cancer patients.

   Unfortunately, this model for decision-making is not always adequate for doctors who

desire to make more ethical decisions. Sometimes doctors must make use of external resources

that help facilitate their ability to make the correct decision. For example, one such resource may

be ethics committees and consultation services which help doctors to make more ethical

decisions and evaluate them after the fact. Such services look at particular cases in order to help

doctors learn how to appraise their situation in light of ethical considerations. They point out

ethically difficult situations and make suggestions about how the dilemma could be solved

ethically and result in the greatest benefit for all involved parties. However, such services are

greatly underused by doctors and an increase in their utilization is necessary if doctors are going

to learn to overcome ethical dilemmas and improve their ethical decision-making skills (Hurst et

al., 2005; Smith & Bodurtha, 1995; Schniedermayer, La Puma, & Miles, 1989).

More responsible healthcare organizations may also be needed. This is because

healthcare organizations are partly responsible for promoting organizational ethics and ensuring

that their employees have access to services that provide support in areas of ethics. Acceptance

of this responsibility is made evident through ethics protocols, guidelines, and programs which

help to reduce the occurrence of ethical dilemmas, but such actions are not sufficient. Efforts

must also be made to reduce the burden and stress which doctors experience during decision-

making. This can be done in a variety of ways, such as by holding multi-disciplinary forums that

provide doctors with an opportunity to air their grievances and collect mutual support and

wisdom. Regardless of the method employed by organizations, it is important that they take into

consideration the time and effort required by doctors to manage ethical dilemmas (Ahmed & Ali,

2013).

Organizations might also offer opportunities for doctors to continue or expand their

education of ethics. Such attempts at education would promote efforts to increase understandings

of ethics and would hopefully encourage doctors to become more informed regarding options for

ethics consultation. Because programs for continued medical education are specifically designed

to improve the communication skills of doctors and help them to better understand dilemmas and

treatment alternatives, education programs could be a highly beneficial resource. Likewise, continued education would also help doctors stay up to date on modern decision-making processes and may even teach them new methods of approaching and managing ethical dilemmas when they occur (Daugherty, 2004). All in all, it is the responsibility of the organization to help alleviate the burden felt by doctors and to provide adequate resources to help doctors manage and resolve conflicts when they occur (Ahmed & Ali, 2013; Daugherty, 2004).

Whichever method is used by organizations, and regardless of the decision-making process employed by doctors, it is important for both organizations and doctors to acknowledge the significance of ethics. Not only should they realize how important ethics education is to making ethical decisions about patient treatment, they also need to understand the significant impact that ethics has on decision-making. After all, ethics has important implications for decision-making. Ethics provides the framework through which doctors make the majority of their decisions about treatment and often guides how they interact with cancer patients. Studying ethics also enables for a clearer understanding of the ethical principles at play in the medical field. This is because it offers practical help in highlighting ethical dilemmas when they arise and offers useful suggestions for resolving such issues as they emerge. Although ethics may be less useful for resolving ethical dilemmas centered on issues of justice or fairness of distribution, this limitation does not hinder its applicability to other conflicts. Ethics holds that enough information should be provided to enable individuals to make appropriate decisions, and it is through this information that doctors will become informed enough to make educated ethical decision about treatment for cancer patients (Smith & Bodurtha, 1995).

In sum, it is not always easy to see how doctors make ethical decisions about treatment for cancer patients. There are many motivations that come into play during doctors' decision-making process, and sometimes doctors try to circumvent making a decision to avoid the complications of ethical dilemmas and other related conflicts. However, although there are strategies which doctors employ in order to avoid conflict, these strategies are not always effective and sometimes doctors are forced to confront ethical dilemmas and engage in the decision-making process. Although the process can be obscured or complicated by external factors, there is a common model for decision-making that is often employed by cancer doctors.

The decision-making model commonly employed by cancer doctors when deciding on a treatment for cancer patients is a five step process which is typically cyclical in nature. This model has five clear stages of (1) contemplation and identification of issues, (2) presentation of options and clarifying of values, (3) patient decision and clarifying of information, (4) application of treatment to patient, and (5) response to treatment and evaluation of outcome. These five steps make up the process through which doctors come to acknowledge ethical dilemmas and find ways to resolve the issues that result from conflicts. Most importantly, this is a decision-making process that enables doctors to overcome the challenges imposed by ethical dilemmas in order to make ethical decisions about patient treatment. The five stages incorporate notions of ethics in order to assist doctors in overcoming ethical dilemmas and challenges of decision-making; by providing a clear process of decision-making the model eliminates confounding variables and simplifies the process, enabling doctors to make more appropriate ethical decisions.

IDENTITY CONSTRUCTION AND SENSEMAKING:

Unlike the previous sections, which centered on doctors and their perspectives, this section is centered on the identity construction and meaning making of cancer patients. More specifically, the purpose here is to identify how the decision-making practices of cancer doctors impacts the identity construction and sensemaking practices of patients. The impact of the doctor-patient relationship on patients will also be considered, with particular attention being given to how patients are influenced by the communication techniques employed by doctors when dealing with cancer patients.

Before going into further detail, an understanding of identity construction and sensemaking must first be provided. Ojha (2005) provides a good explanation of sensemaking and identity construction, combining research by numerous scholars in order to create a broad overview of the two terms. In general, he describes sensemaking as a process through which people attempt to understand something that is unfamiliar or uncertain (Ojah, 2005). He explains how Weick defined sensemaking as, "making sense of uncertainties in environments through interaction," and that it is the process through which meaning is constructed (Ojha, 2005, p.3).

Sensemaking is what enables people to make sense of complex situations and unpredictable environments. It occurs due to an interruption in one's environment which creates feelings of unfamiliarity, leading people to examine the critical issues that they are exposed to and scrutinize the meanings that typically go unchallenged in an organization. As a process, sensemaking provides a method through which people are able to move through everyday life. It gives people the ability to discern key factors such as beliefs, cultures, norms, relationships, values and more. Furthermore, sensemaking is a continuous process that helps facilitate the

development of a sense of identity, thereby tying it to processes of identity construction (Ojah, 2005).

As previously stated, tied closely to this notion of sensemaking is the idea of identity construction. Identity construction is a method through which a person constructs a sense of self. One's identity is influenced and expressed in a variety of ways, including through factors such as race, gender and culture. Various theories seek to explain this phenomenon of identity construction, including social identity theory, which is the most pertinent theory to this analysis. Social identity theory focuses on examining how an individual's identity is constructed in terms of membership. More specifically, it states that people tend to identify themselves according to group membership, defining their identities along social and personal dimensions. Here, social identities are defined according to membership in different social groups, whereas personal identities are defined by the individual characteristics that distinguish one entity from another (Howard, 2000). This process is closely related to the concept of sensemaking because, in order to navigate the world successfully and operate in everyday life, people must make sense of who they are. Each person has his/her own unique identity and his/her own individual process for constructing or coming to terms with identity (Ojha, 2005).

Sensemaking and identity construction are ongoing processes. Due to this continuous nature, they are also processes that are vulnerable to change; more specifically, they can be disrupted or altered as a result of changes to an individual's environment. A cancer diagnosis can act as such a change by challenging a patient's ability to manage life in a significant way, leading to changes in how a patient makes sense of their illness and identity (Wenger, 2013; Vickers, 2012). In the following text an analysis of patient sensemaking will be provided, followed by an examination of patient identity construction.

A study by Sarenmalm, Thorén-Jönsson, Gaston-Johansson and Öhlén (2009) explained the sensemaking process employed by cancer patients. Their study discussed the implications of cancer, showing how a cancer diagnosis requires patients to adjust their experiences in order to make sense of what it means to live with cancer. Unfortunately, this is not an easy adjustment to make for many people, although some people manage to ease their distress by creating new meaning and reassessing important values. The process needed to undergo this adjustment is also rather complex, although it does allow patients to engage in sensemaking practices and so is worth the effort (Sarenmalm, Thorén-Jönsson, Gaston-Johansson, & Öhlén, 2009).

This sensemaking process, which enables patients to make sense of their illness and adjust to their new identity as cancer patients, is a transitional process. Taking place in three stages, this process is continuous and interactive, with each stage overlapping and coinciding with other stages, making the stages nonlinear and non-sequential. The three stages are: (1) confronting; (2) struggling/easing distress; and (3) transcending (Sarenmalm et al., 2009).

The first stage, confronting, involves a shift in the expectations and awareness of the patient. Patients often begin this stage by shifting their expectations of illness and health. They learn what their diagnosis means and come to terms with their probability for successful treatment or prolonged life. Patients become more realistic in terms of their odds for survival and find ways to normalize their illness; they look for ways to cope with and accept their cancer diagnosis. Following this acceptance, patients will experience a shift in their awareness. This is the period when patients become aware of the consequences of cancer (Sarenmalm et al., 2009). They also begin to acknowledge their dependencies and all that they may have taken-for-granted, such as health. This is the moment where individuals start to comprehend that their life has

changed and that they need to adapt to these changes if they hope to make sense of their new

status as cancer patients (Wenger, 2013).

This phase of stage one is especially complex because it varies by patient. Those patients

who are experiencing a relapse with cancer will have a more difficult time coping with their

illness, whereas those who are being initially diagnosed will experience less emotional turmoil.

This is because the reoccurrence of illness is a life-altering event which involves immense

sadness. Of course, this is not to say that the initial diagnosis of cancer it not traumatic as well,

but rather that a relapse of cancer will result in patients' diminished hope. Patients who

experience a reoccurrence of cancer are more sensitive to the emotional distress that is associated

with cancer because they are acutely aware of how easy a relapse can be. Since such patients

have survived cancer once only to have it return, what guarantee do they have that it won't

happen again later on in life? This understanding, that their survival may be a temporary victory,

can lead to diminished hope or confidence in a patient (Sarenmalm et al., 2009).

The second stage is where patients struggle with and ease their distress. This stage is

characterized by patient's efforts to let go of their fears and allow themselves to be reassured. As

a whole, it is understandable that patients with a cancer diagnosis may be experiencing distress

and, therefore, struggle to come to terms with their illness. A diagnosis of cancer represents an

unknown future; patients do not know if they will survive or if they will be able to regain a sense

of normalcy following treatment. One of the ways in which patients can ease the distress is by

letting go of their fears and the things that they have lost. For example, one of the most important

things lost to cancer is one's health, as patients must become accustomed to the side effects of

treatment and the changes to their daily lives. Patients also report experiencing a loss of self,

meaning that they are forced to reevaluate their identity. However, one of the most important

losses experienced as a result of cancer is a loss of the sense of immortality. Here, patients must accept that they may have taken life for granted and that continued life is not guaranteed (Sarenmalm et al., 2009).

In essence, stage two is where patients must let go of their losses and appraise their current situation. In this stage, patients assess their uncertainties and acknowledge their emotional turmoil. The patients' access to knowledge may be important here, as patients who are provided with more in-depth information may find it easier to let go of their losses and ease their distress. In addition, dealing with multiple losses and experiencing the loss of different life values may make it difficult to accept reassurances and let go of fears. This process of letting go largely depends on the individual, as each patient will have access to different information networks and support systems which will assist them in this process. For example, the fears of some patients may be reduced by letting go of life and accepting their impending death (Sarenmalm et al., 2009, p.1122). By contrast, others may choose to find a hobby or something they enjoy doing which helps them keep their mind off of their illness. Ultimately, each patient will employ an individualized strategy for distracting themselves from their diagnosis, enabling them to let go of their losses and reassure themselves of their hope for survival (Sarenmalm et al., 2009).

The last stage, transcending, involves patients reevaluating and remodeling their relationships. This is the stage where meaning is created and patients adjust to their changing perceptions. Here, patients are required to reevaluate their lives, their relationships, and their changing medical condition. During transcendence, patients find new ways of interacting with others and may even perceive a change in their own identity. They evaluate their new experiences and try to create new meaning. For some, this may result in new attitudes or new

outlooks on life but, regardless of the outcome, the result is a consequence of what the patient values and chooses to focus on (Sarenmalm et al., 2009).

As previously stated, during this third stage the relationships of patients are often reevaluated. Although patients may try to protect their family and friends from the effects of their cancer diagnosis, relationships are inevitably changed. As a result, patients often make sense of their illness by reevaluating their relationships. For some patients, this may produce stronger connections, but for others it may mean withdrawing from relationships and weakening bonds. However, even though the method of reevaluating relationships may vary, the majority of patients report a need to create wellness. What this means is that patients seek to create meaning in their life; they want to rediscover happiness and enjoy their life once more. This final stage of sensemaking is where this need is often realized, as patients place greater emphasis on what they deem important and, thus, are able to devote more time to analyzing their experiences and realizing their goals (Sarenmalm et al., 2009).

All in all, the report by Sarenmalm et al. provides a solid model for understanding patient sensemaking. While the method for sensemaking may vary depending on the individual, most patients experience stages where they engage in confrontation, struggle with and ease distress, and experience transcendence. These three stages make up the process through which sensemaking occurs in patients, allowing them to create new meaning and make sense of their experiences and new identities as cancer patients. Patients who have been diagnosed with cancer are facing more than a potentially life threatening illness; they are also facing a period of constant change and challenges. Cancer patients use the process of sensemaking in order to come to terms with their new situation and transcend their illness, using the process as a stepping stone to regaining a sense of wellness and happiness (Sarenmalm et al., 2009).

Although this study by Sarenmalm et al. focused on breast cancer in particular, its findings can be applied to other illnesses that have the potential for end-of-life outcomes as well. The main limitation of this study was that it focused on the experience of women, assuming that men and women would have vastly different experiences of and reactions to cancer (Sarenmalm et al., 2009). However, although other studies may support the idea that men and women experience cancer differently, the basic processes behind their experiences are the same.

A study by Wenger (2013) shows how men have similar experiences to cancer as women. It explained how the experience of cancer is subjective and is, in part, impacted by social expectations of gender (Wenger, 2013). For example, women with breast cancer may feel less feminine because breasts are considered a symbol of femininity within society, whereas men with prostate cancer may feel less masculine because their status as capable males is threatened. In contrast, those individuals who are not afflicted with such a personal illness may not be as personally impacted by cancer because they are still able to enact socially expected roles (Wenger, 2013). This is not to say that some cancers are more personal than others, but merely that some cancers diminish the capacity of patients to engage in socially accepted roles and behavior. According to Wenger, men engage in the same sensemaking processes as women when trying to make sense of their illness (Wenger, 2013).

Going further, a study by Lethborg, Aranda and Kissane (2008) showed how the creation of meaning is important to patients diagnosed with cancer. Living with cancer can be a marginalizing experience, leading patients to feel emotional distress and turmoil and complicating how they enact their identity. Cancer diminishes a patient's ability to achieve the basic human need of making sense of current life situations but it cannot remove the sensemaking processes entirely; it merely complicates them.

The study by Lethborg, Aranda and Kissane explained how patients adjust meaning as a result of cancer diagnoses and described how sensemaking processes are used in order to help patients adjust to their new identity of cancer patients (2008). To begin, it is important to acknowledge that meaning is both created and lost as a result of cancer diagnoses. The ability to engage in sensemaking is essential for cancer patients because meaning can provide a framework, perspective, and counterbalance to challenges that occur as a result of cancer diagnoses. Without this ability to make sense of their experiences, patients would likely be unable to overcome the despair and fear they may feel as a result of being diagnosed with a life threatening illness (Lethborg, Aranda, & Kissane, 2008).

Regardless of the patient's diagnosis or initial beliefs about cancer, sensemaking can also be used as a tool for reducing the disparities between life before and life after cancer. This is important because patients whose life has meaning or purpose are more likely to positively adjust to cancer. This means that sensemaking can be used as an adjustment tool, facilitating patients' abilities to adapt to their new roles as cancer patients and acclimate to the changes that they are experiencing. In addition, it helps patients to maintain balance in their lives, enabling them to stabilize positive and negative emotional states by providing patients with a sense of coherence and a method of analyzing their experiences.

Identity construction is similarly important because it has the potential to impact patients' experience of cancer. According to Ojha, identity is developed through a five stage process. The first stage is characterized by an unexamined identity, one in which the identity has yet to be explored or discussed. Stage two is the conformity stage where patients begin to associate certain values with their identity. This may include positive or negative attitudes, but these labels are often developed in terms of group descriptions rather than individual definitions. In addition,

stage two is the step where acceptance occurs, where someone begins to examine their individual and group identities and accept what it means to enact these identities. This is also where worldviews are developed and accepted as part of one's identity (Ojha, 2005).

In stage three resistance and autonomy occur. This is a more personal stage, one where patients begin to further question their established identities. Stage four is one of redefinition, where people begin to refocus on identity definitions. Here is where they look to redefine and provide new descriptions for their individual and group identities. The final stage is integration. By the time this stage occurs, a person has already developed his/her individual identity and he/she has likely acquired a strong sense of group identity as well. This is the stage where individuals acknowledge their group identities and the identities of other groups. It is also a critical stage because it is where individuals will come to recognize that they are different and learn to accept the existence of various other identities which operate in the world simultaneously (Ojha, 2005).

These five stages are crucial in the development of identity. Although not all scholars agree on the steps or believe that each person experiences all five steps, they are still essential to how identity is constructed (Ojha, 2005). A report by Vickers (2012) showed how illness such as cancer can be especially influential to this process of identity construction because it disrupts established identities and understandings of the self which then threatens an individual's continuation of selfhood. In this context, selfhood refers to an individual's personal identity and self-understandings, and their ability to enact them. This disruption occurs because identity and selfhood are typically embedded in networks of relationships. The survival of selfhood depends on the continued existence of these relationships, and cancer acts as a disruption. Cancer disrupts selfhood by changing an individual's perception of the self and altering others' perception of the

individual as well. Once a cancer diagnosis has been made, people may forget the patient's past self, coming to view the patient in terms of their diagnosis rather than their person. This is partly why the decision-making of doctors has the potential to impact the identity construction of patients, as receiving a terminal diagnosis has the ability to alter a patients selfhood, thereby impacting their identity (Vickers, 2012).

Given these identity construction and sensemaking practices, it is possible to see how doctors' decision-making has the potential to impact how patients make sense of their identity and experience with cancer. For one, the study by Sarenmalm et al. showed that there is a disparity between the impact of an initial cancer diagnosis and a diagnosis relating to a reoccurrence of cancer (2009). This implies that knowledge of cancer itself has the potential to impact patients' sensemaking. After all, patients who have been treated for cancer before will know what to expect when it comes to treatments and their side effects, making them more fearful of a cancer diagnosis than someone with no such prior knowledge. Assuming this is the case, it may be true that doctors' decision-making can likewise influence patient sensemaking, as the type and amount of information doctors choose to provide to patients can influence how apprehensive they are about their illness.

Similarly, doctors' decisions regarding the type and amount of information provided to patients may impact how patients experience and work through the first and second stage of sensemaking. By providing in-depth and informative explanations to patients, doctors may be able to facilitate patients' ability to confront their illness. More specifically, they might help patients to accomplish the first sensemaking stage by providing the information patients need to make sense of their experience and come to terms with their illness. After all, by expanding a

patient's understanding, doctors will be reducing the uncertainty and confusion which surrounds cancer, enabling patients to be more confident when they confront their illness.

Likewise, how doctors choose to explain the diagnosis to patients may influence the second stage by impacting how much distress patients feel. The strategy doctors employ to discuss such matters with patients may impact their emotions, since some methods of disclosure used by doctors may be more empathetic than others. In the same way, some doctors may make the decision to become more emotionally involved with their patients or seek to create stronger doctor-patient relationships. This may then help doctors to reassure their patients and help doctors to ease the amount of distress that patients feel as a result of their illness.

In addition, the decision-making of doctors may impact the identity construction of patients by influencing how the different stages of identity development are experienced. For example, the second development stage of conformity may be influenced depending on the type and amount of information provided by doctors. Depending on how doctors frame the illness and diagnosis, patients may be more likely to develop positive or negative attitudes towards their illness. For instance, if a doctor frames the illness in a negative light and leaves little hope for survival, the patient may be more likely to develop a negative attitude. This may then impact how patients enact their identity roles or create more negative feelings in regards to their identity as cancer patients. Furthermore, how a doctor frames the issue will likely influence the willingness of patients to accept their patient identity, and this acceptance is an important part of completing stage two of the identity construction process.

Likewise, the decision doctors make in regards to diagnosis framing may also impact patient's ability to engage in the fourth stage of integration. This is because patients with negative attitudes toward their patient identity may be less willing to integrate this identity into

their understanding of the self. How a doctor interacts with the patient may also influence integration, as the creation of certain doctor-patient relationships may facilitate a patient's acceptance of illness. Doctors who choose to pursue a closer doctor-patient relationship may make patients more comfortable in discussing their illness, thereby making discussions of cancer less taboo and reducing patient's unwillingness to integrate their patient identity into their sense of self. After all, patients may be more willing to accept and integrate experiences of cancer into their identities if they feel more comfortable with their understanding of cancer as a whole.

All in all, there appears to be a gap in research that looks at the sensemaking and identity construction practices of cancer patients. Although most studies agree that the internal processes of patients are important, there is very little which inquires further into what these processes are and what impact they may have on patients. While I make some hypotheses about how doctor decision-making may be impacting patient sensemaking and identity construction in this section, I did not find any studies to verify my claims. Due to this, it is important to keep in mind that my statements about patients' internal processes are my own personal hypotheses which, while implied by the readings, are not yet definitively proven by research. As a result, I acknowledge that further research into this topic is required and that my hypotheses should not be taken as fact. Rather, they should be used as a catalyst for further research and investigation into how doctor decision-making has the potential to impact the sensemaking and identify construction of patients.

The Doctor-Patient Relationship:

Yet these processes of sensemaking and identity construction influence more than just doctor decision-making because the doctor-patient relationship is also impacted. Other changes similarly result from this impact, for the communicative behaviors of doctors and patients are

influenced and changes to the doctor-patient interactions likewise occur. More specifically, changes to doctors' decision-making, patients' sensemaking and identity construction processes have the potential to impact doctor-patient relationship and communication. This analysis will begin by examining communication between doctors and patients before moving on to look at how doctor-patient relationships are formed and maintained.

In recent years, the medical field has seen a move away from paternalism, under which doctors were expected to make all of the decisions about patient care. Instead, there has been an increasing rise in support for patient self-determination, where patients are expected to be actively involved in their health care and medical decisions. This shift is partially due to a judgment at the Helsinki trials which made patient autonomy an ideal of medicine, making it an important principle that now governs the doctor-patient relationship (Ahmed & Ali, 2013). This shift in medical standard, combined with changes in patients' sensemaking and identity construction, has led to alterations in the doctor-patient relationship and interaction.

A recent study emphasized the importance of communication between doctors and patients and showed the essential need for frequent and precise communication. The study explained how it is important for doctors to engage in skillful, compassionate and understanding communication when speaking with patients because doctors are a source of information and support for their patients (McCullough et al., 2010). Research by Arora (2003) supports this view of communication. Arora's report outlined the importance of doctors' communicative behavior when interacting with cancer patients. He held doctor-patient interaction and communication as a strong influence on how cancer care was provided to patients, stating that it had the potential to lead to positive health outcomes for patients.

In his research, Arora explains how doctors' communication with cancer patients shares many of the characteristics of general doctor-patient relationships. However, he suggests medical relationships pertaining to cancer are unique, stating that there is increased complexity due to the stigma and fear associated with cancer diagnoses, the difficulty in explaining and understanding medical information, and the uncertainty of the treatment outcome. Furthermore, he adds that ambiguity regarding the course of the disease and treatment benefits adds an emotional element to the interaction, making the doctor-patient relationship even more complex (Arora, 2003).

Arora identified three important goals for doctors who are communicating with cancer patients: (1) establishing a good interpersonal relationship with patients; (2) facilitating the exchange of information between doctor and patient; and (3) enabling for the patient's involvement in decision-making (Arora, 2003). Given the inherent uncertainties of cancer, the first goal often requires that patients have a significant amount of reassurance from doctors regarding the normalcy of their reactions and concerns about their diagnosis. Cancer patients rely on doctors to provide support and understanding about their illness, leading to the formation of strong interpersonal relationships between doctors and patients (Arora, 2003).

However, communication is essential to the successful formation of this relationship. For one, it is recommended that doctors use communication to create a warm and trusting environment for patients because such an environment enables patients to be treated as normal individuals rather than as cancer patients in need of assistance. It is also important that doctors show interest in the problems and feelings of patients in order to assist in the formation of this environment. Doing this enables doctors to engage in interpersonal communication with patients, and such communication is often considered a prerequisite for the successful completion of the second goal (Arora, 2003).

The second goal is tied to notions of identity construction and involves information exchange. During this exchange of information, doctors are encouraged to actively listen to their patients, keeping interruptions to a minimum. Such active listening helps doctors to understand the experiences of their patients, which is important because it can increase doctor's comprehension of patients' needs and so result in treatment decisions that minimize disruptions to patients' quality of life (Arora, 2003). Other studies support this belief, showing that strong doctor-patient relationships have the potential to increase the health outcomes of patients (Arora, 2003; Kaplan et al., 1989; Street et al., 2009). Furthermore, Arora shows that this exchange also provides patients with the opportunity, time, and information needed to construct and establish their identity. Just as doctors are given vital information regarding patients' needs and desires, patients are also provided with information which relieves their concerns and confusion (Arora, 2003).

The last goal, facilitating the involvement of patients in decision-making, relies on the successful exchange of information between doctors and patients. This is a goal that focuses on shared decision-making between doctors and patients. It recommends that patients concerns are elicited and that medical knowledge relevant to patients cases are explained in order to build a sound understanding through which shared decisions can be made. In order to stimulate such patient involvement, doctors are encouraged to involve patients in various stages of the decision-making process, enabling patients to share in the responsibility and control. However, achieving this also requires that patients feel comfortable in their role and believe that their opinions will be valued by the doctor (Arora, 2003). This implies that, in order to achieve this goal, patients must have already formed their identities and engaged in sensemaking, enabling them to understand

and be at ease with their new role. Enacting their new responsibilities then becomes less challenging.

However, though Arora provides a clear description of how the doctor-patient relationship is formed and why communication is important to this formation, he does not describe how conflicts such as ethical dilemmas may complicate this relationship. Furthermore, he fails to account for how the length of the doctor-patient relationship impacts communication and interaction. Although he acknowledges that strength of relationship may be tied to how long a doctor and patient have been paired together, he does not offer an explanation as to why this may be important, nor does he differentiate between different types of doctor-patient relationships. For example, is the relationship one of mutual respect and decision-making, or one where the doctor is given majority control and responsibility over treatment? Would this difference in relationship structure have any effect on how the doctor-patient relationship was formed? These are questions left unanswered by Arora's report.

Fortunately, a study by Ridd, Shaw, Lewis and Salisbury (2009) provides explanations for some of the questions that are left unanswered by Arora. Their study focuses on the factors which define the doctor-patient relationship and explain how there are distinctive features that impact how the relationship is developed and maintained, features that then prove to be important for patient care. The researchers reported two main factors as being the most influential to how a doctor-patient relationship is developed and maintained. The first factor is longitudinal care and it refers to how long a patient has been seeing the same doctor. Longitudinal care is key to explaining how a relationship is maintained, as patients have a choice in who they see and can choose to switch doctors should they become displeased with their current situation. The second factor is consultation experiences, meaning that the experiences

which patients have when meeting with doctors can impact the type of relationship that is formed. This is because patients will seek to form relationships with doctors who meet their expectations and needs, and the ability of doctors to meet these requirements is often made apparent through doctor's skill at consultation (Ridd, Shaw, Lewis, & Salisbury, 2009).

The type of relationship that is formed between doctors and patients is often determined by these two factors, as well. For instance, a patient will typically seek a doctor who shares in his/her ideals and seeks to achieve the same goals. Therefore, if a patient is seeking a supportive relationship with a doctor, he/she may choose to pass on working with doctors who have a well-known no-nonsense approach to care. Likewise, patients who want to be involved in their treatment decision may look to form relationships with doctors who are known to prefer shared decision-making approaches to medicine. Once patients have found suitable doctors, they will strive to remain in their care, forming long lasting relationships and engaging in longitudinal care. Similarly, patients will look for doctors whose consultation skills match what they are looking for, leading to the formation of certain types of doctor-patient relationships depending on the initial priorities of the patients (Ridd et al., 2009).

The depth of the doctor-patient relationship is also shown to be dependent on the factors of longitudinal care and consultation experience. The study shows that having a positive consultation experience and engaging in longitudinal care leads to stronger doctor-patient relationships. These relationships are then characterized by elements of knowledge, trust, loyalty, and regard for one another, though context and individual factors also remain important (Ridd et al., 2009). All in all, although the study did not consider many alternative reasons for how different doctor-patient relationships are formed and maintained, it does succeed in providing at least one solid explanation.

Taken together, it is possible to see how patient sensemaking and identity construction processes are tied to the development and maintenance of doctor-patient relationships. Process of identity construction and sensemaking have the potential to impact doctor-patient relationships and communication. Such processes, if not completed or engaged in by patients, have the prospect to hinder the ability of doctors to achieve certain goals of communication. Similarly, how the doctor-patient relationship is formed and maintained depends on certain factors which may be subject to influence by patient's choices. The type of relationship that is then formed is likewise dependent on these factors. All in all, patient sensemaking and identity construction is tied to the doctor-patient relationship, with each process or outcome having the potential to impact how another process is conducted.

CONCLUSION:

In conclusion, the medical field is fraught with complexities. However, those doctors and patients who are required to navigate the intricacies of cancer are subjected to especially complex conditions. For doctors, these difficulties arise in the form of ethical dilemmas and decision-making. Such ethical dilemmas form for a variety of reasons and tend to operate simultaneously, acting as a complication in the decision-making process of doctors. Furthermore, these dilemmas may stem from the same origin, making it difficult to distinguish between multiple conflicts when they occur and compounding the confusion doctor's experience as they attempt to resolve these conflicts. Fortunately, there is a model for decision-making which doctors can follow in order to resolve these dilemmas and navigate the conflicts when and if they occur.

Doctors often react to ethical dilemmas by engaging in certain strategies aimed at resolving or preventing the conflicts as they occur. The decision-making model that is most often employed by doctors when treating cancer patients is a five step process. The steps are: (1) contemplation and identification of issues, (2) presentation of options and clarifying of values, (3) patient decision and clarifying of information, (4) application of treatment to patient, and (5) response to treatment and evaluation of outcome. These steps enable doctors to acknowledge ethical dilemmas as they occur and provide them with a method of resolving the conflicts that they face when trying to make ethical decisions about patient treatment and care. More importantly, it is a decision-making process which aids doctors in their quest to overcome ethical challenges. It helps doctors to incorporate notions of ethics into their decision-making by eliminating confounding variables and simplifying the process, enabling doctors to make more appropriate ethical decisions when treating patients. Although it is not always easy to see how doctors make decisions about treatment for cancer patients, this model provides insight into the decisions-making process of doctors.

However, doctors are not the only ones impacted by their decisions, as patients are likewise effected. More specifically, the sensemaking practices and identity construction of cancer patients has the potential to be impacted by the decision-making of doctors. This potential is significant because the sensemaking and identity construction of patients enables them to make sense of and deal with their illness. The three stages of sensemaking help patients manage the distress they feel as a result of cancer diagnoses, enabling them to adapt to their new lives and overcome the challenges they face by providing greater awareness of their situation. Similarly, identity construction enables patients to accept their new roles as cancer patients. During identity development, patients question and redefine their roles, allowing them to

acknowledge their existing identities and come to understand how their identity impacts both their perspective of the world and their illness.

Such processes can be influenced by the decision-making of doctors as a result of the type of information provided by doctors. After all, patients' understanding of their diagnosis is partly formed as a result of the information provided by doctors, meaning that how and in what manner doctors provide information can significantly impact patients' experience of their illness. This means that the decisions which doctors make about how to interact and communicate with their patients has the potential to impact patients sensemaking and identity construction processes. However, it also has even greater implications; this means that doctors must create strategies for communicating with cancer patients just as they would create strategies for making decisions about patient treatment because both have a significant impact on patients' health.

Final Thoughts:

The studies analyzed in this paper provide insight into how doctors make decisions regarding patient treatment, and how those decisions then have the potential to impact patient sensemaking and identity construction. Furthermore, it shows how complex the process for making a medical decision is. Although there is a model which simplifies decision-making, there is no way to account for all of the confounding variables that may arise and so there is no method of permanently simplifying the decision-making process. Rather, doctors are given a set of loose guidelines which they are encouraged to follow and then left to do as they see fit. Yet this is inadequate preparation for doctors. There needs to be an alternative set of guidelines, ones that help doctors navigate ethical dilemmas and other such conflicts when or if they occur. Methods which teach doctors how to handle these conflicts and provide tips for resolution are needed if doctors are to be prepared to handle the complex cases presented to them by cancer patients.

In writing this paper, it also became apparent that there is a lack of scholarly research on how doctors' decisions impact the sensemaking and identity construction of cancer patients. Although there are reports on these topics, there hardly seems to be an adequate number of studies given the important implications they entail. However, while this means that more research is needed, I do not want to imply that there is a shortage of knowledge available. I merely mean to say that more focus should be placed on how doctors make ethical decisions given the conflicts they must face. Given the many research foci I found, it almost appears as if people are more interested in discussing the wrongful behavior of doctors then they are with ensuring that doctors are able to act appropriately. This should not be the case. Doctors should be given research that helps them facilitate the sensemaking and identity construction of patients, not research that chastises their decisions-making without providing useful understandings of patients or realistic alternatives to models of care.

It is my hope that my research will help doctors see the whole picture. Rather than focus on decision-making or another individual process, my paper hopes to provide a broader view. With this paper, I have sought to provide doctors with an understanding of how they can make ethical decisions given the complexity of their cases and the emotionally difficult nature of their work. More than that, I have also tried to strengthen their understanding that decisions have consequences which go beyond their immediate application. The costs of decisions are not just decided by how well a treatment does or does not work; decisions interact with and affect the sensemaking and identity construction of patients, as well. Moreover, these processes all work together to help form and maintain doctor-patient relationships, meaning that a patient's experience of cancer is almost entirely dictated by these processes and their corresponding outcomes.

Even more important is that the studies reviewed in this paper show that processes of decision-making, sensemaking, and identity construction have the potential to impact patient health outcomes. This means that the life of a cancer patient may very well be decided by how well these processes are understood and enacted. For example, Street, Makoul, Arora, and Epstein explained that communication has the potential to heal, leading to better health outcomes and quality of life in patients (2009). This is because doctors' decisions about communication create the environment through which patients experience cancer. This environment may be one that encourages the formation of a strong doctor-patient relationship and so protects the hope of patients, leading to improved patient care, health outcomes, and quality of life. It may also be one which treats patient consultation as a financial means to an end and ignores the opportunity for strong bonds with patients, leading to no additional health benefits for patients. Either way, it is clear that the decisions doctors make about communication have impacts which extend beyond their initial communicative purpose.

Such an understanding, that decisions have resounding consequences and that these decisions can be made easier with an increased understanding of how certain processes work, may be valuable to both doctors and patients. For one, understanding how ethical dilemmas occur and how to resolve them can make doctor-patient interactions easier (Smith & Bodurtha, 1995). This can result in simplified decision-making because it removes additional conflict which stems from difficult doctor-patient relationships and communication. Additionally, combining these studies in a single analysis provides an understanding of both sides of the story, both of how doctors make their decisions and how patients are involved in and affected by those decisions. This allows for a better understanding of how doctors and patients are reliant on one

another, showing that doctors and patients must work to understand one another's perspective and motivation if they are to achieve the best possible health outcome and patient care.

Having said this, I would like to discuss some future directions for research. In particular, I would like to express my belief that there is a need to examine how doctors and patients are co-dependent on one another. Though paternalistic medical practices see doctors as responsible for patients and in control of patient treatment, this is not necessarily the case. Shared decision-making is becoming increasingly popular within the medical field, showing that doctors and patients can work together in order to achieve a more favorable health outcome. It also shows that doctors are becoming increasingly dependent on patients to collaborate during the decision-making process. After all, doctors need to understand what patients desire and hope to accomplish if they are to meet expectations of care. This means that doctors depend on patients for information just as patients depend on doctors to provide knowledge about their diagnosis and treatment options.

Therefore, there needs to be research that investigates how doctors and patients are co-dependent. Are there processes or standards that encourage this interdependence, and if so what are they? How can doctors and patients better manage their own responsibilities and their responsibilities to each other? Does this balance of responsibilities merely complicate doctor-patient interactions unnecessarily? Is this balance even possible? These are all questions which require answers. In addition, there also needs to be research into how ethical dilemmas impact patients, not just doctors. The majority of research looks at how doctors navigate conflict, but there are few studies that examine how patients are impacted by the existence of these dilemmas or how they react when they occur. If doctors and patients influence one another and rely on one

another for cooperation in order to achieve their goals, then patients inevitably face ethical dilemma as well.

All in all, given my personal experiences with cancer and its impact on my family, I feel a great deal of relief after conducting this research. It is now clear to me that the majority of doctors do the best they can with what they are given and genuinely seek to help cancer patients. Although some doctors may not be as adept at dealing with ethical dilemmas or may make the wrong choice when deciding on patient treatment, this is not because they do not strive to make ethical decisions or provide quality care. Rather, it is because their models for navigating the decision-making process are fraught with ambiguity and complicated by external factors beyond their control. In the end, doctors and patients are trying their best to create a positive result (of patient survival) from a negative situation (a cancer diagnosis) and, while this is not easily accomplished, it is possible given the proper tools.

Looking at the big picture, it is possible to see how ethical dilemmas, doctor decision-making, patient sensemaking and identity construction are all inter-connected. These processes are all complex in their own right, involving multiple steps and various consequences. However, using research from different studies, it is also possible to see themes which emerge and lead to the creation of models that simplify understandings of these processes. Altogether, an understanding of ethical dilemmas is necessary in order to understand how doctors make ethical dilemmas regarding patient treatment and care. Once this understanding is achieved, it is then possible to understand how doctor decision-making has the potential to impact patient sensemaking and identity construction.

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