non-religious person may still therefore have a deep spirituality and spiritual needs. Spiritual care is not just the facilitation of an appropriate ritual but engaging with an individual's search for existential meaning, as reflected in the existential domain of the McGill quality of life questionnaire.⁹

Variables such as religious practice often seem easier to measure. Where participants for research have drawn from communities where religious practice is at high levels, these studies have shown that participating actively in the life of the faith community seems to lead to better health profiles. Religion also strengthens people's ability to cope with life threatening disease,^{3 6 10} and its importance in predicting aspects of psychosocial need in patients with cancer has been reported.¹ These studies are examining religious affiliation and behaviour even though some of them talk about spirituality.

Recently researchers have begun to look at populations that may not be religious but claim to have a clear spiritual belief. King et al reported that 71% of people who entered their acute hospital study had an important spiritual belief, even though many did not express that in a religious way.⁸ Other studies confirm this proportion and are beginning to show the importance of spiritual belief in predicting clinical outcome,⁸ the management of death distress,¹¹ end of life despair,² and assessing quality of life in oncology patients.^{9 12}

Evidence is growing that spiritual belief and religious practice are important predictive factors for a larger proportion of people entering health care than previously thought. Many may benefit from support for this aspect of their life. A need exists for user friendly and brief measures to assess spiritual need in the absence of religious faith, so that it may be addressed properly rather than as some general panacea which is assumed to be good but is not individually tailored. Only in this way may we "ensure that the spiritual elements of disease are taken into account," as recommended in the guidance from NICE.

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Key words and phrases in spirituality literature

Meaning—making sense of life situations; deriving purpose from existence

Existential—searching for personal meaning within one's life, death, and concerns about freedom and isolation

Value—cherished beliefs and standards of, for example, truth, beauty, behaviour, or thoughts

Transcendence—appreciation of dimension beyond self; creating ability to rise above "here and now" experience

Connecting—relationships and communication with self, others, environment, higher power, the sacred

Becoming—links to identity, personal growth, through reflection on life experience

Coping—means of using or developing strategies in critical life events; achieving inner peace

Spirituality—the search for existential or ultimate meaning within a life experience, such as illness. (This belief usually refers to a power other than the self, which people may or may not describe as God, higher power, or forces within nature, and with which they communicate. The power helps the person to transcend the here and now, re-establish hope and the ability to cope)

Religion—is an expression of spiritual belief through a framework of rituals, codes, and practices; the sense of otherness or a power being a deity or supreme being

Philosophical—relates to the same searching, but with a rejection of any influential power external to the self

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New treatments for colon cancer

Though experimental, they may herald a new era of cancer therapy

Until the early 1990s the medical treatment of colorectal cancer represented a therapeutic desert with little or no progress. Since then we have witnessed the establishment of effective adjuvant chemotherapy and the treatment of advanced disease has improved substantially. In the past year colorectal cancer has been at the cutting edge of new developments in medical oncology. Although some of these new treatments are still experimental and not yet standard practice, they are worth flagging up at this

preliminary stage because the proof of principle they have established may herald a change in the way all cancer is treated in future.

Fluorouracil has represented the cornerstone of medical treatment of colorectal cancer for nearly 40 years, but it took until 1990 to show that adjuvant

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Additional references w1-w4 are on bmj.com

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chemotherapy with fluorouracil with levamisole improved disease free and overall survival in Dukes's C (stage III) colon cancer.^{1 w1} Subsequent studies have shown that fluorouracil with folinic acid confers similar benefit but is less toxic and takes six months of treatment rather than a year.^{2 3 w2} This treatment improves absolute survival by an average of 5-10% at five years, which represents a 25-35% reduction in mortality and has now become standard practice. The data on the role of adjuvant chemotherapy for patients with Dukes's B (stage II) disease have been inconsistent, but a recent UK randomised trial in nearly 3000 patients with Dukes's B colorectal cancer has now convincingly shown a small (3%) but significant ($P=0.02$) absolute survival benefit in this group of patients.^{2 3 w2}

Until recently the treatment of advanced disease was disappointing, with fluorouracil and folinic acid yielding response rates of 10-25% with little effect on survival. Several phase III trials have now shown that adding irinotecan or oxaliplatin doubles the response rates to around 50% and increases progression free survival.^{4 5} Irinotecan also increases median overall survival by about three months,⁶ which, although modest, is often of interest to patients with advanced cancer.⁷ A similar survival benefit for oxaliplatin is likely to emerge from current phase III trials.^{w3}

Oxaliplatin has also been shown to downsize liver metastases, to enable potentially curative resection to be performed in several patients whose tumour would previously have been considered inoperable.⁸ The survival rates of 34% at five years and 20% at 10 years of patients undergoing resection after neoadjuvant (given before surgery) chemotherapy with fluorouracil, folinic acid, and oxaliplatin for liver metastases that were originally considered inoperable are similar to those of patients undergoing primary resection.⁸

Thirty years ago Folkman proposed that new blood vessel formation (angiogenesis) was important for cancer growth,⁹ but until now inhibition of angiogenesis has not been shown to be of clinical benefit in solid tumours. A large phase III trial in patients with untreated metastatic colorectal cancer looking at the addition of an anti-VEGF (vascular endothelial growth factor) monoclonal antibody—bevacizumab—to fluorouracil, folinic acid, and irinotecan has recently shown an increase in response rate and progression-free survival.¹⁰ Most importantly it also showed a five month median prolongation of overall survival. As a result of this study bevacizumab has recently been licensed by the US Food and Drug Administration for first line treatment of metastatic colon cancer. This heralds a new era in cancer treatment, not just for colorectal cancer. Median survivals of over 20 months in patients with metastatic colorectal cancer were unheard of just a few years ago and are now within our grasp.

Cituximab, a new antibody to the epidermal growth factor receptor (EGFR) expressed in around 80% of colorectal cancers, has activity and little toxicity in colon cancers that are resistant to chemotherapy, both as a single agent and in combination with chemotherapy.¹¹ This is of modest but real benefit in about 20% of patients with advanced colorectal cancer. Cituximab has been licensed in Switzerland and the US and been recommended for approval by the scientific advisory body of the European Union.

New treatments in advanced disease will often have a much greater effect on survival if used as adjuvant treatment for earlier stages of disease.^{w4} The adjuvant trials looking at the addition of oxaliplatin or irinotecan to fluorouracil and folinic acid have therefore been awaited with great interest.

The Mosaic adjuvant chemotherapy trial has recently been published.¹² This large, international, phase III study recruited 2246 patients with Dukes's B (stage II) and Dukes's C (stage III) colon cancer. The trial looked at the addition of oxaliplatin to standard postoperative adjuvant chemotherapy with fluorouracil and folinic acid and showed that adding oxaliplatin resulted in a reduction in relapse rates of 23% ($P=0.0002$). The increase in disease-free survival was also significant ($P=0.002$). With only three years' follow up it is too early for this to have been translated into a survival advantage, but three year, disease free survival has been shown to be a good predictor of five year overall survival in trials of adjuvant treatment of colon cancer.¹³ If the outcome is confirmed this regimen offers the opportunity of nearly doubling the benefit of adjuvant fluorouracil and folinic acid in colon cancer and will save many thousands of lives.

Several phase III trials are currently ongoing to assess the potential benefit of combining irinotecan with fluorouracil and folinic acid in the adjuvant setting. The use of anti-vascular endothelial growth factor antibodies and of cituximab in combination with adjuvant chemotherapy will now be explored in the adjuvant setting and holds out the promise of further incremental benefits. This has been a remarkable year for colorectal cancer, with new treatments likely to be available for patients with early disease as well as those with advanced disease in the near future. The problem the NHS will have to face is how to pay for them, as undoubtedly they will not be cheap.

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Getting ethics into practice

Clinicians need to be able to analyse and justify their day to day value judgments

In their day to day practice, clinicians make not only scientific judgments about the effectiveness of one intervention in comparison with another but also value judgments. Sometimes such judgments are explicit—for example, when a doctor reflects on his or her own moral views about the permissibility of abortion. In most cases, however, value judgments in medical practice are implicit in what seem, at first glance, to be “clinical” decisions.

Thus doctors may not think of themselves as making value judgments when, for example, considering what would be in an incompetent patient's best interests, weighing up whether harm to a third party is serious enough to justify a breach of patient confidentiality, or assessing quality of life in intensive care. Yet these decisions do indeed entail the making of value judgments, as do others—such as those in priority settings. Good medical practice requires that such value judgments are properly analysed and assessed, just as scientific and technical evidence should be properly evaluated and evidence based. It requires too that, when asked, doctors can justify both the value judgments and the scientific judgments informing their practice. To do so, they need education, support, and guidance, as well as opportunities to share models of good ethical practice in discussion with their colleagues. This week the *BMJ* starts a new occasional series on “Ethics in practice,” which aims to describe cases in which value judgments are needed and to discuss the sort of ethical analysis that might underpin those judgments (p 165).¹

The belief that decision making in medicine has an important ethical component has been apparent for as long as medicine has been practised. Nevertheless, the ethical dimensions of practice have become more prominent recently, initially in the 1970s and 1980s in the United States and subsequently elsewhere, for several reasons.² Firstly, public attitudes to the professions have changed to a welcome willingness to require of professionals that their decisions are based on good reasons rather than simply tradition or authority. Secondly, technological developments such as organ transplantation, critical care, and assisted reproduction have created new ethical problems and intensified old ones. Thirdly, several high profile scandals in medicine, from Tuskegee (where prisoners were infected with syphilis and left untreated) to Alder Hey (where children's organs were retained after autopsies without the parents' consent), have led to increased scrutiny of medicine and to calls for health professionals and managers to justify their practice in ethical terms.

This increased awareness of the ethical dimension of medicine has led to three major developments: laws and guidelines designed to regulate medical practice in ethically sensitive areas, innovative forms of ethics support in clinical settings,³ and an increased emphasis on ethics in the medical curriculum.⁴ Although these developments are welcome, they are not enough.

Law and guidance can provide frameworks for good practice but cannot determine what is good practice in individual cases. Similarly, while providing important sources of education, case consultation, and policy development, clinical ethics committees cannot provide day to day ethics support in all clinical situations. In the United Kingdom the role of clinical ethics committees and the comparative merits of different forms of clinical ethics support are being considered by a Royal College of Physicians working party, due to report at the end of 2004. It is clear, however, that just as laws and professional guidelines need to be complemented by the development of appropriate skills and awareness in doctors themselves, so too will any form of ethics support. Doctors still need to be able to recognise the value judgments implicit in their practice, assess the merits of various competing courses of action, and be able to justify their decisions, at least in part, in ethical terms.

This shows that providing ethics teaching in medical schools is central to developing and maintaining good medical practice. Ethics is increasingly taught to all medical students, and textbooks covering the core topics in ethics have been developed.⁵ Many doctors currently practising will, however, have received little or no ethics education. This implies the need for continuing professional education in ethics. The *BMJ's* new series is aimed at contributing to that continuing education by helping practising health professionals think more deeply about the ethical aspects of their practice.

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