

Therapeutic Options and the Lack of Resources in Breast Cancer Patients: *Bioethical Controversies*

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At the time of writing, I am a surgical resident specializing in oncological surgery, working in an outpatient clinic affiliated with a public hospital in Mexico. It was in this context that I found myself faced with an ethical dilemma about what treatment options to offer patients with breast cancer. When discussing treatment options, should patients be offered hard-to-access or prohibitively expensive options?

In this clinic and its hospital, we see a high volume of patients (approximately 28 patients per day). Approximately 47% of patients have a breast cancer diagnosis.¹ A group of these patients, diagnosed in the early stages of cancer progression, has two therapeutic options: (1) surgery that conserves some breast tissue plus radiation therapy (“conservative surgery”) and (2) surgical mastectomy without radiation therapy post-operation (“radical surgery”). Both options offer a roughly equal chance of healing. It is important to note that after conservative surgery the patient has a maximum period of 8 weeks within which to receive radiotherapy.² If radiation therapy is not completed, the chance of cancer recurrence is high.

While we can perform the conservative surgery, radiotherapy is not available at our affiliated public hospital. Patients must be sent to a hospital in another state about an hour from their homes. Due to the high volume of patients sent to this other institution for radiotherapy, the wait times are long. Approximately 80% of the patients sent for radiotherapy end up not receiving the treatment within the recommended time frame.

In light of this background, I was faced with the following dilemma: Propose to eligible patients the two therapeutic options or to omit the first (conservative surgery plus radiotherapy in another hospital). Since it is difficult to access and costly, it is highly likely that patients will not get radiotherapy in time and thus, are more likely to suffer a recurrence of the cancer. By offering only the second option (radical surgery without radiotherapy), on the other hand, I would prevent them from opting for the surgically conserva-

tive option but ensure a good prognosis.

Cases like this made me wonder if a doctor should always tell the whole truth, even if this has the consequence of offering a therapeutic option that, if chosen by the patient, is highly likely to result in a worse prognosis due to lack of timely access. In other words, is it right to “protect” patients by omitting an inaccessible therapeutic option? Fundamentally, this is a question about the requirements of informed consent. What information does a patient need to make an informed, autonomous decision about breast cancer therapy? According to the Official Mexican Standard 004-SSA3-2012 on the informed consent process, each patient must be explained her therapeutic options, their risks, benefits and possible complications, culminating in the signature of a document. In view of these requirements, am I justified in omitting a therapeutic option that I believe will be inaccessible to the patient?

The Reality of Cancer Patients in Mexico

Cases such as the one described represent a real situation experienced in the various public health services in various parts of the world: The availability of resources limits doctors’ and patients’ options. Poor or low-income patients, rendered vulnerable due to their sociocultural condition and their physical condition as cancer patients, will be the most impacted by this situation.

The reality of cancer patients in Mexico is complex and inequitable. According to a study I conducted with colleagues in 2022, in the oncological surgery outpatient clinic of all the main Public Institutions in Saltillo, 48.7% of patients had breast cancer. Patients had an average of three medical consultations to make the final decision on their treatment. According to the study, 49.8% of patients make the decision to treat them solely based on the information received by the doctor, 39% based on personal reflection, and 11.2% based on discussion with their family members.³ Breast cancer patients are in a grieving process where it is more difficult to

make decisions and it usually requires several consultations to make a well-considered decision.⁴

For surgical oncologists, a workday with 28 consultations for five hours is equivalent to 10 minutes of consultation per patient; that is, conducting an interview, physical examination, review of studies, request for studies, delivery of prescriptions, and sometimes an informed consent process, all in 10 minutes. Doctors are obligated to promote health for the physical and mental well-being of patients by providing efficient, humanistic, and professional care; however, poor working conditions sometimes do not allow the doctor to meet these demands in the best way. In addition, doctors sometimes have limited access to the best diagnostic studies and treatments. Thus, prioritizing resources—including the time allocated to each patient—is unavoidable.⁵

In light of these challenges, clinicians need to think about ways to make patient care more efficient. For example, you might try to avoid conversations that are time-consuming with a lot of explanations or that can be complicated for patients. However, this may be contrary to the norms of respect for the patient's autonomy. It should be noted that in the past, doctors made decisions without consulting patients in what is often referred to as "medical paternalism." Since the 1950s, however, in the face of the recognition of patients' rights, respect for autonomy has been recognized as vitally important. A patient who has an adequate informed consent process with options, risks, benefits, and possible complications, who receives complete information, resolves their doubts, talks with their relatives, and makes the decision of their treatment adheres better to treatment plans and has better results.⁶

Communication Scenarios on Therapeutic Options in Breast Cancer

Faced with a case like the one just described, there are several options to communicate with patients who must decide on the treatment for their breast cancer. We can distinguish at least three scenarios or options: (1) telling the whole truth, (2) omitting information, and (3) a deception or outright lie. In what follows, I discuss these three alternatives and argue that the first is the most ethically appropriate.

Scenario 1: Tell the Truth

In the first scenario, I tell the whole truth and explain to the patient all the therapeutic possibilities. This includes the surgically conservative, though inaccessible, option, and the more radical but locally accessible option.

This scenario merits reflection. Health sciences are characterized by uncertainty, where forecasts are probabilistic with a margin of error. So, today's truth will not be tomorrow's truth. It is necessary to understand, respect, and accompany patients without causing them further distress, without taking away hope, and without violating compassion.⁷ In this case, population-level statistics on access to

treatment, cancer recurrence, and therapeutic outcomes do not always apply to the individual case. This can be difficult to consider and communicate. My patient may be in the 20% who can access radiation therapy in time, or they may be one of the people who has a radical mastectomy and yet gets cancer again. I can't know in advance, and neither can my patient. We are always in conditions of uncertainty. Telling the whole truth requires the doctor to also communicate the uncertainties of the case.

Telling the truth also requires paying attention to how to present therapeutic options, because the way you communicate influences patients' choices. There are several ways to convey the truth, such as the order and emphasis with which the information is presented. An alliance must be achieved with the patient, seeking to understand her values, experiences, and expectations, provide evidence, verify understanding, and reach an agreement. In short, the way the truth is told may have implications for the patient's decision.^{8,9}

In this case, knowing all the options would permit my patient to opt for the most conservative but potentially inaccessible treatment, with the consequent higher risk of suffering a recurrence, so she must be properly informed. If a patient chooses that option, she must accept the risk, and the responsibility for recurrence would not fall on me as a surgeon. However, as a surgeon, I am affected by the patient's decision as well, because I'll be the one who will have to inform her that the cancer has returned, if that method fails. Communicating bad news—and anticipating the communication of bad news—is a stressful situation for the doctor. The communication skills to give this type of information are little-taught in the Faculty of Medicine. According to a study, 20% of oncologists report having anxiety and expressing strong emotions. 42% of other physicians report that the stress of bad news lasts for hours, even three or more days.¹⁰ It's understandable that a doctor would want to avoid that situation.

Scenario 2: Omit Information

In the second scenario, I omit information about conservative surgery, without presenting it as a therapeutic option. This is done with the intention of protecting the patient, since if she has opted for that option and if she does not receive radiotherapy, she has an 80% chance of relapsing the cancer. Instead, I would only offer a radical procedure, removing the breast completely rendering it cancer-free.

In this scenario, the omission could be justified if the patient expresses that she does not want to know the information or wants others to decide. In this way, she autonomously decides to cede decision-making authority to others. But this situation seems unlikely, and the most common situation is where the patient wants to be involved in decisions about her treatment.

From a surgeon's perspective, omission may be inten-

tional or unintentional, meaning that omission can be a result of forgetfulness or ignorance rather than hiding information. In this case, the oldest treatment is radical mastectomy, and if the surgeon or I were not aware of the conservative treatment, by not informing the patient of that option we would be making an unintentional omission. But it would be difficult for this to happen since conservative surgery plus radiotherapy is a treatment that has been scientifically proven for years.

If it is decided to go the route of omitting information, it may happen that the patient or family member asks if they have other options. In this case, if the surgeon and the resident know that there is, we would be faced with a third scenario: deception.

Scenario 3: Deception

In the third scenario, the patient is lied to by telling her that there is only one therapeutic option, that of radical mastectomy without radiotherapy. As in the previous option, the intention here is to protect the patient, since if conservative surgery is performed without radiotherapy there is a recurrence of 80%, while the radical procedure that consists of removing the breast completely allows the patient to be left cancer-free.

That option is attractive for efficiency reasons as it completely avoids getting into conversations about how to access the more conservative surgical option and potentially confusing radiation therapy and statistics. It would also mean that patients would definitely seek a highly effective cancer treatment (mastectomy).

Analyzing the scenarios

There are situations in which it would be justified to carry out clinical deception, based on a commitment to beneficence and/or respect for the autonomy of patients. Clinical deception could be justified, for example, by appealing to the avoidance of physical or psychological harm, or when the patient does not have the emotional or cognitive capacity to make decisions. Another example may be preventing great potential distress to a patient who is terminally ill without curative treatment, when the patient's primary caregiver agrees. Alternatively, there may be cases when the use of deception will improve autonomy, as the case of a patient who, after administering a treatment, has restored cognitive abilities to be able to make decisions. The magnitude and proportion of the good provided and the harm avoided must be assessed.

Assessing whether clinical deception can be justified involves assessing three aspects of the situation: the content of the deception, the duration of this act, and who will participate. In this case, it would be a deception of omitting a long-term therapeutic option that involves the surgical oncologist.¹¹ In nearly all cases, patients are competent to make decisions.

In the present case, lying, that is, claiming that radical surgery is the only therapeutic option, will radically change the woman's life since she will not be able to decide on the therapy that her body will receive, and the therapy itself transforms her body. Although my anguish about the cancer-free period is real, I have a duty to report the truth and accompany the patients, respecting the decision they make.

Let's now go to the case of omitting the option of conservative surgery, which also leads the patient to undergo a radical treatment that maximizes a good outcome from the perspective of being cancer-free, but omits considerations such as function and aesthetics that go into weighing multiple treatment options. Like the case of lying, among the possible consequences of moving ahead with a mastectomy for patients are psychological ones due to aesthetics and sexuality, as well as losing trust in the doctor if or when they learn that they had other options. However, significant physical damage is avoided if the cancer returns. For the patient, this medical decision is of utmost importance, deciding to preserve their breast or have it completely removed, and balancing aesthetics and sexual function with the goal of being cancer-free. The effects of the decision are lifelong. Placing these factors on the scale, it is better to offer all the options to the patient, indicating the reality of her situation so that she can make the decision about her body.

Wanting the best for my patients is consistent with letting them decide. The anguish of having a patient with a recurrence clouded my judgment. At first, I thought it was right to omit or deceive the patient for their good by acting in a paternalistic way. Historically, this system was used in the past, but we have good reason to believe today it is better to make a joint decision with the patient. According to the principle of autonomy, the physician has the obligation to explain all therapeutic options and empower the patient in his or her decision-making. That is done in the informed consent process.

In short, telling the truth helps to maintain the patient's trust and respects her autonomy, so in principle, it should be an obligation for the doctor. This has the advantage of safeguarding trust, a precious resource that when lost is difficult to recover.¹² Autonomy is respected when a competent patient has all the necessary information to make a decision. Informed patients adhere better to treatment, participate actively, and make better decisions.

Conclusion

Surgical oncologists train to remove cancer and save lives. When you're training, you still have the drive, the motivation, and the feelings to save all the patients. But I can't make decisions for my patients. I must learn to accompany the decisions they make after I have provided them with all the information: about their options, risks, benefits, and possible complications. I must accompany without increasing the damage, without taking away hope, without generat-

ing false expectations, or violating compassion. Learning to accept the patient's decision when it doesn't agree with what I would do is difficult. We must be convinced that the right thing to do is to accompany our patients. In conclusion, to tell the truth, is to respect autonomy. It is not right to "protect" patients by omitting a therapeutic option, let alone by deceiving them.

Works Cited

1. P. Frigerio, et al., "Consideraciones éticas en paciente quirúrgico oncológico en Coahuila de Zaragoza," *Anuario Colombiano de Ética* 3 (2022): 10–22.
2. W.J. Gradishar, et al., "Breast Cancer Guideline," *Journal of the Royal Society of Medicine* (2023).
3. P. Frigerio, et al., "Consideraciones éticas en paciente quirúrgico oncológico en Coahuila de Zaragoza," *Anuario Colombiano de Ética* 3 (2022): 10–22.
4. J. Moral de la Rubia & M. Miaja Ávila, "Empirical Contrast of the Kübler-Ross Five-Phase Model of Grief in Women With Cancer," *Psychological Thinking* 13, no. 1 (2015): <https://doi.org/10.11144/javerianacali.ppsi13-1.cemc>.
5. I. N. Abbasi, "Protest of Doctors: A Basic Human Right or an Ethical Dilemma," *BMC Medical Ethics* 15, no. 1 (2014):

1–5. <https://doi.org/10.1186/1472-6939-15-24>.

6. D. Wendler, "Are Physicians Obligated Always to Act in the Patient's Best Interests?," *Journal of Medical Ethics* 36, no. 2 (2010): 66–70. <https://doi.org/10.1136/jme.2009.033001>.
7. S. Haack, "Todo la verdad y nada mas que la verdad," *Doxa. Cuadernos de Filosofía Del Derecho*, no. 35 (2012): 571. <https://doi.org/10.14198/doxa2012.35.25>.
8. R.M. Epstein, et al., "Communicating Evidence for Participatory Decision Making," *Journal of the American Medical Association* 291, no. 19 (2004): 2359–66. https://doi.org/10.1007/978-3-319-17530-0_1
9. D.J. Malenka, et al., "The Framing Effect of Relative and Absolute Risk," *Journal of General Internal Medicine* 8, no. 10 (1993): 543–48. <https://doi.org/10.1007/BF02599636>.
10. S. Haack, "Todo la verdad y nada mas que la verdad," *Doxa. Cuadernos de Filosofía Del Derecho*, no. 35 (2012): 571–587. <https://doi.org/10.14198/doxa2012.35.25>.
11. A. Brummett & E. K. Salter, "Mapping the Moral Terrain of Clinical Deception," *Hastings Center Report* 53, no. 1 (2023): 17–25. <https://doi.org/10.1002/hast.1454>.
12. S. Bok, *Lying: Moral Choice in Public and Private Life* (Pantheon Books, 1978).

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