Informing Cancer Patients of Diagnosis and Treatment Options

To the Editor: Spanish Law 41/2002 of November 14, 2002,[1] regulating patient autonomy and rights and obligations in matters of health documentation and reports, updated the legal and ethical standards regarding information for patients. The information and decision-making process in the health care setting is founded on a person's right to decide on issues concerning his or her own health. Based on their own values and personal objectives, patients have the right to accept or reject health care interventions. If patients have the right to know the risks and decide with their physician on health matters, physicians need to develop a new perspective on patients' competence to make responsible decisions. They also need to attain new skills relevant to that changed perspective. If we exercise the principle of autonomy for cancer patients as well, this assumes that most patients are capable of accepting, understanding and, consequently, rejecting a diagnostic test or treatment. In the Spanish health care profession, however, many practitioners still consider it unwise to have patients be privy to the medical information generated in the course of treatment, either because such physicians believe patients are incapable of understanding the complexity of procedures or because they consider such understanding unnecessary—or even counterproductive—to achieving the final objective, which is curing the disease or alleviating its effect. Nevertheless, patients' confidence in physicians' ethics and professionalism can only be reciprocated by considering patients as adults, autonomous individuals responsible for their actions according to their own values, which may not coincide with those of the physician.[2] Cancer patients' needs are not only technical; they also have to do with understanding their new problem and learning how to cope with it. Such holistic learning should be facilitated by communication between the patient and physician. Information is important in this process since, from the moment a diagnosis of cancer is established, a patient's life project takes a radical turn; everything is set in abeyance owing to a new all-pervasive conditioning factor, and each individual's ability to assimilate such news will depend on education, culture, emotional intelligence, personality, beliefs, and values. Accordingly, personalized attention is essential since each patient needs his or her own space and time. Providing information should be thought of not as an isolated clinical act but as a process in which the patient needs to come to terms with the information at each step. According to Broggi,[3] "the patient does not want merciful lies but merciful ways to approach the truth." The need to know the truth is not the same in all people—or even in the same person at different moments—and a patient needs to have his or her unique personality respected and possible irrationality and fear tolerated. Health care professionals need communication skills and insight to sense in each case how much the patient wants to know and at what moment, when to simply be with the person and when to speak. We need to read the meaning of gestures and silences—all to avoid imposition of a cruel truth, our own values, or even our own fears. Open communication among members of health care teams is to be encouraged, but this is not incompatible with choosing one member to coordinate the process of providing information.

Obviously, good information-giving processes require appropriate and, if possible, comforting environments, and above all enough time to talk. Information is also a variable in the ethical quality of patient-physician relations, and those in charge of medical centers should keep in mind that quality cancer care requires a certain minimum amount of time and this must not be questioned.

In Spain, the family is an important agent, one that often claims real informed consent for itself and that can occasionally deny it to the actual patient. What is easiest for physicians is to cooperate with the family that is playing out this role; however, in doing so physicians deny the patient the right of privacy and information concerning health, prognosis, and vulnerability—even while everyone else around is cognizant. The family must be made to see that it is the patient who is the central receiver of information even though informing the family, with the permission of the patient, must also be done at the right pace and time, to the right degree and in the proper manner.

For cancer patients the integration of the disease into their lives is of prime importance. Therefore, it is insufficient for professionals to merely avoid negligence: they must also assume the unavoidable obligation of promoting beneficence—that is, what patients consider best for themselves according to their own values. This is the meaning of excellence in caregiving today: respect for patients' rights joined to the search for what is right, all within the context of patient autonomy.[4]

Lucía Pantoja Zarza[a]
and Juan Ortiz de Saracho y Bobo[b]

[a]Comité de Ética Asistencial, Hospital El Bierzo, Ponferrada, León, Spain
[b]Sección de Neumología, Hospital El Bierzo, Ponferrada, León, Spain

1. Ley 41/2002, de 14 noviembre, básica reguladora de la autonomía del paciente y de derechos y obligaciones en materia de información y documentación clínica. BOE n.º 274, de 15 de noviembre de 2002. p. 40126-32.
2. Soriguer Escofet FJ. Cuando el médico decide por el paciente. In: Couceiro A, editor. Bioética para clínicos. Madrid: Triacastela; 1999. p. 127-32.
3. Broggi MA. Algunas proposiciones sobre el proceso de la información clínica y el consentimiento informado. In: Couceiro A, editor. Bioética para clínicos. Madrid: Triacastela; 1999. p. 145-50.
4. Couceiro A. Ética profesional y cuidados paliativos: en busca de la excelencia. In: Couceiro A, editor. Ética en cuidados paliativos. Madrid: Triacastela; 2004. p. 31-48.