CANCER THERAPY—THE PATIENT'S CHOICE?

Presidential Address

ARTHUR I. HOLLEB, MD*

DURING THE PAST THREE YEARS OR SO, articles in lay publications, primarily those magazines addressed to millions of women, have emphasized the right and privilege of patients to make the final decision regarding the type of treatment for their cancers.

The stimulus for these articles has come primarily from a relatively small group of physicians who propose that standard and generally accepted radical surgical procedures be discarded as outmoded, unnecessarily mutilating, and offering no greater benefit than simpler and less disfiguring operations. The focus of attention has been directed to the treatment of breast cancer and answering the question: to have, or not to have, a mastectomy.

It soon became evident to the press, and television and radio producers that a medical controversy existed which would be of considerable interest to health-oriented consumers—of which there are many in the United States.

At times, the media presented accurate factual information, correct clinical data, and fair descriptions of both sides of the question in an effort to educate their readers about breast cancer—the number one cancer killer of women.

At other times, this sensitive subject was handled with sensationalism, emotionalism, and an ethic presumably related to women's liberation. Surgeons advising mastectomy were depicted as sadomasochistic male chauvinists who apparently enjoy excising the female breast, depriving women of this symbol of femininity, while giving no thought to the psychological impact of mastectomy.

It was discouraging to find that so-called "definitive" articles on the role of mastectomy for the treatment of breast cancer consisted of short quotations from both proponents and antagonists, which created public confusion rather than edification. One manuscript, ready to go to press, told its readers that an alternative to surgery for operable breast cancer was present day chemotherapy—a statement which, if true, would certainly please us all, but one which is hardly an appropriate educational message for today. Unfortunately, coverage by other forms of media were also unsatisfactory at times; interviews and appearances on television or radio programs allowed little time for in-depth, unemotional discussion. Rather than stressing the need for earlier diagnosis and the discovery of minimal cancer, the controversy itself seemed to be of more interest than down-to-earth information on how to save lives.

The controversy was made more intense by presenting an image of surgeons as inflexible and unwilling to even remotely consider altering a standard procedure that has been done for so many years. Surgeons were accused of not taking sufficient time to discuss the purposes and goals of a proposed operation, of being too hasty in dismissing inquiries, too mechanical about admissions and discharges too oriented to routine handling of all patients without enough attention to individual needs. There was no mention that perhaps patients and their families do not always hear or comprehend what they are being told preoperatively by physicians.

In other words, the rumor is now circulating that physicians don't really know how best to treat breast cancer. If this is true, then most certainly patients will know even less. The confusion generated by this controversy has been even further compounded by advice to American women which states: "If your doctor advises a radical mastectomy, find another doctor!" or an admonition to family physicians to boycott the radically oriented surgeon, or advice which promotes lumpectomy (also referred to as partial mastectomy, tylectomy, and extended tylectomy) as the treatment of choice for women with small and peripherally located breast cancers. Unfortunately, such confusion has also extended to some parts of

Presented at the Twenty-Sixth Annual Meeting of The James Ewing Society, Louisville, Kentucky, April 26–28, 1973.

* Senior Vice President for Medical Affairs and Research, American Cancer Society, Inc., New York, N. Y.

Received for publication July 17, 1973.

the medical profession; it was recently reported at a conference on breast cancer that some physicians are excising breast cancers in their offices as though the lesions were sebaceous cysts.

How are we going to react to this controversy and confusion? I think physicians must always be flexible enough to change a standardized or long-accepted procedure, but also we must be reluctant to accept change for the sake of change itself, or change based on evidence which is scientifically inconclusive or yet to be proved superior to current techniques. We should encourage clinical investigation if initial results appear promising, but promptly discourage it if preliminary reports indicate a notable lack of value. We must bring the patient and selected members of the family into discussions concerning the treatment plan and give clear explanations of the proposed procedure, its value and its potential problems. We should be agreeable to other consultations if the patient desires, but we must also convince her that "shopping" for opinions may result in unwise delay. If alternatives exist for a particular patient, these too must be explained and discussed in terms which the patient can understand. This is the essence of informed consent.

But above all, we must remember that in the United States, 1 out of every 15 newborn girls will develop breast cancer; that 2 to 3 new cases of breast cancer are diagnosed every 17 minutes around the clock; and that one woman dies of breast cancer in the same 17 minutes. Current methods of treatment can now achieve significantly high cure rates, and as modern technology discovers the disease at earlier and earlier stages, the cure rates can be expected to improve even further. Therefore, we must be abolutely certain that an alternate choice of treatment for breast cancer will not reduce survival and become a retrogressive step.

The physician, with his knowledge of disease processes and his thorough evaluation of the patient's individual medical status, is best suited to decide which treatment offers the best chance of cure. Whether the informed patient accepts or rejects the physician's proposal—in the latter case also acknowledging that she may greatly reduce her period of survival or increase the chance of recurrence—is largely a matter of degree of confidence; the patient's confidence in the knowledge and skill of the physician. This is as it should be and probably as it will be for generations to come.