

# THE PATIENT WITH MALIGNANT LATEROCERVICAL ADENOPATHIES - AN ACTIVE OR A PASSIVE PARTICIPANT IN MEDICAL DECISION- MAKING?

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**Keywords:** malignant latero-cervical adenopathies, cancer, diagnosis, prognosis, active participant

**Abstract:** The diagnosis of laterocervical adenopathy leads to profound changes in the lives of both the patient and his/her family since adenopathy often represents a consequence of a malignant tumour, with or without genetic filiations. Every neoplastic process has a negative impact on the quality of life directly and indirectly, personally and socially and requires a complex approach to satisfy the personal and social needs of both the patient and his/her family so as to eventually obtain an improvement of the quality of life in the new conditions. The honest yet, at the same time wise communication of the diagnosis with all its implications, of the prognosis as well as of the therapeutic options, represents a key factor in the doctor - patient relation which contributes simultaneously to the achievement of the highest possible degree of conscious autonomy of the patient.(1,4)

**Cuvinte cheie:** adenopatii laterocervicale maligne, cancer, diagnostic, prognostic, participant activ

**Rezumat:** Diagnosticul de adenopatie laterocervicală aduce schimbări profunde în viața pacientului, dar și a familiei sale deoarece, frecvent, adenopatia reprezintă o consecință a unei tumori maligne, cu sau fără filiație genetică. Orice proces neoplazic are un impact negativ asupra calității vieții direct și indirect, personal și social și presupune o abordare complexă care să satisfacă nevoile bolnavului personale și sociale, dar și ale familiei sale, pentru ca în final să se obțină o îmbunătățire a calității vieții în noile condiții. Comunicarea onestă dar și înțeleaptă a diagnosticului cu toate implicațiile sale, a prognosticului și a opțiunilor terapeutice reprezintă un factor cheie al relației medic-pacient, care contribuie totodată la realizarea unui grad cât mai mare de autonomie conștientizată a pacientului.(1,4)

The diagnosis of primitive or secondary malignant laterocervical adenopathy is considered by most of the patients as a „fatality”, being historically associated with the verdict of death, a verdict which is difficult to receive and to accept, which gives rise to powerful emotional reactions and which becomes a painful existential trial, sometimes even a traumatic one, requiring complex adjustment from every point of view. The fatality of this diagnosis for Romania also derives from the current iterative context of the shortage of cancer medication, because the absence of this vital medication necessary to save or to prolong the lives of the patients actually deprives them of any hope, faith, or the chance to live. Moreover, what is even worse, is the constant rumour-spreading which creates catastrophic psychological premises. The absence of trust in the Romanian state, which although undertaking to provide access to free medication and treatment for patients with cancer, at the same time condemns them to the anticipated death by failing to fulfil its obligations, also contributes to strengthening the axiom „cancer means death”, in which many people already believe. The management of health care for patients with cancer continues to remain a controversial field in medical practice, a field dominated by numerous questions, answers, comments, ethical and moral conflicts. Oncology and especially oncological surgery are dominated by two trends, a paternalist one which cultivates the pious lies and another one insisting on the cruel „naked truth”, based on „sincerity”. Although some doctors recommend, as a way of overcoming communication barriers in the doctor-patient relation, to avoid the so-called partial truths by conveying complete messages and to reduce the emotional

distance (the effect can also be a reverse one), other doctors recommend to inform cautiously the oncological patient about the diagnosis, especially about the prognosis, because negative or positive expectations, which can encourage or depress a patient, help or condemn him/her, have a huge impact on the evolution of the disease ... sometimes suffering being more destructive than the disease itself.

„There are no guarantees in life, there are only hopes, risks and challenges”, and what „mobilizes the resources inside us are the hopes and not the certainties” (Petre Țuțea)

Our point of view involves the cultivation of „lucid hope”, a median, vectored attitude. The communication of the information regarding the prognosis should be done with certain reserves because we have to take into account the individual characteristics of every patient concerning the evolution of the disease and, why not, we should even take into account the possibility of the occurrence of spontaneous or scientifically unexplainable healing. Such a healing should not be regarded as a miracle, but as a possible evolution, since cancer is not always an irreversible, incurable process, with or without treatment. Specialty studies have shown that the spontaneous healing or complete remission of cancer occurs as a result of the stimulation of the immune system.(2) Such a stimulation can be achieved through the improvement of the quality of life, as well as a result of positive expectations regarding the evolution of the disease or by the unexplainable triggering of immune stimulation. It has been scientifically proved that positive and negative expectations have opposite effects on the concentration of cortisol and prolactin in the blood, two hormones which

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contribute to the activation of the immune system.(7) While expecting the occurrence of complete healing, hope can offer the patient personal motivations, in an inexplicable, spontaneous, uncontrollable manner, which determine him/her to change his/her lifestyle, such changes having the capacity to improve his/her health considerably. One can say that the refusal of hope is nothing else but making the decision to die. In general, the approach of the oncological patient should be done according to the geographic area with its local customs (see the wailers) where the patient is located and according to his/her social and professional level, and especially according to the general culture and medical knowledge of the patient, all these factors having an influence on the manner in which the information conveyed by the physician is perceived. Likewise, in the approach of the patient with malignant laterocervical adenopathies, the patient's type of reaction according to his/her psychological profile must also be taken into account, so that the great variations of the „recipient of medical information” require the constant adaptation of the doctor to the particular characteristics of the interlocutor. Therefore, the doctor-patient relation must have an interactive, dynamic character, whereas the packaging of the information may range from transparent and suggestive to semi-opaque.

The correct information, a natural right of the patient, is considerably influenced by the legal doctrine of informed consent, which requires the doctor to tell the truth about the disease to the patient and confers the patient the capacity of an active participant in therapeutic decision-making.(6) However, the manner in which this information is conveyed is very important, as this must not be conveyed brutally, but step-by-step in a succession supported by the previous statement. Informing the legally involved persons emotional, more or less sentimental has to be pervaded by realism and the sketching of a prognosis which should be as close as possible to the „likely” evolution. Most of the times communicating the diagnosis of cancer is extremely difficult for the doctor as well, since the manner of communicating such a diagnosis is vital for the subsequent evolution of the patient. In the management of the patient with malignant laterocervical adenopathies, respectively concerning the communication of unfavourable information to the patient, there are two main positions, each of them being based on sound arguments. In some cultures, the management of patients with cancer is performed entirely on the basis of informed consent, in order to observe the patient's autonomy by observing his/her values and decisions. The discussions with these patients contain information as complete as possible regarding the diagnosis and the prognosis of the disease, because in the absence of such information, the patient cannot be considered a fully active participant in the medical decision-making, contrary to the paternalist paradigm.(3) However, many doctors recommend a cautious approach towards the patient with cancer, an approach which does not fully observe his/her status as an active participant and which has as its objective the preservation of the patient's hope together with the regeneration of his/her will to live and to go on living.

The communication of the so-called partial truths or absolute truths represents a valuable psychoprophylactic and psychotherapeutic factor. By completely revealing the medical information, the doctor abdicates from his/her responsibilities. The patients expect their doctors to filter and to interpret the conveyed information. In addition to the duty of being honest with the patient, the doctor has the duty to provide reasonable hope for the patient with cancer.(3) Doctors must know how to offer and to nurture hope for the patients with cancer. However, we often reach the fragile boundary which separates the territory between formulating a realistic prognosis, in order to facilitate

making an informed decision, and attempting not to rob the patient of hope. This may prove to be a real challenge and an assumed risk. In order to maintain or even improve the quality of his/her life, the patient with cancer should benefit from a complex approach which supposes a combination between the standard treatment (surgical intervention, chemotherapy, radiotherapy, immunotherapy, hormonal therapy) and the complementary treatment (psychotherapy, nutrition, physical exercise, naturist treatments), an approach which should foster emotional and spiritual support, besides the improvement of the somatic symptoms. Empathy in communication is extremely important as well, because with its help the doctor can better understand the states the patient is going through and can encourage an open, free expression of such states.(5) The reserves in the „realist” communication with the patient which we recommend are based on the medical scientific limits concerning the evolution of cancer (spontaneous healing, unexplainable healing) as well as on the primary principle of medicine stated by Hippocrates „primum non nocere”, with the psycho-emotional peculiarities of every individual patient. The communication with the patient's next of kin (people having a legal status) is less cosmeticised in order to build a lucid, yet advised, partnership with the goal of establishing a stimulating atmosphere around the patient where filtered sincerity can find its place.

Medical progress, the performances in the field, the improvement in the statistics for the respective disease, the annihilation of the term „incurable” and the increase of the level of information represent the main adjustments of the transmission and reception of the partnership and of the evolution towards an overall balance of the stocks and investments within the framework of the moral contract between the patient and the physician. The delivery of „truth” in the doctor-patient communication always involves a thorough knowledge of the patient, such knowledge not being devoid of controversies. „Our life ... oscillates between two contradictions ... the duty to tell the truth and the necessity to hide it.” (Tudor Arghezi). Statistics, the expression of statistics, the Gaussian curve and their flaws require more prudence and the „wise” individualization of communication.

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