

Care Ethics: An Approach to the Ethical Dilemmas of Psycho-Oncology Practice

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SUMMARY

In a 1990 editorial in the *New England Journal of Medicine* about ethical imperialism in medical, the Editor, Dr. Marcia Angell, wrote that "Knowledge, although important, may be less important to a respectable society than the way it is obtained." Clinical practice is based on medical knowledge, which should always be taught in compliance with the ethical standards that have developed over time in response to the medical abuses that have been perpetrated throughout history. Furthermore, clinical activities involve a complex and emotionally laden relationship between two or more human beings who are deeply, but asymmetrically, engaged. Hence, clinical practice must constantly be held to high ethical standards in all areas: the physical, intellectual, psychological, and moral dimensions that coexist in human relationships.

Learning the basics of bioethics and the complexities of bedside ethical dilemmas must become a standard part of the expertise of psycho-oncologists. The aim of this chapter is, first, to offer a balanced and comprehensive review of the theoretical basis of bioethics, with special reference to care ethics, and to provide insight into the application of such principles in negotiating and solving the most common ethical dilemmas encountered in oncology practice. Second, the chapter analyses the role of cross-cultural differences in many bedside ethical problems. As cultural differences in disclosure of information to cancer patients are common, an in-depth discussion of truth telling serves to illustrate the influence of culture on ethical norms. Throughout the chapter, I reference clinical cases encountered in my own practice as a medical oncologist in the United States and in Italy to illustrate common difficulties in ethical deliberation. Some information has been modified to protect patients' confidentiality.

INTRODUCTION

The word "ethics" derives from ancient Greek, which could mean either "custom" or "character," and was used to refer to the appropriate norms of conduct in all aspects of life.¹ Ethics has always had a relevant role in medicine. The Hippocratic Oath of 420 BC, considered to be the first document of medical ethics in western cultures was based on the paternalistic role of physicians, who held center stage in the patient-doctor relationship, and swore not to harm their patients and to provide them beneficent care, according to their best judgement.² The next authoritative western document on medical ethics was the *Code of medical ethics* written by Sir Thomas Percival in 1803, which also considered professional conduct in hospitals.³ The American Medical Association published its first *Code of ethics* in 1847, subsequently revised it, and updates it regularly to meet the new challenges posed by rapid developments in modern medicine.⁴

In contrast with the Hippocratic tradition, modern western medicine has moved from a paternalistic to a participatory model, where patients and physicians share rights and responsibilities within the therapeutic relationship. Doctors must always strive to respect the patient's autonomy while they face the many ethical issues that may arise throughout the course of the patient's illness. The word "bioethics," from the Greek *bios* = life and *ethos* = ethics, was coined by the U.S. oncologist Potter in 1971, who applied it in a descriptive, naturalistic way to all ethical issues related to medicine and biotechnologies.⁵ Bioethics has since rapidly grown into a well-defined scholarly field, with many different theories and schools of thoughts. Bioethics is now integrated in most medical

curricula, and it is taught in dedicated courses for health professionals at all major medical schools worldwide.

New medical interventions have positively changed the fate of humankind through the rise of new biotechnologies and the expansion of diagnostic and therapeutic possibilities. However, they bring a greater moral responsibility regarding health-related matters, since biomedical interventions can also be inappropriate or create new problems at the ethical and social levels. Consider the example of genetic testing for cancer predisposition: on the one hand, it may enable members of high-risk families to find out whether they carry genetic mutations allowing them to engage, if they choose, in measures of prevention or early diagnosis. On the other hand, experts, patients, and the public have expressed concern about the value of cancer genetic testing, because of the potential for negative repercussions at the psychosocial and ethical levels.⁶ Mutation carriers, for example, may be subject to different forms of discrimination. A *BRCA* positive patient told me she was equally worried about passing onto her daughters the risk of cancer, and of their being exposed to discrimination because of her diagnosis. "With good laws, she said, my daughters may find great jobs, but they may still not be seen as ideal spouses or mothers." Until recently, many at-risk individuals have foregone genetic testing for cancer susceptibility to avoid potential discrimination. Most medical societies, including the American Society of Clinical Oncology, have therefore cautioned physicians and strongly advised them to inform all patients of the potentially negative psychological, social, and ethical implications of genetic testing, including the risk of genetic discrimination.⁷ In many countries, such as in the United States, where the Genetic Information Nondiscrimination Act (GINA) was approved by Congress on May 1st 2008, legislators have relied on the contributions of bioethicists to address the ethical issues raised by the new developments of genetics.⁸

Bioethics is, in fact, related to both medicine and the law, in its four main functions and scopes. First, in its analytic function, bioethics evaluates relevant innovations in medicine and biotechnologies with regard to the range of morally acceptable actions and of the possible constraints to such actions. Second, bioethics provides methodological and procedural guidelines to healthcare professionals: not necessarily offering predetermined solutions, but rather teaching ways to tackle different ethical issues in clinical practice. Third, in its pragmatic function, bioethics looks for practical solutions to bedside ethical dilemmas, taking into account the different perspectives of the involved parties. Fourth and finally, bioethics has an anticipatory function with regard to the directions that medicine may take: it explores and debates the potential moral and social consequences of new and developing medical interventions and technologies.

BIOETHICS AND THE PATIENT-DOCTOR RELATIONSHIP

In 1988, Drs. Pellegrino and Thomasma in their pivotal textbook of bioethics entitled *For the patient's good: The restoration of Trust in Medicine* assert that the philosophical foundations of bioethics are rooted in the nature of the patient-doctor relationship.⁹ The relationship is based on the fiduciary act that arises when a person in need—the patient—seeks the help of a fellow human being—the physician—who has specific medical knowledge and expertise. Patients and physicians establish a therapeutic alliance based on reciprocal obligations in view of a common therapeutic goal. Within their alliance, they trust each others as fellow human beings, with both reason and emotions, who are committed to the same healing purpose.

In opposition to the old paternalistic model, today we increasingly see the patient-doctor relationship in terms of a partnership based on patient's autonomy and right to share in decision making.^{9,10} The nature of this relationship, however, is not to be interpreted as a usual contract among peers, but rather a *covenant*—historically, a special form of contract that entails a moral obligation bound by reciprocal trust, despite the differing roles of those involved.⁹ The patient-doctor relationship is an asymmetric relationship of help. Asymmetry between patient and doctor has three main dimensions: the existential one, related to the different positions that patient and doctor have with respect to illness; the epistemic one, related to their different degrees of knowledge and expertise with regard to the patient's illness; and the social one, related to their respective roles within the relationship and with respect to society.¹¹ A power imbalance results from the asymmetry in the patient-doctor relationship, and reciprocity is born out of a special connection between nonequal partners.¹²

ETHICAL DELIBERATION IN CLINICAL MEDICINE AND THE ROLE OF PRINCIPLES

Ethical deliberation in clinical medicine is a complex process that requires knowledge, principles, and virtues. Illness enhances vulnerability and dependence, making care and trust indispensable, particularly as ethical issues and dilemmas arise.^{13,14} These deliberations require open discussion and honest mediation¹⁵ and it must always be kept in mind that patients and doctors do not necessarily share similar values or norms. When cross-cultural differences give rise to bedside misunderstandings or even conflicts, it has been said that *"the patient and the physician must negotiate their different views of illness and of health, as well as their different perceptions of the patient-doctor relationship, to achieve their common therapeutic goal."*¹⁶

Ethical deliberation in clinical contexts often makes use of the so called *prima facie* principles of *nonmaleficence*, *beneficence*, *autonomy*, and *justice*. These four principles were first applied to bioethics by Beauchamp and Childress in their textbook entitled *"Principles of Biomedical Ethics."*¹⁰ They are called *prima facie* principles, because they are essential, basic ethical principles that may come into conflict; one principle can render the others inoperative. The high degree of universality and practicality of these four principles provides a basic framework for the resolution of ethical dilemmas within existing pluralism, although they may conflict with each other. For example, a cancer patient or his or her family may demand additional chemotherapy at an advanced stage of cancer, while the physician believes that continued treatment would not be beneficial to the patient, and potentially even harmful. In this instance, the principles of autonomy and beneficence come into conflict.

Moreover, the same *prima facie* principle could be invoked to justify opposing ethical choices at the bedside.¹⁷ In truth telling to cancer patients, either disclosure or nondisclosure can be justified in the name of autonomy or beneficence, when applied to different individual and cultural contexts. In certain cultures outside the Anglo-American world, withholding information is considered an act of beneficence to protect cancer patients from painful truths and their possible negative psychological consequences. By contrast, in most industrialized countries, informing patients is considered the physicians' duty, because it respects patient autonomy.¹⁸ The principles of autonomy and beneficence, in this and many other cases, are in fact interrelated, rather than conflicting.¹⁹ Full disclosure to the patient is simultaneously an act of autonomy and beneficence, as it gives the patient information enabling him to make the best choices according to his own values.¹⁷ Thus, while the principles of bioethics can be a very useful tool for a preliminary reading of clinical ethical dilemmas, ethics of virtue and care are necessary to account for the complexity of ethical deliberation in clinical medicine.

ETHICS OF CARE AND RELATIONAL AUTONOMY

Care ethics, born out of the major contributions of women philosophers to contemporary moral debate, is based on the recognition that not all the relationships that we establish in our life are symmetrical.^{12,14,20,21} Throughout the course of our lives, we also engage in relationships

Textbox 89-1. Relational autonomy means that:

We define and exercise our *autonomy* within the context of our *connectedness* to others.
Autonomy is more than a matter of individual *rights and choices*.
Autonomy refers to the capacity to *make choices* and the *possibility of enacting them*.
Both *internal factors* and *external resources* contribute to one's autonomy.

where our vulnerability is at stake and we need to establish trust in other people from whom we receive help and assistance. Care ethics, which has been successfully applied to clinical practice and the patient-doctor relationship, starts with the recognition of the asymmetry of knowledge and power between patients and health professionals. The patient-doctor relationship is a concrete relationship between "particular others," each with a body, mind, and soul.^{13,21} Patients do not consult a doctor to acquire general medical knowledge, but to find specific answers and gain an understanding of their particular illness. Physicians respond to patients in view of their knowledge and personal expertise on a certain illness or treatment.²² Equality in the patient-doctor relationship is different than equality among peers, and it rather arises from the relationship itself.

Care ethics in clinical medicine also takes into account the relational nature of patient autonomy.^{18,23-25} Autonomy has traditionally been understood in terms of an individual's right to make his or her own choices. The act of choosing is meaningless without action, as an individual's choices influence, and result from, many internal, external, and contextual variables: Choice does not occur in a vacuum. As a result, understanding autonomy in a relational way entails not only recognizing the importance of the responsibilities that arise from our connections to others, but also acknowledging the internal and external factors that shape our choices, while respecting varying cultural, socio-economic, and contextual aspects of decision making (Textbox 89-1).

For example, a woman who has discovered that she carries a *BRCA* mutation predisposing her to a very high chance of developing breast or ovarian cancer, will not only make decisions about the best prevention and management of her own health, but will also be faced with the question of whether to inform her children and relatives, who may also carry the same genetic mutation and future cancer risks.⁷ A lung cancer patient living in a rural area may be offered the chance to participate in a clinical trial run at a distant cancer center. The patient may wish to enroll in the trial, yet he is living alone and is limited by financial and transportation issues, which ultimately prevent him from participation. For many female cancer patients who are mothers with multiple responsibilities, participation in clinical trials may depend on external factors such as the availability or affordability of child care. *I once offered palliative care to one of my long-time patients with extensive metastatic breast cancer, who had been through multiple unsuccessful chemotherapy and radiation treatments over the course of several years. She told me that she agreed with me about the futility of trying to a different chemotherapy, except for the fact that she was the only caregiver to her two handicapped sons, both in their twenties. To her, even one extra day of life was worth.*

Care ethics in clinical medicine is based upon *attention*, *responsibility*, *responsiveness*, *integrity*, and *trust*. Patients should be able to trust their physicians and healthcare professionals, institutions, and healthcare structures, but also science itself. Care ethics is not always sufficient to cover all domains of bioethics, but can be extremely helpful in providing guidance in bedside dilemmas. Care ethics utilizes the guiding moral principles of bioethics, with the principle of justice serving as the unifying element in ethical dilemmas that arise due to the relational aspects of care ethics.²⁵

ETHICAL DILEMMAS IN ONCOLOGY PRACTICE

Ethical dilemmas in medicine are extremely complex and are often magnified in oncology by several factors: the severity of the illness and

Textbox 89-2. Common ethical dilemmas in oncology practice

Communication and information about diagnosis and prognosis
 Communication about medical errors
 Decision making in transitions through different stages of cancer
 Decision making about end-of-life care
 Use of experimental treatments and integrative therapies
 Counseling about genetic risks and genetic testing

the negative metaphoric implications that a cancer diagnosis may carry within a patient's cultural context; the physical and psychological suffering of the patient, which can become extreme during difficult treatments or at end of life; the medical, psychological, and social ramifications of living with cancer, including social stigmatization and discrimination; the uncertainty related to cancer prognosis and treatment, standard or experimental; the use of multimodal therapies that result in fragmentation of care and subsequent involvement with many oncology professionals; and finally, the patient's difficulty in attempting to balance her desire to be involved in her own care with the desire to be guided by oncologist while still feeling respected and supported in the psychological and spiritual journey through and with cancer.¹⁸

Many of the ethical dilemmas that oncology professionals encounter in clinical practice relate to different aspects of communication and information with cancer patients. These can arise from a wide range of issues, such as: diagnosis and prognosis; decision making in different phases of cancer, especially regarding end-of-life care, experimental treatments, and integrative therapies; and counseling about genetic risks and testing (Textbox 89-2).

Dilemmas may also arise from cultural differences between patients and members of their treating oncology teams.^{16,26,27} For example, giving bad news to an uninformed cancer patient whose family has requested the physician not to do so, is an example of cultural insensitivity often encountered in multicultural oncology practices. *In my clinical practice, I find myself presenting the information to cancer patients and their families differently, depending on whether I am practicing in Italy or in the United States, where the cultural expectations are still divergent. In the United States I am often expected to convey statistical information on risks and prognosis during the initial chemotherapy consultation, while in Italy this would generally be inappropriate, as patients may feel overwhelmed and confused by such information, rather than helped.* High ethical standards in communication require that oncologists avoid being blunt and, rather, convey information in a sensitive timely manner. The notion of "offering the truth" to cancer patients, based on allowing individual patients to choose their own paths, has been proposed as an effective way to respect patients' autonomy in light of their own cultural norms.²⁸ But a closer understanding of care ethics would lead one the patient context and culture carefully before following any predetermined route in a straight line.

CROSS-CULTURAL DIFFERENCES IN ONCOLOGY AND THE IMPORTANCE OF CULTURAL COMPETENCE

Cross-cultural encounters in the clinic are increasingly frequent and they are reported as a common source of bedside ethical dilemmas. Cultural differences between patients and health care professionals may give rise to conflicts with respect to truth telling, end-of-life choices, prevention and screening, and involvement in clinical trials (Textbox 89-3).^{16,29} The acquisition of knowledge and skills in delivering culturally sensitive care has, therefore, become a requirement in medical training in many increasingly multiethnic societies, such as the United States. The American Academy of Family Physicians *Guidelines on end of life care* states that "Health professionals should recognize, assess, and address the psychological, social, spiritual and religious issues, and cultural taboos realizing that different cultures may require significantly different approaches."³⁰

Textbox 89-3. Cross-cultural differences may give rise to conflicts with regard to:

Truth telling
 End-of-life choices
 Prevention and screening
 Adherence to medical recommendations
 Involvement in clinical trials

Textbox 89-4. Why do we need cultural competence in oncology?

Many societies are becoming multiethnic and multicultural
 Cross-cultural differences are increasingly involved in bioethics
 Cross-cultural differences between patients and healthcare workers can give rise to serious misunderstandings and conflicts
 All medical encounters are to some extent an exercise in cultural competence
 Cultural competence leads to improved therapeutic outcomes and decreased disparities in medical care

Culture has profound implications in all aspects of society, and is present at many levels. For example, medicine, oncology, and psycho-oncology are all individual cultures: they each have their own language and status within. Depending on the extent to which the patient and the physician are engaged in their relationship, every clinical encounter is an exercise in cultural competence, as each person carries his own personal and cultural identity.¹¹ Cultural differences influence the interpretation of ethical principles and norms, especially with regard to the meaning and role of patient autonomy.^{18,31}

Culture, described in complex ways in the anthropological and sociological literatures, can be defined as the sum of the integrated patterns of knowledge, beliefs and behaviors of a given community.³² Culture influences our attitudes toward truth telling; the focus and style of decision making and end-of-life decisions; our views of the therapeutic relationship; and the trust we have in physicians, nurses, and institutions.²⁹ Cultural differences also play a significant role in the existing disparities in access to cancer care and research.³³

The acquisition of cultural competence in oncology is a multilayered task that presupposes awareness of one's own culture, beliefs, and values. One cannot understand cultural differences without being aware of the culture of medicine. Cultural competence also requires the acquisition of specific knowledge, skills, and attitudes, and in individual caregivers, qualities of humility, empathy, curiosity, respect, sensitivity, and awareness. It needs awareness of the risks of stereotyping, racism, classism, sexism, ageism, and many culture-specific prejudices which, often contribute to a distorted view of culture.²⁹

It has been shown that cultural competence improves appreciation of differences in healthcare values among people belonging to different cultures, furthers communication between patients and physicians, and facilitates the solution of ethical dilemmas in the clinic, which, in turn, leads to improved therapeutic outcomes and decreased disparities in medical care (Textbox 89-4).^{33,34} These goals are better achieved if the caregivers are practicing in a culturally competent healthcare system, flexible enough to meet the needs of different patients or groups of patients.³³ Teaching cultural competence requires providing caregivers with relevant information about different cultures with respect to many health issues, including the role of patient autonomy, the involvement of families, and the meaning of suffering and dying. Patients themselves are the best teachers of their own beliefs and preferences.^{29,34,35}

ETHICS OF TRUTH TELLING AND WORLDWIDE EVOLUTION OF ATTITUDES AND PRACTICES OF DISCLOSURE

Truth telling is at the core of bioethics. It relates to both the role of patient autonomy and to the influence of culture on the modulation and

expression of ethical norms.²² Bioethics originated within the Anglo-American context and its long standing tradition of respect for individual rights, including the right to self-governance, privacy, and personal liberties. Patients must be fully informed about their diagnosis, treatment options, risks, and prognosis, to be able to exercise their autonomy. Information leads to better patient participation in decision making and increases patient compliance and satisfaction.³⁶

While the doctrine of informed consent was born in 1947 as a result of the Nuremberg Trial, a milestone study of truth-telling practices in the United States published in *JAMA* in 1961, showed that 10% of surveyed physicians would never reveal a cancer diagnosis.³⁷ Over the following two decades, physicians' truth-telling practices in the United States changed dramatically and in the late 1970s 98% of surveyed U.S. physicians revealed a cancer diagnosis to their patients.³⁸

In nonwestern cultures, including some ethnic minorities within the United States, truth-telling attitudes and practices were rarely discussed until the late 1980s.³⁹ During the 1990s, numerous reports suggested major cross-cultural differences in truth telling.⁴⁰⁻⁴² In cultures centered on family and community values, the word "autonomy" was often perceived more as synonymous with "isolation" than of "freedom," and a protective role with respect to the ill person was attributed to families and physicians.⁴⁰ Basic information and bad news were often withheld from patients, or strongly censored, to avoid taking away hope or causing them severe distress, while physicians tended to tell the full truth only to one or two close relatives. In this "conspiracy of silence," doctors and relatives were often caught in the web of half-truths, and patients were left to suffer alone, deprived of the chance to ask questions and receive answers, put in order their affairs, or say good-bye to their loved ones.⁴⁰ Some patients responded heroically by becoming the protectors of those who are trying to protect them.

In my first years of oncology training patients were treated with state-of-art oncology therapies, yet I met several young women with bone metastases from breast cancer. Those patients had agreed to be treated for severe arthritis by doctors and family members who wanted to protect them from knowledge of their dire prognosis. Yet, a few of these women were clearly aware that their cancer had metastasized, but feigned ignorance because they wanted to protect their families and especially their small children. A 17-year-old boy with advanced lymphoma asked me not to disclose to his family the failure of his last treatment, something he had obviously perceived from the continuous growth of his lymph nodes and his increasing systemic symptoms. He asked to see me one night when I was on call and explained that his mother had already lost two small infants and she should be able to talk to him about his dead sisters until his last day. A middle-aged engineer with metastatic gastrointestinal (GI) cancer asked me to make a house call because of respiratory distress. When I arrived at his home, he was sitting quietly at his desk, and told me he needed to know the truth about his prognosis, because he had to make important work decision that would have affected his large family. He reassured me, though, that he would have never let them understand that we had spoken and that he knew the truth.

A dramatic shift in truth-telling attitudes and practices has occurred worldwide in the past two decades, especially in European, Middle Eastern, and Asian countries.⁴³ A 1999 study of western and nonwestern American Society of Clinical Oncology (ASCO) members attending the annual meeting showed no difference in disclosure rates of cancer diagnosis.⁴⁴ The reasons for the evolution of truth-telling attitudes and practices worldwide appear remarkably similar to those that determined the shift in the United States between the early 1960s and the late 1970s.²⁷ Among the main contributing factors are therapeutic advances in the field of oncology, growing public knowledge of the nature and treatment of cancer, adequate training of physicians in palliative and end-of-life care, increasingly strict legal requirements for information and informed consent, and patient and public activism.

The international literature now suggests that cancer patients across cultures share similar communication needs and preferences and that content, style, and setting are all essential aspects of communication. However, cross-cultural differences in truth-telling still persist, and literature reviews suggest that only a relative minority of cancer patients in nonwestern countries expect truthfulness about their illness or wish

to participate in the decision making, as compared to an overwhelming majority in western countries.⁴⁵ Patients' awareness of the severity and curability of their cancer is reported as still poor in many countries. In addition, the actual rate of disclosure remains low even among physicians who believe in patients' right to information, as documented in a 2000 survey of 675 Northern Italian physicians conducted by Dr. Grassi and colleagues.⁴⁶ A 2008 study of Italian oncologists in southern and northern Italy, however, shows that most of them now inform their patients.⁴⁷

Variability in truth-telling rates worldwide can be attributed to several factors: age and gender, urban versus rural residence, type of treating institution, and family involvement.⁴⁸ The extent and modalities of family involvement varies, and sometimes in some countries, families make decisions in place of the uninformed relative. In many countries, especially in Asia, the family is always consulted before revealing a cancer diagnosis to the patient, and many nonwestern families still oppose truth-telling to cancer patients.^{15,49} A survey of the relatives of 150 Turkish cancer patients showed that 66% requested that the truth be withheld from the patient.⁵⁰ As families take part in the care of their sick relatives in every culture, they cannot be excluded from the process of information and communication unless it is the expressed wish of the patient.⁵¹ A common ethical dilemma arises when a family requests the hospital staff not to disclose the truth to the cancer patient in a country, such as the United States, with strict requirements for informed consent.^{26,27}

In my oncology clinic, I have met elderly cancer patients from nonwestern countries who wish to be informed of their treatment options, including ongoing clinical trials, despite their family's strong opposition. An Islamic patient, affected by metastatic breast cancer, who always came for her visits accompanied by several family members, once left me a note written in broken English that she knew exactly how widely spread was her cancer and that she didn't want any life support measures. In the note, she had also asked me not to tell her family about what she knew.

A recent study of a multicultural patient population being treated at a large cancer center, suggests that information should be tailored to individual, family, and community values, especially when dealing with specific requests to withhold or to downplay the truth.²⁶ However, oncology professionals must adhere to the ethical norms and legal requirements of their own country. If those norms see withholding the truth as an infringement on the patient's autonomy, they should explain to family members that they have a duty to inform the patient, but that they will do so gradually and with extreme sensitivity.^{26,27} In most cases, it is advisable to ask cancer patients how much they wish to be informed, and it is important to repeat such question at different times during the course of the illness and treatment. Furthermore, in the course of a chronic illness such as cancer, which often entails frequent visits to specialists and periods of hospitalization, almost all patients will inevitably be told or will overhear the truth at some point. As a result, they may lose trust in the treating physicians and team members who have withheld information from them.^{26,27}

CARE ETHICS AND THE ROLE OF CANCER PATIENTS' FAMILIES

Cancer affects not only sick individuals, but also their families. As Drs. Baider, Cooper, and Kaplan De-Nour discuss in their textbook *Cancer and the Family*,⁵² a successful healing process requires that physicians interact effectively with patients' families and loved ones.⁵² Cancer alters the internal dynamics of the family, whose members, mostly women, take on increased care giving responsibilities, especially at the end of the cancer patient's life. It is therefore necessary to address the psychosocial and ethical needs not only of cancer patients, but also of their families and communities. Primary caregivers always deserve special attention.

In many cultures, patients' relatives are the first, and sometimes the only people, to receive adequate information, and may be the locus of decision making. Studies of sources of support for breast cancer survivors of differing ethnicities show differences in their perceptions of their own role within their families and of the importance of their families in helping them make important medical decisions.^{53,54}

Each family has distinct informational needs, and requires guidance and support when faced with ethical dilemmas.^{55,56} While the intervention of relatives may add a layer of complexity to the patient-doctor

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relationship, oncologist and psycho-oncologists now learn how to address the concerns of family members, while respecting patients' information and decision-making needs.⁵⁶

Relativism is an enriching reality in modern societies, but it has also become the source of major ethical quandaries in the practice of clinical oncology. In caring for cancer patients, oncologist and psycho-oncologists must learn to respect cultural differences without falling into cultural determinism or ethical relativism. As the basic principles of human dignity apply to all individuals in every social and cultural context, sensitivity to individual and cultural differences should not prevent oncology professionals from respecting and fostering their patients' rights to self-determination. They can do this by investing the time and energy to know their patients and understand their wishes, before ethical dilemmas arise. The adequate practice of care ethics is an ongoing process.

An ethics of principles, virtues, and care must also acknowledge the limitations of medicine and physician. Because the care ethics model values the role played by people outside the medical team in most healing processes, it always includes families, friends, and communities in ethical analysis and deliberation. The ethical role of families as the ultimate caregivers for our cancer patients can never be underestimated. Miscommunication and conflicts, however, can occur between cancer patients and family members. Improving understanding and concordance among patients, family caregivers, and physicians is part of the ethical responsibilities of oncology professionals. Psycho-oncologists have special professional qualifications and ethical duties to assess and clarify the underlying tensions that could lead to future ethical dilemmas, and to find shared solutions to ethical dilemmas on the basis of respect and trust.

REFERENCES

1. Angell M. "Ethical Imperialism?: Ethics In International Collaborative Clinical Research." *New Engl J Med*. 1988;319:1081-1083.
2. Aristotle. *Nicomachean ethics*. Ross D, trans. Oxford and New York: Oxford University Press; 1925.
3. Hippocrates. *Oath of Hippocrates*. In: WHS Jones, (eds). *Hippocrates*. Cambridge: University Press; Harvard 1868.
4. Percival T. *Medical ethics: A code of institutes and precepts, adapted to the professional conduct of physicians and surgeons*. Manchester: S. Russel; 1803.
5. American Medical Association. *History. Council on ethical and judicial affairs. Code of medical ethics. Current opinions with annotations*. American Medical Association; 1997:v-vi.
6. Potter VR. *Bioethics: Bridge to the future*. Englewood Cliffs, NJ: Prentice Hall; 1971.
7. American Society of Clinical Oncology. "Statement of the American Society of Clinical Oncology: Genetic Testing for Cancer Susceptibility." *J Clin Oncol*. 1996;(14):1730-1736.
8. Hudson KL, Holohan MK, Collins FS. Keeping peace with the times—The Genetic Information Nondiscrimination Act of 2008. *N Engl J Med*. 2008;358:2661-2663.
9. Pellegrino ED, Thomasma DC. *For the patient's good: The restoration of beneficence in health care*. New York and London: Oxford University Press; 1988.
10. Beauchamp T, Childress JF. *Principles of biomedical ethics*. 4th ed. New York: Oxford University Press; 1994.
11. Surbone A, Lowenstein J. Asymmetry in the patient-doctor relationship. *J Clin Ethics*. 2003;14:183-188.
12. Held V. "Feminism and Moral Theory." In: Kittay EF, Meyer D, (eds). *Women and moral theory*. Savage, MD: Rowman & Littlefield; 1987:111-128.
13. Pellegrino ED. Altruism, self interest, and medical ethics. *JAMA*. 1987;(258):1939-1940.
14. Baier A. *Moral prejudices. Essays on ethics*. Cambridge, Massachusetts & London, UK: Harvard University Press; 1994.
15. Edgar A. A discourse ethics approach to quality of life measurements. In: Surbone A, Zwitter M, (eds). *Communication with the cancer patient. Information and truth*. Annals of the New York Academy of Sciences; 1997:30-39.
16. Kagawa-Singer M, Blackhall LJ. Negotiating cross-cultural issues at the end of life. *JAMA*. 2001;286:2993-3001.
17. Tuckett AG. Truth-telling in clinical practice and the arguments for and against: a review of the literature. *Nurs Ethics*. 2004;11:500-513.
18. Surbone A. Telling truth to patients with cancer: what is the truth? *Lancet Oncol*. 2006;7:944-950.
19. Pellegrino ED. Is truth-telling to patients a cultural artifact? (Editorial) *JAMA*. 1992;268:1734-1735.
20. Noddings N. *Caring: A feminine approach to ethics and moral education*. Berkeley: University of California Press; 1984:91-94.
21. Kittay EF. *Love's labor. Essays on women, equality and dependency*. New York and London: Routledge; 1999.
22. Surbone A. Truth telling. In: Cohen-Almagor R, (ed). *Medical ethics at the dawn of the 21st century*. New York: New York Academy of Sciences; 2000; 52-62.
23. Sherwin S. A relational approach to autonomy in health care. In: S Sherwin, Coordinator, The feminist health Care Ethics Research Network, *The politics of women's health: Exploring agency and autonomy*. Philadelphia: Temple University Press; 1988:19-44.
24. Donchin A. Understanding autonomy relationally: toward a reconfiguration of bioethical principles. *J Med Phil*. 2001;26:365-386.
25. Mahowald MB. *Genes, women, equality*. New York, Oxford: Oxford University Press, 2000.
26. Anderlik MR, Pentz RD, Hess KR. Revisiting the truth telling debate: a study of disclosure practices at a major cancer center. *J Clin Ethics*. 2000;11:251-259.
27. Surbone A. Cultural aspects of communication in cancer care. In: Stiefel F, (ed). *Communication in cancer care. Recent results in cancer research*. Heidelberg: Springer Verlag; 2006(168):91-104.
28. Freeman B. Offering truth. One ethical approach to the uninformed cancer patient. *Arch Intern Med*. 1993;153:572-576.
29. Kagawa-Singer M. A strategy to reduce cross-cultural miscommunication and increase the likelihood of improving health outcomes. *Acad Med*. 2003;78:577-587.
30. Russell Searight H, Gafford J. Cultural diversity at the end of life: issues and guidelines for family physicians. *Am Fam Physician*. 2005;71:515-522.
31. Blackhall LJ, Murphy ST, Frank G, Michel V, Azen S. Ethnicity and attitudes toward patient autonomy. *JAMA*. 1995;274:820-825.
32. Olweny C. The ethics and conduct of cross-cultural research in developing countries. *Psychooncology*. 1994;3:11-20.
33. Surbone A. Cultural competence: why? *Ann Oncol*. 2004;15:697-699.
34. Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong II O. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Rep*. 2003;188:293-302.
35. Betancourt JR. Cultural competence and medical education: many names, many perspectives, one goal. *Acad Med*. 2006;81:499-501.
36. Fallowfield LJ, Jenkins VA, Beveridge HA. Truth can hurt but deceit hurts more: communication in palliative care. *Palliat Med*. 2002;16:297-303.
37. Oken D. What to tell cancer patients. *JAMA*. 1961;175:1120-1128.
38. Novack DB, Plumer S, Smith RI, Ochtill H, Morrow GR, Bennett JM. Changes in physicians' attitudes toward telling the cancer patient. *JAMA*. 1979;241:897-900.
39. Holland JC, Geary N, Marchini A, Tross S. An international survey of physician attitudes and practices in regard to revealing the diagnosis of cancer. *Cancer Invest*. 1987;5:151-154.
40. Surbone A. "Truth Telling To The Patient." *JAMA*. 1992;268:1661-1662.
41. Carrese J, Rhodes L. Western bioethics on the Navajo reservation: benefit or harm? *JAMA*. 1995;274:826-829.
42. Authors Various. In: Surbone A, Zwitter M, (eds). *Communication with the cancer patient: Information and truth*. 2nd ed. Baltimore: Johns Hopkins University Press; 2000.
43. Mystadikou K, Parpa E, Tsilila E, Katsouda E, Vlahos L. Cancer information disclosure in different cultural contexts. *Support Care Cancer*. 2004;12:147-154.
44. Baile WF, Lenzi R, Parker PA, Buckman R, Cohen L. Oncologists' attitudes toward and practices in giving bad news: an exploratory study. *J Clin Oncol*. 2002;20:2189-2196.
45. Surbone A. Persisting differences in truth-telling throughout the world. (Editorial) *Supp Care Cancer*. 2004;12:143-146.
46. Grassi L, Giraldi T, Messina EG, Magnani K, Valle E, Carlei G. Physicians' attitudes to and problems with truth-telling to cancer patients. *Supp Care Cancer*. 2000;8:40-45.
47. Bracci R, Zanon E, Cellerino R, et al. Information to cancer patients: a questionnaire survey in three different geographic areas in Italy. *Supp Care Cancer*. 2008;16:866-877.
48. Seo M, Tamura K, Shijo H, Morioka E, Ikegame C, Hirasako K. Telling the diagnosis to cancer patients in Japan: attitude and perceptions of patients, physicians and nurses. *Palliat Med*. 2000;14:105-110.
49. Ozdogan M, Samur M, Bozcuk HS, et al. "Do not tell": what factors affect relative attitudes to honest disclosure of diagnosis to cancer patients? *Supp Care Cancer*. 2004;12:497-502.
50. Farber SJ, Egnew TR, Herman-Bertsch JL, Taylor TR, Guldin GE. Issues in end-of-life care: patient, caregiver and clinical perceptions. *J Palliat Medicine*. 2003;6:19-31.

51. Baider L, Cooper CL, De-Nour K. (eds). *Cancer and the family*. 2nd ed. Sussex, England: Wiley & Sons, Ltd; 2000.

52. Kagawa-Singer M, Nguyen TU. A cross-cultural comparison of social support among Asian-American and Euro-American women following breast cancer. In: Baider L, Cooper CL, De-Nour K, (eds). *Cancer and the family*. 2nd ed. Sussex, England: Wiley & Sons, Ltd; 2000.

53. Phipps E, Ture G, Harris D, et al. Approaching end of life: attitudes, preferences, and behaviors of African-American and White patients and their family care-givers. *J Clin Oncol*. 2003;21:549-554.

54. Surbone A. The role of the family in the ethical dilemmas of oncology. In: Baider L, Cooper CL, De-Nour K, (eds). *Cancer and the family*. 2nd ed. Sussex, England: Wiley & Sons, Ltd; 2000:513-534.

55. Clayton JM, Butow PN, Tattersall MHN. The needs of terminally ill patients versus those of caregivers for information regarding prognosis and end of life issues. *Cancer*. 2005;103:1957-1964.

56. Holland J, Johansen C, Surbone A, Baider L. Care giving in context. *Am Soc Clin Oncol Educational Book*. 2006;27:151-163.