

COMMENTS

Angelina's choice: private decision, public impact

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The decision of the actress, Angelina Jolie (AJ), to undergo preventive risk-reducing bilateral mastectomy has elicited extreme responses, in support and against. We will discuss whether her decision was justified and if there are other options available to women. AJ, who is 38 years old, inherited the BRCA 1 gene. Because of the lack of randomised trials, there is controversy about the overall benefit that various risk-reduction strategies offer carriers of the BRCA 1, but some of the strategies offer a clear benefit. The decision to opt for mastectomy must be driven by the patient's choice, evidence on the balance of the risks and benefits, the quality of life after surgery and issues relating to body image.

There is undoubtedly a level of risk associated with being a carrier of the BRCA 1 gene. The facts regarding the risk must be presented to patients in such a way that it enables them to make an informed choice. The Breast Cancer Linkage Consortium has estimated the lifetime risk of the development of breast cancer among BRCA 1 carriers as 19% at 40 years of age and 85% by the age of 70 years, though the relative risk of developing breast cancer goes down with advancing age (1,2). These data possibly overestimated the lifetime risk as the families from which they are drawn had to have at least four cases of breast cancer at ages of below 60 years to be included. A study which is more representative of the general population has estimated the lifetime cumulative risk of the development of breast cancer among carriers of the BRCA 1 mutation to be 46% and 59% at the ages of 70 and 80 years, respectively (3). These estimates of risk combine the effects of age and genetic predisposition, as the contribution of genetic risk is reduced with increasing age.

A prophylactic bilateral mastectomy (PBM), which is what AJ underwent, is not a foolproof option and there are other less drastic measures available. Some of these are increased surveillance (regular check-ups, including clinical breast examination, mammograms and MRI scans) (4); selective oestrogen-inhibiting medication, which may cut the risk by half (5-7); and prophylactic bilateral salpingo-oophorectomy (8), which also reduces young women's risk of developing breast cancer by about 50%. The downside of PBM followed by reconstruction is that it is a highly specialised, complex procedure which involves a long recovery period, pain, risk of infection and changes in skin sensations. It is also irreversible.

Given the facts available, was the decision justified? The decision is a very personal one and was possibly driven by strong psychological and emotional factors. Women who opt for such a strong measure find it difficult to overcome their fear and anxiety with regard to the disease. Breast cancer patients experience fear following the diagnosis of cancer, and also fear disfigurement, recurrence, suffering, death, and the possibility their children contracting breast cancer, but they learn to live with it, fight it and overcome it. AJ willingly and knowingly took the very action that causes the same physical and mental trauma that a diagnosis of breast cancer brings. Prevention and cure both have to be weighed against the price to be paid. It is important to balance the benefits against the financial, physical and psychological damage. Often, one even forgoes the cure because the damage is greater than the benefit. AJ may have beaten the odds for breast cancer, but may yet succumb to some other event.

Sweeping generic statements on "taking action" in case of susceptibility to cancer may promote fear and confusion, and possibly direct women to overestimate their risk and opt for overtreatment. Those who choose AJ as their role model may be especially inclined to adopt such a course. By virtue of the fact that AJ is a celebrity, any choice she makes is open to debate and discussion, but she is in no way responsible or accountable for this. However, when she chooses to champion a personal choice on a public platform, she must be accountable and open to questioning. Women who do not have the requisite knowledge, financial wherewithal or the same access to medical expertise, or even those who do not fall in the same risk group, may blindly follow AJ's example, without being totally aware of the pitfalls associated with it.

One may argue that AJ has the right to take her own decision since it is her body and her life. What is objectionable is the glorification of the whole affair. She has been aided and abetted by the media, which has put her on a pedestal and implied that this is the way to prevent breast cancer, thus devaluing at one go all the efforts to promote early detection through inexpensive and non-invasive methods.

When personal choices are acclaimed and gain popularity and recognition, they need to be assessed in terms of how valuable they are to others and whether they can be replicated to suit most people. Awareness thus created, if not supported by reality, can have dangerous implications for the lives of many who may fall prey to such influences and act accordingly.

Caution needs to be exercised while raising issues that may cause fear and confusion, which, in turn, lead to an undesirable eagerness to adopt certain medical practices in situations that do not warrant them. Awareness and treatment need not be synonymous with over-awareness (anxiety) and over-treatment.

All in all, we believe that AJ's choice was too drastic, but it is a matter of ethical duty to present the option to patients so that they can weigh the pros and cons and make an informed decision about not opting for less invasive and effective strategies.

References

1. Easton DF, Ford D, Bishop DT. Breast and ovarian cancer incidence in BRCA1-mutation carriers. Breast Cancer Linkage Consortium. *Am J Hum Genet.* 1995 Jan;56(1):265–71.
2. Thompson D, Easton DF, the Breast Cancer Linkage Consortium. Cancer incidence in BRCA1 mutation carriers. *J Natl Cancer Inst.* 2002 Sep 18;94(18):1358–65.
3. Satagopan JM, Offit K, Foulkes W, Robson ME, Wacholder S, Eng CM, Karp SE, Begg CB. The lifetime risks of breast cancer in Ashkenazi Jewish carriers of BRCA1 and BRCA2 mutations. *Cancer Epidemiol Biomarkers Prev.* 2001 May;10(5):467–73.
4. Sardanelli F, Podo F, Santoro F, Manoukian S, Bergonzi S, Trecate G, Vergnaghi D, Federico M, Cortesi L, Corcione S, Morassut S, Di Maggio C, Cilotti A, Martincich L, Calabrese M, Zuiani C, Preda L, Bonanni B, Carbonaro LA, Contegiacomo A, Panizza P, Di Cesare E, Savarese A, Crecco M, Turchetti D, Tonutti M, Belli P, Maschio AD. High Breast Cancer Risk Italian 1 (HIBCRI-1) Study. Multicenter surveillance of women at high genetic breast cancer risk using mammography, ultrasonography, and contrast-enhanced magnetic resonance imaging (the high breast cancer risk Italian 1 study): final results. *Invest Radiol.* 2011 Feb;46(2):94–105. doi:10.1097/RLI.0b013e3181f3cdf.
5. King MC, Wieand S, Hale K, Lee M, Walsh T, Owens K, Tait J, Ford L, Dunn BK, Costantino J, Wickerham L, Wolmark N, Fisher B, National Surgical Adjuvant Breast and Bowel Project. Tamoxifen and breast cancer incidence among women with inherited mutations in BRCA1 and BRCA2: National Surgical Adjuvant Breast and Bowel Project (NSABP-P1) Breast Cancer Prevention Trial. *JAMA.* 2001 Nov 14;286(18):2251–6.
6. Phillips KA, Milne RL, Rookus MA, Daly MB, Antoniou AC, Peock S, Frost D, Easton DF, Ellis S, Friedlander ML, Buys SS, Andrieu N, Noguès C, Stoppa-Lyonnet D, Bonadona V, Pujol P, McLachlan SA, John EM, Hooning MJ, Seynaeve C, Tollenaar RA, Goldgar DE, Terry MB, Caldes T, Weideman PC, Andrulis IL, Singer CF, Birch K, Simard J, Southey MC, Olsson HL, Jakubowska A, Olah E, Gerdes AM, Foretova L, Hopper JL. Tamoxifen and risk of contralateral breast cancer for BRCA1 and BRCA2 mutation carriers. *J Clin Oncol.* 2013 Sep 1;31(25):3091–9. doi:10.1200/JCO.2012.47.8313
7. Waters EA, McNeel TS, Stevens WM, Freedman AN. Use of tamoxifen and raloxifene for breast cancer chemoprevention in 2010. *Breast Cancer Res Treat.* 2012 Jul;134(2):875–80. doi:10.1007/s10549-012-2089-2
8. Kauff ND, Satagopan JM, Robson ME, Scheuer L, Hensley M, Hudis CA, Ellis NA, Boyd J, Borgen PI, Barakat RR, Norton L, Castiel M, Nafa K, Offit K. Risk-reducing salpingo-oophorectomy in women with a BRCA1 or BRCA2 mutation. *N Engl J Med.* 2002 May 23;346(21):1609–15. doi:10.1056/NEJMoa020119

Criteria for a just strike action by medical doctors

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Introduction

In response to a strike action by some doctors at the Safdarjung Hospital, the Delhi Medical Council issued a statement, in December 2010, that it was "...of the view that under no circumstances doctors should resort to strike as the same puts patient care in serious jeopardy and such actions are also in violation of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002" (1). Statements such as this are common responses of medical councils across the world whenever they are confronted with the increasingly difficult issue of striking doctors. Evidently, these statements are not effective in stopping doctors from repeatedly engaging in strike action. In India, the statement by the medical council was, for instance, followed by many strikes, amongst which was the well-publicised nationwide strike initiated by the Indian Medical Association in June 2012 (2). It is not difficult to see why strike action by doctors will continue, in India and elsewhere, despite opposition by the medical councils. The usual reasons why doctors go on strike relate to issues concerning pay, contractual relationships, and work conditions. It would appear that as long as doctors maintain their employee status, they will, just like other occupational groups, engage in industrial disputes with their respective employers.

Strike action by doctors always precipitates intense ethical debates. Those who see strike action as unethical often cite some of the following arguments in support of their view (3):

- Doctors are already overpaid and cannot justifiably continue to demand more.
- Doctors should be selfless healers who are not really in it for the money, but to care for the sick.
- Doctors cannot strike because if they do, it will result in avoidable deaths and suffering to the sick.
- A strike by doctors amounts to holding the sick and weak to ransom for material gain.
- Doctors are supposed to adhere to a professional code of conduct that prohibits them from participating in strikes.

Academic writers on this subject tend to either offer arguments supporting the above, or offer counterarguments. This approach is appropriate for answering the question of whether strike action by doctors is always unethical, as held by the Delhi Medical Council, for instance. A number of ethicists have argued persuasively that strike action by doctors is not always unethical and may, in fact, be justified under some circumstances. This conclusion is usually reached after providing counterarguments to the list of arguments enumerated above (3–5). This paper builds on the work done