Words of sorrow

Rodger Charlton

My last house visit of the morning was to a 66 year old lady from whom I had not heard since her hospital appointment. I had seen her a few days earlier at the surgery with a persistent cough. Her chest x ray examination suggested a lung tumour. I had explained to her that the problem might be nasty and she should see a specialist to exclude serious disease, including cancer.

She was distraught. But, to my surprise, she was less upset by the diagnosis of cancer than by the way she had found it out. "I did not want to know that I had cancer and I should never have been told in that way." Obviously her recollection of events may not

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accurately match the outpatient consultation. But it was what she remembered, and what she remembered was a hurried telling in a busy clinic with little explanation and no opportunity to ask questions.

From then on until she died, nearly two years later, she kept on saying, "It should never have been done in that way." Despite regular contact and a second opinion, this consultation was never forgotten and marred the outcome of her illness.

She was reluctant to leave her house and deterred friends from calling because she feared that she looked different because she had cancer. At a time when her physical deterioration was minimal, she lost interest in food and the desire to live and took herself to her bed, which she never left.

She died as peacefully as pharmacology would allow, but with an illness that should not have created the psychological and emotional pain that it did. This all seemed to her and to me to result from the initial hospital consultation.

Was this the only way she could deal with a fatal illness? Was her grieving process stuck in the stage of anger? Or could her pain have been eased by a more gentle, skilled breaking of that bad news? Of course we cannot be sure. I certainly do not blame anyone. The task of breaking bad news is a common one and, although difficult, is not one which any of us would like to admit we do badly. But perhaps the time we think we are learning to do it well or, worse still, the time we think it is getting easier is the

time to consider our own complacency.

It is almost universally accepted that we should tell patients the truth about their diagnosis when asked and usually when not asked. To do otherwise deprives our patients of a basic human right—autonomy. But there may well be circumstances such as these in which it may be inappropriate.

Mr J was a widowed man in his late 70s who lived alone in a farmhouse. He had been known to have chronic lymphatic leukaemia for four years and was on a small dose of melphalan. He suffered no problems apart from annual bronchitis, which may or may not have been related. Twenty years previously he had suffered a severe endogenous depression requiring treatment with electroconvulsive therapy.

I had looked after him for three years, having taken over his care from a retiring partner. At our first meeting Mr J told me that he had anaemia for which he was taking tablets. He seemed quite content with this explanation and did not inquire further when given the opportunity. He was quite active, did his own domestic chores, and looked after his garden.

A routine letter arrived from the hospital to say that his care had been transferred from one of the physicians to the haematologists because of heavy workload. I had seen him recently and he was doing well. He then called me one day in quite a distressed state after his visit to the new clinic. A doctor whom he had never met before told him that he had leukaemia. He said that he knew he was going to die, just as a friend of his had done, and that there was nothing more that anyone could do for him. I tried to tell him that his perceptions about his illness were not correct and that he had in fact had his chronic leukaemia for four years, with no ill effect, but he would not believe me.

I visited the next day. He felt unwell and "chesty" and had pyrexia and a chest infection. He said, "I hope that I will soon die of this leukaemia. I don't want to suffer as my friend did." After being admitted to hospital he deteriorated rapidly and died a few days later. It seemed that he had lost the will to live as a result of this unsatisfactory hospital consultation which in effect demolished the sensitive care of the previous four years.

It seems deceitful not to tell a patient the whole truth and yet can there be times when it can be justified? These rare experiences emphasise how important communication skills are in determining what individual patients wish to know and what they understand by emotive terms such as cancer and leukaemia. If patients indicate that they do

not wish to know the diagnosis and prognosis of their illness it may be that they are denying the illness, which is a natural psychological reaction. Until full realisation takes place they should not be unnecessarily confronted, but always given the opportunity to find out.

Times have changed since Freud mused: "No one believes in his own death, or, to put the same thing in another way, that in his unconsciousness, every one of us is convinced of his own immortality."

Times have also changed since D Oken's study reported in the *Journal of the American Medical Association* in 1961, in which 90% of doctors in the United States said that they did

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not tell patients with cancer their diagnosis. I wonder if the pendulum has swung too much in the other direction and we tell a small minority of patients the truth when it is unkind or inappropriate to do so. As a patient said to me recently, "These are not black and white issues. I had an elderly relative who had cancer of the liver. His general practitioner knew him very well and feared that he would turn his face to the wall if told. He had a good quality of life for over two years. But a locum general practitioner told him about his condition and he did indeed give up and died four weeks later."

The pain that these patients suffered still remains with me. They are extreme cases. None of us wishes to break bad news and none of us wishes to receive it. And yet it is often our painful duty to do so. Robert Louis Stevenson said, "Sometimes death leaps suddenly upon its victims like a thug." We all need better preparation for this task to do it sensitively and with a commitment to follow up patients. It is an area which deserves attention in medical training, before and after graduation. After all, as D Pope in *Patient Management* in 1991 stated, "it is not just what a patient has that matters, it is what we let it do to them." As J C Murdoch said in 1991 in the *New Zealand Medical Journal* of breaking the news to parents that their child has Down's syndrome: "That a good telling is possible, is obvious from the fact that some succeeded where others failed."

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