Ethical dilemmas in breaking bad news

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Introduction

One of my concerns after joining a cancer hospital was the manner of conveying the diagnosis to the patient with cancer. Most of us receive little formal training on this aspect of medicine during undergraduate and postgraduate training. All I can recall is telling the relatives of patients with acute myocardial infraction or stroke of a 25% possibility of death.

Observing the approach of colleagues has been of little help. Some colleagues embark on a very positive approach; giving the patient and relatives hope (albeit false) and believing that the patient is blissful in his ignorance. Others take a middle path and explain all the facts to the relatives while keeping the patient in the dark. Few explain at length the diagnosis, stage of cancer, options on treatment, side effects, financial burden and short and long term prognosis. Thereby they upset some patients and families.

Keeping the diagnosis from the patient

'Please do not tell the patient that he has cancer.' is a frequent request made to me by relatives. I recently came across a situation where the relative who accompanied and then looked after a bachelor patient with terminal cancer kept the patient and other relatives in the dark and managed to change the patient's will before his death. Many factors such as illiteracy, ignorance, misconception, superstition, domestic and social problems, fatalistic attitudes and other prejudices add hurdles to the information process. Patients returning with recurrence or progression of disease complain about the lack of proper information during the primary treatment. I soon realised that there is no simple solution.

Osler cautioned those dealing with fatal illness: 'It is not for you to don the black cap and assuming the judicial function, take hope away from any patient... hope that comes to us all.' Unfortunately, several medico-legal and ethical factors make us don the black cap.

Relevant issues

The first issue concerns the confidentiality of doctor-patient relationship. Can the doctor discuss the illness with the relatives and friends who accompany the patient, without first telling the patient about his disease and obtaining his permission to tell others? Second, because of the Consumer Protection Act and the high cost of investigating, treating and supporting patients with cancer, should we not inform the patients fully about the disease, the benefits, complications and economic costs before he signs the consent form? Third, many cancer therapies are still experimental and can be provided only in the setting of a clinical trial. Bearing in mind the ethical aspects of experimental therapies, a fully informed, written consent needs be obtained. Would not informing the brave ones lead to selection bias in studies? Fourth, many patients with advanced disease, already told the nature of their illness, come for a second verdict with lots of hope.

Attitudes towards cancer

In India, the fear and hopelessness engendered by the diagnosis of cancer is very strong and is often based on hearsay or anecdotal experience of relatives or friends. The degree to which people are adversely affected by the diagnosis of cancer is related to the individual's ability to adapt and come to terms with thoughts and feelings focused on their own mortality and altered body image.

In the West, some are unhappy with the diagnosis of cancer but most surveys indicate that the majority of patients seek more information from their doctors. Although the number of doctors in the West who shy away from disclosing the diagnosis of cancer to their patients has decreased, there are many who genuinely believe that what the patients do not know will not harm them.

The convenient practice would be to give information only to those patients who actively seek it. The ideal balance between frankness and details that may provoke is not universally established, nor is it the same for all patients. In cancer, more than in any other illness, the dynamic view emphasises the beneficial effects of participation by the patient on the outcome of therapy.

For many cancers there are no standard treatments and for many others different therapies provide similar results. Furthermore, conflict of interest between various specialists (surgeon, chemotherapist, radiotherapist) results in raising the hopes beyond those justified by the facts.

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Possible solutions

The specialist dominated, often autocratic, approach to cancer treatment, the standard pattern in the ***1960s*** in USA and UK, has undergone a change to a more open dialogue where the patient and physician are equal partners in decision making. A multi- dimensional approach is required to meet physical, psychological, social and spiritual needs.

The need for specific information varies between patients. In general, patients wish to be well informed about the diagnosis, therapeutic options, side effects and outlook. Some prefer details. Others are content with limited information. Still others prefer to have the possibilities of complications minimised or blunted. Breaking bad news therefore requires skills in communication and an understanding of the patient's mind and preferences.

We can take a cue from screening for AIDS and counsel all those who are afraid to face the diagnosis of cancer. Since up to 75% of patients with cancer in the west seek alternative therapies that offer hope, another approach may be to provide non- conventional therapy under the same roof.

Once I have identified the brave ones after a few meetings, I prefer to talk directly to them. For those who are scared, I disclose the news first to the spouse or a major son or daughter. As rapport builds up during therapy more information can be provided directly to the patient. Unfortunately, many patients with advanced disease come for a single consultation when palliation of symptoms is only therapy. Should we tell these patients the bitter truth? I follow Ambroise Pare's advice: 'Always give the patient hope, even when death seems at hand.' I believe that if your time has not come, even your doctor can't take you away.

References:

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2. Fallow Field LJ: Giving sad and bad news. *The Lancet* 1993;341:476-78.

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The Ministry of Information & Broadcasting, Government of India has allocated the title ***Zssues in Medical Ethics*** for our journal. We shall be implementing this change from Volume 4 starting January 1996.

Based on the feedback received from several subscribers and well-wishers here and abroad, we are introducing further changes. We are increasing the number of pages (including the cover) from 24 to 32 per issue. We are also doing our best to improve the layout with a view to making our pages easier on the eyes. These changes will increase the cost of production but we are not passing this on to our subscribers.

We continue to look forward to hearing from you. This journal is intended to serve as a forum for discussion on the ethics of the medical profession. It can succeed in its mission only if each of you participates in debates and express your own views, opinions and practices.

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