THOUGHTS ON WHAT TO TELL THE PATIENT WITH CANCER

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THE welfare of the entire patient as well as the treatment of his disease is the concern of the physician. To permit rapport between physician and patient, and to evoke intelligent cooperation in the therapeutic program, the patient usually must possess some knowledge of his disease. When a patient has cancer, the skillful and sympathetic interpretation of the disease may be for him the most important factor in the management of his case, and may demand the utmost delicacy, sensitivity, and sense of timing from his physician.

No set formula is to be followed as to what the physician tells the patient. Adherence to a specific policy such as—always tell a patient he has cancer— is as faulty as rigid observance of the opposite policy of—never tell a patient he has cancer. Indiscriminate application of the first policy may add unnecessary anxiety to physical suffering in a patient who neither wants nor needs the information. Indiscriminate application of the second policy may deprive him of information vital to his future.

Surgeons, and other physicians, who have occasion to treat many patients with malignant disease, generally develop a talent for handling this problem. It is usual for them fully to inform the patient who inquires about his illness or who must know for reasons of business or family responsibilities, but to inform him in such a way and at such a time that a major emotional upset is avoided. Often the patient has suspected the true diagnosis, sometimes for many months, and the explanation of his symptoms on a rational basis helps to restore a calm that has been shaken by uncertainty.

It has been my experience that patients with progressive cancer, who have been kept in ignorance of it by well-intentioned physicians, almost invariably are grateful for my frank answers to their questions. These patients were victims of a policy strongly advocated by a distinguished internist and teacher who pronounced from the rostrum in my hearing his belief that a patient with cancer should *never* be told that fact. I can only assume that this physician had a limited experience with patients having malignant disease, and that the few patients he actually treated had such advanced disease that no useful purpose could have been accomplished by discussing their problem with them. One wonders whether his practice could have included an intelligent woman who had undergone a mastectomy, a working man who had had an arm amputated (or needed to be convinced it should be amputated because of bone sarcoma), a patient whose basal-cell skin carcinoma had been undoubtedly cured by simple excision, or a father of small children who had specifically asked before his operation that he be told the exact nature of his illness so that he could make the best provisions for his family.

It is a patient with a limited intellect who will not suspect the meaning of repeated trips to the department of radiotherapy. If the information that he has cancer is intolerable to him, he will not commit suicide (as the family often fears), but he will reject the knowledge and create some satisfactory illusion for his psyche.

If a man or woman of affairs and responsibility asks a direct question about the nature of his disease, the physician assumes an unwarranted paternalistic attitude (and runs the risk of legal retribution) in failing to answer honestly. Some years ago, an industrialist who was a patient of mine had a cancer of the stomach which we thought we had removed completely. I told his wife the news immediately after the operation, and she insisted that her husband not be told. Furthermore, she was in his room and by his side every time he asked me a leading question, and her facial expression warned me into silence or deception, the way a baseball pitcher "looks" a runner back to first base. Convalescence was uneventful, but at his first postoperative visit, in the presence of his wife, the patient smiled enigmatically and asked me why I had lied to him. His own company insurance form had crossed his desk, giving the diagnosis. Fortunately his wife backed me up when I told him I had wished to tell him but she would not permit it. The matter was dropped, but it was the last time I have permitted anyone to exact from me a promise of silence or deception. The physician *must* preserve his right to act as he thinks best.

An argument that has proved helpful in convincing some families of the disadvantages of falsehood, is the observation that if the physician is willing to lie to the patient, he will also be willing to lie to members of the family when they in turn become patients. Thus, if he has good news to tell them, they can never be rid of the haunting suspicion that he is concealing bad news. It is also worthwhile to remind the family that the patient may learn his true diagnosis from a source other than the physician, and in a way far more disastrous to his peace of mind.

General Principles

Although no specific policy is advisable, it will help the physician to follow certain principles.

The responsibility of the physician is to the patient, or to his legal guardian, and not to his family, employer, or friends. Near relatives and friends almost invariably underestimate the ability of the patient to cope with a grave prognosis.

Truthfulness in the long run is almost always preferable to deception no matter how kind the motive prompting the deception.

Callousness or brutality in telling a patient is not synonymous with truthfulness, and is always avoidable.

No one knows exactly how long the patient is going to live, and there is always something more that may be done to alleviate the suffering. To quote in substance a distinguished teacher and clinician, Dr. J. Englebert

Dunphy[1]: "The patient with cancer is not afraid to suffer and he is not afraid to die, but he is afraid of being abandoned."

Factors Affecting the Information to Be Given the Patient

There are a number of factors that should influence both the timing of information given to the patient and the manner in which it is imparted. These factors include: (1) the probable course of the specific disease in the patient; (2) the nature of the responsibilities of the patient; (3) the emotional stability of the patient; (4) the physical state of the patient; (5) the probable wishes of the patient with respect to learning of his disease.

1. *The probable course of the specific disease in the patient.* If the lesion is in all probability cured, or if there is a reasonable chance that it is cured, in most instances the physician should so inform the patient promptly. This will encourage examinations and will also spread the news that some patients are permanently cured. Patients almost never experience a significant depression from such information.

If the lesion is hopeless and rapidly progressive, there will be patients who should not be told unless they specifically ask, or have responsibilities to others which may be directly affected. If a biopsy specimen has been taken, a few days of grace may be obtained by telling the patient his questions will be answered after the final pathologic report is available. The possibility of malignancy may be mentioned at this time, if it was not discussed before the operation. An occasional patient will insist on exact knowledge even in the recovery room a few hours after operation: under these circumstances it is usually best to give a straightforward answer at once.

The patient with the lesion that is hopeless, but in whom palliation may achieve essentially a normal state of health for many months (as in a biliary bypass procedure for a cancer of the pancreas which produces jaundice), poses a difficult problem. Certainly in patients judged to be unstable emotionally, the exact information should be withheld if possible until symptoms recur. This is probably a wise course to follow with all patients except those who make a point of asking direct questions.

2. *The nature of the responsibilities of the patient.* It is most unwise, if not actually unmoral or illegal, to withhold information, no matter how unwelcome, from the head of a household or a person in an important business or professional post. If such a patient does not make an inquiry, it is my practice to ask him direct whether or not he wishes to ask any questions. If he does not, I feel that my legal and moral obligations have been discharged. If he does not inquire, one may assume that the patient is aware of his trouble but does not wish to have it put into words.

If the patient is a mother with young children, and the husband does not wish her to be told, the physician need not volunteer information, but he should answer

direct questions from the patient. The same policy may be followed if the dependent wife of the patient is aware of the problem.

If the patient is a child, the decision as to how to handle information should be left with the parents or legal guardian, with the physician as consultant. An occasional patient under the age of 21 years will be benefited by being told in the right way and at the right time. Children with papillary carcinoma of the thyroid, who, although probably cured, will take thyroid hormone daily for the rest of their lives, should have the reason explained to them at some suitable time. Teen-agers are well able to cope with such knowledge.

3. *The emotional stability of the patient.* Some patients, characteristically women but occasionally men, will present clear evidence of an immature and dependent personality. Such patients rarely ask leading questions. If they ask questions, often the form of the question will tell the physician what they want the answer to be: "I don't have cancer, do I?" lets the physician surmise that the patient does not wish to hear that he has cancer. If the patient has no outside responsibilities, or if he has, and a responsible relative knows the diagnosis, no issue should be made of telling it to the patient.

4. *The physical state of the patient.* Patients who are moribund when the diagnosis of cancer is made should not be roused to be told what is killing them. When disease is obviously far advanced and life expectancy is to be reckoned in days or weeks, the patient and his family may be expected to be aware of the absence of health, for whatever reason, and it is hardly useful in any sense to burden the patient further.

Patients who have subnormal intellects or are otherwise incapable of understanding the issues, should not be burdened with information they cannot properly assimilate.

5. *The probable wishes of the patient with respect to his learning of his disease.* Here the experience of the physician plays a paramount role. The safest procedure is to assume that the patient will ask questions about the things concerning which he wishes information. The mode of asking will guide the physician to the appropriate answer.

Two Lay Objections Often Voiced to Telling the Patient He Has Cancer

1. *The patient will commit suicide.* Sometimes the patient will be quoted by relatives as having said that if he ever gets cancer, he will take his own life. This is frequently given as a reason for withholding the truth. In my personal experience of about a thousand patients having malignant disease of various types, I know of no suicide as a result of telling a patient he has cancer. The experience of other surgeons confirms this observation. If suicide occurs, it must be rare.

2. *The patient "can't take it" and will collapse emotionally.* A brief period of depression is a natural aftermath for the patient who learns of a hopeless condition. Most patients make a philosophic adjustment. Some will reject the knowledge to the point of apparently forgetting or ignoring it. It is a rare patient who lapses into profound depression, and the physical suffering that is usually present in such a patient is more likely to be the precipitating cause than the knowledge of his condition.

Answering the patient's questions is the safest guide. I have had patients state they wished some questions answered when I had time, but the questions when finally asked never touched on any unpleasant topic, but were concerned with such matters as, "When do I go home?"; "What is my diet to be?"; and so on. Some patients who have been told of the possibility of cancer before operation, never ask about it afterward. Such guides are more reliable, for withholding information, than the advice of close relatives and friends, who may remember him when he was at his most unstable emotional control, and who may unwisely try to make the physician promise not to tell the patient. I point out to such families or friends the sequence of events that all too often may occur with a patient who has a progressive disease but who is ignorant of its nature. The patient experiences exhilaration in the first few days after an operation if he believes something was accomplished. Then, with the disappearance of the operative pain, the old symptoms will reassert themselves and he will know he is not really improved. It is natural that he will lose faith in a physician who has not helped him and who appears to be belittling his symptoms. Families may take such a patient on a round of cancer quacks, expending thousands of dollars in order to maintain "morale." If the family sides with the physician, the patient can only conclude that his family too is against him. Withholding knowledge does not lessen the ravages of the disease, and it may make it worse by reason of the mystery of it.

Conclusion

The responsible physician should have no hesitation in frankly but tactfully answering questions asked by the patient, never estimating probable duration of life too closely, and always pointing out the availability of additional medical means of helping the patient. Patients in all likelihood cured of their cancers should usually be so informed. Patients with responsibilities should be given the opportunity to ask questions, although they may not avail themselves of it. Legally, the patient is entitled to pertinent information concerning his health, possessed by his physician. Emotionally, the patient often is calmed, rather than is agitated by a better understanding of his condition. The one situation where temporary deception may be in the best interest of the patient, is when palliation may produce months of normal health; but even then, direct questions should receive direct answers.

The physician will never go far astray if he answers the patient's questions truthfully yet tactfully.

Reference

1. Dunphy, J. E.: Changing concepts in the surgery of cancer. New England J. Med. **249:** 17-25, 1953.