



POSED BY MODEL, GETTY IMAGES, AND TIMES PHOTOGRAPHER, MIKAEL BUCK

Things to remember if you are the patient

- 1** Bring a friend along.
- 2** Ask your friend to take notes.
- 3** Don't ask for details about your prognosis at your first meeting with the hospital consultant.
- 4** Ask your consultant if he or she is an oncologist and request a referral to an oncologist if he is not.
- 5** Always tell your partner and children what is happening.
- 6** Make certain that you understand what the benefits are of the treatment that's being offered.
- 7** Make sure that you understand what the disadvantages of treatment might be.
- 8** Ask the doctor to summarise at the end of the consultation.
- 9** And for after that conversation... remember, there is always hope, and talking helps.

patients will incorrectly recall what the doctor has said to them, not because of a conscious process, but because their mind has been unable to cope with bad news and has modified it.

After talking about a cancer diagnosis, the next discussion point is treatment. The patient may not wish to hear details and the doctor has to be sensitive to this. The information may be too much to take on board, and so it is up to the doctor to read the signs and understand that enough is enough. More next time. Detail given later.

In that first conversation there is a broad brushstroke approach to the generality of cancer and its treatment, but it is prognosis that the patient is really interested in. Yet prognoses are fragile, statistical straws that are generalities relating to populations of patients but not to specific individuals. To give a prognosis for 70 per cent survival may be great news as a bottom line for the patient group as a whole but, in its specific, does not apply to the individual. Within the cohort of 100 patients who will be the lucky 70? Who will die and who will live? The statistic applied to the individual is almost an irrelevance. And patients have such a different view of statistics. What to a doctor is good news, 70 per cent survival, to a patient would mean bad news — a 30 per cent chance of death.

All of the detail of survival, all of the descriptions of treatment, are usually too much for a patient to take in at one interview. At the end of the talk the doctor generally will try and summarise his or her view in two or three sentences to ensure that they understood by asking the patient to repeat what has been said.

For doctors, breaking bad news can be a profound experience. My first conversation with a cancer patient was as a medical student and I found the implications of what I'd said very, very difficult.

We'd just spoken to a 50-year-old man about his leukaemia. His survival chance was very poor because at that time there was no effective chemotherapy and, for him, the realisation of his end was entirely understood. He turned away from us as we told him what was wrong, rolling over in his bed to face the ward wall. His desperation enveloped me, his sadness engulfed me. It was as if I were him.

At the end of the day, we students gathered in the medical school bar. It was frequented by the senior staff who'd come for a beer. Heinz Wolf, one of the two staff psychiatrists at the medical school, was there that evening. Wolf was a good old-fashioned Viennese psychiatrist, the sort with a heavy Germanic accent and eyes that seemed to know almost everything. He sat with us, saw that I was unhappy and found out why. He said that I was

experiencing how it really was and that I had felt things as they really were. He told me that with time I would cope a little better because time heals and allows the doctor to cope. My father, who was a psychiatrist, summarised the "doctor's way" so brilliantly, with his view that to be a good doctor you had to feel — but not too much. It's true. To feel too much

Angela Smith

My breast cancer diagnosis felt like being hit with a brick. I had some discomfort and had visited my GP for a check-up. The next day, I was sent to the breast cancer ward for tests. The consultant told me that he was not worried — that he thought the discomfort was an infection.

After the initial discussion, I was asked to wait. I waited and waited and was at the hospital for almost the entire day. The nurses kept telling me the doctor would see me in a minute. I thought they were busy, but now I know the significance of a delay. Eventually, I was asked to go into a room where the consultant and a breast cancer care nurse were waiting. I didn't at the time, but I now know that if a nurse is there, it means they are probably going to tell you bad news. I thought I just had an infection and my guard was down. I will never forget the doctor's words: "There are some abnormal cells in the samples that we have taken." My blood ran cold.

I knew exactly what he meant. I said: "But I was expecting to go back to work." Both the nurse and the doctor stayed quiet as I talked and tried to process the information. I remember repeating that I had a car full of files that I needed to work on. It felt as if a bomb had gone off.

They didn't give me much more information in that discussion but I went outside with the breast cancer nurse. When giving me the diagnosis, the doctor avoided using the most shocking word — cancer. The doctor looked miserable and I didn't need him to elaborate: I knew what abnormal cells meant. The nurse was



very tuned in to the shock that the news had caused and gave me a pack of information, which said on the front "For you to read when you are ready". When I looked at it later, I think it was the first time that I saw the mention of the word cancer in relation to my illness.

The diagnosis came over the new year and I had to call my ex-husband so that he could tell my children, who were away with him. My daughter followed him upstairs as she heard him saying "Oh dear" and shut the door behind him.

I had all my initial meetings with the doctor alone as things moved so quickly. I saw the GP on the Wednesday, I was at the hospital for the tests on the Thursday and by Friday I was in surgery. I had ultrasounds and X-rays and they talked me through everything they discovered as they found it. I was on my own in the hospital bed when the doctor sat down beside me to say that a lumpectomy wouldn't be enough and that I needed a mastectomy. I learnt then never to go near a doctor unless I had someone with me.

Now I have been clear of cancer for ten years and while I try not to think about it, I will never forget the pain and shock of that day.

means that you can't cope, and the doctor's spirit and strength is so important in the maintenance of hope.

I am often asked by family and friends of patients how they should talk to their loved one with cancer. It is not complicated, just listen. Being there is often enough. In dark days more is needed. Talk about good times, tell them of your lives together, ask them what they are worried about and tell the doctor of their fears, above all tell them that you will be OK when they're gone. If being there is not enough, ask what he or she is really worried about and then ask the doctor to talk to them.

Hope is not an illusion. It is a rock. You should encourage your loved one to have hope. It's a truth, not a lie, because at every point in a cancer patient's life there is hope, whether it is hope of cure or hope to ease symptoms. All along the way at every point in the path of a cancer patient's journey there are moments of hope, hope to go on, hope to deal with things, hope to inspire, hope to conspire against the devil that produced this disease.

Hope is not a cliché. It has come with the development of so many incredible treatments for cancer produced over the years of my life as a cancer doctor. Where before there were so few drugs,

now there are medicines that inspire; extraordinary medicines that have been manufactured on the basis of our understanding of the biology of cancer. We know now about the details of an individual cancer cell's biology, and with this understanding we have designed treatments that are specific to individual cancers. We have marvellous molecular therapies that target these changes.

Thirty years ago there were two or three tumours that were curable, but now death rates from many common cancers have fallen by 30 or 40 per cent and survival times, even in the presence of very advanced disease, have doubled or trebled. In my own unit over the past year we have looked at three new drugs for the treatment of cancer, two of which actually work.

So, it is true now that with these amazing clinical developments, conversations with cancer patients can realistically be about hope, and the doctor's responsibility is in communicating that inspirational hope.

Jonathan Waxman is the Flow Foundation Professor of Oncology at Imperial College London. His book, *The Elephant in the Room*, is out now. jonathanwaxman.co.uk

It's bad news... but there's always hope

Cancer sufferers live nearly six times longer than 40 years ago, a new report says. **Jonathan Waxman** describes the difficulty of telling patients they have the disease

Hello Mr Barnes, we haven't met before, how do you do? My name is Doctor Revell. I'm sorry, but you have cancer." It's the conversation that many of us dread, that we know we might have some place, somewhere, sometime.

But is this really how a doctor breaks the news that a patient has cancer? It certainly shouldn't be. In practice, the experienced doctor tries to work out what sort of a patient, what sort of a person, he or she is communicating

with. The doctor's judgments on how to talk to patients are made from the nuances of patients' behaviour, their manner, dress, educational background, from their responses to questions, the responses of their families, a whole galaxy of semiotics almost too complex to define.

From these impressions the doctor will feel his or her way towards understanding how the patient would like to deal with critical information. In breaking news, doctors go a bit at a time, asking questions and sensing from the patient's responses what he or she would like to know and what he or she would benefit from hearing in conversation about their cancer.

I have had countless such conversations in my years of being an oncologist. The truth may be told, but exactly how it is communicated successfully is a matter of sensitivity and skill.

Medical language is highly technical and generally incomprehensible even to the most educated of people, so the conversations that doctors have with cancer patients have to be very basic. The doctor usually starts by asking what the patient already knows about his or her problem. Often the patients' answers will be guarded, because they

The moment of truth: right, the oncologist Jonathan Waxman

are trying to find out what the doctor knows, mentally cross-referencing their answers with those given by previous health professionals.

There may be denial that any information has been given to the patient, who will say that he or she doesn't know what is wrong. So the doctor will ask: "Would you like me to tell you?" The doctor will then go a bit at a time, starting by telling the patient that they have found a growth. Amazingly, many patients have no understanding of the significance of the word "growth", and will ask the doctor what he means. The doctor will reply: "Well, by 'growth', we mean cancer or tumour."

In the flesh tones of conversation, a doctor will pick up clues of the degree and depth of the information required by that patient. The doctor will be listening to the nuances beneath the conversation. His or her words have to be judged carefully because every one of them is important and every one can be misremembered or misarticulated.

The doctor knows that what patients may hear him or her say is not necessarily what they remember. Many

