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Telling the patient

"The heart is grossly enlarged," said the postgraduate student after completing his examination, while a multinational force of his colleagues crowded around the patient's bed.

"Would you like to have an enlarged heart?" the instructor snapped.

"No, sir," answered the student, taken aback by the unexpected vehemence.

"Then don't say it in front of the patient," said the instructor.

The year was 1960. The instructor was Paul Wood, at that time doyen of British cardiology. It was also the time when doctors still deemed it imprudent to frighten their patients with bad news. Syphilis was still the specific disease, a cancer was a lump, patients were not told their blood pressure readings, and physicians spoke of "accelerated" hypertension so their patients would not think they had a malignancy.

Since that time the bedside manners have changed. Doctors no longer speak Latin to conceal the diagnosis. They tell what the blood pressure is, draw little sketches of malignant tumors, and let patients read their charts. For informed consent for a barium enema they now must list every possible danger lurking along the way to the x ray department: "You may fall down the elevator shaft; you may get stuck between floors and develop hypernatremic dehydration; you may trip on a banana skin because the cleaners are out on strike; you may die of passive smoke inhalation; they may mistakenly give you calomel instead of barium; the stuff may go up or down the wrong way; they may perforate your bowel; the barium may get absorbed and you may develop hypokalemia; you may never make it back to your bed; or the computer may reassign your bed and you may spend the night lying on the floor or sharing a bed with a stranger."

The medical literature is also replete with pronouncements by ethicists, lawyers, wise physicians, and people with cancer on how to impart bad news and offer truth without devastating the patient. These articles, often interspersed with passages from *The Death of Ivan Ilych*, emphasize that paternalism is dead and that patients need to know the truth so they can make appropriate arrangements. The doctor is variously advised to be detached but compassionate, not impersonal, not afraid to show emotion. Privacy is desirable, good eye contact recommended. The doctor should preferably be seated and should consider taking off his or her white coat--especially if it is blood stained. Doctors are advised to speak slowly and deliberately, choosing their words carefully. "X has died," for example, is thought to sound more humane than "X is dead."

Other articles point out that the patient has a right but not a duty to hear the bad news. Accordingly the doctor must probe gently, in what has been characterized as a series of complicated dance steps between doctor and patient, to determine how much the patient does want to know. Cultural differences are worth bearing in mind, doctors from eastern and southern Europe being more evasive and patients less inclined to want to hear the truth.

Such was the case of an elderly man from Cyprus--about to go home after a laparotomy--when his doctor brusquely told him that he had cancer, that he hoped it had been all removed, that it could recur, that he had a good chance of living many years, but that again he may not. The patient was incensed. He said that he had not asked and did not want to know. He promptly changed doctors and lived many years after this encounter.