COMMUNICATING WITH CANCER PATIENTS

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Communicating effectively with people can be a tricky business at the best of times. When the subject matter is incurable cancer, it can be a nightmare for doctors and patients. Do it well, and patients have a reasonable chance of adjusting to their situation; do it badly and they can become bitter and broken with a memory of the experience which they take to their deathbed.

To communicate well is such an important skill for doctors that it is worth reflecting on the art of it and examining our own performance against a few benchmarks of good practice.

Much of what doctors do is quickly and easily accomplished. Communicating well with patients in these circumstances may simply be a matter of imparting information courteously in clear and simply language. With cancer, as with some other incurable conditions, most patients regard the diagnosis as a death sentence and what we say to them brings them face to face with their own mortality and all the fears associated with an uncertain future. In these circumstances, communication is more than simply imparting information, although this is an important part of it. It involves establishing mutual confidence, trust and security in a relationship that will last throughout the course of the illness. Communicating effectively, therefore, is more a process than an event and is much more than the words that are spoken. The manner in which we conduct ourselves and the gestures we use are also important. Tact, sensitivity and gentleness are among the many qualities required. Touch, hugs, silence and laughter all have their place. What follows are some suggestions about the consultation process and the patients' responses which are intended to increase your awareness and thereby to improve your consultation skills when talking to patients with cancer. They mainly apply to the encounter when bad news is disclosed but many are relevant to any doctor/patient interaction.

THE CONSULTATION

- Always remember the simple courtesy of introducing yourself, shaking hands and inviting the patient to sit down when you meet for the first time. If this takes place at the bedside try to adopt a sitting position on the edge of the bed or a bedside chair, or simply squat by the side of the bed so that you are as near to eye level with the patient as possible.

- Try to ensure that the conversation takes place in a private room with a close relative or friend in attendance. Failing this (or in addition), a nurse known to the patient is a good substitute. Patients rarely request that they deal with you and your message on their own. If patients are too ill to sit or to be moved from an open ward, draw the curtains round the bed, position yourself as above and speak clearly and softly, yet loud enough so that the patient can hear what you have to say.

- Maintain eye contact and don’t look shifty.

- Have all the relevant clinical information to hand and know a plan of action. Where there are uncertainties it may be appropriate to share them. Be honest at all times and do not attempt to hide anything when direct questions are asked. Stick to facts and avoid speculation. This applies particularly to question about lifespan and how the future will unfold. Estimates are usually wrong and are difficult for patients to live with.

- Avoid euphemisms for cancer. Patients may misinterpret them. Try to steer the conversation so that patients use the word 'cancer' first. You will simply confirm it. This can be done by open questions such as 'Do you have any idea what may be the matter with you?' or 'Do you have any suspicions yourself?' Most cancer patients suspect the diagnosis before it is confirmed.

- Invite questions, for it is vital that patients have the information they require. Rather than telling what you know, however, try to respond to their questions. In this way patients dictate the amount and the pace of the flow of information. Some patients carry a tape to record the conversation. This should be encouraged.

- Don’t feel awkward with silence. Let the patient be the first to break it.

- Encourage patients to express their fears. Many of these are based on an experience of cancer in a relative or friend from years before. Common misconceptions are that cancer is always painful, deforming or odoruous. They may need reassurance that most symptoms can be treated and that suffering can be avoided.

- Touch can be an important component of a doctor/patient communication episode. A squeeze of the hand at the right moment can be reassuring and a hug can be comforting. With hugging, it is probably best if the patient makes the first move and prudent to have a nurse somewhere in the background.

- Avoid using words like ‘nasty’, ‘aggressive’, ‘rampant’ or ‘eating away’ when describing the cancer. They conjure up images which horrify many people and have no place in a clinical context. The ‘aggressive’ lymphomas are generally those which have the greatest potential for cure, yet to patients the word implies a rapidly fatal outcome.

- Investigation results are a difficult issue, particularly radiological investigations which indicate the extent of the
disease or the response or resistance of the disease to treatment. The implications to patients are enormous and systems should be in place for the results to be transmitted to patients without delay. At best, the radiologist will discuss the findings on completion of the test. Otherwise a telephone call to the clinician who arranges to meet or speak to the patient or the GP thereafter is reasonable. To wait for an outpatient clinic appointment which may be some weeks away is not acceptable.

- Make sure that GPs are informed about the clinical details and the content of the conservation with their patient. The cancer nurse specialist can act as an intermediary with the primary care team and the various agencies for psychological, social and practical support in the hospital, hospice or the community.

- It helps if you can conclude the conversation on a positive note. Try to focus on what can be done rather than what is not possible, for this can leave the patient with a sense of hopelessness. Be prepared to discuss treatment options where these exist, so that patients have a sense of control and ownership over the course of action which is agreed. It is always useful to indicate the general purpose of any treatment plan. If cure is possible, say so. The reason for adjuvant therapies is to increase the cure rate and it is better described this way than by saying it reduces the relapse rate, although of course it amounts to the same thing. If cure is not possible, treatments such as surgery and chemotherapy can sometimes bring about disease control which results in an improvement in symptoms and, usually, an increase in life expectancy. It is helpful to present it to patients this way. If there is no case for active intervention either because of inoperability or chemotherapy resistance, it will be necessary to explain this to patients and the reasons why. Rather than say 'there is nothing more we can do' try saying that 'the emphasis in treatment has switched from the disease process to the management of your symptoms' or 'we shall focus on the quality of your life and whatever happens you won't be dealing with it on your own'.

THE RESPONSE

Whilst doctors can, with care, get this much right, dealing with the patient's response may be more difficult because responses are unpredictable and it is all too easy to be thrown by them. Take anger, for example. The messenger becomes confused with the message, and the doctor can become the target of the patients' or relatives' fury, which is really directed towards the disease itself. There is no easy way to handle this. Calmness is required. Stay seated and try not to react whilst the anger dissipates. Being confrontational will make matters worse. You may pinpoint a cause for the anger which is to do with the process of the diagnosis. At some point it would be necessary to go over the ground in detail, offering reassurance or apology as appropriate. More often, anger is about unfairness, why me?, a life spinning out of control. Time, perspective and an action plan will go some way towards resolving it. This also applies to the patient who responds with panic. In both situations it is unlikely that much progress will be made in the first consultation. For one thing, much of what is said is not heard and patients will recall their feelings and your attitude rather than any explanation which you have given. Hence the importance of your conduct during the consultation. The support services are critical at this stage. Wherever possible a cancer nurse specialist should be present, with the patient's permission, during the consultation, or be available very soon after it. This enables the nurse to hear what is said and witness the response. As well as being useful for any future encounter she may have with the patient and family, she acts as a calming influence and is seen to be 'on the patient's side' in the battles that lie ahead. Usually the nurse will arrange to phone or visit the patient soon after the consultation, when she will cover the ground again, but this time in the comfort of the patient's home and after the initial shock has passed. Referral may be made to the network of local support services made available through CancerCare, which includes a range of options for relaxation, counselling and psychotherapy.

Withdrawal is the most difficult response to handle. At least with anger and panic, the patient is communicating. When there is little or no response (or worse, if there is denial of what is being said), considerable patience is required. It is rarely appropriate to give factual information which has not been asked for by the patient. If after posing the question 'is there anything you would like to ask me about your illness/condition?' the answer is 'no' this must be respected. It is, however, important to give the patient the opportunity to ask. There are patients who simply do not want to know and for them, this approach may be the only way they can cope and face the future. This may be one of the few situations when it is reasonable to inform a close relation rather than the patient about the diagnosis, although the patient's consent to this should always be sought first.

THE ADJUSTMENT

With incurable cancer, the situation usually unfolds over time, which gives patients the opportunity to adjust to each phase of the illness. There are difficult times such as relapse, withdrawal of active treatment and the terminal phase, when particular issues arise, notably those about death. Terminal illness brings physical dependency. We can only 'be', we can no longer 'do'. One of the sadnesses about our culture is that our worth is measured in terms of our status, our achievements and our monetary value. One of the lessons we must learn is that our true worth is who we are and how we are with one another. This revelation can be transforming. It may bring about a desire to re-establish broken relationships, to set the record straight, to deal with unfinished business and to forgive and be forgiven. A healthcare professional who has developed a relationship with a patient based on the principles described above may be in a uniquely privileged position to facilitate this process of adjustment and confrontation with death.

There are curious examples of patients whose adjustment is blocked by some painful experience which has been suppressed and not dealt with, often from long ago and since forgotten. Manifest as unusual or disturbed behaviour, the patient is unaware of the connection. The astute healthcare professional will explore the patient's background and may discover the cause. One such example was a woman in her 60s with widespread metastatic bone disease from breast cancer. She was physically disabled by cervical spine instability and required total nursing care. She was difficult, demanding and uncooperative, behaviour which was out of character yet understandable in the context of her illness and her expectation that death was imminent. A family history from the patient led us to believe she was an only child. A careful review of her life history with a longstanding friend revealed that she had had a brother who had died in adolescence. Raising this with the patient was distressing and painful. She told us that she and her brother
had been inseparable. When he was obliged to join the Royal Air Force as part of the war effort she was so angry that she never said goodbye. He was killed during the first training exercise, not even gloriously on the field of battle. As she relived the experience she talked to her brother as if he were there. Tearfully she asked for his forgiveness. The remaining two weeks of her life were different: her anger had dissipated and she died at peace.

**SUMMARY**

Good communication with patients is essential to good clinical practice and is especially important in establishing a trusting and secure relationship between doctors and patients with an incurable illness. The observations in this article are drawn from the experience of my work with patients with cancer. I believe that they are widely applicable and should form the basis of any relationship between doctors and their patients.

**RECOMMENDED**

**Short story:**
A Small, Good Thing

**Where:**
Cathedral, by Raymond Carver, published by The Harvill Press, London
ISBN 1 86046 387 8
Available in Waterstones and Hammicks, £8.99

**What's it about?**
Ann Weiss places an order for a birthday cake with a baker. Her life is overtaken quite slowly by a catastrophic event which brings the two of them into conflict at first. Later on, they talk into the early morning about their lives, the hospital, the doctors and more.

**Why is it worth reading?**
Because it reminds us about the power of reconciliation when communications go wrong. It says much about the commonplace of medicine and is beautifully written.

**INSTRUCTIONS**

Contributions are invited. Almost anything which is pleasurable or gives an insight into the human condition will be considered. Creative work is preferred but classical scientific monographs may be accepted.

The recommending author should say how readers can gain access to the work. They should give a brief synopsis without revealing too much, rather like a book cover, and explain why fellow readers should make the effort.