Prostate Cancer and Prostatic Diseases (1998) 1, 177–178
 1365–7852/98 $12.00
http://www.stockton-press.co.uk/pc

Editorial

Breaking bad news

Being told for the first time that you are suffering from prostate cancer is a defining moment that one is unlikely ever to forget. Since prostatic malignancies are so common, clinicians quite often find themselves in the position of being the one who has to break the bad news. There are good and not so good ways in which this can be done, but prostate cancer counselling is not a topic often discussed. Traditionally doctors have shied away from telling their patients the truth: in 1672 the French physician Samuel de Sobiere[1] considered the idea, but thought that it might seriously jeopardise his medical practice! In 1961 a landmark paper by Oken[2] revealed that 90% of surgeons in the United States would not routinely discuss a diagnosis of cancer with their patients. Subsequent studies showed however that a growing proportion of patients wanted to know about and understand their diagnosis.[3] Attitudes have gradually been adapted to meet patients' needs, especially in the United States, and nearly 20 years after the Oken study Novack *et al*[4] repeated the survey. They showed that by then there had been a sea change in attitude among doctors, with more than 90% of American physicians saying that they would tell their patients if they had cancer. However, this change has not always been mirrored in other parts of the world: a survey of British family practitioners and hospital consultants in the early 1980s, for example, showed that 75% and 56% respectively did not routinely tell their patients about a diagnosis of cancer.

It is not hard to understand the main reasons why clinicians wish to avoid sharing bad news with their patients. It can be harrowing to be the harbinger of gloom and then have to support and assist patients as they absorb and understand the nature of their illness. Traditionally clinicians have found two main justifications for keeping their patients in the dark. Firstly, the facts might upset them. This is undoubtedly the case, but that line of reasoning has never been acceptable to any other profession in which the news might be bad, for example stockbrokers, lawyers and so on. Secondly they, and sometimes the close relatives, presumed that patients do not really want to know.

In fact several studies have confirmed that the opposite is the case: for example Meredith *et al*[5] studied 250 patients attending a cancer centre in Scotland. They found that 79% of patients wanted to know as much as possible about their disease and 96% specifically wanted to know if their disease was cancer. Almost all the patients wanted to know the chances of cure and details about the side effects of treatment. In another study[6] patients reported that they felt it their right to have information about their diagnosis and that they should determine who else was told. All patients felt that family members should be told provided that the patient had given permission, but nearly two thirds felt that if the patient did not wish the information to be given, then the family should not be taken into confidence.

How then should the caring physician break the bad news to a patient newly diagnosed as suffering from prostate cancer? Naturally most of us feel uneasy when in this position and perhaps anxieties about techniques of communication underlie most of the arguments for not telling the truth. One of our difficulties in the field of prostate cancer is the considerable uncertainty that persists about the most effective treatment option. Furthermore, many of us have had little or no training in counselling and we are often pushed for time in our busy clinics. The difficulty is to convey the information sensitively and supportively in a way that the patient can understand and not to appear rushed. Many of my own patients have admitted that they understand hardly any of the things that they were told in that traumatic interview when the bad news was broken. 'As soon as you said the word *cancer* doctor, my mind went blank.' Having a close relative in the consulting room at the time of the consultation provides a second person to absorb the information as well as providing emotional support to the affected individual. Written information about the disease and its affects on the patient and his partner to digest when they get home is usually much appreciated. Urologists could learn much from the breast surgeons who have, not only well developed, easy to understand literature available, but also specially trained nurses to provide counselling and support for patients immediately after the diagnosis of cancer has been disclosed and afterwards as the news sinks in. Information about specific patient support groups available can also be very helpful, many of which are now very active on the Internet.

The impact of urological cancer on the patient's partner is another important, but often neglected area. The treatments that urologists use in prostate cancer commonly impact on sexual function and these need to be discussed not only with the patient but also with his spouse. The consequences of loss of libido, erectile dysfunction and ejaculatory disturbances need to be sympathetically explained to both partners. Failure to do so effectively can have a very negative impact on the relationship. As men, particularly older men, who have been diagnosed as suffering from cancer are particularly reliant on the social support that stems from intimate relationships, withdrawal from sexual relationships may have severe consequences on both their quality of life and overall health. These issues are discussed in depth in a review article in this issue of *Prostate Cancer and Prostatic Disease*. Sympathetic, unhurried counselling of the couple about this aspect of their lives, as well as about the treatment and its side effects is obviously essential.

Learning how to break bad news sympathetically and effectively is an acquired skill. The materials are now

available to help us all in this respect. There are books[7] and videos that describe the practicalities of breaking bad news, which include ways of finding out whether the patient wishes to know or not. There are even materials available for patients to help them to get the best out of communications with doctors, although we should hardly need our patient's help in order to help them.

Nowadays there is no excuse for the clinician who simply does not want to perform this important part of his/her job. It needs to be done and with attention to detail it can be done well. It has aptly been said that 'if the breaking of bad news is done badly, patients and their families may never forgive us; by contrast, if we get it right they will never forget us'. The challenge for clinicians everywhere dealing with prostate cancer sufferers is to improve this important aspect of their work.

RS Kirby

References

1 De Sorbiere S. Advice to a young physician respecting the way in which he is to conduct himself in the practice of medicine. In: Katz J (ed). *The Silent World of Doctor and Patient*. Free Press: New York, 1984, pp 10–12.
2 Oken D. What to tell cancer patients. *JAMA* 1961; **175**: 1120–1228.
3 Northouse P, Northouse LLO. Communication and cancer: issues confronting patients, health professionals and family members. *J Psychosocial Oncol* 1987; **5**: 17–45.
4 Novack DH *et al*. Changes in physician's attitudes toward telling the cancer patient. *JAMA* 1979; **241**: 879–900.
5 Meredith C *et al*. Information needs of cancer patients in the west of Scotland. *BMJ* 1996; **313**: 724–726.
6 Benson J, Britten N. How much truth and to whom? Respecting the autonomy of cancer patients when talking to their families—ethical theory and the patients' view. *BMJ* 1996; **313**: 729–731.
7 Buckman R, Kason Y. *How to Break Bad News—A Practical Guide to Healthcare Professionals*. Macmillan: London, 1993.