Coda

Breaking the news

We all commiserated as our colleague told us about her awful consultation the previous day. She had had to tell a man in his fifties that his ultrasound scan had shown a mass in the head of his pancreas, almost certainly a carcinoma. The man clearly hadn’t been expecting bad news, and had turned up at the surgery on his own, with a rather jaunty manner. To make matters worse, she had never met the man previously—she was covering for someone else that day. We squirmed and offered our sympathy as she described the encounter unfolding from moment to moment. She was honest enough to admit that she hadn’t actually liked the man, who had been a bit smelly. At the end of the consultation she had wanted to hug him, or at the very least to touch him on the arm, but found herself unable to. We were all experienced educators as well as clinicians, and we tried to cover every angle in our discussion: the painfully inappropriate circumstances in which we often have to break bad news; the way in which negative impressions can disable our compassion; and how we aspire to the impossible task of spelling out a death sentence nicely, and feel like failures when it never quite happens that way.

Yet afterwards I pondered on her story and I couldn’t get another, heretical thought out of my mind: why did the doctor have to tell the truth? There must have been a dozen ways in which she might have delayed or underplayed telling the man the full scan result, at least until a relative could be present—or until the patient’s usual doctor was available. We were all experienced educators as well as clinicians, and we tried to cover every angle in our discussion: the painfully inappropriate circumstances in which we often have to break bad news; the way in which negative impressions can disable our compassion; and how we aspire to the impossible task of spelling out a death sentence nicely, and feel like failures when it never quite happens that way.

Yet afterwards I pondered on her story and I couldn’t get another, heretical thought out of my mind: why did the doctor have to tell the truth? There must have been a dozen ways in which she might have delayed or underplayed telling the man the full scan result, at least until a relative could be present—or until the patient’s usual doctor was available. It took little imagination to think of various forms of subterfuge that she might have used: ‘the result isn’t back yet...’, ‘it’s back but it’s not entirely clear...’, ‘I’m a bit puzzled about its significance and I need to discuss it with a colleague...’ If such prevarications had raised the patient’s anxiety, would that have been so terrible, especially by comparison with what actually did happen? I recalled that a generation ago, few doctors would ever have dreamed of telling this man the truth in this way. And surely no group of medical educators at that time would have failed to mention, or even to think, that it might have been done differently.

Autres temps, autres moeurs. But culture makes a difference too. A week later, I was teaching a group of interpreters and linkworkers, mainly from eastern Europe. The same theme arose again. One of them described, with horror, how a friend of hers had been to see a doctor in London who had told him—‘by himself, on the spot, there and then’—that he had a lymphoma. Back home, she said, no-one would ever give someone such information without first checking with the family whether the patient had the resilience to absorb it, or to cope with it. When she said this, her peer group murmured their agreement, and by implication expressed their disapproval of the brutal and uncompromising frankness of British doctors.

As it happens, her views find support in cross-cultural research about death and dying. In many parts of the world, and among many cultures, people still take a far more circumspect approach to the disclosure of a terminal illness than we generally now do in the West. According to medical anthropologists and family researchers, this may have nothing to do with paternalism or with a fear of being honest. Instead, it may arise from a belief in the crucial importance of sustaining hope as a life force, together with a radically different understanding of the duties of the individual towards the family and vice versa.

‘In cultures where the family is the unit of identity and responsibility,’ writes Lucy Candib from the University of Massachusetts, ‘interdependence is the higher value, not individualism... The patient knows that family is protecting her and that this is what families should do... Non-disclosure is not a matter of lying. Ambiguity may be seen as the most suitable strategy to allow the patient to maintain tranquillity’.

Candib cautions us, however, against making simplistic assumptions that everyone from within a certain culture will share the same preference for or against knowing the truth. She advises physicians to ‘offer the option of truth’ when breaking bad news, regardless of where the patient
comes from. She suggests using questions such as these: ‘Will you want to be making the decisions about your care with the doctors, or do you want your family to be making those decisions?’ and ‘When we understand what is causing your illness, will you want us to tell you about it, or to talk with your family about it?’

This kind of sensitivity to cultural and individual norms is gaining increasing support among medical ethicists. Following several decades of so-called ‘principlist’ ethics (based on the four well-known principles of autonomy, non-maleficence, beneficence and justice), an increasing number of theorists now seem to be moving towards a more flexible and relativist approach known as ‘narrative ethics’. One of the central tenets of this approach is that every situation is unique and unrepeatable, and cannot be fully captured by appealing to universal principles. Any decision or action is therefore justified in terms of its fit with the individual life story of the patient, and needs to be sought through conversation rather than based on prior notions. Narrative ethics also ‘encourages multiple voices to be heard and multiple stories to be brought forth by all those whose lives will be involved in the resolution of a case. Patient, physician, family, health professional, friend and social worker, for example, may all share their stories in a dialogical chorus that can offer the best chance of respecting all the persons involved in a case’.3

Seen in this light, our colleague’s assumption that there was only one right action when faced with the jaunty man with pancreatic cancer might be seen as an example of die-hard principlism, with an excessive bias towards the notion of autonomy. But then again, to be entirely fair to her, where can most of us find a ‘dialogical chorus’ to help us with our ethical dilemmas, on an average working day in the National Health Service?

John Launer

References