Summary

This chapter focuses on four crucial situations representing important challenges for physician–patient communication: diagnosis, relapse, progression of disease and terminal illness. The psychological aspects of each situation are discussed and a framework for communication is provided. The aim of the chapter is to invite the oncology clinician to think about these different stages of disease and to support him or her in the communication with the patient.

Communication with cancer patients is a difficult task in clinical practice and it is especially challenging when informing about diagnosis and prognosis, when relapse occurs or when the disease is progressing. Physician–patient communication has undergone considerable changes and has become—compared to decades before, when medicine was based on a more paternalistic model of care—a central duty and challenge of the oncology clinician. The following chapter aims to discuss key elements of communication in the above-mentioned specific situations; it is based on our clinical experience as psycho-oncologists and teachers of communication skills training (Razavi and Stiefel 1994; Stiefel and Razavi 1994; Razavi et al. 2003; Berney and Stiefel 2004; Delvaux et al. 2005; Voelter et al. 2005; Bragard et al. 2006).

4.1 Disclosing a Cancer Diagnosis

To face a diagnosis of malignant disease is an extreme stressor. What has been a silent and reliable body suddenly becomes a source of doubts and fears, disturbing—together with the associated investigations and therapeutic propositions—the psychological and social balance of man. However, reactions to these events vary considerably from individual to individual, depending on a variety of factors, such as personal resources, social support, coping and defence mechanisms, such as denial. In other words: individual strengths and vulnerabilities shape the response to the bad news of a cancer diagnosis. Communicating such a diagnosis, therefore, requires an adjustment to the individual information needs and coping capacities.

The oncologist often does not know the patient to whom a diagnosis of cancer has to be announced. A few elements may therefore be of help for the evaluation of the patient's psychological state to which information will have to be adapted. The main question is, when communicating with a newly diagnosed cancer patient, whether he is a vulnerable patient to whom communication has to be especially tailored or whether he is a patient who may be informed in a standard way, taking into account the usual recommendations when announcing a cancer diagnosis (see next section).
4.1.1 Perceiving the Patient’s Strengths and Vulnerabilities

As stated above, the oncologist may not know the patient for very long and it may be inadequate or impossible to obtain detailed biographical information before breaking bad news. A few elements, related to the current situation, may therefore be of help to quickly evaluate the psychological strengths and vulnerabilities of a patient (see Table 1).

The patient’s delay between the occurrence of the first symptoms and consulting a physician is such an element. The longer the delay, the more likely the patient may have used denial; denial is directly related to psychological vulnerability. As a psychological defence mechanism, denial protects the individual from painful experiences he cannot bear (Weisman 1979). Other important elements concern the current state of the patient. Is he able to function in his professional and private life? Was he disturbed by the situation in a way that hampered his capacities to work or to care for the family? Was he able to maintain social contacts and activities or was he paralysed by the occurrence of the medical problems? Symptoms related to bodily functioning may also indicate a psychological vulnerability of the patient; how did she sleep and eat, did she suffer from gastro-intestinal symptoms, was she unable to relax? If patients are able to express their feelings, are the emotions in an adequate range or are they overwhelming the patient? If different elements indicate an important vulnerability, information should be carefully adapted to the individual.

4.1.2 Discussing Diagnosis with a Psychologically Vulnerable Patient

With a general clinical impression based on some of the above-mentioned elements and the verbal and non-verbal communication of the patient, the oncologist can identify the patient’s strengths and vulnerabilities. If the clinician faces a vulnerable patient who seems to be very stressed and almost unable to cope, communication of the cancer diagnosis should be adapted in a way that the patient obtains the information he needs without increasing the psychological pressure (see Table 2). Communicating diagnosis should then focus on the most relevant aspects, leaving out details and future steps that do not have to be taken immediately (Voelter et al. 2005). Special attention should also be paid to the therapeutic options the oncologist has to offer; a clear agenda of the next steps and information about the accessibility of medical care at any time will reassure the patient. Asking the patient if there are additional questions and concerns or if she would like to have a significant other to be with her at the next consultation, may close the consultation (Maguire et al. 1996). In other words, information of vulnerable patients should be kept clear and simple and it should be also emphasized that the therapeutic steps are specifically defined and usually well tolerated.

Vulnerable and overwhelmed patients are sometimes confused and ask a lot of questions in an attempt to gain control over the situation; but any additional information, even if it is medically correct and adapted to the questions, may

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Table 1: Indicators of psychological vulnerabilities of a patient

- Important patient’s delay despite alarming physical symptoms
- Inability to work or to assume other responsibilities
- Occurrence of severe sleep or gastrointestinal disturbances
- Experience of long-lasting periods of overwhelming emotions
- Social withdrawal, substance abuse, self-destructive behaviour

Table 2: Breaking bad news to the psychologically vulnerable patient

- Try to understand patient preferences with regard to information
- Focus on the “essentials”, use understandable words, avoid “jargon”
- Provide a clear framework/management plan
- Emphasize that beneficial therapeutic options exist
- Invite patient to cope “day by day” and “step by step”
- Inform about well-known medical experience with patient’s disease