In the decade between 1920 and 1930 the life-span of the normal Italian population was about 50 years, and it gradually increased, reaching a mean of 70 years in the decade between 1980 and 1990 (ISTAT report: Le Regioni in cifre, Rome 1990). Approximately the same trend has been found in all developed countries: for Benton R. Adkins et al. (Surgical Care for the Elderly. Williams and Wilkins, Baltimore, 1988) the probability of survival in the United States has reached 16 years for people of 65, and more than 10 for people of 70.

This increasing longevity in the human species is due, at least partially, to reduced or delayed tumour-related mortality: around half of the known types of cancer are present nowadays in a completely curable phase, and more than another third can be effectively palliated, allowing for our patients to have several years of normal or nearly normal survival.

The best achievements have occurred in some forms of less common tumours, like the lymphomas and germ cell tumours, but also breast cancer and small-cell lung-cancer, and most of the characteristic infantile cancers have increased chances for survival and cure. Many of our patients have been observing for years this improved course in their relatives and friends: but this favourable evolution has not yet changed the myth bound to the word cancer; and so it is with the prejudices of many doctors, who still too often adhere to the mentality of lay people.

But Cancer, the word itself, for the man on the street still means “going straight to death with plenty of suffering”.

Concern about the risk of deteriorating the life-quality of the informed cancer patient has long been an alibi for non-communication. Sometimes patients are not so concerned since the start with their first signs and symptoms, but often they are, and they overtly show such concern: the doctor may be human, silent and involved in the patient’s psychological suffering; but remaining silent however is not justified: let us see why.

One author states: “In Total Care we need informed consent, informed choice and good communication between patient, family and medical staff. These are essential for improving the quality of life (QoL) of cancer patients”
(Deeken, 1995). Indeed an old-fashioned paternalism in information, apparently easier to manage, has become incongruous, while the awareness of the problem favours in patients the ability to cope with such difficulties. Now the Law, Moral, and Insurance rules, require a different approach, and the treatability of many cancer conditions has helped change this outlook.

“Death must be met with dignity by a conscious person, who has been informed and has been a protagonist during the disease course”, says Cattorini philosophically in his 1996 report. According to the opinion of this author, the QoL of the terminal patient is deteriorated by all ways of facing death different to the one that he proposes.

_Our personal experience_ is that the sensible doctor feels anxious and nearly frightened when preparing to speak the truth, but we at all times feel relieved after having spoken, because the reaction of the patient is usually human and constructive, beyond the negative expectations of relatives and friends.

The reason for this is that sharing all information with the patients has favoured the patients’ active participation in treatment planning: the informed patient generally hopes to be able to help modify the disease course and will share or even favour the active optimism of the therapeutic team. Santos in 1994 also affirmed: “The knowledge of the truth has commonly a positive effect on the doctor/patient relationships.” Accordingly it may (and should) be a real effort in our daily practice to disclose information. At first, patients may be struck by what the doctor opens up, but just some hours or a couple of days later, inevitably they will reach a more serene approach.

Doubts concerning diagnosis, the terror of the unknown, fear over the obscure words and the unpredictable nature of suffering, are transformed by this information into an active and constructive approach, and there is less space left for despair.

In a loyal cooperation, the patient and doctor become allied in combating the disease. The aim of their battle cannot always be the victory (or cure). But “not-being-alone” makes a big difference: this condition is often referred to as “therapeutic alliance”.

Gupta in 1996 reported the example of a Hindu woman, living in a small country-town of India, where she was surrounded by a sweet and loving family, who was found to have a cancer: nobody spoke frankly to her in her native area, and she was sadly living this fear of the unspeakable and unknown. Then, for treatment, she was brought to a Canadian hospital, where all the diagnostic, prognostic and treatment programs were made clear by sensitive physicians and nurses. Not only did she adhere to the program and attain a more serene attitude, but when going back home she searched for people