Telling the patient

AUDREY W. M. WARD LL.B., Dip. Soc. Studies
Independent Research Worker, Medical Care Research Unit,
Department of Community Medicine, University of Sheffield

Was it your very predicament that
made me sure I could trust you, if I were
dying, to say so, not insult me with soothing
fictions?
W. H. AUDEN. *The Art of Healing.*

SUMMARY—The general practitioners of 279 patients who died from malignant disease were asked whether they discussed the diagnosis and prognosis with the patients. Thirteen per cent did so. They were more likely to discuss with women than men, and social class patients 1 and 2 than classes 3, 4, and 5. They thought that notwithstanding whether or not the matter had been discussed nevertheless 46 per cent of the patients knew. The chief carers (usually relatives) of the patients thought that 54 per cent of the patients knew.

Introduction

During an investigation into terminal care in malignant disease in Sheffield, an opportunity arose to find out which patients were told by their general practitioners of their condition, and which of them ' knew ' what was the matter.

Several investigators (Fitts and Ravdin, 1953; Rennick, 1960) have found that generally doctors do not tell, basing their behaviour on the belief that ". . . people as a whole are far happier if they do not know."

The evidence for this belief is scanty, mainly on account of the difficulty of asking patients their views; but studies which have been undertaken, for example by Kelly and Friesen (1950) and Aitken-Swan and Easson (1959), suggest that the reverse may be the case, and that patients do want to be told.

Studies of doctors' behaviour so far have investigated the usual conduct of the respondents, and have not related their answers to individual patients (Oken, 1961; Cartwright, 1973).

Method

In 1971 the study of terminal care mentioned above included questions to general practitioners about specific patients. A complementary enquiry was also directed to the responsible relatives or other chief carers.

The patients were the 279 people who died in Sheffield during the months of May to August of carcinoma of the pharynx, bronchus, breast, stomach, colon, and rectum. As soon as possible after the death the general practitioner was asked either if he would be interviewed or if he would complete a questionnaire. Both forms of enquiry included the questions:

(1) Did you ever discuss the diagnosis and prognosis with the patient?
(2) Notwithstanding your answer to question (1) did the patient know?

Ninety per cent of the doctors answered these questions.

Three months after the death the chief carers were also asked whether they thought that the patient knew, and 87 per cent of them answered this question.

Results

The general practitioners discussed the diagnosis and prognosis with 13 per cent of their patients. The proportions were significantly different between the sexes, 22 per cent of the women being told and only 7·5 per cent of the men ($\chi^2=9·67$, $p < 0·01$).

This difference might possibly have occurred because for one of the sites (breast) there were no male patients; and doctors may be more ready to discuss a malignancy in a conspicuous site where some of the treatments are easily apparent to the patient. But where breast has been excluded from the list of sites there remain significantly more women who were told (table 1).

TABLE 1
WERE THE PATIENTS TOLD?

Sites	*Men*		*Women*	
	Yes	No	Yes	No
Pharynx	–	3	2	–
Bronchus	8	92	1	20
Breast	–	–	7	17
Stomach	2	29	6	16
Colon	2	14	3	11
Rectum	–	10	1	7
	12	148	20	71
All sites	7–5%		22%	
(Excluding breast)			19%	

χ^2 (Men v women, excluding pharnyx and breast, and 28 not known)=(2df) 6·67; 0·05>p p<0·05

Age made no significant difference to the likelihood of patients being told but there was a difference between the social classes (table 2). The doctor was more likely to discuss the diagnosis and prognosis if the patient was of social class 1 or 2 (26·8 per cent) than if he was of classes 3 (9·4 per cent), and 5 (11·9 per cent) (χ^2 8·3405; 0·05>p>0·01).

TABLE 2
WERE THE PATIENTS TOLD? (BY SOCIAL CLASS)

Social class	*Men*			*Women*		
	Total	*Number told*	*per cent*	*Total*	*Number told*	*per cent*
1 and 2	25	6	*24·0*	17	5	*29·4*
3	95	4	*4·2*	54	10	*18·5*
4 and 5	40	2	*5·0*	19	5	*26·3*
Total	160	12	*7·5*	90	20	*22·2*

Men social class 1 and 2/3, 4, and 5 $\chi^2=10·4779$ 1df $p<0·01$
Women social class 1 and 2/3, 4, and 5 $\chi^2=0·1447$ 1df n.s.

The difference is most clearly marked among the male patients, 24 per cent (six) of those in social class 1 and 2 being told against four per cent (six) of those in social classes 3, 4 and 5. This appears to confirm Cartwright's (1973) findings on the response of general practitioners when faced with some hypothetical situations. Among the women the difference was not so acute, 29 per cent (five) of those in social classes 1 and 2 were told and 20·6 per cent (15) of those in classes 3, 4 and 5.

In a series which contained an average of only two patients per doctor it is not possible to draw any firm conclusion about the characteristics of doctors who said they

discussed the diagnosis with their patients. Twenty-two doctors out of about 140 said that they did so on at least one occasion. However, out of the six of these who had more than one patient in the series only one consistently told all two of his patients. This seems to indicate that it is the differences between patients rather than between doctors that have the greater influence on action.

The second question " notwithstanding your answer to question (1) nevertheless did the patient know?" brought a greater affirmative response. The general practitioners considered that 46 per cent of their patients knew their diagnosis, 42 per cent of the men and 52 per cent of the women. When the chief carers were asked the same question they considered that 56 per cent of the men and 50 per cent of the women knew. There was 70 per cent agreement between the doctors and the chief carers as to the patients' probable understanding (table 3).

TABLE 3

DOCTORS' AND CHIEF CARERS' ASSESSMENT OF PATIENTS' UNDERSTANDING

a

Doctors' opinion of patients' understanding	*Did the doctor discuss the diagnosis?*			
	Yes	*%*	*No*	*Cannot recall*
Patient knew	27	*25*	80	1
Patient ignorant	5	*4*	120	3
Not known	—	—	19	24

b

Chief carers' opinion	*Doctors' opinion of patients' understanding*				
	Patient knew	*%*	*Patient ignorant*	*%*	*Not known*
Patient knew	72	*66*	37	*34*	17
Patient ignorant	23	*25*	69	*75*	15
Not known	13		21		13

Discussion

Why then, if the doctor so often believed that the patients knew the truth did they not discuss the matter with them? Lasagna (1970) has suggested that doctors consider it pointless and cruel to do so; that it is too disturbing for the doctor; and that he may know his patient less well than in the past.

One doctor in this enquiry revealed himself when he said ' I think we are always playing a game of bluff.' It could be that to discuss the matter would bring one nearer to reality, and " human kind cannot bear very much reality " (T. S. Eliot). Another doctor who appreciated that he was playing a game said " He asked and I lied. He didn't believe me."

Neither of these doctors could bring himself to come any nearer to the truth. Hinton (1967) has suggested that " Many scrupulous people who care for the dying find themselves concealing the truth in a manner they always wished to avoid."

Certain conflicting approaches bear on the problem.

There is the legal duty which a doctor may owe to his patients to tell them the truth about their condition. Edmund Davies L. J. (1973), speaking extra-judicially, comes to the conclusion that there is a dearth of authority for such a duty, but that if a patient makes it clear to his doctor that he is contemplating certain property dispositions, or giving

directions to his lawyer consequent upon the diagnosis, then the doctor if he continues to act as medical adviser is " legally obliged to tell . . . the whole truth and nothing but the truth."

Although the Lord Justice does not mention it, it would appear that by analogy a doctor would be obliged to tell a patient if he knew that he had taken out some form of ' cancer insurance ', and would need a written diagnosis in order to claim benefit.

Apart from legal affairs the doctor should perhaps consider that the patient might want to attend to personal and family matters. A son or daughter living abroad might make a visit sooner rather than later; or a couple might spend an extra holiday together.

Then there is the duty to treat patients as " full, moral and responsible human beings," a duty which is shared by anyone in a caring position *vis a vis* another. Robinson (1973) emphasises that the truth we know about another person " is his truth, and in a sense we have no right to talk about it (e.g. to a relative) behind his back." Obviously this attitude is not appropriate when he is confused, simple, sedated, or indicates that he prefers not to know; but probably few are in that state from the time they are diagnosed (Milton, 1972).

It may be that the ethical injunction to ' do no harm ' conflicts with the injunction as to disclosure, and that doctors consider the former to be overriding. But in view of the probability that at least half of the patients ' knew ' some of the truth of their condition, would not the trust and confidence that one hopes exists between doctor and patient be better served by a greater willingness to discuss the matter?

Acknowledgements

I thank Professor Eric Wilkes for suggesting this study; and the doctors and relatives of the patients who provided the information.

REFERENCES

Aitken-Swan, J. & Easson, E. C. (1959). *British Medical Journal*, **1**, 799–782.
Asher, R. (1955). *Proceedings of the Royal Society of Medicine*, **48**, 376–377.
Cartwright, A., Hockey, L. & Anderson, J. L. (1973). *Life before death*. London: Routledge & Kegan Paul.
Edmund Davies, L.J. (1973). *Proceedings of the Royal Society of Medicine*, **66**, 533–536.
Fitts, W. D. & Ravdin, L. S. (1953). *Journal of the American Medical Association*, **153**, 901–904.
Hinton, J. (1967). *Dying*. p. 128. Harmondsworth: Penguin Books.
Kelly, W. D. & Friesen, S. R. (1950). *Surgery*, **27**, 822–826.
Milton, G. W. (1972). *Medical Journal of Australia*, **2**, 177–182.
Oken, D. (1961). *Journal of the American Medical Association*, **175**, 1120–1128.
Rennick, D. (1960). *New Medical Materia*, **2**, 51, (March).
Robinson, J. A. T. (1973). *Proceedings of the Royal Society of Medicine*, **66**, 536–537.

INFLUENCE OF PREGNANCY SPACING ON OUTCOME OF PREGNANCY

To assess the significance of the length of time between two pregnancies on the outcome of the second we used information collected by the British Perinatal Mortality Survey of 1958. From questionnaires on the 16,994 singleton births in the first week of March 1958 and the 7,117 singleton stillbirths and neonatal deaths in March, April and May 1958 we abstracted information on the date and outcome of any preceding pregnancy. The inter-pregnancy interval was taken as the length of time between this preceding pregnancy and the last menstrual period before the index pregnancy.

The most important factors influencing pregnancy spacing were outcome of the preceding delivery, social class, and maternal age. When these variables had been taken into account we found that the length of inter-pregnancy interval had little effect on stillbirth rates. High neonatal death rates, however, occurred when interpregnancy intervals were less than six months ($p<0{\cdot}005$), though longer intervals had no significant effects.

Fedrick, Jean & Adelstein, Philippa (1973). *British Medical Journal*, **4**, 753–756.