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Delivering Bad News: Deal with Collusion for Love

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Bad news is “any news that adversely and seriously affects an individual’s view of his or her future,”¹ and talking about one’s cancer diagnosis is one of them. Delivering bad news is a complex, necessary communication skill that should be effectively learned, especially by oncologists. Giving bad news has two key parts: transferring information to patients and responding to patients’ emotional reactions.²

Every patient has a unique cultural and family background; therefore, individualized care communication is critical.

On a typical day in my office, I was sitting behind my desk and waiting for the next patient to arrive. A man in his thirties poked his head around my office door and mentioned that the patient was his mother and desperately asked me not to reveal anything about her diagnosis to her.

“Doctor, my mother is 86 years old and hope is the only thing that has kept her alive. My father passed away last year, and I don’t want her to suffer more,” he said. Then he stared at me for a few seconds waiting for my approval.

He left the room and quickly returned while pushing his mother in a wheelchair. She was referred to me by her oncologist for palliative care consultation. The woman in the wheelchair had such a big smile on her face that I dared to crack a joke about how his son was pushing the wheelchair and if she was not happy about the ride, I would have his driver’s license revoked.

Noticing “terminal breast cancer” on her consultation sheet erased the smile from my face. Her oncologist had left the note that she was “NOT suitable for any invasive treatment.” The son was

still standing behind the wheelchair signaling by constantly moving his hands to remind me to keep our big secret. It was so distracting that I decided to find an excuse to send him away. “Sir, please pick up a new patient folder from the front desk at the end of the corridor.”

As soon as he left, the mother leaned toward me and whispered, “I have advanced cancer and I’m going to die soon. I don’t want my son to know how bad this is. He has already had enough pain since his father passed away last year.” I instantly realized that the situation is more complicated than I expected, and I should act very tactfully. The son returned with the folder and I struggled to pretend nothing happened in his absence.

“What can I do for you, Mrs. A?” I asked. It was not my usual opening question. Before she had a chance to say anything, her son jumped in and said: “She has an old peptic ulcer that makes her uncomfortable, especially after eating; and also she needs some appetite pills to gain more weight.”

It was time for me to make a serious face and asking him to allow his mother to answer the questions. “Yes, yes, he’s right. My stomach is painful all the time, and I feel nauseous every time I try to ...,” she stopped speaking. After an uncomfortable pause, she suddenly broke down in tears and asked her son to forgive her for not being able to stay with him long enough.

There was not much work for me to do. The “news” were broken. I was not certain how they would react to this new situation. Perhaps it would help to bring them closer to each other.

This is a common scenario in my clinic: “collusion for love!” Every day I see patients with terminal cancer who have no clue about their conditions, and I am warned by their relatives not to disclose the diagnosis or prognosis to them. In this particular case, it was more complicated: a tripartite collusion. Although collusion with relatives is not recommended, sometimes (especially in busy clinics) it is a more convenient option for physicians than disclosure.

While western medicine emphasizes honest

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disclosure of bad news to patients by physicians, depending on the cultural context, every patient needs an individualized response from the physician.

In today's Iranian palliative care practice, considering the family dynamics is unavoidable for the physician to provide the best solution. This dynamic is referred to as “relational autonomy.” In eastern societies in which family unit is the main supporting source for the patients—economically, emotionally, socially, and spiritually—dealing with family's involvement in patients' medical decision making is deemed critical.³ Changing the paradigm from just giving bad news to “sharing news” is a more preferred policy. This strategy has its own challenges and barriers, but, by learning and following the available guidelines, physicians can achieve the best results.²

Conflict of Interest

The authors have nothing to disclose.

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