Breaking Bad News: The First Time

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The education of a doctor is long and arduous. It involves many years of study and lonely nights in the hospital. Somewhere along the way there are certain seminal events that shape us as we mature. One of these is the inevitable first encounter with death and dying. This is about my experience with telling people about terminal illness.

My name is Don Smallman and I am a fourth year medical student at Dalhousie University. I was two and a half weeks into my clinical clerkship at the time. My first rotation was Family Medicine, which I thought would be a good way to start - broad and general. I spent my first two weeks in a busy practice in North End Halifax dealing mainly with hypertension and diabetes in elderly Haligonians. My second two-week placement was in rural Nova Scotia, and on my third day I watched as my preceptor passed three potential death sentences - three diagnoses of cancer.

All three had very different stories. The first was an older man in his late seventies. He had been losing weight rapidly for about three or four months - over fifty pounds. He had undergone some investigations, and he was here for the results. The upper GI series showed an abnormality in his stomach. It was not expanding as it should, the stomach wall was stiff and inflexible, suggestive of a type of gastric carcinoma called linitis plastica. It has a very poor prognosis, often just a matter of months. My preceptor was very straightforward with him, she did not pull any punches. He took it fairly well, stoic as are all men of his generation who had lived through the Depression and a world war. He said that he had lived a good life and with the weight loss was expecting something like this. Still, I could tell that he was in a state of shock, and he had tears in his eyes as he left the office.

Later that afternoon we saw another man, sixty-five years old, who had been investigated for abdominal pain of undetermined origin. My preceptor and the consulting surgeon thought that he had gallstones, and he was scheduled to undergo further tests the next day. However, an abdominal CT scan showed a 3 centimetre mass in the upper lobe of his right kidney. The soft tissue density of the mass suggested a probable renal cell carcinoma. My preceptor told him about the unexpected result and that he would probably need a nephrectomy. The patient asked to have his wife with him, so I went out to the waiting room to bring her in. We then went over the test results again and the likelihood of a possible cure with the operation. Unlike the first patient, they were not expecting a diagnosis of cancer. Although they did not break down and cry, emotions were very close to the surface. They were too shocked to ask many questions. They thought that he would have his gallbladder out and that would be it. Instead they have a difficult road ahead of staging tests, a nephrectomy, waiting for the pathologist's report and then possibly radio- or chemotherapy. They were looking forward to a long retirement, and they may still have one, but it will be very different from what they imagined. There will always be regular follow-up visits to search for metastases.

The last patient of the day was a forty-five year old woman, mother of three grown children. Two months ago my preceptor had felt a small lump in her left axilla, and thought it to be a swollen lymph node. She referred the patient to a radiologist for a mammogram, and the report had just come back. My preceptor read it out loud to the patient. The right breast was clear. The left breast, on the

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lateral view, showed a 2 centimetre stellate lesion in the upper outer quadrant, near the axilla. I knew from my pathology courses that this was an ominous finding. The stellate nature of the lesion was highly suggestive of malignancy.

The woman, upon being told that she probably had breast cancer, burst into tears. My preceptor put her arms around her and comforted her as best she could. I felt a bit awkward, unsure of my role. I was still in shock from the previous couple, not to mention the earlier patient with the stomach cancer, and I had not had the time to process what had happened. My own grandfather had died at the age of 68 of renal cell carcinoma several years ago, so I knew what a devastating disease cancer can be and how quickly it can spread. I knew that her life expectancy was altered. I knew that some physicians see breast cancer as a systemic disease with micrometastases even at very early stages. The doctor tried to provide as much hope as she could without shielding the truth from her. This was a fine line to walk, and she did an admirable job. But I am sure that the patient stopped hearing anything once the word "cancer" was spoken.

All three patients face difficult roads ahead. All have further invasive diagnostic tests to face, each with their own risks. The prognosis was worst for the first patient. He was already symptomatic and palliation was probably the only course of action. The second two might do all right, but even if curative surgery is successful they will always be worried about the next visit to the doctor and the next chest x-ray or CT scan.

Two years of medical school did not prepare me for a day like that day. I had read the textbooks, attended the lectures and tutorials and written all of the exams. I had practiced my clinical skills of history-taking and physical examination, learning to listen to the patient and form differential diagnoses. I felt like I was becoming a sensitive listener who could empathize with the patient. I was not, however, ready to watch three lives irrevocably changed right in front of me. I could see the paradigm shift in each one, as they tried to process the dreadful information just given them. Cancer is everyone's worst nightmare, the body turning on itself, feeding on itself, growing uncontrollably.

I knew that eventually I would be put in the situation where I would have to break bad news to someone. I had seen how it was done on TV, and had imagined myself doing it. 'Mrs. Smith, your son came to the hospital with very serious injuries, etc....' This situation was different for me. The personal impact of telling someone that their whole image of the future, all of their plans and dreams, were now completely changed was very powerful. I think that one of the most important tasks that doctors have is the breaking of bad news, to patients and their loved ones. The way in which it is done can make a great difference to the patient, to let them know that they are not alone and that you will be there for them every step of the way. Since that day there have been other patients with more bad news, and I have developed my own style modelled on what I have seen before. It is hard, but it also can be very rewarding to do it in such a way that you know you have made a difference.

I think about those three patients a lot now. I hope that they will all pull through, that the biopsies will be negative or the treatments cure them forever. I know that this is probably wishful thinking, though. Learning about cancer, the signs and symptoms, pathobiology and statistics, did not prepare me for that day. On that day I put a face on cancer...three faces, and I will never forget them.

AUTHOR BIOGRAPHY

Dr. Don Smallman is a graduate of Dalhousie Medical School. He received his MD and Bachelor of Sciences (Medicine) in 1998. His undergraduate degree in Biochemistry was also from Dalhousie University. Dr. Smallman's research interests are in ocular genetics and molecular biology, and he recently began a residency in Ophthalmology at Dalhousie.

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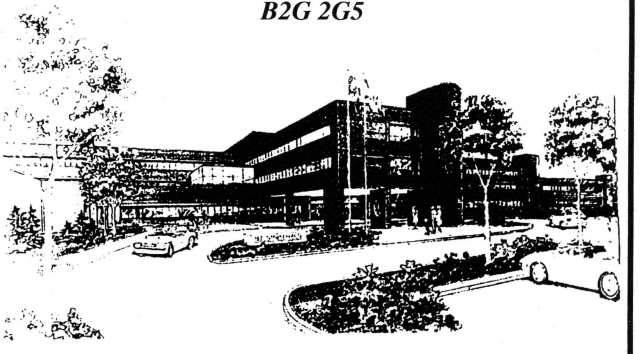

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