BRADFORD VTS TEACHING AIDS July 2026

Talking With Cancer Patients

A practical guide to communication, honesty, hope and support in cancer care.

> After a cancer diagnosis there is often a long life still to be lived. Our job is to protect its quality — and good communication is the treatment we can always give.

Who it is for
GP trainees, IMGs, trainers and the wider primary care team

Focus
The consultation, breaking bad news, honesty, quality of life, support

Style
Plain English, easy to remember, built for the first read

Modernised for 2026 from the 1992 study-day pack *"On Talking With Cancer Patients"* by **Dr W.A.F. McAdam**, Consultant Surgeon, Airedale General Hospital. The humane core is kept; the out-of-date and unsafe material has been removed and replaced with current UK guidance (full list at the end).

START HERE

What this guide is about

Cancer is best thought of as a **chronic illness**. It needs the same coping strategies as any long-term condition — with the added weight of fear of death and fear of pain. The central message of the original pack still holds:

> **THE BIG IDEA**
> **A cancer diagnosis is often followed by a long period of life.** The quality of that life can be ruined by fear and poor communication — or protected by good communication. Making that life better is a core part of our job.

The threads that run through it

Six connected skills. Each has its own module in this pack.

Figure 1. The six threads of the pack, all serving one goal: helping the patient live better.

A NOTE ON THE ORIGINAL

For 1992, Dr McAdam's pack was humane and ahead of its time. Its emphasis on **letting the patient speak, treating communication as a learnable skill, honesty, hope, quality of life and patients' rights** all hold up well today. Those parts are kept and updated here.

THE MINDSET

Two roads after a diagnosis

The moment someone hears the word “cancer”, the road ahead splits. The disease is only part of the story. How we *communicate* often decides which road the patient travels.

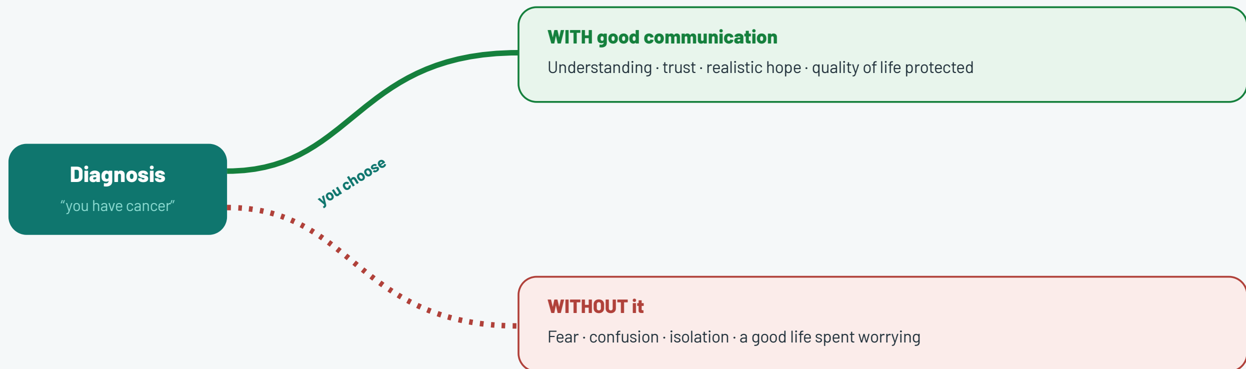

Figure 2. Communication is the lever. It steers the patient towards a life protected, not a life ruined by fear.

REMEMBER IT THIS WAY

Good communication is not the wrapping paper around the medicine. **For a frightened patient, it is part of the medicine.** It reduces distress, builds trust, and helps people take in and act on what you say.

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MODULE 1

Listen first — the consultation & history

Most of what a patient needs to tell us, they will tell us — **if we let them speak and we listen for the cues.** This is the foundation skill under every cancer conversation and under the RCGP consultation and SCA.

70%

of patients, given the space, spoke for two minutes or less — and told the doctor what mattered.

Blau's classic observation. Letting people finish costs little time and gains a great deal. Yet studies show doctors often interrupt within seconds.

Where consultations go wrong

Decades of work (Maguire and others) found the same repeating faults. Watch for them in your own recordings:

- ✗ Interrupting too early, before the story is out
- ✗ Sticking to the physical, ignoring feelings and worries
- ✗ Missing verbal and non-verbal **cues** of distress
- ✗ Using jargon the patient cannot follow

- ✓ Open the door, then **stay quiet** and let them talk
- ✓ Name the feeling you notice ("you seem worried")
- ✓ Ask what they already know and what they want to know
- ✓ Check they understood — ask them to say it back

A simple flow to follow

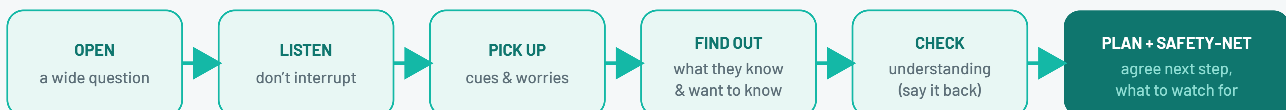

Figure 3. One reliable route through any cancer consultation.

YOU MUST

Actively seek feedback on your consultations. **Communication skills are learned, not inborn.** In GP training this means video review, Consultation Observation Tool, role-play and simulated patients — the methods proven to improve real performance.

EVIDENCE & SOURCE

Maguire, Fallowfield and Sanson-Fisher showed communication skills improve with structured feedback and that gains persist for years. Aligns with the **RCGP curriculum** and the SCA's focus on consultation skills.

MODULE 2

2 Honesty & shared decisions

In 1992 the pack still asked *"should we tell the patient the truth?"* **That debate is over.** Honest, kind information and shared decision-making are now the default and the professional standard.

YOU MUST

- **Presume every adult has capacity** to make their own decisions, unless properly assessed otherwise.
- **Find out what matters** to the patient, and what they already know, before you give information.
- **Give the information they need** to decide — the benefits, harms and reasonable alternatives, including doing nothing.

YOU MUST NOT

- **Collude with relatives** to hide a diagnosis from a patient who has capacity and wants to know. The information is the patient's.
- Force full detail on a patient who has clearly said they do not want it — but still give the basics they need to consent.
- Decide alone how much a patient "can take". Ask them.

KEEP MCADAM'S BEST PHRASE

"Gentle frankness." Be truthful, but deliver it with kindness and at the patient's pace. Honesty and compassion are not opposites — the skill is doing both at once.

Telling risk so it lands (NICE NG197)

How you say a number changes what people understand. Use plain, consistent figures.

Do this	Not this
Use natural frequencies: "about 10 in 100 people"	Percentages alone: "10%"
Use absolute risk: "goes from 1 in 1,000 to 2 in 1,000"	Relative risk: "the risk doubles"
Keep the same denominator: 7 in 100 vs 20 in 100	Mixed: 1 in 14 vs 1 in 5
Give a clear time frame and check they followed it	Vague words: "rare", "common" — people read these very differently

WHAT YOU MIGHT SAY

"Before I go on — what's your understanding so far, and how much detail would you like from me today?"

This one question honours capacity, checks their starting point, and lets *them* set the depth. It is the heart of shared decision-making.

SOURCES

GMC, *Decision making and consent* (in force Nov 2020) — seven principles, presume capacity. NICE **NG197**, *Shared decision making* (2021) — risk communication. *Montgomery v Lanarkshire* (2015): you must disclose the risks a reasonable patient in that position would think material — judged from the patient's view, not the doctor's.

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MODULE 3

Breaking bad news

There is no painless way to break bad news, but **the way it is done can help or harm** how a person copes for months afterwards. A simple structure keeps you steady. The most widely used memory aid is **SPIKES**.

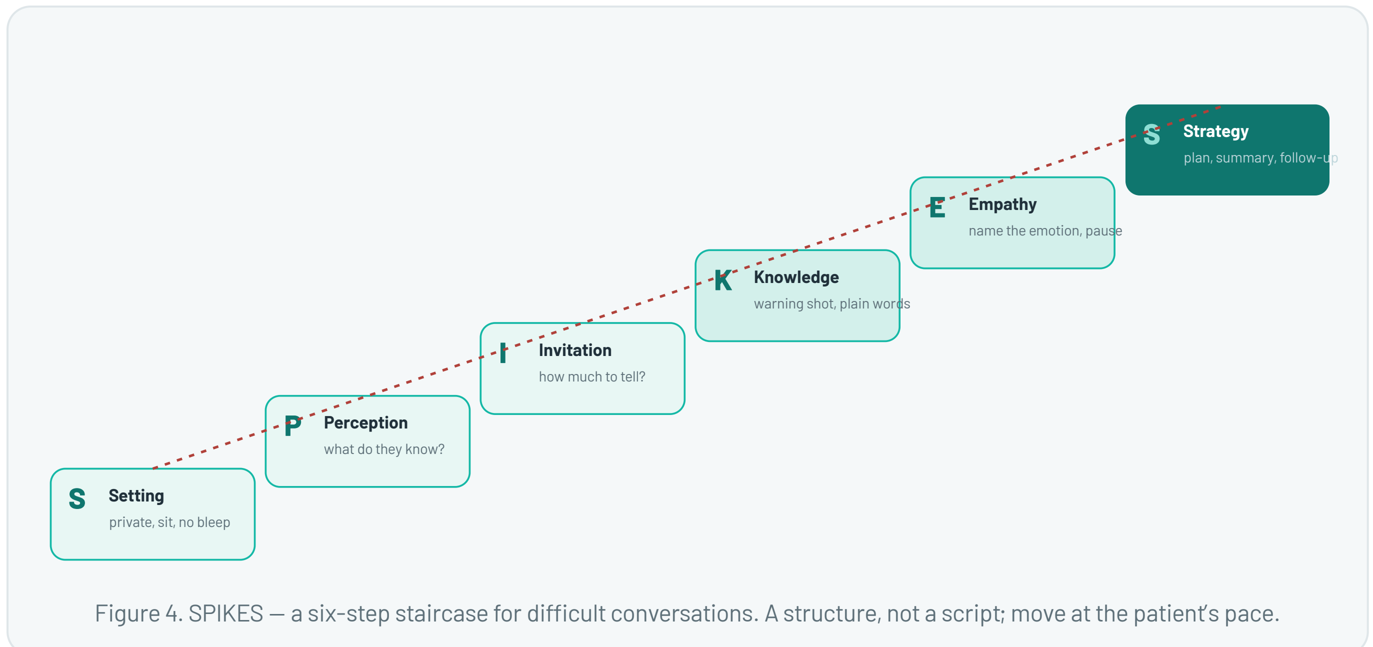

Figure 4. SPIKES — a six-step staircase for difficult conversations. A structure, not a script; move at the patient's pace.

WARNING SHOT

"I'm afraid the results are more serious than we'd hoped."

Then pause. Let them signal whether to go on. Avoid burying the news in jargon.

AFTER THE NEWS

"That's a lot to take in. Take your time — I'm not going anywhere."

Silence is a tool. Don't rush to fill it with facts.

AN ENDURING GOOD IDEA — KEEP IT

McAdam championed **"getting it taped"** — giving patients a recording of the bad-news talk to replay at home. The modern version: **offer a written summary**, or record the consultation for them. Patients and families value hearing it again; it reduces anxiety and misunderstanding. This has aged very well.

SAFETY-NETTING (NICE NG12)

Whenever cancer is suspected or being investigated, you **must** tell the patient **which symptoms to watch for and when to come back**, reassure those at low risk that most people referred do not have cancer, and give information in a format and language they understand. Record what you advised.

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MODULE 4

Hope, coping & quality of life

Quality of life is the real target. Calman gave us a clear way to picture it: quality of life is **the gap between a person's hopes and their reality.** The wider the gap, the worse it feels.

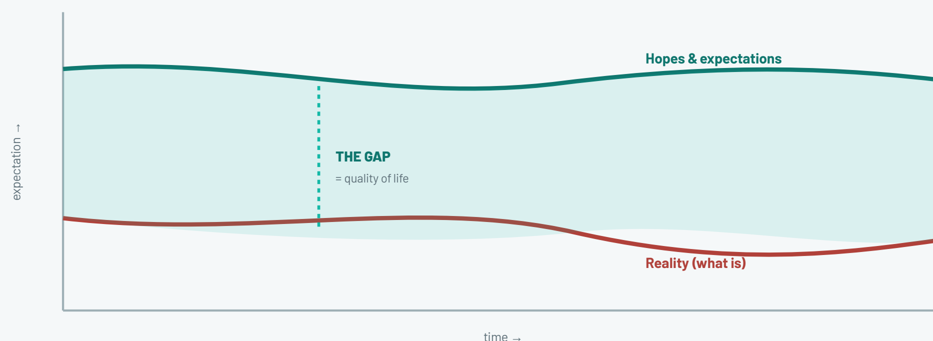

Figure 5. Calman's "gap" hypothesis. Improve quality of life by narrowing the gap — two honest ways below.

1. Raise reality

Control symptoms and pain, treat what can be treated, give practical help and support. Lift the lower line closer to their hopes.

2. Adjust expectations — gently

Help hopes become realistic and reachable, **without crushing them**. Aim the upper line at goals that can actually be met.

THE RULE ON HOPE

Never deny hope. Never give false hope. Hope can shift from "cure" to a good day, a family event, comfort, dignity. Helping hope adapt is one of the most useful things we do.

Correcting a myth the original pack carried

● MYTH VS FACT — "A POSITIVE ATTITUDE BEATS CANCER"

✗ **Myth:** a "fighting spirit" or positive thinking makes cancer shrink or helps you live longer.

✓ **Fact:** large, careful studies show attitude and coping style **do not change whether cancer grows or how long a person lives.** Telling people they must "stay positive to survive" can **blame the patient** when they feel low or the disease advances.

✓ **What helps instead:** good symptom control, honest information, practical and emotional support, and letting people feel whatever they feel — these genuinely improve quality of life, which is the right goal.

Sources: Watson et al. (1999); Petticrew et al. (systematic review); Coyne & Tennen (2010), *Positive Psychology in Cancer Care*. Consistent conclusion: people with cancer should not feel pressured to adopt a particular attitude to improve survival.

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MODULE 5

Support the whole person

Doctors and nurses cannot meet every need. Part of the skill is **knowing when to widen the circle of support** — and doing it early.

LOSS

Bereavement starts early

Loss begins at diagnosis, not just at death — loss of health, role, certainty. Acknowledge it. Signpost bereavement support for patient and family.

COPING

The "sick role"

People cope with cancer as with any long illness. Support their own strengths and let them keep as much normal life and control as possible.

GROUPS

Support groups

A well-run group offers belonging and shared experience. Value it for support — not as a way to change survival.

● SIGNPOST EARLY — AND VERIFY LOCALLY

National sources that endure: **Macmillan Cancer Support**, **Maggie's**, **Marie Curie**, **Cancer Research UK**, and your local **hospice** and NHS cancer services, plus the patient's own **practice / PCN** team.

The 1992 pack's phone numbers and many named groups are gone or changed (for example BACUP has merged into Macmillan). **Always check current local services before signposting.**

What every patient with cancer should be able to expect

A modern reading of CancerLink's Declaration of Rights, in line with the NHS Constitution and GMC standards.

- ✓ Equal care and respect, whatever their background
- ✓ Dignity, and their needs taken seriously throughout
- ✓ To be told honestly, in a sensitive way, that they have cancer
- ✓ To share in every decision about their care
- ✓ Full information on options, benefits and risks
- ✓ To give informed consent before any trial
- ✓ A second opinion, and the right to refuse treatment
- ✓ Support and information for their family too

NOTE ON RECORDS & RIGHTS

Patients' access to their own records is now governed by the **Data Protection Act 2018 / UK GDPR**, not the 1992 pack's Access to Health Records Act 1990 (which now mainly covers deceased patients' records). Write every note as if the patient will read it — because they can.

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MODULE 6 · TOOLKIT

Questions to ask — and to expect

These practical tools are the enduring heart of the original pack. They still work. **Start where the patient is.**

McAdam's 8 questions for a cancer patient

Ask flexibly, in any order — jump to whatever the moment opens up.

1. What do you already know, and who told you?
2. Who else has talked to you about it?
3. Have you had any previous experience of cancer?
4. What sort of person are you — how do you usually cope?
5. What do you think and know about cancer?
6. Do you like to read up and find things out?
7. Where do you find strength — faith, family, something else?
8. How do you feel about complementary or alternative approaches?

WHY QUESTION 1 MATTERS MOST

Whatever they've been told — even by you — build on **their** understanding, not your assumption of it. It anchors the whole conversation.

The questions patients most often ask

Rehearse your answers to these now, so you are not caught flat-footed later.

- ? Will I die from it? When?
- ? Will it hurt?
- ? Will I be disfigured or need a bag?
- ? Is it catching?

- ? Does it run in families?
- ? What did I do to cause it?
- ? What can I do to help myself?
- ? What are the side effects of treatment?

USE THE WORD

"Yes — it is a form of cancer, and here is what we can do about it."

Say "cancer" plainly (once you know they want to talk about it) so you can both discuss it openly. Dodging the word breeds fear.

ONE-PAGE RECAP

The whole pack on a card

Every consultation

- ✓ Open wide, then be quiet and listen
- ✓ Pick up cues — feelings as well as facts
- ✓ Ask what they know and want to know
- ✓ Check understanding — get it said back
- ✓ Agree a plan and safety-net clearly

Bad news — SPIKES

- **S** Setting: private, sitting, no interruptions
- **P** Perception: what do they already know?
- **I** Invitation: how much do they want?
- **K** Knowledge: warning shot, plain words
- **E** Empathy: name the feeling, allow silence
- **S** Strategy: plan, summary, follow-up

Honesty & consent

- ✓ Presume capacity
- ✓ Gentle frankness — truth with kindness
- ✗ Don't collude to hide a diagnosis
- ✓ Numbers as natural frequencies & absolute risk

Hope & quality of life

- ✓ Narrow the gap: raise reality, adjust hopes gently
- ✓ Never deny hope; never give false hope
- ✗ Don't tell people attitude changes survival
- ✓ Offer a written summary or recording

IF YOU REMEMBER ONE THING

Listen first, tell the truth kindly, protect hope, and support the whole person. **Do this for your cancer patients, and every other patient gets a better deal too.**

PROVENANCE

Source & what has changed

Original source

McAdam, W.A.F. (1992). *On Talking With Cancer Patients — An Annotated Bibliography for Medical Students, prepared for a Study Day with Final Year Students.* Airedale General Hospital, Steeton, West Yorkshire. February 1992.

The original reproduced chapters and articles (with the authors' consent) by Goldberg, Maguire, Fallowfield, Baum, Pietroni and Calman, plus appendices of questions, contacts and the CancerLink Declaration of Rights.

What was taken out or updated — and why

TWO THINGS ARE NOW CONSIDERED ACTIVELY WRONG

Most of the pack is simply dated. Two ideas, though, have crossed from "unsupported" into "we now caution against this", and **must not be repeated** from the original:

- The **Bristol Cancer Help Centre study** conclusion that alternative-therapy patients "fare worse".
- The claim that a **positive attitude or "fighting spirit" changes cancer outcomes** — because it ends up blaming patients.

Removed / outdated (1992)	Current position (2026)	Why it changed
Bristol Cancer Help Centre study cited as showing alternative-therapy patients "fare worse".	Conclusion removed.	The 1990 study was later shown to be **seriously flawed** — the Bristol women were more ill at entry (unmatched groups), and it was only interim. It caused real harm to patients and the centre.
"Positive thinking / fighting spirit beats cancer" (Peale, Simonton visualisation, Greer).	Removed and corrected.	Large studies show attitude does **not** change survival, and pressuring patients to "stay positive" can blame them. Good support and symptom control help quality of life instead.
"Should we tell the patient?" treated as an open debate; deciding how much they "can take".	Honest, shared decision-making is the default.	GMC *Decision making and consent* (2020) and NICE NG197 (2021): presume capacity, tell the truth kindly, do not collude to withhold.
Paternalistic consent — doctor decides what to disclose.	Patient-centred consent.	*Montgomery v Lanarkshire* (2015) replaced the old doctor-led standard: disclose the risks a reasonable patient would think material.

Removed / outdated (1992)	Current position (2026)	Why it changed
Access to Health Records Act 1990 as the law on records.	Data Protection Act 2018 / UK GDPR.	The 1990 Act is largely superseded and now mainly covers deceased patients' records.
Favourable citation of the MRC / chiropractic back-pain trial.	Removed as an endorsement.	Later, larger evidence is more mixed. NICE positions manual therapy only as part of a package including exercise, not a stand-alone winner.
Claim that antidepressants are "almost entirely" placebo, and the "doctor as witch-doctor" framing (Goldberg chapter).	Not carried forward as teaching.	A contested minority view and an of-its-era model of psychiatric illness — not suitable as settled teaching for trainees.
Directory of phone numbers and named groups (e.g. BACUP, Tak Tent, local numbers).	Replaced with current national categories + "verify locally".	Contacts are long out of date; BACUP has merged into Macmillan; local services have changed.
Era-typical language, gendered defaults and personal religious content woven into teaching.	Modernised, inclusive wording.	Reflects current professional norms and a diverse trainee and patient population.

Would this raise eyebrows today?

Nothing in the pack was malicious or dangerous, and it would be unfair to call a thoughtful 1992 teaching pack outrageous. But a few things would surprise trainees if you handed them over now.

- ! **Patient-blaming in the positive-thinking material.** Recommending Peale and the Simontons to cancer patients on the premise that attitude shapes the tumour is the one genuinely problematic idea. It has moved from "unsupported" into "we now actively caution against this", because it can make patients feel at fault when they feel low or the disease advances.
- ! **The "witch-doctor" chapter.** Goldberg's reproduced chapter includes a long, vivid account of a Guatemalan *espanto* healing ceremony — a shaman massaging the patient with eggs — and repeatedly frames modern doctors as "witch-doctors" prescribing "Wondercure". It is a legitimate academic argument about non-specific healing, but it reads as jarring in a student pack.
- ! **The closing flourish.** The pack ends by rewriting *1 Corinthians 13* to put "a doctor newly qualified from Leeds Medical School" in place of the word "love". Eccentric and affectionate rather than offensive — but not something you would put in teaching materials now.
- ! **A charming accident.** A stray handwritten "Thomas the Tank Engine Parker" scribble survives on the Cancer Research Campaign advert page — an artefact of the original scan rather than anything intended.

IN FAIRNESS TO THE ORIGINAL

For 1992 this was humane, thoughtful work. Its instincts — listen first, be honest, protect hope, treat the whole person — were ahead of their time, and they are exactly what this updated version keeps.

BRADFORD VTS — IMPORTANT DISCLAIMER

This document is provided **exclusively for educational and training purposes** as a teaching aid. It does **not** constitute formal clinical guidance. Information may change after publication. Every user **must independently verify** all medical information, prescribing guidance, procedural protocols, referral criteria and legal requirements against current national guidance (NICE, GMC, BNF, MHRA, relevant Royal Colleges), local policies and the appropriate authorities for their own area before applying anything in practice.

Key sources: GMC, *Decision making and consent* (2020). NICE NG197, *Shared decision making* (2021). NICE NG12, *Suspected cancer: recognition and referral* (2015, updated 2026). *Montgomery v Lanarkshire Health Board* [2015] UKSC 11. Data Protection Act 2018 / UK GDPR. Watson M et al., *Lancet* (1999); Petticrew M et al. (systematic review); Coyne JC & Tennen H (2010). Maguire P, Fallowfield L & Buckman R on communication and breaking bad news. Calman KC, *quality of life "gap" hypothesis* (1984). Adapted from McAdam WAF (1992). SPIKES: Baile WF et al. (2000).