A Case of Informed Consent Obtained from a Patient with Terminal Cancer and his Family using Family Function by the Primary Care Physician

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ABSTRACT

We evaluated the contents and characteristics of informed consent obtained by the primary care physician from a male patient with advanced cancer and his family, and clarified the influences of the informed consent on family function. This patient was diagnosed as having advanced cancer at the age of 46 years, underwent surgery/chemotherapy, but died after 4 months at the hospital. Semi-structured interviews were held with the elder daughter of the patient, and notes on the patient's disease, the course of treatment, his family's responses, and the informed consent obtained by the primary care physician were taken during the interview. The informed consent obtained by the primary care physician had the following characteristics: (1) The physician transmitted accurate and detailed information on the treatment methods, side effects, and prognosis by appropriate communication techniques with consideration for the feelings of the patient and his family, and proposed choices so that they could participate in the decision of treatment principles. (2) During the entire course, the primary care physician frequently visited the bedside and encouraged the patient and his family to express their feelings of anxiety and to ask questions, giving continuous emotional support. With the progression of the disease and explanation by the primary care physician, the patient and his family expressed and shared feelings such as grief and powerlessness and supported each other. Gradually, they began to show practical/adaptive coping behavior and could accept the patient's death. Appropriate informed consent obtained by the primary care physician promoted the family function of this family.

Key words: Patient with terminal gastric cancer, Informed consent, Supportive communication by the primary care physician, Family function, Participation in decision making

Cancer has been ranked first as the cause of death in Japan since 1981. A survey performed by the Asahi Newspaper in 2000 showed that 76% of respondents would want to be informed of the diagnosis of their developed cancer14). The Information Disclosure Manual of the National Cancer Center Hospital10) shows that disclosing cancer information to patients has passed the stage of questioning "whether patients should be informed" and has reached the stage of considering the quality of informing, i.e., the methods of informing patients of the facts and subsequently coping with the patients, particularly in hospitals specializing in cancer.

Shimoyama et al11) described how medical care in Japan is shifting towards patient-centered care, and "informing" focused only on telling patients of the diagnosis is gradually changing to "explanation and consent" in which consent is obtained after intelligible explanation, or "informed consent".
(IC)". There have also been studies and reports on the methods of informing cancer patients of the truth and subsequent support\(^{1-5,6,12,13}\). In this study, we report such a case.

The patient already had advanced terminal stage cancer on admission after detection of abnormality in a health examination. However, he received an explanation of his pathological condition from the primary care physician and actively fought the disease with his family, and died peacefully, accepting death and leaving nothing to be regretted. His family had also been able to accept his approaching death.

The purpose of this study was to clarify the appropriate acquisition procedure of IC obtained by the primary care physician from a patient who died of advanced cancer and his family, the involvement of his family, and the process in which mutual support increased in the family.

### STUDY METHODS

1. **Subjects and data collection methods**

   The patient (Mr. A) was a 46-year-old male. He was diagnosed as having cancer and underwent early surgery but died about 4.5 months after recurrence. To evaluate this course, a semi-structured interview was performed twice with his elder daughter who provided care for him. The contents of the interviews were: the explanations given by medical staff members especially the primary care physician (Dr. B, gastroenterological surgeon), the acceptance of surgery and treatment by the patient and family, changes in the patient’s feelings, the daily life of the patient and his family, and changes in the feelings of the family who provided care for him. Notes were taken during the interviews. Each interview required about 2 hours and was performed in a quiet private room. The investigation period was from February to March 2004.

2. **Ethical considerations**

   A document providing an outline of the study was shown to the daughter, and the objective of the study, the items of investigation, and handling of the results were explained. She was also told that she could refuse to answer questions or discontinue the interviews, and her consent for the study was obtained.

### OUTLINE OF THE CASE

1. **Patient and his family**

   * The patient (Mr. A) was a middle-level manager of a major computer company and 46 years old when the diagnosis became definite. He had lived alone near the company for several years but on weekends regularly returned home, where the rest of his family lived.

   Before living alone, he had lived with his family. However, it was difficult for him to have dinner with them because he had to work late. Instead, he spent every weekend with his family and lived a cheerful and happy family. Mr. A was a father who loved his family, and played the central role in creating a strong family bond.

   * His wife, a 42-year-old full-time housewife, lived with their elder daughter (Daughter D) and younger daughter (Daughter E). She developed dizziness and was in a poor condition after being informed of her husband’s disease. She had trusted in him and asked his opinion on every single issue. He had always made the decisions on important issues.

   * Daughters D and E were 3rd year high school and junior high school students, respectively, preparing for entrance examinations for college and senior high school, respectively.

### 2. Course after diagnosis in Mr. A

   After health screening sponsored by the company, he was advised to undergo closer examination, and underwent gastroscopy. Although he had no symptoms, he was told that the test results were positive, and was admitted to Hospital C near his family’s house.

   After gastroscopy and histopathological examination, a diagnosis of gastric cancer (stage IV) was made. Abdominal CT showed extensive lymph node metastasis, and total gastrectomy was indicated. One week after admission, total gastrectomy was performed, followed by chemotherapy. CT after chemotherapy showed a reduction in the size of the lymph nodes, but the condition advanced to peritonitis carcinomatosa after 1 month.

   After another 1.5 months, he developed nausea and was diagnosed as having a metastatic cerebellar tumor on CT. Since the brainstem was compressed, the tumor was immediately resected, and the neurological symptoms were alleviated. However, 2 months after craniotomy, cancer recurred in the cerebellum with the appearance of nausea and dysarthria. Subsequently, he grew markedly weaker, showed deterioration of the respiratory state, and died 4.5 months after admission.

### RESULTS

His clinical course after admission was classified into the following 5 periods.

1. From admission to gastric surgery (about 1 week)
2. From total gastrectomy until the initiation of chemotherapy (about 2 weeks)
3. Chemotherapy (about 1 month)
4. Surgery for brain metastasis and postoperative period (about 2.5 months)
5. From re-metastasis to death (about 3 weeks)
Explanations by the physician and the responses and thoughts of Mr. A and his family in each period were as follows.

1. From admission to gastric surgery (about 1 week)

In the evening of Day 2 after admission, Dr. B asked Mr. A and his family (wife, 2 daughters, and wife's mother) to come to the family consultation room, and gave the following explanation with a nurse attending: the tumor was malignant and could not be completely resected because of distant lymph node metastasis, and its prognosis was poor. Dr. B offered 2 treatment choices: (1) chemotherapy alone without surgery and (2) surgery followed by chemotherapy, recommending (2) because surgery had more therapeutic effects and might delay the progression of the disease and prolong the survival period. The explanation required 20-30 min.

Mr. A and the other 4 family members went down to the lobby on the first floor. He only said, "I have to have an operation", but the other members remained silent. He returned to his hospital room alone. His family returned home, but they were so distraught that they had little conversation.

The following day, Dr. B confirmed Mr. A's intention, to undergo surgery, and both he and his wife, who had come to see him, signed the consent form for surgery. Although both Mr. A and his wife gave consent to the treatment after considering the physician's explanation and agreeing with his recommendation, the consent was given at a time when they were confused and markedly disturbed, having been told only 1 month after the close examination that the disease was advanced cancer and that it had already metastasized and the prognosis was poor.

During the period between explanation and surgery, Dr. B frequently visited the bedside of Mr. A, and told him that he would do his best to fight the disease with Mr. A. Dr. B answered his questions about the disease and surgery without reservation, and told him that he was ready to answer any question if his family felt unsure about even the slightest matter. Thus, Dr. B gave adequate consideration to the anxiety and concern of Mr. A and his family. Mr. A, who was about the same age as Dr. B, trusted him. Total gastrectomy with Roux-en-Y anastomosis was performed in early November.

2. From total gastrectomy to the initiation of chemotherapy (about 2 weeks)

Dr. B visited Mr. A's hospital room every morning and evening after the operation. Mr. A's wife spent the day in his hospital room every day. Since the hospital was located on her way to school, Daughter D, a high school student, visited her father on her way to school every morning and on her way home from school in the afternoon, and went home with her mother in the evening. Daughter E traveled to the hospital by bus after school every 3-4 days.

When the daughters had no school, all the family spent the whole day in the hospital room. They told Mr. A what had happened at school and at home as if they had been together at home. Conversation was initiated spontaneously by all of them. About two weeks passed.

3. Chemotherapy (about 1 month)

After Mr. A's condition became stable, Dr. B explained the treatment methods to Mr. A and his family, saying, "There are two treatment choices, chemotherapy and radiotherapy. Chemotherapy has more therapeutic effects on cancer metastasis." Dr. B also explained the adverse effects of chemotherapy in detail. As a result, Mr. A selected chemotherapy.

During the chemotherapy period, the results obtained after blood examination were explained to the patient and his family. The family together listened to the Dr. B's explanations of the effects of chemotherapy. Dr. B explained symptoms such as abdominal pain and nausea to Mr. A each time these adverse effects occurred. Whenever Dr. B met members of the family around the hospital, he talked to them and enquired about concerns. Mr. A was in poor condition and could not return home overnight for the New Year vacation. His daughters spent much time during the winter vacation and on holidays in his hospital room with their mother.

During this period, Mr. A thought much about the future of his family. He asked his wife to bring important papers (life insurance) that had been in his keeping to the hospital room and made necessary preparations. He told his wife and daughters that he had completed all the papers, and that they would have sufficient financial security after his death, so Daughter D should go to college without worrying about money.

Looking back on this occasion, Daughter D said in an interview that she thought her father was firm and strong despite the hopelessness of his condition, that he was worrying much about the family, he would be leaving, when he should have been worrying about his own health, and that he was also worried about his wife's health. She felt sorry that he worried so much about his family. This chemotherapy required about 1 month.

4. Cancer metastasis to the brain, brain surgery, and postoperative period (about 2.5 months)

Although chemotherapy was discontinued, nausea persisted. CT indicated a metastatic cerebellar tumor. This diagnosis and the methods of
treatment were explained by Dr. B and a neurosurgeon by a method that differed from the previous method. First, explanations were given only to the wife and elder daughter. Then after about 1 hour, the pathological condition and treatment methods were explained to Mr. A in the presence of the family members. Dr. B explained that radiotherapy was an option, but that surgery would be safer and more effective, and that the tumor needed to be removed immediately by surgery. He also explained in detail the advantages and disadvantages of radiotherapy and surgery, the probability of success with surgery, and possible sequelae. Mr. A asked the physician, "Must I undergo the surgery?", and the physician answered, "Your life will be at risk without it," and said no more. Therefore, Mr. A immediately consented to surgery. In mid-January, enucleation of the tumor by left suboccipital craniotomy was performed. The family was aware that the condition of Mr. A was deteriorating with the progression of the disease.

After the operation, Dr. B gave serial explanations of the prognosis, which changed according to the patient’s condition. First, Dr. B gave explanations to the family, telling them that he would repeat the same contents to Mr. A. During this period, the family conducted themselves in a way that would not disturb Mr. A’s mind. After a short interval (after 1 hour), Dr. B repeated his prognosis to Mr. A always in the presence of the family. Dr. B carefully explained the facts about the disease to Mr. A and his family each time his condition changed. This process further increased the trust of the patient and his family in Dr. B. The patient and his family shared the same information without secrets, faced death as an entity, and spent more time together.

5. From re-metastasis to death (about 3 weeks)

In March, Mr. A and his family were told by Dr. B that his condition had become very bad. Later, his wife alone was informed that his condition would deteriorate further if ascites should begin to accumulate, and that death was approaching. The family prepared for his death. The wife and elder daughter vacated his apartment and began to make preparations such as listing contact addresses of relatives/friends in case of emergency and accepting his coming death. From 2 days before his death, his wife stayed in his hospital room 24 hours a day. One day before his death, the elder daughter intuitively felt that something was unusual. At about 5:00 in the morning on the day of his death, his wife, who was present at his bedside, called the elder daughter at home and told her, "Something is different. Come to the hospital now, because he may be dying." The two daughters hurried to his hospital room.

Mr. A looked at his family and said, "I am sorry (for dying so soon). Please stay together and do your best." The family said, "Thank you. We will do our best." Mr. A said, "I am so happy," and lost his consciousness. Relatives arrived thereafter, and he died a few hours later.

**DISCUSSION**

Using this case as an example, we discuss the appropriate procedure of obtaining informed consent from patients with terminal cancer and the families supporting them.

1. **Comparison between the protocol of informed consent recommended for patients with advanced (terminal) cancer and this case**

Baile and his colleagues\(^2,3\) described a protocol for disclosing unfavorable information - "breaking bad news" - to cancer patients about their illness. The protocol (SPIKES) consists of six steps (Table 1)\(^3,9\). They state that the goal enables the clinician to fulfill the four most important objectives of the interview disclosing bad news: gathering information from the patient, transmitting medical information, providing support, and eliciting the patient’s collaboration in developing a strategy or treatment plan for the future.

Following is discussion and evaluation of informed consent obtained by Dr. B according to the 6 steps of SPIKES (Table 1).

[Step 1: S] He created an appropriate setting for explanations as this step suggests.

[Step 2: P] [Step 3: I] However, he did not use approaches proposed in these steps such as the assessment of the knowledge of the patient/family and the degree of information they wished to obtain by asking questions such as "What is your understanding of the reasons we did the test?" \(^3\) or "When the test results are completed, are you the type of person who likes to know everything?" \(^2\). The principle in these two steps is asking questions before the physician explains (implement the axiom "before you tell ask") \(^3\). However, Dr. B did not use this method not proceed to the next step before obtaining definite answers to his questions from the patient and his family.

[Step 4: K] Baile et al \(^3\) provided some guidance methods which might improve giving medical facts, as follows; first start at the level of comprehension and vocabulary of the patient. Second, try to use nontechnical words. Third, avoid excessive bluntness. Fourth, give information in small chunks and check periodically as to the patient’s understanding. Using such communication techniques, Dr. B provided the following contents that recommended for in IC \(^3\): (1) the name, stage, and prognosis of the disease, (2) rationale of treatment (purpose, importance, necessity), (3) concrete contents of treatment, (4) expected treatment effects and adverse events, (5) benefits and drawbacks to the patient expected after treatment, and (6) a
guarantee to allow any questions and a free selection of treatment methods.

Though the contents of (1), (4), and (5) were very disturbing to the patient and his family, adequate consideration of the communication method and contents by Dr. B, who also explained (2), (3), (6), may have minimized their shock and confusion.

In addition, Dr. B not only explained all these items whenever there were slight changes in the pathological condition and treatment methods but also frequently visited his bedside and asked the patient whether he had any questions, eliciting questions, and answering them. These considerations were noteworthy and further strengthened and deepened the trust of the patient and his family in Dr. B.

[Step 5: E] This step is empathic responses to the patient's emotion. Baile et al noted that the physician can offer support and solidarity to the patient by making an empathic response when an emotional reaction is expressed. In this case, emotional reactions such as anger, loneliness and sorrow were not always strongly expressed by the patient or his family whenever Dr. B explained.

First, Dr. B said that he would do his best to fight with the disease with Mr. A, and thereafter, he also said that he was ready to answer any question if his family felt unsure about even the slightest matter. By this approach, he "elicited concerns of the patient/family" , promoted the "ventilation of feelings" , and "offered availability".

Kaye stated that the 3 communication methods have the following importance.

"Elicit concerns": The provision of opportunities to talk about worries allows patients to clarify the cause of their own distress and pain and decide the order of priority of worries.

"Ventilation of feelings": The ventilation of feelings in dialogue has therapeutic importance. Patients can understand their own feelings and change them into controllable ones by verbally expressing their feelings. The promotion of the ventilation of patients' feelings by medical staff also represents their sympathy with patients' feelings.

"Offer availability": This is important for the following reasons. (1) Patients do not remember the details of the contents at first. (2) Patients take time to adjust their own feelings. The next opportunity to listen to their talk helps patients.

In this case, Dr. B constantly followed the 3 steps, which enabled the patient/family to adjust their feelings and control these feelings to some extent, rather than merely being filled with grief, while facing strong feelings such as fear and sorrow.

[Step 6: S] Baile et al noted that the difficult discussion for sharing responsibility on decision-making about the treatment plan can be greatly facilitated by using several strategies. First, the physician should explore patients' knowledge, expectations, and hopes, second, make sure they frame hope in terms of what is possible to accomplish.

In this case, Dr. B did not spend much time confirming the knowledge, prospects, and requests of the patient/family.

Comparison between the entire flow of IC obtained by Dr. B and patient/family's responses and SPIKES shows that Dr. B did not explore "the degree of information the patient and his family wish to obtain" or follow such steps as coping with the expression of feelings such as grief and a sense of powerlessness by the patient/family. Nevertheless, Mr. A and his family could face and

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**Table 1. Six-steps SPIKES protocol for breaking bad news (partly modified from reference 2)***

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
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<tbody>
<tr>
<td>1. S-SETTING UP the interview</td>
<td>Create an appropriate Setting that provides for: privacy, patient comfort, uninterrupted time, sitting at eye level, and inviting significant other if desired. All assist in establishing patient rapport.</td>
</tr>
<tr>
<td>2. P-Assessing the patient's PERCEPTION</td>
<td>Elicit the patient's Perception of his or her problem; e.g., &quot;Tell me what you understand about the reason we did the tests.&quot;</td>
</tr>
<tr>
<td>3. I-Obtaining the patient's INVITATION</td>
<td>Obtain the patient's invitation to disclose the details of the medical condition; e.g., &quot;How would you like to get the information about the test results? Would you like me to give all the information or sketch out the results and spend more time discussing the treatment plan?&quot;</td>
</tr>
<tr>
<td>4. K-Giving KNOWLEDGE and information to the patient</td>
<td>Provide Knowledge and information to the patient: give information in small chunks, check for understanding frequently, avoid medical jargon.</td>
</tr>
<tr>
<td>5. E-Addressing the patient's EMOTION with empathic responses</td>
<td>Empathize and explore emotions of the patient: e.g.; to a crying patient, &quot;I can see that you weren't expecting this kind of news.&quot;</td>
</tr>
<tr>
<td>6. S-STRATEGY and SUMMARY</td>
<td>Provide a Summary of what you said and negotiate a Strategy for treatment or follow-up.</td>
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accept each stage of the reality, i.e., painful treatment for a long period and his death, and endured by adaptive coping.

There may be two factors associated with this success. One was Dr. B's excellent methods of information provision and empathetic responses as described in [Step 4: K] and [Step 5: E]. The other was the good function Mr. A and his family had from the start. Though both the patient and family constantly received supportive communication from Dr. B and deeply trusted him, they did not depend on Dr. B. This suggests their high-level family function. The IC obtained by Dr. B may have promoted family function, and the family members themselves may have further enhanced this function. The actions of Dr. B on family function are discussed in the following.

2. Actions on family function

The Information Disclosure Manual of the National Cancer Center\(^\text{10}\) includes the principle of informing the patient and also the principle of not informing the family prior to informing the patient as a means of the family. This is because of the possibility that the family informed first opposes informing the patient. Kaye\(^7\) in "Breaking bad news", suggested the importance of "talking with the family" and described the communication techniques at the time of talking. Using either approach, consideration should be given to the presence and influence of the family when IC is obtained.

In this case, the pathological condition was explained to the patient and his family together before the first operation. However, after brain metastasis, an explanation was given to the family first. Dr. B may have selected this approach after carefully evaluating his previous continuous involvement. The following reasons for the selection of this approach can be considered.

Until brain metastasis, the patient as the father supporting the family played the central role in the family. He endured the disease and painful treatment for the sake of the family, showing a realistic consideration for his family's future. However, the cancer progressed, and his disability became marked. Dr. B observed his course and noticed how the family function supporting Mr. A began to increase.

First, Dr. B may have considered, observing the family members visiting the hospital room daily, that "This family is coherent, and there are close bonds among the family members and flexibility for role sharing and cooperation."\(^4\)

Next, he may have considered that the wife and daughters understood and accepted his explanation of the severity of the condition and its subsequent gradual aggravation and had understanding, internal strength, and sensible control ability.

Concerning the patient himself, Dr. B, who was about the same age as the patient may have expected that Mr. A, who was very thoughtful of his family and had difficulty in performing his role as a father in the prime of life, would suffer the double distress of observing his family's agitation after being informed of the "brain metastasis" in addition to his own distress after being informed of his own pathological condition. We speculate that Dr. B considered such a situation to be too harsh on Mr. A and so avoided it.

After considering the above carefully, Dr. B gave an explanation to the family first. The wife and daughter were at first shocked but composed their feelings over an hour and they gave each other support. When the feeling of the family became stable, Dr. B gave the same explanation to Mr. A and his family together and obtained IC from both. The family could become composed and supported Mr. A in his shock, anxiety, and sorrow.

The explanation given by Dr. B first to the family and then to Mr. A in the presence of the family was totally truthful and based on the facts of the case, and therefore, did not cause any difference in understanding between Mr. A and his family. The family, including Mr. A, could express their sorrow, and distress, and share these feelings, mutually strengthening their sense of solidarity. Sharing the same time and atmosphere may also foster the sharing of feelings which are beyond expression.

In this case, Dr. B frequently made contact with the patient and his family after providing substantial information to them, and asked them if they had any other concerns, gave them supplementary explanations, promoted the expression of feelings, provided emotional support, and extended the provision of information and supportive communication in terms of emotion. He established and maintained a relationship of deep mutual trust with the patient and his family.

As a result, the family was able to express appropriate anticipatory grief, mutually supported each other, and cope realistically with situation. In this course, the family further enhanced family function, acquiring a high self-care ability and not requiring intervention by medical workers.

3. Characteristics of the method of obtaining IC by Dr. B

1 and 2 above suggest the following characteristics.
1) Information that the patient might want to obtain was considered and provided in advance of his questions and objectives specifically explained in accordance with his knowledge and the stage of his illness.

SPIKES recommends that information and goals should be given after adequate confirmation of the degree of understanding of the disease by the patient or the degree of information...
the patient wished to obtain. However, Dr. B gave explanations prior to any clear expression by the patient of his desire to know.

A previous study showed that in many cases patients and their families find it difficult to take the initiative to ask for information from medical staff. In addition, when there is an inconsistency between anticipation and reality, the family shows exhaustion, conflict, and a sense of guilt, causing awkward family relationships8).

In the present case, such difficulties did not develop due to Dr. B's consideration, and the family could realistically cope with the disease at an early stage.

2) Explanations were given to the family first using their healing ability
The family stress adjustment/adaptation model shows elements for adjustment/adaptation to the situation in which a family faces disease in a family member.

Among these elements, those applicable to this case were close and cooperative family members and their ability to control situations. Due to these elements, the high healing ability of the family may have been maintained.

Though psychological shock in patients informed of a diagnosis of cancer is marked, whether anxiety increases or not after being informed is more closely associated with patients' rating of their family, coping with the disease, and their view of the meaning of the disease than with the severity of the disease itself. Inadequate family cooperation and support increases anxiety9).

Kaye7) stated that "talking with the patient and family" is so important that "without this stage, what has been done becomes useless", and "support is provided so as to clarify the degree of mutual understanding of the patient and family."

We speculate that Dr. B appropriately evaluated the healing ability of the family, minimized the patient's shock, anxiety, and grief using this healing ability, and could further enhance the mutual understanding, support, and coping ability of the family.

3) Dr. B gave the same explanation to the patient and his family and always responded sympathetically after the explanation (sharing information and continuing supportive communication).

Kaye7) stated that most patients desire the following when "bad news" is disclosed: (1) an appropriate amount of information, and (2) opportunities to talk about the situation, i.e., communication with therapeutic effects.

In this case, Dr. B continued to provide the above 2 prior to any request from the patient and his family. As a result, he maintained a relationship of trust with the patient and his family, frequently provided emotional support, and enhanced the healing ability of the family.

CONCLUSION
At present, people die in hospital even after undergoing advanced treatment, and an appropriate acquisition procedure of IC by medical workers will become even more important in the future.

In this case, the IC obtained by Dr. B promoted the healing ability of the family. These effects were obtained by the following 2 approaches.
(1) Before the patient and family asked questions, Dr. B gave explanations to them, as described in Step 4 of SPIKES ("provide correct information to the patient/family"). This reduced his family's anxiety and also brought the family closer together. Thus, the IC was obtained after careful consideration.

(2) From a certain point during the course, Dr. B gave explanations to the family before the patient. The supportive IC obtained by Dr. B elicited the healing ability of the family, and his emotional support and supportive communication induced a spontaneous increase in the healing ability of the family. As a result, the family function was strengthened, and high self-care ability was exerted without intervention by other medical staff.

Whenever Dr. B gave explanations to the patient and his family for obtaining IC, he himself may have felt powerless and the unbearability of the situation. However, he continued to support the patient and his family. The IC obtained by Dr. B enhanced the healing ability of the family and led to the acceptance of the patients coming death.

The task of medical workers at present and in the future is to overcome their own distress and to continue to provide medical care while supporting patients and their families.

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