# Talking the same language

Alberto Costa ■ GUEST EDITOR

Cancer patients are starting to expect more in terms of communication with doctors and cancer doctors are becoming increasingly aware of the need to rethink their way of talking to patients.

A well-informed patient is likely to get the best benefit from medical care, and good communication is therefore an essential part of good treatment. But in cancer, as we know, this isn't always easy. The task of explaining to a breast cancer patient the meaning of all the information on her pathology report is often as difficult a task as performing the surgery!

Patients want to be informed in a face-to-face consultation, in a comfortable environment and without being rushed. We need to resist the temptation to 'gain time' by giving the pathology results over the phone or standing in a corridor or in front of a lift that we are about to hurry into. We should stand up for our right to dedicate the necessary time to this important moment, without answering the phone or being distracted by other people.

The patient should be advised to bring someone with her to the consultation, and be given the chance to read the report in advance or to have a copy in front of her during the explanation. She or her caregivers may have spent hours searching on the Internet about the disease, because they want to know more to do better. As doctors, it is important that we respect these efforts and take time to discuss any questions the patient may have. The presence of a nurse can make a big difference.

If things are done well at the time we communicate the diagnosis the patient will never forget it, and everything will be easier for both them and the oncology team.

We also need to look at the language we use. Why do we still need Latin words like *in situ*? The proposed new classification of breast cancer, which replaces DCIS with DIN (Ductal Intraepithelial Neoplasia) and LCIS with LIN, makes sense (Veronesi, *JCO* 2009). Lay people equate the word *carcinoma* with *cancer*, so why keep using the term *carcinoma* for something we define as a *pre-cancerous lesion*? Then we could use the term *ductal* and/or *lobular carcinoma* for what we now have to call *invasive* or *infiltrating* – very scary words to anyone's ears. And why do we still use (in many languages) the word *positive* to mean *with cancer* (and *positive lymph nodes* to mean metastatic) and *negative* to mean *all is well*? Before meeting us, people thought that positive was good and negative was bad. A bit strange these doctors…

Alberto Costa is the director of the European School of Oncology, and editor of *The Breast*