

Essay/Personal Reflection

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Any sufficiently advanced technology is indistinguishable from magic

Arthur C. Clarke (1962), Profiles of the Future:
An Inquiry into the Limits of the Possible

It is difficult to give bad news to patients. There is a rich literature on the subject including what makes telling bad news difficult and communications skills training. This article will briefly review the difficulties, then introduce the role of magical thinking as an unconscious influence in delivering bad news.

“Bad news” can be “any news that adversely and seriously affects an individual’s view of his or her future.” The “badness” of the news can be thought of as the gap between the patient’s expectations and the medical reality. Therefore, a clinician cannot presume to know how patients will react to “bad” news, before finding out what the patient knows: “Before you tell, ask” (Buckman 2005).

Conceptually, there are 3 major themes that describe the interaction of the oncologist and patient when revealing bad news. First is the oncologist’s assessment of the patient and his or her needs. Second is evaluating the pros and cons of informing the patient. Third is the emotional aspects that affect both the patient and the doctor (Bousquet et al. 2015).

Communicating bad news elicits strong emotions. Studies have shown that oncologists experience heightened autonomic arousal and strong emotional reactions such as anxiety, anger, guilt, failure, and frustration (Buckman 2005). These reactions make it challenging to maintain an objective assessment. As a consequence, doctors may downplay, redirect, or camouflage bad news, often unconsciously. Sometimes this helps, if only short-term; sometimes this may erode the patient’s trust.

There are many difficulties in communicating bad news. A doctor does not knowingly want to cause pain to a patient. Furthermore, the death of a patient is at some level a failure, which brings guilt and shame. Finally, facing death, again and again, reminds us of our own mortality, with attendant fears and unconscious influences on decision-making (Wein 2023).

Many articles note 2 extraneous but exacerbating factors. There is not enough time available to the clinician to follow the conversation through. Second, often the clinician is alone without support or feedback from colleagues or mentors.

The difficulty of giving bad news is characterized by uncertainty, risk, and anxiety. People in general turn to magical or superstitious beliefs to relieve the anxiety and to restore a sense of control. “Magical thinking can be thought of as a modifier of anxiety in the face of the unknown” (Markle 2010).

Magical thinking can be defined as believing that one event happens as a result of another, without a plausible and/or provable causal link. Magical thinking has similarities to scientific thinking – in that both involve cause and effect – and some writers suggest magical thinking was the precursor. However, unlike magic, science postulates plausible hypotheses and tests them to prove a causal association.

Magical thinking is the belief that one’s thoughts, words, or use of symbols can influence the course of events in the material world (Malinowski 1954/2015). Magical thinking presumes a causal link between one’s inner, personal experience, and the external physical world. Examples include beliefs that prayers or other intercessory activities can alter the movement of the Sun or timing of the rains. An example of medical magical thinking is: “Since sharks do not get cancer, if I eat shark cartilage, then I will be cured of cancer.”

Wish fulfillment, a form of magical thinking, discourages talking about certain subjects. For example, to “speak of the devil” results in the person suddenly appearing (Malinowski 1954/2015).

Frazer alternatively divided magic into 2 types: sympathetic and contagious. The latter is based upon the physical contact, in which 2 things that were once connected retain this link. An example is causing an enemy to fall lame by stabbing his footprint. Sympathetic magic (or homeopathy) operates upon the premise that “like affects like.” This means that one can transfer characteristics of one object onto a similar object. An example is of rubbing the skin of a dead snake on one’s legs to protect one from snakebites (Frazer 1922/2003).

In the face of anxiety and danger, reluctance to tell bad news may be in part due to the fear of magical thinking. That is, we are apprehensive of saying to a patient, “You are going to die,” lest our words cause the prediction to come true. Occasionally, I have caught myself hesitating with this association in mind. Other oncologists have shared similar superstitious apprehensions, including the evil eye. The magical association is no more than a response to anxiety and the impossible task of predicting the future. Superstitious behavior is not uncommon “even” today. Athletes may have a favorite bat and fixed rituals, people “knock on wood” and the number 13 is unlucky.

A curious anecdote tells of a visitor to the home of Niels Bohr, the famous physicist. A horseshoe was hanging over the front door. The visitor in amazement asked Bohr whether he believed in superstition. Bohr allegedly replied: Of course, not. But I have heard it said that a horseshoe can bring luck whether you believe in it or not.

There are several rational things we can do to make telling bad news both less daunting and more beneficial. The first is to hold a clear insight into the psychology of yourself and the patient. Second is to have honesty and openness as your gold standard. Acknowledge to the patient this is difficult. Engage the patient, and

do not just hold hands. Third, remember Yalom’s wise edict: “It is the relationship that heals” (Yalom 1980). Fourth is that although one is apprehensive, even anxious, the best approach is to harness one’s courage and act. Finally, as a trainee once taught me, it is best to keep in mind that the only guilty party in the room is the cancer.

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