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We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

Problems of communication in acute leukaemia

STR.—All physicians who care for adult patients with acute leukaemia are deeply concerned by the problems of communication between hospital staff, the patients, and their relatives. The paper by Hilary Gould and Dr P J Toghill (17 January, p 210) is therefore a welcome attempt to explore this area in a systematic way.

The authors start from the premise that "it was not the usual policy to tell every patient he or she had acute leukaemia." They present two principal criteria for exceptions to this general rule, but surely *all* adults have some "family or financial responsibilities" and most patients will ask some questions about their illness, if given a suitable opportunity. Many patients attending a haematology department consider the possibility that they have leukaemia and those who actually have the disease are often the most reluctant to voice their fears. The response to a patient's

questions must therefore be governed by the patient's own attitude as judged by the physician; and the subtleties of communication must rely on some insight into the varying degrees of acceptance, aggression, hope, and denial that are displayed.

It is important to begin the discussion with some sort of plan which the patient and his relatives can grasp and which can form the foundation of a trusting relationship. From this beginning it is possible to convey more information, adapting it to the patient's personality, background, and mental state. Relatives may be helpful in assessing the patient's ability to accept the "truth" but few people know how they or their loved ones will react in these circumstances. A close relative's judgment of what should be said to a patient with acute leukaemia may therefore be no less fallible than that of the physician. The equation of "truth" or "not truth" is, of course,

too simple. The complaint of not being told enough or of being given too many details is often based on insecurity and inability to relate to the medical team. In the group described by Hilary Gould and Dr Toghill only nine of 26 patients knew of the diagnosis and one of them "learnt the diagnosis by mistake from a relative." Is this less of a disaster than learning the truth from a laboratory technician, a request form, or casual chatter in the haematology clinic?

We agree that management is easier for doctors and nurses when the patient knows of the diagnosis. The explanation offered for the physician's reluctance to tell patients that they have leukaemia is often that the patient will be unable to face the truth and that their wellbeing must remain paramount. If we agree that there is no standard answer, no standard patient, no standard relative, and no standard disease, we must also remember that