Learning Objectives:

The purpose of an interview to break bad news:

- establish a potentially therapeutic dialogue between the patient and physician
- divulge information to the patient.

The foundations of effectively breaking bad news:

- common courtesy
- actively listening to the patient
- acknowledging the patient’s needs.

Introduction

In this course, one of the goals is to learn specific skills which enable better communication with patients. One of the special types of interviews between physicians and patients is one in which bad news is communicated. As physicians, breaking bad news is a difficult and unusual part of our job. As in other difficult situations, having a plan or a set of guidelines for doing this can improve our ability to communicate effectively. These guidelines also provide a model for effectively communicating other kinds of less challenging information to patients as well. While what follows is not presented as the only effective way to communicate difficult news, it is an approach that is practical and useful, based on some coherent and consistent principles, and learnable. The goal of this exercise is to improve the likelihood that the common problems in this type communication will be avoided. The most common problems are relatively simple errors: faults in common courtesy, failures in listening or in acknowledging the patient’s needs.

The debate in the past was whether to tell patients bad news. Because it now is generally held that all mentally competent patients have absolute rights to any medical information that they require or request, the debate has moved from “whether to tell” to “how to tell” or more important, “how to share the information” (stressing the fact that this process is part of a dialogue between the patient and the physician, not a one-way pronouncement from the physician to the patient). The plan should be neither unthinking and insensitive truth-telling nor truth-concealment. Effective sharing of bad news includes a method for determining the individual’s wishes for information and of tailoring our information-sharing to that person’s desires and interest. This principle will be discussed in more detail as part of the Six-Step Protocol below.

What makes bad news “bad”?

- any news that drastically and negatively alters the patient’s view of her or his future
- “badness” of any bad news depends on what patient already knows or suspects about future
- impact depends on size of gap between patient’s expectations and situation’s medical reality
- cannot judge impact of news on individual until aware of what patient already knows and expects

Interviews about bad news consist of:

- A component of divulging information
- A dialogue between professional and patient that may provide patient a therapeutic benefit
  (This division is not what actually happens since both transactions occur simultaneously.)

Bad news itself causes distress, but supportive, sensitive interviewing may minimize distress.
APPENDIX C

The Six-Step Protocol

The protocol below is a set of guidelines to promote confidence and to decrease feelings of distress in situations of delivering bad news. It is not a rigid agenda to follow inflexibly. In many instances, it will be impractical to utilize every aspect of the protocol; common sense should guide which aspects to employ. The protocol is designed to cover the various aspects of a long-term relationship around a serious, debilitating, or potentially lethal disease. Common sense will guide its utilization in other situations, such as emergencies or in breaking news to a family about the death of a family member. All health care professionals involved in the patient’s care may contribute to the support of the patient after the patient has heard the news.

Step 1. Start off well

Unless it is absolutely unavoidable, an interview about bad news with patients or their families should be carried out in person, not over the telephone. Occasionally there is no alternative and you will need to make do with a telephone conversation. There are suggestions for telephone contacts later.

Advance preparation

- When possible, plan for when and how potentially bad news is to be delivered
- Know basic information about the disease or injury, such as prognosis and treatment options
- Know the patient as best you can; recall prior behavior in stressful situations or scan chart for clues

Get the physical context right

Privacy

- Take the patient or relative to a separate room so you can sit down in privacy.
- If no interview room is available and the patient is an inpatient, draw the curtains
- Sit down if possible; this sends important signals that you are there to listen and that you are, to some extent, under the control of the patient. Ideally, you should be at eye level with the patient or family member. Very rarely, you may have to conduct an interview standing (if there is no place to go and the interview must be held at that moment)
- If possible, leave your beeper with someone or turn it off. If not possible, set it to silent mode.

Who should be there?

- If possible, let the patient decide ahead of time who is to be present when the news is given.
- If there is a visitor, ask them gently, who they are or what relationship they are to the patient (Are you a relative of Mrs. Brown?).
- If neither the patient nor the visitor gives any inclination to end the visit, ask the patient if he or she would like to continue the interview with the visitor present.

In situations of giving bad news to a family, especially of a death, providing continued support and help with further decisions and arrangements is essential to proper care of grieving families.

- Having a nurse, a chaplain, or other health professional available is important.
- This person should be appropriately introduced and their role clarified (This is Chaplain Jones/our social services specialist, Ms. French and she/he will help you in making whatever arrangements you need to make).

This other professional should be capable of:

- answering questions about the arrangements that are required.
- assisting in contacting other critical resources (ministers, other family, means of transportation).
- providing emotional support.
Physical Considerations

Attend to the usual courtesies: make sure the patient is covered, use the appropriate name, keep a comfortable distance, and pay attention to your own body language. Find out if the patient is comfortable. It is ill-advised to try a meaningful conversation if the patient is in pain, nauseated, or sedated. In some instances, the need for the interview is pressing and you must proceed. In those instances you may say, “I know you’re not feeling well, but perhaps we can talk for a few minutes now, then I could come back later when you’re feeling better.” Starting the interview this way sends several important messages to the patient:

- gives the patient the idea that your are interested in his or her condition
- demonstrates that the conversation will be two-way
- gets the patient talking
- allows you to assess the patient’s current medical symptoms, mental state, and vocabulary

Step 2. Find out how much the patient knows

In this step you obtain the patient’s impression of what is already known about the illness to establish what is known about the illness’ impact on the future, not about the diagnosis’ basic pathology or nomenclature. Here are some phrases to use to initiate this part of the interview:

- What have you made of the illness so far?
- What have you been thinking about this nausea/unsteadiness/breast lump...?
- Have you been very worried about this illness/ these symptoms?
- What did the previous doctors tell you about the illness/operation?
- Have you been thinking that this illness might be serious?
- Have you been worried about yourself?
- When you first had the symptom X, what did you think it might be?
- What did Doctor X tell you when he sent you here?
- Did you think something serious was going on when...?

As the patient replies, listen for information on three major aspects of the patient’s situation:

**The patient’s understanding of the medical situation**

How much has she or he understood and how close to medical reality is that impression? If the patient, at this point, says that they have been told nothing at all, it may or may not be true. Even if untrue, accept the patient’s statement as a denial symptom; do not confront the patient immediately.

There are two possibilities for the response. One, the patient may be about to ask information from you, and may semi-deliberately deny previous information to see if you tell the same story. Two, you are unlikely to appear supportive if you launch a confrontation.

**The style of the patient’s statements**

Pay particular attention to the patient’s emotional state, educational level, and articulation abilities. If the patient says, “My doctor thought it might be multiple sclerosis; I’m told the visual evoked potentials show optic neuritis,” obviously a great deal of ground has already been covered. However, if the patient says, “The surgeon said the breast lump was a lesion; I was glad it wasn’t a tumor or even worse, a cancer...,” then information-sharing will have to start with more basic information.

**The emotional experience of the patient**

There are verbal and nonverbal elements.

**Verbal:** Try to assess emotions that the patient is talking about, and the emotions the words used imply. Also, be aware of emotions the patient is trying not to talk about.

**Nonverbal:** What other clues are there to the patient’s emotional state? Is the patient sitting back away from the doctor, leaning forward, crying, wringing his hands?

The goal is not to judge responses as normal or abnormal, but to discover clues to the patient’s emotional state.
Step 3. Find out how much the patient wants to know

This is a critical step or choice in an interview, but the point at which it is established --whether or not the patient wishes to know what is going on -- it is not necessarily difficult in itself. Omitting this stage leaves the later parts of the interview on very delicate grounds (unless the patient has earlier made a strong statement about wanting or not wanting information). Without a clear invitation (or declination) to share information, you will feel unsure of whether you are giving the patient too much or too little information. **It is important to develop a respect for what the patient wishes to know about his or her illness.** Most patients indicate they want full disclosure of the various aspects of their illness. In instances when the patient indicates he or she does not want to be told the details, special skill is required to balance the patient’s desire for limited information about the nature of their illness with providing the information necessary to make a treatment plan in which the patient can effectively participate. Again, at this point, **the key lesson is to develop a respect for what the patient wishes to know about his or her illness.**

There are some who raise concerns about asking patients directly what they want to know. In any conversation about bad news, the real issue is not, “Do you want to know?” but, “At what level do you want to know what’s going on?” Obviously, doctors’ statements are not the only source of information available to patients. Patients know how they feel, they know that they are being sent for tests or for surgery, they know what other patients say, what other staff members say, and if doctors say nothing, they know that they are not hearing good news about a simple reassuring diagnosis. If the patient is using denial, he or she is able to insulate himself or herself against the impact of all this—and will do the same against the impact of the question, “What do you want to know?” In other words, at some level every patient knows (or will know) when things are not going well. In asking the patient about information-sharing, you are simply finding out whether or not the patient wants the information discussed overtly.

You cannot assume who wants to know and who does not want to know bad news; there is a very low chance of doing any harm in asking. Asking patients what they want allows them to exercise their preferences. The majority will wish for full disclosure. Those who do not, however, will not be robbed of using denial mechanisms, and additional distress is not a common sequela.

Some examples of how to phrase the question to find out how much the patient wants to know:

- If this turns out to be something serious, are you the type who likes to know exactly what’s going on?
- Would you like me to tell you the full details of the diagnosis?
- Are you a person who likes full details --or do you prefer just to hear about treatment plan?
- Do you like to know exactly what’s going on or would you prefer the outline only?
- If your condition is serious, how much would you like to know about it?
- Would you like me to tell you the full details of your condition--or is there someone else that you’d like me to talk to?

In emergency situations, where the patient maybe unconscious and you are speaking with the patient’s family, you can alter the above suggestions. For example:

- I know a lot has happened. Do you want to know exactly what’s going on or would you prefer the outline only?

Chances are good that they will want a detailed description of what is going on; family not prepared to hear details will have the opportunity to excuse themselves from the discussion.

Overall, these approaches allow the patient to indicate how much or how little they want to hear without cutting off communication. You are saying explicitly that you will maintain contact and communication about treatment and other issues, not about the details of the disease. If the patient expresses a desire not to discuss the details of his or her condition, you should leave the door open for later. For example, “That’s fine. If you change your mind or want any questions answered at future visits, just ask me at the time.”
Step 4. Share the information (Aligning and Education)

Decide on your agenda (diagnosis/treatment plan/prognosis/support)

Even before you start this part of the interview, you should have some idea of what you are trying to achieve with the interview. This depends on the patient’s specific situation and in part on your particular relationship to the patient. If you are not the physician in charge of the patient’s care, it may not be your role to explain the treatment plan, although you can still act as an advocate for the patient. This would include finding out how much the patient understands and what his or her main concerns are. The four objectives for structuring the information you share are:

1. Diagnosis  
2. Treatment plan  
3. Prognosis  
4. Support

Start from the patient’s starting point (Aligning)

By now, you have heard how much the patient knows about the situation and the vocabulary in which the patient expressed it. This serves as a starting point for information-giving. Reinforce those parts of what the patient has said that are correct (using the patient’s words if possible) and continue from there. It gives the patient a great deal of confidence in himself or herself (as well as in you) to realize that his / her view of the situation has been heard and is being taken seriously (even if it is being modified or corrected). This process has been called “aligning,” a term to describe the process by which you line up the information you wish to communicate on the patient’s knowledge baseline.

Educating

Once you have started at the patient’s starting point (aligned yourself with the patient), you now have to bring the patient’s perception of the situation closer to the medical facts as you know them. The process of sharing information is much like an educational process. In order to effect this process, you will need to apply slow and steady guidance over the direction of the interview. To do this, it is first necessary to assess the magnitude of the divergence between what the patient understands and the medical facts. The education process is then a process of changing the patient’s understanding in small steps and observing the patient’s responses. The key ingredients of this component of the interview are steady observation and continued gentle guidance of the interview’s direction rather than sudden lurches.

Some useful guidelines for patient education are:

- **Give information in small chunks**

  - Medical information is hard for patients to digest; many fail to retain up to 50 percent of information given.
  
  - If there is an apparently large gap between the patient’s perception and the reality of a situation, you may facilitate the patient’s understanding by giving a warning that things are more serious than they appear to the patient (“Well, the situation does appear to be more serious than that...”).
  
  - Following the warning, a narrative of events can be used to help the patient understand what has been happening. (“When you had those bruises, your blood test showed that you weren’t making some components in the blood called platelets. They’re made in the bone marrow and that’s why your doctor wanted a bone marrow test to see what was wrong. It was that test that showed the problem...”)
• Use English not “Medspeak”

⇒ Use of technical medical terminology may isolate and alienate the patient who finds it unfamiliar.

<table>
<thead>
<tr>
<th>“Medspeak”</th>
<th>English</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blast cells</td>
<td>Leukemia</td>
</tr>
<tr>
<td>Demyelination</td>
<td>Multiple Sclerosis</td>
</tr>
<tr>
<td>Abnormal growth</td>
<td>Tumor (then) cancer</td>
</tr>
<tr>
<td>Space-occupying lesion</td>
<td>Tumor (then) cancer or blood clot</td>
</tr>
<tr>
<td>The prognosis is guarded</td>
<td>The situation is serious</td>
</tr>
</tbody>
</table>

• Check reception frequently

⇒ Check that the message you are transmitting is being received. Taking time to do this also serves to break up the information into small sections.

Examples:

• Am I making sense?
• Do you follow what I am saying?
• Does it all seem sensible to you?

These interjections serve to:

• Demonstrate that it matters if the patient does not understand
• Allow the patient to speak
• Allow the patient to feel an element of control over the interview
• Validate the patient’s feelings

• Reinforce and clarify the information frequently

⇒ One way is to get the patient to repeat the general drift of what you have said
⇒ Repeat important points yourself (I know it is difficult to remember all this, so again...)
⇒ Use diagrams and written messages
⇒ Use prepared written materials or recorded material when available, but be sure you are familiar with the contents

• Check your communication level (adult to adult)

⇒ Be conscious of the level at which you are talking. Ideally, all doctors and adult patients communicate adult-to-adult. See if you are giving the patient permission/signals to communicate at this level. A common problem is “talking down” to patients. This distances the physician from the patient.

• Listen for the patient’s agenda

⇒ There is danger in going through a bad-news interview without listening to the patient’s worries and concerns.
⇒ Try to elicit the patient’s list of important worries (the patient may be more concerned about the effects of a colostomy on his or her sex life than about the long-term complications of ulcerative colitis).
⇒ Identifying concerns does not mean that you must deal with the concern immediately. You can say that you understand the concern and will return to it in a moment.
⇒ Listen for buried questions that usually come at times when you are distracted with some other activity (while you are talking, after you have moved on to another topic). When the patient does this, finish your own sentence and then follow up with the question.
Example:
The patient was a young family physician with breast cancer with bone metastases unresponsive to chemotherapy. During her admission she had indicated clearly that she did not wish to talk about the future or about her personal feelings. She remained uncommunicative and ‘closed’ on all subjects except the immediate day-to-day physical issues. I made a couple of offers to listen if she wanted to talk, but did not press her. On one visit I told her that I had only a little time on that particular ward-round. We finished talking and as I got to the door and put my hand on the door handle she said, ‘What about euthanasia, then?’ I turned around and sat down and asked her to tell me what she meant. We then had a highly valuable conversation in a relatively short time. In retrospect, she must have felt that, since I had only a short time on the ward, she felt she would be able to stop the conversation easily if it became too difficult for her. This may have given her the additional incentive to start the discussion.

Try to blend your agenda with the patient’s reaction

⇒ You may blend them in quite overtly (“I know you’re worried about hair loss, and I’ll get to that in a moment, but I would like first to cover why we recommend chemotherapy in the first place.”)

Step 5. Responding to the patient’s feelings

- Identify and acknowledge the patient’s reaction. The success or failure of the breaking-bad-news interview ultimately depends on how the patient (or family member) reacts and how you respond to those reactions and feelings.

- While this introductory exercise does not allow for an in-depth description of the issues involved in responding to patients’ feelings, here are some points to consider when confronted by the patient’s feelings:

  1. Patients respond to bad news in ways characteristic of their own coping strategies.

  2. Their responses can be assessed by three criteria:
    - Social acceptability (set the limits generously)
    - Adaptability: is this response helping the patient to cope?
    - Flexibility: if this is not helping, can you intervene to help; if not, can someone else?

  3. In the event of conflict, try to:
    - Step back and not be swayed by the conflict itself
    - Take action to bring some resolution, do not wait and only react
    - Define areas that cannot be resolved

  4. There are numerous ways a patient may react to hearing bad news.

    Many of these reactions reflect specific difficulties certain patients have in working with health care professionals (persistently angry, very demanding). The most consistently useful tip for responding to patients’ reactions to hearing bad news is: if the patient cries, at least offer a tissue. While this may seem trivial, this silent gesture may be the most humane and effective response you can give to your patient’s feelings.
Step 6. Planning and follow-through

- Organizing and planning
  
  The patient is counting on you to offer plans for the future. In summary, you should try to put together what you know of the patient’s agenda, the medical scenario, and the plan of management. Offer the clinical perspective and guidance, demonstrating that you are on the patient’s side.
  
  Demonstrate understanding of patient’s problem list elicited during the interview
  
  Indicate you can distinguish what problems can be fixed and what cannot be fixed. With both medical and psychosocial problems, some are fixable and some are not. Acknowledging the distress caused by unfixable situations provides a support for the patient to continue the difficult task before him. (I know that its difficult not being able to work at this time but your treatments are important for your recovery).
  
  Make a plan or strategy and explain it. Patients need to know that you have some plan in mind—even if it consists of little more than “We’ll deal with each problem as it arises”, which means, at least, that you will not abandon the patient.
  
  Prepare for the worst and hope for the best. If there is resistance to making plans for the worst scenarios (paralysis, or deterioration and death), it is important to realize and to state that the human brain is functionally compartmentalized, and is quite capable of making plans for the worst while still hoping for the best. For example, drawing up a will does not cause instant death, nor does it rob the person of his or her will to live. We constantly make plans and then live as if those plans will not be needed.
  
  Identify the patient’s coping strategies and reinforce them. Patients usually have dealt with other difficult situations in their lives. Helping the patient identify how they responded to those situations is a good indication for the future.
  
  Identify and incorporate other sources of support.

- Making a contract/Follow-through

  The final part of the interview is the summary and contract for the future. The summary, which also requires a great deal of thought, should show the patient that you have been listening and have picked up the main concerns and issues. You should give an overview of the two agendas, the patient’s and yours.

  Once the main points are summarized, ask if there are any other questions at this time.

  Make a contract for the future ("I’ll see you at our next visit in two weeks" or, “We’ll try the new anti-sickness medicine and I’ll see you tomorrow on ward rounds.”)