Breaking bad news: practical advice for busy doctors

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Breaking bad news is a difficult task faced daily by the busy doctor. This article draws on some of the literature on the topic and offers some practical advice on how to break bad news.

Good communication is essential for a good doctor–patient relationship. Problems of communication in medical practice are common and are a major cause of patient complaints (Matthews, 1998).

Research has indicated that young doctors generally lack interpersonal skills and are poor at conveying information to patients (Egnew et al, 2004). One of the communication tasks they find the most difficult and which is a frequent source of patient dissatisfaction is the breaking of bad news (Eggly et al, 1997; Department of Health, 2000; Thompson, 2002).

WHAT IS BAD NEWS?

Bad news is equated with anything that changes a person's view of the future in a negative way (Buckman, 1992). In the clinical setting it is commonly associated with the diagnosis of a terminal illness such as cancer. However, bad news can take many different forms: the diagnosis of schizophrenia, a positive test for the human immunodeficiency virus (HIV) or the loss or complication of a pregnancy (Vandekieft, 2001).

Telling a young mother that her newborn baby has Down's syndrome or explaining to a middle-aged father of three that he has inoperable stomach cancer is daunting for the inexperienced doctor. How do you deliver news that could potentially shatter someone's life? Breaking bad news is undoubtedly one of the most challenging tasks in a doctor's education.

WHY IS IT IMPORTANT TO KNOW HOW TO BREAK BAD NEWS?

Breaking bad news is a task undertaken frequently by doctors, which is inherently stressful. This is particularly the case when the doctor giving the bad news is inexperienced, the patient is young or the prognosis is poor (Ptacek and Eberhardt, 1996). Over the last three decades there has been a change in the medical culture with a move away from paternalism to a more collaborative doctor–patient relationship. Patients are much better informed about diseases in general and doctors are also more aware of their duty to respect the ethical principles of patient autonomy and informed consent. Thus, patients want more information and doctors are more inclined to give it. In addition, in western developed countries in particular, there is always the threat of litigation as a result of poor communication (Baile et al, 2000). So bad news needs to be taken seriously and delivered tactfully.

WHY IS BREAKING BAD NEWS DIFFICULT?

Buckman (1984) suggested that doctors find it so difficult to break bad news because of their various fears and anxieties. These include the fear of being blamed personally for the bad news, the fear of causing harm, the fear of unleashing emotions from both the patient and themselves, and the fear of not knowing all the answers. He added that once a doctor begins a conversation, certain psychological factors start to operate which push him/her into taking responsibility for the disease itself, making it even more difficult. Examples of this are trying to paint an optimistic picture in order to hearten the patient even if the news is bad (shielding), and exerting control over the information in order to compensate for failure to control the disease process. Other factors which may come into play and complicate the task are time constraints, religious beliefs, and failure to come to terms with one's own mortality (Maguire, 1985; Wilkinson, 1991).

DOES BAD NEWS CAUSE HARM?

Since time immemorial there has been a widely held belief in medicine that giving bad news to patients may destroy their hope and cause long-

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term psychological harm. In fact the reverse is true. Insufficient information about a serious diagnosis is more likely to cause poor psychological adjustment. A Dutch study found that children who received open information about their cancer diagnosis at the initial stage of the disease were significantly less anxious and depressed up to 3 years later than those who received less open information (Last and van Veldhuizen, 1996).

Pinner and Bouman (2003) conducted a prospective study on the attitudes of early dementia patients towards diagnosis disclosure. They found that 92% of patients wished to be fully informed. At 1-year follow up there were low rates of depression (6%), and no catastrophic reactions or suicide cases.

HOW SHOULD BAD NEWS BE BROKEN?

Until quite recently the issue of how bad news should be broken was dominated by expert opinion, taking the form of practical advice based on anecdotal experiences of senior clinicians. However, some studies have now investigated patients' perceptions of the manner of bad news delivery and its relationship with satisfaction and psychological adjustment.

Parker et al (2001) surveyed patients about the factors they considered important when a doctor breaks bad news. The most important factors were the doctor's competence, honesty and attention, the time allowed for questions, a straightforward and understandable diagnosis, and the use of clear language. Preparing the patient for bad news, having family members present, giving written information, talking about feelings and being reassuring are also associated with higher levels of patient satisfaction and lower levels of psychiatric morbidity (Schofield et al, 2003) (*Figure 1*).

EASING THE TASK OF BREAKING BAD NEWS

Of the various models devised for the task of breaking bad news, two in particular are useful: the SPIKES six-step protocol (Baile et al, 2000) and the ABCDE mnemonic (Rabow and Mcphee, 1999).

Being honest
Being competent
Being reassuring and attentive
Using clear language
Preparing the patient for bad news
Having family members present
Providing written information
Talking about feelings

Figure 1. Good communication practice.

The SPIKES protocol

Intended to help doctors break bad news in an empathic and straightforward manner, SPIKES stands for:

- Setting up the interview,
- Assessing the patient's Perception
- Obtaining the patient's Invitation
- Giving Knowledge to the patient
- Assessing the patient's Emotions
- Strategy and Summary.

Setting up: Find a quiet and private location to break bad news. See the patient with close family or friends should he or she wish. Set aside adequate time for the task and minimize interruptions (e.g. pagers). Sit down and make good eye contact.

Perception: Before giving any information, check the patient's awareness of his/her condition, by asking 'What have you been told about your problem?' or 'What do you think might be going on?'

Invitation: Some patients express a desire for full information, some do not. Therefore, find out how much the patient wants to know. For example, you could say 'How would you like me to give the information about your test results?' If the patient does not want to know the details, offer to answer any questions in the future should he/she change his/her mind.

Knowledge: If the patient is unaware of the severity of the condition, it is useful to give a warning of bad news. This may be a statement such as 'I'm afraid it looks more serious than we first thought.' Allow a pause to let the comment sink in. If the patient indicates a desire for more information, give it in small doses, proceeding at the patient's pace. Avoid jargon but do use euphemisms as these can soften the blow ('some abnormal cells', 'a growth', 'a shadow on the X-ray').

Emotions: Once you have confirmed the diagnosis (e.g. cancer), go on to explore the patient's resulting feelings: 'How does that make you feel?' Allow time for the release of emotion and empathize: 'It must must be devastating for you.'

Strategy and summary: Discuss any concerns that result from the bad news. Foster an appropriate level of hope. This may be to ensure adequate pain relief in the palliative care setting or, in the case of a cancerous breast lump picked up very early, eradication of the problem. At the end of the consultation, summarize the discussion, screen for any remaining questions, and make it clear that you will be available to talk again.

The ABCDE mnemonic

These recommendations, summarized by a simple mnemonic, have a lot in common with the SPIKES protocol, so will be covered more briefly. ABCDE stands for:

- Advance preparation
- Build therapeutic relationship
- Communicate well
- Deal with patient/family reactions
- Encourage and validate emotions.

Advance preparation: After arranging a private location, prepare yourself for the consultation by reading through the case notes. Mentally rehearse what you are going to say.

Build therapeutic relationship: Introduce yourself with a handshake. Warn of the bad news and find out how much the patient wants to know.

Communicate well: Be clear and confident, avoiding any medical jargon. Be compassionate, allowing for the expression of emotions.

Deal with patient/family reactions: Assess and respond to the patient's emotional reaction and be empathic.

Encourage and validate emotions: Explore what the news means to the patient and deal with their concerns. Offer realistic hope. Finally, attend to your own needs and be attuned to the needs of other medical and nursing staff.

GETTING HELP WITH BREAKING BAD NEWS

While practice using these models can help make the task a bit easier, there are some other sources of help. Attending a workshop on communication skills can be of great benefit and can improve your confidence in breaking bad news (Farrell et al, 2001; Ladouceur et al, 2003). A good starting point is your hospital library or postgraduate education centre to find out about courses in your region. There are some helpful web sites dealing with breaking bad news (www.breakingbadnews.co.uk; http://eduserv.hscer.washington.edu/bioethics/topics/badnws.html). Practice the art of reflection; think of some difficult communication scenarios you have faced, and how you could have perhaps dealt with them differently. Some practice scenarios are included to get you started (*Figure 2*).

CONCLUSIONS

Breaking bad news is a daily activity for busy clinicians and one which they dread and often do badly. By being prepared and using some of the practical tips in this article, the bad news consultation can be made less daunting and difficult. **HM**

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Figure 2. Practice scenarios.

Case 1
Mrs Jones, a 33-year-old secretary with two young children, discovered a lump in her right breast while showering. Following urgent referral to hospital she underwent a lumpectomy. You are in the surgical outpatient clinic this morning and you have received the pathology report: invasive ductal carcinoma. She is due in next. How will you handle the consultation?

Case 2
Mr Peters, a 23-year-old business graduate who works in the city, has been admitted for the second time this year after suffering a 'nervous breakdown'. He was due to be married next week. He is still hearing derogatory voices discussing him and is convinced that MI5 are after him. The diagnosis is paranoid schizophrenia. His parents have made an appointment to ask when he will be discharged. What will you say to them?

KEY POINTS

- Ensure the location is comfortable, quiet and private.
- Set aside convenient and adequate time for the consultation.
- Check what the patient knows about the condition.
- Fire a warning shot.
- Give information at the patient's pace by observing cues.
- Explore the patient's feelings and elicit their concerns.
- Foster an appropriate level of hope.
- Be honest, caring and empathic.