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Afaf Girgis PhD & Rob W. Sanson-Fisher PhD

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Breaking Bad News 1: Current Best Advice for Clinicians

Afaf Girgis, PhD, and Rob W. Sanson-Fisher, PhD

Reviews of the literature on how to convey bad news to patients with serious diseases have identified a paucity of empirically based information to guide clinicians in undertaking this difficult task. In 1994, consensus guidelines for clinicians that incorporated the views of medical oncologists, general practitioners, surgeons, nurse consultants, social workers, clergy, human-rights representatives, cancer patients, hospital interns, and clinical directors of medical schools were developed in Australia. Since then, the guidelines have been published widely and incorporated into other documents outlining recommendations for the best practices. The most recent version of the guidelines on breaking bad news is reported in this article. Revisions based on feedback from key groups, including medical schools and clinicians, and on comparisons of the views of breast cancer patients with their providers' views on the importance of each recommendation in the guidelines are included, and suggestions for future research are detailed.

Index Terms: bad news, cancer, diagnosis

Research findings indicate that a substantial percentage of cancer patients want to be told about their diagnoses¹⁻³ and want information about other aspects of their illnesses.⁴ Over the last 40 years, patients have increasingly wanted to know about their diagnoses.⁵ The vast majority of cancer patients in a study published in 1994 said they wanted all available information, whether good or bad, about their condition.⁶ Reports in the literature also indicate that the majority of patients want to be actively involved in making decisions about treatment.^{7,8}

Are Patients' Needs for Information Being Met?

Healthcare providers appear to have a different perception about the types of information that patients desire, and they tend to underestimate the amount of information the patients want. This often results in patients' dissatisfaction with the medical information they receive. In a study of a

cancer control program for people over 65 years of age, more than 75% of those surveyed believed that doctors created undue worry in the minds of older patients by failing to give them enough information about their illness.⁹ More than 40% of the 358 cancer patients who responded to another study reported that their expectation that they would be fully informed about issues related to their diagnosis and treatment, including test results, survival prognosis, and odds of treatment success, were unmet.¹⁰

Patients' dissatisfaction with the amounts and types of information they receive is reflected in the substantial proportion of healthcare complaints. In Australia, more than one tenth of complaints during the last few years have concerned patients who believed that they had been given misleading information or an inadequate or wrong diagnosis. In an Australian state, for example, the levels of these complaints in communication were 10.2% (173) in 1991/92, 9.8% (171) in 1992/93, and 11.2% (165) in 1993/94.¹¹⁻¹³

Some doctors fear that giving bad news to patients will lead to undesirable emotional reactions with long-term

Drs Girgis and Sanson-Fisher are with the New South Wales Cancer Council Cancer Education Research Program (CERP) in Newcastle, Australia.

harmful consequences. Reports in the literature suggest that although disclosure may have a negative emotional impact in the short term, most patients will adjust well in the long term.¹⁴ Gratitude and peace of mind,¹⁵ positive attitudes,¹⁶ reduced anxiety,¹⁷ and better adjustment¹⁸ are some of the benefits that patients report from having been told about their diagnosis of cancer. In fact, uncertainty is a major cause of emotional distress for patients; relief from this uncertainty can, in itself, be therapeutic.¹⁹

Some evidence suggests that the way that the bad news is given can exacerbate or alleviate some of the distress and anxiety. For example, breaking bad news abruptly has been found to increase its negative impact.²⁰ Research findings also suggest that if health professionals are frank and unambiguous in the words they use, cancer will continue to evoke anxiety in the short term, but the patients will feel more capable of coping with their cancers.²¹ Patients also report particularly negative reactions^{3,22} as a result of (a) news delivered over the telephone or in the recovery room, (b) doctors' withholding information, and (c) clinicians' failure to provide information about the availability for additional help. Patients also indicate that letters and tapes of the "bad news" consultation are helpful and may increase their level of satisfaction with and retention of the information.^{4,23,24}

Do Physicians Feel Competent at Breaking Bad News?

Medical schools have only recently begun to provide training for undergraduates in how to communicate such information, but opportunities for this type of training remain scarce.²⁵⁻²⁷ Consequently, most doctors emerge from their training well equipped to provide high quality technical care but ill prepared to provide interactional aspects of care.^{20,26} A survey of Australian interns indicated that 64% felt competent in their technical skills, such as examinations and inserting intravenous lines, but only 35% felt competent at interactional skills, including breaking bad news.²⁸ More recently, a survey of surgeons found that more than three quarters rated skill in breaking bad news important or very important to being a good surgeon and that formal training in breaking bad news to patients²⁹ should be part of surgical training courses. These data suggest that health professionals believe that breaking bad news is an important task, but they feel inadequately trained to do it effectively. Twenty-eight percent of medical oncologists surveyed in a report published in 1995 reported that they suffered from clinical levels of anxiety and depression; these clinicians viewed communication difficulties as contributing significantly to their stress and lack of personal fulfillment.³⁰

Are There Guidelines on How To Break Bad News Effectively?

A 1994 MEDLINE³¹ search of the literature on breaking bad news for the years 1973 to 1993 identified publications in the area of communicating bad news.³² More than one third of the resulting citations were based on opinion, and almost two thirds were letters, opinions, reviews, case reports, and non-data-based descriptive papers; only four randomized, controlled trials were listed during the period of more than 20 years. A comparison of the review of the literature published in 1995³² with that undertaken by Walsh et al (see pp 61-72) to cover the period since the first review (ie, 1994 to August 1997) suggests that little progress has been made in terms of identifying empirically based evidence on how to break bad news effectively.

In 1992, recognizing the immediate need for guidelines on breaking bad news and the likely delay in developing guidelines based on empirical studies, the New South Wales Cancer Council and the Postgraduate Medical Council in Australia collaborated in a consensus process to develop an interactional skills package on conveying poor prognoses. Consensus methods define levels of agreement on controversial subjects and are widely accepted for developing guidelines in the absence of other evidence.³³⁻³⁵ Advocates of consensus methods suggest that this approach can create structured environments in which experts are given the best available information, allowing their solutions to problems to be more justifiable and credible.³⁶ Such strategies, however, provide Level 4b evidence,³⁵ which is not as reliable as evidence obtained from a systematic review of all relevant randomized controlled trials (Level 1), from at least one properly designed randomized controlled trial (Level 2), from well-designed controlled trials without randomization or well-designed cohort or case-control analytic studies (Level 3), or from descriptive studies (Level 4a). Despite their limitations, consensus guidelines can offer healthcare providers a useful guide until more rigorous data are available.

Since their development in 1992,³⁷ the "breaking bad news guidelines" have been published widely³² and have been incorporated into the Australian National Health and Medical Research Council's publication *Clinical Practice Guidelines for the Management of Early Breast Cancer*.³⁸ A slightly modified version of the guidelines, based on feedback from healthcare providers and communication skills trainers in Australian medical schools, has been reprinted with an accompanying training videotape. It was designed especially for use by surgeons, general practitioners, junior medical officers, and nurses.³⁹ The following principles and steps are a summarized version of these revised guidelines

and are intended as a guide that should be adjusted according to each situation. These guidelines may not be appropriate for use with pediatric patients because some issues, such as consensus, require special consideration.

GENERAL PRINCIPLES FOR BREAKING BAD NEWS

Although doctors and nurses always have to respond to specific circumstances as they present themselves, the general principles listed below, which are designated by the letter *P*, are important for clinicians whenever they must give patients bad news. These principles can act as a guide for helping to ease, as much as possible, a situation that most patients experience as distressing and upsetting. The principles can also remind doctors and nurses of the importance of attending to the patients' emotional state, in addition to providing information about their medical condition. See the sidebar for a summary of essential steps.

Who Tells Patients

P 1 One person only should be responsible for breaking bad news.

P 2 The person who breaks the news should ideally be the primary care physician or senior consultant who has had ongoing contact with the patient and will continue to be involved in the patient's care, such as planning the treatment. The task of breaking bad news should not be given to junior medical staff by default.

What to Tell Patients

P 3 The patient has a legal and moral right to accurate, reliable information, especially in cases where informed consent is required. The doctor also has a duty to disclose information to the patient.

P 4 The doctor's primary responsibility is to the individual patient. Responsibility to relatives or significant others is important but secondary. The doctor should be aware, however, that discussing the issue of telling the patient with relatives may be valuable in certain circumstances (eg, when the patient's cultural background is Mediterranean, Jewish, Muslim, or Southeast Asian). Avoid conspiracies of silence, which may affect rapport with the patient. If necessary, use a professional interpreter for cultural or linguistic assistance.

P 5 Give accurate and reliable information so that the patient understands any implications. Ensure that the patient understands treatment options and the reasons for any future investigations.

P 6 Always ask patients how much information they want about their prognosis. They may not be aware of the range

of information you can provide; therefore, it may help to outline the sorts of areas that can be covered.

People have different ways of coping with the implications of their diagnosis. Some cope by learning as much as possible about the situation so they can feel more in control; others prefer not to know and cope by avoiding thinking about it. People who use avoidance strategies may cope less well if these strategies are taken away.

P 7 Information giving should be a staged process that occurs over several consultations. An initial desire about the amount of information wanted may change and patients may feel more able to cope with more information over time, so ask on more than one occasion how much—or what else—the patient wants to know.

When to Tell Patients

P 8 The doctor should prepare the patient for the possibility of bad news as early as possible in the diagnostic process. The possibility of bad news is usually the reason for further tests and referrals, and the patient needs to be aware of this.

P 9 If a number of investigations or tests are being performed, do not give results of each test individually unless the patient understands that you are still awaiting other results. Plan a consultation for the time when all of the results will be available.

P 10 Tell the patient his or her diagnosis as soon as it is certain.

P 11 Make every attempt to tell patients in person except in exceptional circumstances. In some cases (eg, when patients have returned home if they live in a rural area), it may be necessary to give patients the news by telephone. In these circumstances, telephoning the news should be used only if that is the specific patient's preference. The physician should first ensure that the patient has appropriate support structures to assist following the telling of the news.

P 12 Make sure that sufficient time is available for the consultation at which the bad news is communicated.

Where to Tell Patients

P 13 Make every effort to ensure privacy and help the patient feel comfortable. In a hospital setting, for example, (a) avoid giving the patient the news during ward rounds, finding a private room if necessary; (b) close the curtains around the patient's bed; (c) sit at the bedside at eye level with the patient rather than standing over her or him; (d) ensure that the patient is clothed, not naked; and (e) ensure that interruptions, such as beepers and telephone calls, do not occur.

**Essential Steps in Breaking Bad News
to Medical Patients**

Give bad news in a quiet, private place.
Allow enough uninterrupted time in initial meeting.
Assess patient's understanding and emotional status.
Provide information simply and honestly.
Encourage patients to express their feelings.
Respond to patients' feelings with empathy.
Give a broad time frame for the prognosis.
Avoid conveying that "nothing more can be done."
Arrange a time to review the situation.
Discuss treatment options. Offer assistance in telling others.
Provide information about support services.
Document the information given.

Involving Others

P 14 Patients should be offered the choice of having family and significant others present to provide emotional support. Family members, friends, or others can help the patient recall information. Furthermore, if the patient chooses to cope by denying the diagnosis, the third party will be able to confirm that the patient was informed of the diagnosis if a problem arises.

P 15 Where possible, arrange for another health professional, such as a nurse or social worker, to be present when breaking bad news and during ongoing consultations. This person should be someone to whom the patient will have access for support and who can supplement information after you have left. Patients should be asked if they are comfortable with this arrangement.

P 16 Ensure that the patient's general practitioner, primary care physician, and other medical advisers are promptly informed about what you have told the patient and how the patient has responded to the news (eg, acceptance or denial). The healthcare provider can use this as a starting point for giving the patient more information.

Nonverbal Communication

P 17 Use nonverbal cues to convey warmth, sympathy, encouragement, or reassurance to the patient. In most cultural groups, this involves making eye contact, facing the patient, not interrupting when the patient is speaking, nodding encouragingly, and giving full attention to the patient. It is critical that the patient feels that you have time to talk and listen. Hence, avoid writing notes, reading the patient's

files, or looking elsewhere when the patient is talking to you. In some cases, touch can be very reassuring for the patient, and in other cases it may not be appreciated. The medical officer needs to use his or her judgment in this situation.

Dealing With Language and Cultural Differences

P 18 Use a trained health interpreter whenever there is a language difference between the doctor and the patient. Avoid using untrained people, such as family or a member of the hospital general staff, who may interpret incorrectly. A health interpreter service is available in some areas. Where this type of assistance is not easily accessible, use a telephone interpreter. These services are free in some countries.

P 19 Be aware that the culture, race, religious beliefs, and social backgrounds of patients may affect how they deal with the information they receive. Health professionals should become informed about these matters for the full range of patients they serve. If required, the physician should consult a health professional who has detailed knowledge and experience with the specific subculture.

**SPECIFIC STEPS (S) FOR BREAKING
BAD NEWS TO PATIENTS**

Ensure privacy and adequate time

S 1 Share the troubling information with the patient in a place that is quiet and private.

S 2 Allow enough uninterrupted time during the initial meeting for the patient to think about what you are going to tell her or him so that the patient is able to discuss it with you and ask you questions. Ensure that interruptions, such as beepers, telephone calls, and physical intrusions, do not occur. People may need different amounts of time to deal with the news. If the first consultation needs to be short because of time limitations, be certain to arrange a second consultation within 24 hours to follow up on the information you have given to the patient.

Assess understanding

S 3 Assess the patient's understanding of the situation. The patient may already be quite aware that the prognosis is likely to be bad or may have very little awareness of this. The patient's response will provide an appropriate starting point for you.

Provide information simply and honestly

S 4 Give the patient the diagnosis and prognosis honestly and in simple language but not bluntly. Avoid technical jargon or euphemisms (eg, *tumor, growth, metastasis, illness*)

that obscure the truth. If the patient has cancer, then use the word *cancer*. Give the facts relevant to the diagnosis and management of the patient's condition. The person may still be adjusting to the news, so the facts may need to be repeated or revised several times and on different occasions. Where relevant, write the information down or use pamphlets and diagrams.

Encourage patients to express feelings

S 5 Allow and encourage patients to express their feelings freely. Some immediate reactions may be crying, stunned silence, disbelief, anger, or acute distress. Accept patients' feelings and concerns by letting them know that it is quite normal to feel this way. This helps patients feel accepted and makes them more likely to discuss their concerns. Have tissues available for both patients and relatives.

S 6 Respond to the patient's feelings with empathy. Touch can be used to convey warmth, sympathy, encouragement, or reassurance.

Give a broad time frame

S 7 Avoid giving a prognosis with a definite time scale. If possible, however, give patients broad, realistic time frames that will allow them to sort out personal affairs while they are still well enough.

S 8 Avoid the notion of "nothing more can be done." Even if the disease is too far advanced for curative treatment, try to reassure the patient that you will provide support (medical and nonmedical) for as long as is needed to make the patient's remaining life as comfortable as possible. Where the treatment is palliative, do not pretend that it is likely to cure the disease and do not let the patient make that presumption.

Arrange review

S 9 At the end of the consultation, arrange for a time in the immediate future (preferably within the next 24 hours) to review the situation with the patient and his or her family or significant others. In the interim, either be personally available or nominate someone else who will be available to respond to the patient's questions or concerns. Write this information down.

Discuss treatment options

S 10 Tell the patient that you can discuss the possible treatment options and their side effects at this stage if he or she would like to know about them. Make it clear to the patient that you will discuss these options together, that a treatment recommendation will be made, but that the patient will be

involved in the final decision about treatment. As far as possible, ensure that there is consensus among the healthcare providers about the treatment options *before* discussing these with the patient at the bedside.

Offer assistance to tell others

S 11 Ask the patient whom he or she would like to tell about the diagnosis. Offer assistance and support in telling these people, including children, other family members, or employees. Encourage family meetings to discuss issues that arise over time and to answer questions honestly. If children are involved, then bring in a health professional used to dealing with children.

Provide information about support services

S 12 Give the patient detailed information about the availability of various support services, such as chaplains, disease-specific support groups, palliative care services, bereavement counseling for families, hospices, and so on. Suggest referral to these individuals or groups if the patient wishes. Emphasize that the patient's personal physician will also be an important support.

Document information given

S 13 Document what the patient has been told, which family or other individuals have been told, who is permitted to know about the patient's situation, and the patient's reactions to the news. Be concise and include this information in the patient's medical record. This will ensure that consistent information is available to all of the healthcare providers involved in caring for the patient. Include this information on the discharge summary that goes to the patient's general practitioner or internist and to any others involved when he or she leaves the hospital.

Do Patients and Providers Agree on the Guidelines?

An important way to determine the appropriateness of guidelines for conveying bad news is to compare different healthcare providers' perceptions with those of patients. Each of these groups offers different, but important, perspectives on what constitutes good quality care when the clinician is breaking bad news.

We participated in a research study to identify the specific guidelines deemed to be essential by three important groups involved in the process of breaking bad news—patients, doctors, and nurses. As part of the study, we compared the patients', doctors', and nurses' perceptions of how essential each of the principles and steps listed above was in the process of giving the patient the news effectively.⁴⁰ In addition, 84 breast cancer patients, 64 medical oncologists,

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and 140 nurse oncologists were asked their opinions about the importance of the original 15 general principles and the 12 recommended steps for breaking bad news.³²

At least 70% of the three samples in the study indicated that the following steps were essential every time bad news was delivered:

1. Assess the patient's understanding of the situation.
2. Tell the patient the diagnosis and prognosis honestly and in simple language but not bluntly.
3. Allow and encourage the patient to express his or her feelings freely, by crying, for example.
4. Avoid giving a prognosis with a definite time scale.
5. Discuss the possible treatment options at this stage.

The following principles were agreed to by at least 70% of the three samples:

1. One person only should be responsible for breaking bad news.
2. The patient has a legal and moral right to accurate, reliable information.
3. The primary responsibility is to the individual patient.
4. Ensure that the patient understands treatment options and the reasons for any future investigations.
5. Tell the patient his or her diagnosis as soon as it is certain.
6. Inform the patient in person, almost never by phone.
7. Make every effort to ensure privacy.
8. Use eye contact and body language to convey warmth, sympathy, encouragement, or reassurance to the patient.

Given the paucity of Levels 1, 2, or 3 evidence to define the best ways of conveying bad news, the high agreement between patients and providers in this Level 4 study should define the minimal level of care until more information is available from randomized controlled trials. It is not clear which findings from the three practitioner groups should be used as the "gold standard" for making recommendations. It can be argued that patients' perceptions are the most important, given that the patients receive the bad news. Furthermore, the results of recent research reinforce the importance of clinicians' assessing patients' preferences on relevant items in each individual situation—the amount of information the patient wants; whether the patient would like to have a family member, friend, or other health professional present when the news is discussed; whether the patient wants assistance in telling others; and so on.⁴¹

What Next?

Although descriptive research is important for determining perceptions of the importance and preferences for the

different components of the guidelines, clinical trials are urgently needed to determine whether having healthcare providers adopt these guidelines is effective in improving patient outcomes. Clearly, the guidelines would be of little value if they did not affect such variables. However, the choice of relevant outcomes should be considered carefully. Although some obvious outcomes may include patients' perceived needs, quality of life, and satisfaction levels, other outcomes may be important. An appropriate time frame for collecting these outcomes needs to be determined because breaking bad news may have short-term as well as long-term effects on patients. Further research is also required to determine the differential effectiveness of alternative caregivers. This is clearly an area that warrants more attention, given the increasing demands on clinicians' time. In Australia, such trials are under way to determine how using breast cancer nurses affects patient outcomes. Finally, if such guidelines are found to improve patient outcomes following rigorous controlled trials, effective strategies for promoting the adoption of these guidelines need to be identified. Ideally, systematic, randomized controlled trials, which provide the highest level of evidence of efficacy, should be used.^{35,42}

NOTE

This article was prepared by the New South Wales Cancer Council Cancer Education Research Program team. The views expressed are not necessarily those of the Cancer Council.

For further information, please address correspondence to the authors care of the Secretary, New South Wales Cancer Council Cancer Education Research Program, Locked Bag No 10, Wallsend, NSW, Australia, 2287.

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