Breaking bad news: advice for hospital doctors

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Learning outcomes

This module should help you:

- Develop an approach to breaking bad news that encourages an individual response to the unique needs of each patient
- Provide strategies to help the patient identify and address those complex feelings, concerns, and/or fears created by bad news
- Develop skills in facilitating a Common Ground plan that incorporates the clinical realities with the values of the patient
- Use time effectively so that the patient education leads to better understanding and improved patient care.

About the author

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Why I wrote this module

For many hospital doctors, informing a patient about a potentially lethal or debilitating condition can be frightening if they do not have much experience of dealing with strong emotions. The fear that the patient may get emotionally overwhelmed and that this might in turn overwhelm the physician can result in a focus on clinical details as a way of avoiding the emotional challenge. Accepting that a period of emotional ventilation is normal and often therapeutic can be helpful.

Peer review

This module was reviewed by Professor Mari Lloyd-Williams, Honorary Consultant in Palliative Medicine, Division of Primary Care, School of Population, Community and Behavioural Sciences, University of Liverpool, Liverpool.

Read

Breaking bad news (BBN) is one of the most challenging yet, when done effectively, one of the most rewarding communication issues that you will face as a hospital doctor. This module will address how to plan for and deliver bad news. While overall principles and guidelines are important, these general approaches need to be individualized for each healthcare provider and patient.

Delivering bad news - not just for cancer

For any patient a wide variety of diagnoses may require the delivery of bad news. Consider applying this module's principles when discussing life and death situations as well as in many other potential situations where you have to break bad news, for example:

- Serious and debilitating illnesses, such as multiple sclerosis and parkinsonism
- Illnesses and complications that may signal a profound loss in functional status, such as stroke, myocardial infarction, and serious trauma
- Conditions affecting cognitive/emotional function, eg dementia and depression
- Common but serious illnesses that have potentially life threatening complications, eg diabetes, hypertension, elevated cholesterol, etc.
- Conditions impacting not only the patient but also family members and loved ones, including miscarriage, sexually transmitted disease, etc.
- Any condition may have personal implications making it a bad news event for that patient. Look out for a patient's reaction that is more striking than you might expect. In such cases there is likely to be some personal, familiar, or cultural experience to explain the reaction.

The five step, patient centred approach to breaking bad news

There is good evidence that clinicians can learn and use an effective model or template to break bad news.[1] Just as it is helpful to mentally rehearse the steps involved in performing a lumbar puncture, planning how to break news can give confidence to hospital doctors who may otherwise feel apprehensive. Feeling more comfortable and in control means you will be better able to meet your patient's needs.

The model proposed in this module is patient centred.[2] The patient centred model of communication focuses on eliciting and incorporating the patient's perspective on the illness into the encounter. Nowhere is this more important than in breaking bad news.[3,4] In fact, each of the most referenced models of breaking bad news emphasizes getting the patient's perspective on the bad news. In the SPIKES model the "P" refers to the patient's perspective of the condition and its seriousness and the "E" refers to exploring the patient's emotions and empathising as the patient responds.[5] In the ABCDE model the D refers to "Dealing with patient and family reactions."[6]

The five step, patient centred model described below is recommended because it places the emphasis on responding to the patient's intellectual and emotional reaction when hearing the bad news. As a memory aid, recall that attention on the patient lies at the third of five steps, the central and most important place in the model: the patient is at the CENTRE of the patient centred model.

The five step, patient centred approach to breaking bad news	
Step 1	Advance planning
Step 2	Forecasting and delivering the bad news
Step 3	The patient - emotions, perspectives, agenda, and preferences for proceeding
Step 4	Delivering information, including the use of decision aids
Step 5	Establishing common ground - negotiating a plan; checking for understanding/ feasibility/ mutual responsibility

1. Fallowfield L, Jenkins V, Farewell V, Saul J, Duffy A, Eves R. Efficacy of a Cancer Research UK communication skills training model for oncologists: a randomized controlled trial. *Lancet* 2002;359:650-6
2. Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam CL, Freeman TR. Patient Centered Medicine, Sage Publications 1995
3. Maguire P, Faulkner A. Communicate with cancer patients: Handling Bad News and difficult questions - How to do it. *BMJ*. 1988;297:907-9.
4. Quill TE, Townsend P. Bad News: Delivery, Dialogue and Dilemmas. *Arch Intern Med* 1991;151:463-8.

5. Baile WF, Buchman R, Lenzi R, Glober G, Beale EA, Kudelka AP. SPIKES - A six step protocol for delivering bad news: application to the patient with cancer. *Oncologist*. 2000;5:302-11.
6. Rabow MW, McPhee SJ. Beyond breaking bad news: how to help patients that suffer. *West J Med* 1999;171:261.

The patient centred approach to breaking bad news

1 Advance planning

Advance planning begins when the patient is scheduled for a test or procedure, the results of which may result in bad news. It is best to anticipate how the test results (whether positive or negative) will be delivered to the patient. The question of when to schedule the follow up appointment is important. Avoiding unnecessarily long delays between assessment and disclosure is known to be very important to patients.[1]

It is often useful to ask the patient who else might participate in the follow up visit. It will usually generate less angst if this discussion occurs in advance rather than calling to inquire after the test or procedure if a spouse or loved one would care to accompany the patient to the visit.

Be prepared

In advance of the visit make sure that you:

- Read and understand the results
- Talk to the clinician performing the procedure
- Discuss the case with a consultant who may later get involved in the case
- Anticipate questions and find answers. One question that frequently arises is, "Are you certain? Might there be a mistake?" A call to the clinician performing the procedure may improve your response to this question.

1. Fallowfield L, Jenkins V, Farewell V, Saul J, Duffy A, Eves R. Efficacy of a Cancer Research UK communication skills training model for oncologists: a randomized controlled trial. *Lancet* 2002;359:650-6

2 Delivering bad news

Establishing current level of understanding

Unless the patient immediately asks, "What is it, doctor?" it may be useful to know what the patient already has been told or knows about the situation. Patients often hear things from other consultants, from technicians, or from seeing results. Such information and the patient's reaction to what they have already been told or have surmised can be helpful when planning the best approach to sharing the bad news.

Forecasting

For many patients, bad news is most difficult to deal with when it arrives without warning. The goal of forecasting bad news is to allow the patients to anticipate or brace themselves, even for just a moment, before the bad news is delivered.[3] This can be done with a statement as simple as, "I'm afraid I have some bad news to share with you."

Delivering the bad news

With the patient mentally and emotionally "braced," deliver the bad news in a way that is clear and free of potential misinterpretation. Your knowledge of the patient will allow you to choose language that the patient will understand. Be clear and brief; use lay or street terms (cancer is more understandable than lymphoma) and avoid jargon.

It is usually best to deliver both the diagnosis and treatment together when both are bad news, for example, "I'm afraid, that after consulting with our surgeon that the news is bad. You do have gangrene and will need an amputation below your knee." When the treatment is an order of magnitude less disturbing than the diagnosis (though still likely to be upsetting), leave that for the information sharing step.

Avoid euphemisms or jargon which may hide the real message, such as:

- You have a nasty tumour or growth
- The pathology report identified Hodgkin's disease
- The blood work shows a sub-clinical infection with Human Immunodeficiency Virus
- The cause of your dad's problem appears to be multi-infarct cognitive loss.

Recall that bad news is BAD. Delaying the realisation of the bad news, regardless of the good intentions, does not eliminate the pain.

Instead, use clearer disclosures that both allow the patient to respond realistically and for you to help them with that response:

- The lump that you feel is breast cancer
- The report shows a type of lymph node cancer, called Hodgkin's disease
- You are infected with the AIDS virus
- Your dad's confusion, sometimes called dementia, was caused by number of small strokes.

This succinct delivery of the emotionally charged news ends the phase of breaking bad news and begins the phase of attending to the patient and his or her unique response to such information.

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3 The patient's emotions, perspective, agenda, and readiness to proceed

The most appropriate follow up to the succinct statement of bad news involves a set of communication skills that redirect the focus to the patient's reaction and needs.[8] A variety of approaches, used in various combinations, achieve this goal. These approaches include:

Silence

With adults, silence, while underused, communicates respect that the information provided deserves time to sink in and provides an opportunity for the patient to respond. Silence is often accompanied with other non-verbal indicators that the clinician is respectfully waiting for the patient to respond, eg a slight lean forward, perhaps a touch to the arm, a slight move of the tissue box, indicating the clinician understands that the information received was traumatic.

Provide direction

It may be appropriate to use a segue to guide the patient, for example, "Before I tell you about this condition and its treatment I'd like to pause and hear your initial reaction to the news." This comment may be followed by more silence.

Acknowledging anticipated feelings

For example, "I suspect that must have been difficult to hear?" or "people often have strong feelings at times like this, but not every patient's feelings are the same. What are you experiencing?"

For a variety of reasons, a minority of patients will prefer not to express their feelings at this time. See the "Reflect" section for ways to deal with such situations

Provide tissues, appropriate touch, and time when expressions begin to flow.

Use active listening

Some emotions and concerns are difficult to express explicitly. Patients often provide an opening to these feelings with "clues" or statements that imply a deeper but unspoken concern. Use active listening to explore the meaning of such implied concerns.[9] See the "Reflect" section for examples of active listening.

Elicit the patient's perspective and experience

Explore what the patient knows and what the patient's experience has been with the condition in question. Knowing the patient's personal experience with the condition helps to guide further conversations.

Determine preferences for how best to proceed

Before continuing, check:

- The patient's readiness to hear additional information
- The level of detail and explanation desired

- The ideal time for this conversation (it may be at some later time)
- Whether others should be present.

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2. Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam CL, Freeman TR. Patient Centered Medicine, Sage Publications 1995
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7. Schofield PE, Beeney LJ, Thompson JF, Butow PN, Tattersall MH, Dunn SM. Hearing the bad news of a cancer diagnosis: the Australian melanoma patient's perspective. *Ann Oncol*. 2001;12:365-71.
8. Gillotti C, Thompson T, McNeilis K. Communicative competence in the delivery of bad news. *Soc Sci & Med*. 2002;54:1011-23.
9. Lang F, Floyd, M, Beine, KL. Clues to patients' explanations and concerns about their illness. A call to active listening. *Arch Fam Med* 2000:9;222-7.

4 Delivering detail

Establishing the agenda

Before beginning to share information, check the patient's questions and agenda. The patient's agenda will include issues and concerns identified while exploring the patient's feelings and perspective during step three, as well as any additional areas identified now. Summarise what you plan to address:

- A description of the condition (in the amount of detail defined by the patient)
- Prognosis (guided by the preference for degree of detail determined in Step 3 above)
- Available treatments with the pros and cons of each
- Your intent to tailor the treatment plan to the patient's values, interests, and expectations
- All unique patient identified agenda items.

Ask - Tell - Ask

Use this approach:

- **Ask** (what the patient already knows about the condition)
- **Tell** (details about the condition that will be needed by the patient)
- **Ask** (what the patient understands about what has just been shared)

This approach is valuable for the following reasons[10]:

- The patient's response will provide valuable information on the patient's knowledge base, and the type and level of language that are appropriate
- Having the patient speak first identifies their current affective tone. The explanation that follows should address both the content needed to fill in the knowledge gaps, as well as patient's feelings
- Patients often have a solid grasp of certain health information. Knowing this avoids unnecessary repetition
- Patients' misconceptions are identified before beginning. When such misconceptions exist, a special focus of attention will be needed in these areas
- It is always best to build on what the patient knows. Retention of information will be easier when new information is placed in the context of what is already known.

Telling

Having listened to the patient's understanding, proceed to share the needed informational details mentioning essential medical terms (explaining them in lay terms).

Provide information in manageable segments, frequently checking for understanding and asking questions to keep the disclosure in contact with the patient

Aids to explanation/decision

The real test of sharing information effectively is how well the patient understands and can use the information provided. This is tricky business. Every aid to facilitate adult learning in a high stake situation should be encouraged. Some of the approaches that may help such learning and comprehension include the following:

- As previously described, by asking the patients their level of understanding and their agenda
- A picture is worth a thousand words. Either draw clinically relevant material or identify and use pictures relevant to the condition and anatomy.

Decision aids - finding or developing decision aids for those common and important information sharing sessions can be valuable. Recent studies indicate that the use of picture rich, flow sheet oriented decision aids helps patients retain valuable information. In addition, decision aids have been shown to impact patients' decisions about complex bad news situations.[11]

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9. Lang F, Floyd, M, Beine, KL. Clues to patients' explanations and concerns about their illness. A call to active listening. *Arch Fam Med* 2000:9;222-7.

10. Platt FW, Gordon GH. Field Guide to the Difficult Patient Interview, 2nd edition. Lippincott Williams and Wilkins 2004
11. Whelan T. Effect of a decision aid on knowledge and treatment decision making for breast cancer surgery. *JAMA*. 2004;292:435-41.

5 Establishing a common ground decision

Common ground requires a shared understanding (between patient and physician) of the facts in the situation and a mutual appreciation for each other's values and interests. When achieved, common ground results in the patient's and physician's acceptance of a plan that uniquely addresses that patient's needs. Achieving common ground is challenging. Most, but not all, patients want to be involved in shared decision making. How to respectfully incorporate each patient's values will be addressed in the "Reflect" section of this module.

For now, this state of common ground can be facilitated through a variety of strategies as follows:

Use decision analysis

This is a semi-formal approach that walks the patient through a process of weighing the pros and cons of all of the decisions related to the bad news situations. This decision analysis approach is congruent with the nature of most medical decisions, which almost always require a compromise between some potential benefit and some potential complication. It is often helpful during the common ground/negotiation stage for the physician to:

- Elicit the patient's perspective and share your experience
- Compare the short term *v* long-term impacts.
- Contrast the benefits *v* cost/problems.[12]

Incorporating patient's values

A variety of patient values can have a major impact on the decision that is appropriate at that time. Explore the patient's thoughts and feeling regarding the following values[13]:

- Short term as opposed to long term survival (even at the risk of increasing short term morbidity and mortality)
- The importance of limiting pain and discomfort
- Relationship with families
- How the illness impacts family members
- Religious beliefs
- Financial considerations for the patient and family
- The importance of "being in control."

The best way to incorporate such values is to systematically explore the patient's values and beliefs, eg "Could you describe how important . . . is in your life?"

Exploring ambivalence and establishing criteria

For some patients a decision may be clear and unambivalent. For example, one patient might do anything regardless of the discomfort or cost to maintain survival for every day possible. By contrast, another patient might reject any treatment to prolong life.

Patients usually have various levels of feelings about aggressive care as opposed to comfort. It is often helpful to mention that patients frequently have mixed feelings. When the patient confirms such ambivalence, the use of criteria setting may help to recognise both sides of the ambivalence. For example, the patient may choose to initiate therapy but with a clear intent that certain criteria for success must be met in order to continue the therapy. Review of such criteria should be ongoing.

Summarise

Having found a solution that feels comfortable both to your patient and to yourself, it is best to summarise the decision. The summary should include current decisions and criteria for future modification of the plan.

Checking for understanding, feasibility, and mutual responsibility

Checking understanding

While no one would object to checking to ensure that a patient understands, in fact checking for understanding is not routine and is frequently overlooked.[14] There are two ways to check for understanding. One approach is to ask a closed ended question, for example, "Do you understand?" While this may be simple and perhaps non-threatening to the patient, many patients who claim to understand do not. A preferred approach is to ask what the patient understands about the condition and treatment plan. This is the second ask of the ask tell ask approach.

In a recent study, when we asked patients their preferences on the way to assess their understanding, they strongly preferred the question "What do you understand?" to, "Do you understand?" Patients also preferred to be forewarned at the beginning of the discussion that there would be a "quiz" at the end.

Checking feasibility

It is always appropriate to ask this in an open ended way, such as "How does that sound to you?" Listen carefully for both the verbal and nonverbal response. If there is any hint of uncertainty in the response, be sure to explore further for concerns with the plan's feasibility.

Mutual Responsibilities

Finally, check or reaffirm that the patient's explanation of the plan includes their responsibility and timeline as well as your responsibility.

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12. Eddy DM. Comparing benefits and harms: the balance sheet. *JAMA*. 1990;263:2493, 2498, 2501 passim.
13. Singer PA, Martin DK, Kelner M. Quality End-of-Life Care. *JAMA* 1999;281:163-8.
14. Campion P, Foulkes J, Neighbour R, Tate P. Patient centredness in the MRCGP video examination: analysis of large cohort. *BMJ* 2002;325:691-2

Key points

- In breaking bad news, the key is to address the patient's initial feelings, ideas, expectations, and the patient's preferences for how best to proceed. Build the bad news disclosure around the patient's perspective
- Plan in advance. Consider how (preferably face to face), when (timely), where, and who else will be present
- Forecast bad news. Give the patient a chance to prepare for what follows
- In expressing bad news, directly state the bad part of the news: statements should be short, simple, clear, and include most of that which is bad
- The patient can choose to express or not to express feelings, but should be given the opportunity and encouragement to do so
- Patients often express their emotions via clues that imply, rather than explicitly state, those feelings. The physician should explore these clues in an effort to facilitate the patient's addressing important feelings
- Before explaining the clinical details of treatment, first determine what the patient already knows and has experienced about the condition being discussed
- Modify your explanation to incorporate what the patient has shared regarding feelings, ideas, experience, and expectations
- Comparing pros and cons (both short term and long term) is a useful approach to explain medical treatments that cut both ways
- Pros and cons (decision analysis) is a useful approach to elicit patient's values and perspective on treatment decisions

Reflect

How to reflect

Reflecting isn't just about closing your eyes and having a think. To really reflect you should ask yourself these questions:

- What do I think this learning module was about?
- Can I apply it in my work?
- What barriers am I likely to come across?
- How will I manage these barriers?
- How will I know if I'm doing things better?

When to elicit the patient's perspective

The most significant difference between the patient centred model of breaking bad news and other published models [5,6] involves the question of whether to discuss the patient's knowledge, concerns, and expectations before actually breaking the bad news. Should you first ask the patient, "What do you think may be going on with your symptoms?" or should you tell the patient the results of the test and then explore the patient's reaction?

In most circumstances a patient centred approach to communication encourages us to first determine the patient's concerns or understanding before trying to explain some important information. That model also encourages us to explore a patient's ideas about their symptoms.[9,15]

Breaking bad news is, in our experience, an exception to this general patient centred guideline. When the patient is aware that you, the clinician, have information (such as test results) about his or her condition, the patient is usually anticipating (often fearfully and apprehensively) what that information may be.

Questions about their ideas and expectations may be distracting and frustrating in such situations. After forewarning of bad news, we encourage that you deliver the emotionally charged information briefly and succinctly, without jargon or euphemism.

The ideal time to check the patient's ideas, emotions, and expectations will be after the bad news but before the detail about the condition and possible treatments. It is the patient's perspective on the bad news that is important then.

On tempering the bad news

What about tempering the bad news of the initial disclosure with a "hope-maintaining" disclaimer, like "You do have cancer, but it's a type that can be treated"?

It is natural and understandable for clinicians to try to balance the bad news with something that puts it in a more positive light. But while the intent of this approach is considerate and may be appropriate at times, consider the message that it may communicate, that the patient should not be that upset.

The reference to successful treatment encourages the patient to move away from their personal experience to specifics of technical care issues. Such a statement might prompt a response, "What kind of treatment?" Furthermore, such a statement communicates your wish that the patient does not get upset and tends to discourage the ventilation and emotional exchange that often follows such disclosures. Consider saving your good news "reframe" until after the patient's initial reactions.

Non-expression of feelings

While this module emphasises the importance of opening the door to discuss a patient's feelings and reaction to the bad news, some patients will choose not to walk through the door. How do you handle such a situation?

For example, in the play W;t[16] Dr Kelekian informs his patient, Vivian Bearing PhD that she has ovarian cancer. The dialogue goes as follows:

Dr Kelekian: You have cancer, Miss Barring. You have advanced metastatic, ovarian cancer.

Dr Bearing: Go on.

Dr Kelekian: You are a professor Miss Barring.

Dr Bearing: Like yourself Doctor Kelekian.

Dr Kelekian: Ah, yes. . . . Now then. You present with a growth that, unfortunately, went undetected in stages one, two, and three. Now it's an insidious adenocarcinoma, which has spread from the primary adnexal mass . . .

Dr Bearing: Insidious?

Dr Kelekian: Insidious means undetectable at an---

Dr Bearing: Insidious means treacherous.

Dr Kelekian: Shall I continue?

Dr Bearing: By all means.

In this ominous situation, neither of the two academicians chooses to show their feelings or the potential for feelings. Even though the patient may say, "Go on" consider that she may conceal very strong feelings that are present, but not expressed for personal or cultural reasons: the patient as much as admits this to herself after the interview, while sitting alone on her bed. She laments, "I should have asked more questions. I knew there was going to be a test."

In this situation despite the initial directive to go on, it is still appropriate to explicitly offer the opportunity to allow her feelings to surface.

When such an overture continues to result in requests for disease related information, it is appropriate to:

- Respect the patient's repeated request for information
- Express your willingness to address feelings in the future

- For example use a statement like, "I respect that at this point you would prefer to get the information needed to make your decision. Most people, at some time in the course of such treatments, will have some strong feelings of one kind or another. I would encourage you to bring those up if and when they do occur. I will be very willing to address any such feelings at any time."

Responding to Clues

Patients often communicate their feelings and concerns with clues (expressions and behaviours with implied rather than explicit meaning) How would you respond to the following statements from a patient who has just received bad news diagnosis, such as multiple sclerosis, parkinsonism, or multiple myeloma?

Patient Clue	**Physician's Response**
"Should I get a second opinion?"	"A second opinion can be very helpful. I suspect that this diagnosis is difficult to accept." (Pause and silence to encourage the patient's expression of real feelings of shock, loss, and fear.)
"Multiple sclerosis? What . . ." (There is a six second pause representing prolonged internal search. This usually represents the patient deep in thought or feeling about some conflicted area.)	"Would you be comfortable sharing your initial reaction? It may be helpful to discuss it."
For the second time in your discussion about managing this condition the patient asks the same question, "Do you think my health is up to it?" (Since you previously stated that you believed her health would be up to it, and yet she repeats this question a second time, this suggests that there is some unspoken concern about the treatment or her condition.)	"You seem concerned about either the treatment or your health; what are you thinking?"
In response to the bad news the patient says, "Oh my goodness that's a horrible diagnosis." (While the diagnosis is one that included much morbidity and mortality the specific meaning of that illness to this patient may very well get missed if this "horrible" clue is not explored.)	"Yes, many patients feel that this is a horrible disease. Yet each person reacts differently. What to you is the most 'horrible' thing about this situation for you?"

In general the appropriate response to expressions and behaviours that may carry additional and deeper information is to restate the clue as you heard or saw it and explore with the patient for additional meaning. For further information on responding to clues, see Lang, et al.[9]

Maintaining Hope

What about the importance of maintaining hope? How should a physician reconcile the wish to maintain hope with an approach of honest and full disclosure (so the patient can make an autonomous and informed decision)?

While many patients want the physician to be "hopeful" this does not mean that the patient wants distorted information. Regarding hope, it is clear is that no patient wants to hear, "There is nothing else I can do." This is not only hopeless but in fact approaches abandonment.

Many dying patients, when asked what they understand as their prospects for the future will accurately respond they are not going to be cured. In such situations a statement by the clinician, "You've mentioned to me the importance of maintaining your comfort and dignity at this point in your disease. I give you my absolute commitment to do everything to maintain your comfort. I will be there every step of the way to help."

Such a statement while acknowledging the terminal nature of the illness will be seen by the great majority of the patients as one that is filled with hope and reassurance.

Don't tell Mum

How should you handle a situation in which a family member approaches you in the hall and states, "I know Mum's results will be getting back soon from the biopsy. I've talked to my brothers and sisters and we are all in agreement that Mum will not be able to take the news if she has cancer. Her sister died of cancer and it was horrible. We as a family ask you not to tell her that she has cancer."

This issue comes up more in some cultures than in others. The family members clearly have their mother's best interest in their hearts. The conflict is between their wish for an optimistic mental state and quality of life (beneficence) and the ethical principle of autonomy (that the patient should be free to make his/her own decisions.) A patient centred communication approach explores and respects the wishes of the patient, even when that wish is clearly not to participate in the decision process. The key to solving this dilemma rests in getting the directive for involvement or non-involvement directly from the patient and not from the family.

An appropriate response to such a situation might be, "I do hear your concern about your Mum's wellbeing and how she might prefer to hear or not hear the specific results about her condition. The way that I handle such a situation is to ask the patient, your Mum, whether she would like to receive the results directly or whether she would prefer that the family members receive the information. I will respect her decision and will be happy to work with you and your family."

Doctor's recommendations *v* patient's autonomy

As a physician with great respect for your patient's autonomy, you would not want to tell your patient what to do. Given your values, what do you say when a patient asks you, "What would you do in this situation?" or "What do you think I should do?"

First consider that providing your recommendation does not necessarily detract from autonomy. Patients who have never been through a particular situation or healthcare choice respect and seek out the opinion of trusted physicians. While the patient has the ultimate decision making authority, providing a thoughtful recommendation is almost always appropriate.

I find the most appropriate response to be one that first explores the patient's set of values related to the decision at hand (see above). With a clear understanding of the patient's values and beliefs it is appropriate to state, "Given what you've told me about what's important to you, I'd recommend . . . as the best approach to achieve those goals." Such an approach offers recommendation based on the physician's experience, yet remains grounded in the patient's perspective and values.

How will this change my practice?

In order to provide patients with the maximum support in bad news situations, every practice should review its policies and procedures for returning information to patients who undergo diagnostic procedures. When the likelihood of an abnormal result and the seriousness of the condition under investigation is high, consider scheduling the "sharing of results" face to face and to include appropriate family support members as desired by the patient.

Communication with the patient should emphasise the following:

- Considering the patient's feelings, values and experiences at the centre of the BBN interview
- Do your homework to obtain answers to your own questions as well as the patient's potential questions about the patient's condition and potential treatments
- Consider what about the condition and the treatment is bad news. Distil this into a brief, clear, jargon free, statement. Deliver this with a forewarning and compassion, then pause and allow the patient's reaction take centre stage
- Find ways to encourage the patient to share feelings, concerns, ideas, and experiences about the condition and preferences on how and when to proceed. While you want to support expressions of feelings, respect the patient's right to postpone such expressions if the patient clearly indicates a preference for "biomedical data" at this moment
- Find or develop instructional and decision aids to help share information with the patient in an efficient manner
- Use negotiation/common ground strategies like "decision analysis," criteria setting, and brainstorming to help patients incorporate their values, interests, and concerns with the pros and cons of medical advances.

For additional reading see Buckman's text on How to Break Bad News.[17]

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Competing interests:

None declared.