Palliative Care Perspectives : Chapter 7: Communication : Sharing Bad News

One of the most difficult tasks a clinician faces is the sharing of bad news: "Mr. Jones, I've some bad news; the biopsy came back positive for cancer." On call in the middle of the night, you rush to a code. Despite all efforts, the patient dies. Your job is to call the patient's husband or wife, mother or father. Even moments of great joy may contain the seeds of immense sorrow: "Mrs. Smith, I'm sorry, there is something wrong with the baby...."

Few would deny the importance of sharing such news, yet historically very little training has been offered to clinicians to help them improve their ability to give bad news. Rarely is it included in formal course work in the preclinical years of medical school. One could reasonably argue that such training should occur during clinical training. However, there is evidence that sharing bad news is rarely modeled by attending physicians, who, in theory, have had the most experience with this task. For example, in a recent survey we conducted of medical interns, 5 of 27 (19%) interns surveyed reported never having seen an attending physician share bad news, 4 of 27 (15%) reported seeing it once, 12 of 27 (44%) reported seeing this two to three times, and only 6 of 27 (22%) reported seeing this four or more times.[21] Similar findings exist in the literature for other disciplines, such as surgery.[22] Given the frequency with which bad news must be shared, these rates are remarkably low. Informal discussions with house staff suggest that physicians-in-training learn on their own or from other physicians-in-training. Learning to give bad news has become part of the hidden curriculum for residents in training, part of the resident subculture.[23] This is clearly far from ideal. Teachers in the field largely agree that certain steps should be followed in sharing bad news with minor variations.[24-29]

Preparation

1. To the greatest extent possible, bad news should be shared in person. Sometimes we have no choice but to share bad news by telephone. However, if possible, sharing in person is far preferable. Cryptic and scary urgent calls such as, "Mrs. Jones, you must come in right away, I've got to talk with you," should be avoided if at all possible. When doing a lab test or procedure with a high probability that bad news will result, one might schedule a follow-up meeting that will quickly follow test availability. Or one might advise a patient or family that regardless of good or bad news, they will be called to come in to discuss the results. It is usually advisable to have a support person there for the person receiving bad news, if possible.

2. Find a quiet place, minimize distractions, and allow adequate time. It can be incredibly difficult to find a quiet place without distractions. Often, one must improvise. Try to find a chair for yourself and the other person(s). Sitting down shows you are paying attention and not about to rush somewhere else. Avoid speaking in hallways and while on the run. Notify staff that you do not wish to be interrupted. Set your beeper on vibration mode. Be honest about how much time it will take to address the bad news, and set that time aside. A quiet setting, often in stark contrast with the usual noisy, hectic world of medicine, also establishes a context that is respectful but communicates that something important is about to happen.

3. Do your homework. Have needed medical information available. If unfamiliar with the implications of the bad news, find out what you can. Identify special issues or barriers that might interfere with communication-language or cognitive disorders, for example-and attempt to compensate (have a translator available if a language barrier exists). If referral is needed and follow-up appointments need to be scheduled, have these planned to the extent possible before sharing bad news.

Making a Connection

Especially if the person to receive bad news suspects or believes bad news is coming, do not drag out introductions. However, you do need to make a connection with the person. Certain tasks that frequently come up in this important but usually brief stage are:

1. Introductions. Introduce yourself and any others with you. If others are present who you do not know, find out who they are.

2. Assess the recipient's status. Inquire about his or her comfort and immediate needs. As in other communication, you may wish to assess the recipient's understanding of the situation. This will not only help you make the transition to sharing the news but will help you assess the patient's perception of the circumstances. You might start with, "What is your understanding of what has happened" (or why a test was done, etc.)? Buckman has suggested that we assess what the recipient is willing and able to hear.[26]

Sharing the News

Really bad news is like a neutron bomb. The "radiation" produced allows only the simplest messages to penetrate all the static.

1. Speak slowly. Use clear, unambiguous language.

2. Give an advance alert. You might say, "I'm afraid I have some bad news. . . ." Pause only a couple of seconds after this.

3. Give the news. This should be very brief at this stage, only a few short sentences: "The biopsy didn't turn out as we had hoped. It revealed cancer."

The Aftermath

1. Await the reaction quietly. Be prepared for the unexpected. Recipients may respond in a variety of unpredictable ways. They may cry, faint, scream, be silent, laugh, or immediately ask factual questions. They may even appear not to have heard you. Whatever the response, let it happen. Be present and connect. Do not try to compensate for your own discomfort by talking to fill this most uncomfortable space.

2. Watch and listen for a signal that they want you to respond. The signal may be a question or a sign that they are open to an empathetic response. Responses should remain fairly simple at this stage. Respect the shock. Avoid the temptation to monopolize the encounter with a lot of data, such as all the possible therapeutic options. Sometimes physicians will try to use the shock to unburden

additional bad news or details. They may think, "Might as well get it over with and tell it all," or they may think that providing details will compensate somehow for the shock and engender hope. You may assess the person's reaction with a direct inquiry: "This must be hard for you. What is going through your mind now?"

3. Follow the person's lead. Some recipients can handle more new information than can others. Generally, you should validate the person's reaction. Bad news usually means that the person's world has just been turned upside down. The sudden loss of any semblance of control is part of this initial shock. You may help reestablish some control by following the person's lead: "Would you like more information now or should we talk later?" "Who would you like to come be with you?" This need to reestablish some control must be balanced against the reality that many recipients are very fragile and will need help even with very basic things. You can inquire how you could best be of help: "Is there someone we can call for you?"

Transition to Follow-Up

1. Schedule a follow-up meeting. Have a concrete plan for follow-up in the very near future (often later that day or within a couple of days - not a month later). This follow-up meeting is a good time to address more specific questions that will arise and to share more detailed information. The recipient may be given tasks to accomplish before the meeting. You may ask if they wish a support person to be present (if not already involved) or that they write down concerns or questions: "Why don't you write down any questions you have for that meeting."

2. Be clear about what your role will be in the process and who will be available for support. If you are going to be in it for the duration (perhaps as a primary caregiver for a newly diagnosed terminal illness), tell the patient that you will be there for him or her. If you are going to hand off support to another, be clear about who that person will be and how contact will be made. Clarify what the relationships will be among the patient, the new caregiver, and youself. Help facilitate this new connection.

3. As you began, so should you end. As the encounter draws to a close, look for a way to leave with an empathetic connection. Let the recipient know you care.

Pay Attention To and Respect Your Own Feelings and Needs

I purposely used the term sharing bad news rather than giving to highlight that we share in the pain that comes with bad news.[30] To the extent we empathize with the receiver of the news, we will hurt. We also have our own physician and clinician pains. We like to be able to fix things and tend to be perfectionists. Facing bad news means acknowledging that we cannot fix everything. If the patient's earlier health care was less than perfect, which it may have been, or if mistakes were made, as occasionally happens, we feel terrible. At the very least, sharing bad news (and doing it well) requires huge amounts of energy and may leave us feeling drained.

Our profession leaves little time or space to attend to our own needs and feelings. However, we ignore them at our peril. I have no simple recipe for how to attend to such needs any more than I can suggest where to find a chair to sit with your patient. You may take a few minutes' time out and walk in the garden. You may go to your call room and cry or take a shower. Perhaps you will pray or meditate. I have found that finding a friend or colleague with whom to talk is very valuable. Most clinicians I know are far harder on themselves than on anyone else. Usually, support is best offered by another in the same

profession. Some of the anguish in a profession can only be understood by another in the same profession. When in doubt, be kind to yourself.

For all the pain associated with sharing bad news, such news draws us back to our common humanity. In such situations being a doctor or a nurse is not enough. The issues raised by bad news exist for all of us. We all will receive bad news. We all will suffer loss and eventually die. I suspect it is this truth that we most fear. It is understandable that we might want to run away. However, to the extent we can engage our hearts in the process of sharing bad news, with all the hopes and fears this entails, we will, I believe, become better clinicians and better people.

<<< Previous Next >>> [Go Up]

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