BREAKING THE BAD NEWS

Breaking bad news comes in various forms. It is a regrettable but important duty that must be done conscientiously. Over the course of a career, a busy clinician may disclose unfavorable medical information to patients and families thousands of times. Breaking bad news to patients is inherently aversive, described as “hitting the patient over the head” or “dropping a bomb”. It is also a complex communication task. In addition to the verbal component of actually giving the bad news, it also requires other skills. These include responding to patients' emotional reactions, involving the patient in decision-making, dealing with the stress created by patients' expectations for cure, the involvement of multiple family members, and the dilemma of how to give hope when the situation is bleak.

Prepare for the Consultation

- If you get the news, and it is your responsibility to tell the patient, get a receptionist to call the patient and make an appointment. Do not do so yourself as bad news must be transmitted in person and not over the telephone. If you do not speak to the person he does not have a chance to question you. The receptionist can plead ignorance.
- The patient may like to be accompanied by a spouse or someone close to them.
- Ensure you have protected time. This may mean turning off bleeps or mobile phones. It may mean making a longer than usual appointment. If it happens during a surgery in which you are running late, run later. You may get the patient to return in the near future to discuss the matter more but do not seem rushed or too eager to get on. To you this may be just another day at the office but to the patient and the family it is a pivotal day of their lives.
- Make yourself as fully conversant with the facts as possible. This means the facts about this case, like the exact type of tumor and stage, as well as more general issues about the disease. This applies not just to cancer but to all diseases that fall into the bad news category.
- You may feel that this is such an intimate moment that you do not want a registrar or medical student present, but if they can be unobtrusive in the background this could be an important learning opportunity. Similarly, if you can video the consultation under the rules for consultation analysis, it could be an excellent learning tool for you and for others, but the matter of obtaining signed consent may make you feel uneasy. Do what you feel is right for that person at that time.

Communication

- Use language that the patient will understand and give plenty of opportunity to interrupt if they want something elucidated. The level of comprehension will depend upon the education of the patient but avoid jargon, technical terms and abbreviations. It is a common complaint from patients that medical staff spoke to them in language that they did not understand. Give pauses and check understanding.
- Find the patient's starting point. What do they know already? What have they been led to expect?
- A warning shot to prepare them may be helpful. "I'm afraid that it is rather bad news". Give this a moment to sink in.

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- How much detail does the patient want to know? What is the level of education? One meta-analysis found that women, young patients and more highly educated patients wanted to receive as much information as possible. Asian patients were shown to prefer that relatives be present when receiving bad news more than Westerners and to prefer to discuss their life expectancy less than Westerners.
- Break the consultation into stages like diagnosis, implications, treatment, and prognosis and if appropriate, be reassuring about terminal care. It is the terminal stages that people fear most. It is not essential to cover all aspects immediately if you feel it will be too much to take in at once.
- Patients will vary in the amount of honesty they want and may appreciate some ambiguity if the prognosis is very poor; an individual assessment will need to be made. Honesty includes being honest about what you do not know. As a GP you cannot be expected to be able to give exact figures for survival rates and a suitable reply might be, "With your cancer at your stage the chances are quite good. I am unable to give you exact figures but the consultant would probably know and he may even have his own figures for those whom he treats."
- Make sure that they understand the nature of risk and what these figures mean. What is 5 year survival? There is a tendency to interpret any survival rate above 50% as a certain cure and any below 50% as certain death. A 95% cure rate still means that 1 person in 20 will die of the disease. An 80% mortality means that 1 person in 5 will survive. Look at the figures from both directions. You are talking risk. You do not have certainty about the outcome. It is also worth being positive about continuing medical advances.
- Observe the patient and see how he is coping. Is now the time to discuss treatment or will that be better in a few days time? How much does the patient really want to know? Read the subtle signs. If in doubt ask outright. Do not expect to deal with everything in one session.
- Agree a plan for further follow up. If there has been a lot of information to impart this will need repetition or clarification in the future.

Concluding the Consultation

Finish with a summary and try to conclude on an "upbeat note".

It may go something like this: You do have cancer and it is a serious illness but it is not necessarily a death sentence, especially these days. You will need a major operation followed by some treatment that will make you feel very unwell but you can get through it. You are in good hands and you have lots of people around who care about you. If the worst does come to the worst we can control pain without knocking you out and without loss of dignity. You have a fight on and we can win. One of the most important features is your attitude. Remember that if you have any problems or want to discuss anything we are here for you.

You may also make a follow up appointment. Try to leave on a positive note.

Record the consultation as you would any other. If appropriate, inform other colleagues involved in care, such as consultants. This type of consultation fortunately does not happen very often but

it is an ideal learning experience. Reflect on what went well and what if anything you would have liked to have done better.

Imparting bad news is an emotional experience for the doctor as well as for the patient, so take a moment to recognize this and calm yourself down before moving on to the next consultation.

Avoiding Pitfalls

There are traps for the unwary that must be avoided.

Do not avoid seeing the patient or leave them anxiously waiting for news. Sometimes anticipation can be worse than even the worst reality. Treat others as you would wish to be treated yourself.

Read the notes. Get the facts before you start.

You need privacy and no interruptions. In a hospital, hospice or residential home, make sure you will not be disturbed. If necessary switch off phones or bleeps.

Be factual but sympathetic. Always be empathetic however you may feel personally. You may feel that the person's lifestyle makes him responsible for his or her HIV, cirrhosis or lung cancer but never let it show. Better still; do not let yourself become judgmental. For as you judge others so too you will be judged and "Let he who is without sin cast the first stone".

Give time for the information to sink in and the opportunity to ask questions before moving on.

Do not seem rushed.

If the patient does not seem able to take any more be prepared to end the consultation and to take it up again later. Look for all the cues, verbal or other. "Do you want to leave it for now and we can discuss it more when you are feeling ready?" Perhaps they would like you to speak to someone else or to have someone with them for the next meeting.

If asked the question, "How long have I got to live?" never be precise. You will always be wrong. To the patient and family 6 weeks means 6 weeks and not 5 weeks or 7.
Never say that nothing can be done or the patient will lose all hope.

If you have written material to give that may be useful.

Whilst trying to be positive never lose track of the fact that this is a serious and potentially fatal disease. Be optimistic but do not promise success or anything else that may not be delivered.

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Sample Conversation

Doctor: Hi Jessica. How are you feeling today?

Patient: A bit better.

Doctor: That's good to hear. Are you still feeling nauseous?

Patient: No, I haven't felt sick to my stomach since you switched my medication.

Doctor: Great. Say, your test results came in this morning.

Patient: It's about time. Is it good news or bad?

Doctor: I guess it's a bit of both. Which do you want first?

Patient: Let's get the bad news over with.

Doctor: Okay. It looks like you're going to need surgery to remove the tumour from your leg. After the operation you're going to have to stay off your feet for at least three weeks. That means no soccer.

Patient: I was afraid you were going to say that.

Doctor: Now for the good news. The biopsy shows that the tumour is benign, which means it's not cancerous. We're going to take it out anyway just to be on the safe side.

Patient: Wow, that's a load off my mind. Thanks Doctor.

Doctor: Don't get too excited. We still need to get to the bottom of all of this weight loss.

Patient: I've probably just been so worried about this stupid lump.

Doctor: These things often are stress related, but we're still going to do a few blood tests just to rule a few things out.

Patient: Things like what? Cancer?

Doctor: Actually, I'm thinking more along the lines of a food allergy.