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Breaking bad news

'Bad news' has been defined as any information which adversely and seriously affects an individual's view of his or her future; whether news is bad or not can only be in the eye of the beholder[1] . The news may be cancer but it may equally be Parkinson's disease, rheumatoid arthritis, schizophrenia, psoriasis, diabetes or any other life-altering disease. It may be about a child who has brain damage or a serious congenital condition. One study found that 50% of parents were dissatisfied with the way they were told about their child's congenital deafness[2] .

Breaking bad news well is an essential skill for all doctors, as it is something they will do hundreds if not thousands of times in their professional careers. Historically it was given scant attention in medical training[3] . This is, however, changing. Consultation skills in general and the specific skills needed for breaking bad news are now a core part of the medical school curriculum. Poor communication, particularly with cancer patients, has been shown to be associated with worse clinical and psychosocial outcomes, including worse pain control, worse adherence to treatment, confusion over prognosis and dissatisfaction at not being involved in decision making[4] . For the clinician, communication difficulties lead to worse job satisfaction and higher stress levels, as well as being behind a high proportion of errors and complaints.

Studies suggest that a number of factors, aside from deficient knowledge, can affect a doctor's ability to impart bad news sensitively, including burnout and fatigue, personal difficulties, behavioural beliefs and subjective attitudes, such as a personal fear of death[5] [6] . A systematic review and meta-analysis has demonstrated that attending a communication skills training course does have a moderate effect on communication behaviour and attitudes but there is a gap in research with few studies investigating patient outcomes; further studies in clinical practice are required[7] . The need for training may not be immediately obvious to the health professionals involved[8] .

Breaking bad news is a complex skill as, in addition to the verbal component, it also requires the ability to recognise and respond to the patient's emotions, dealing with the stress that the bad news creates and yet still being able to involve the patient in any decisions and maintaining hope where there may be little. There is also the likelihood that it will be a triadic consultation with relatives present. SPIKES is a six-step protocol which has been shown to improve the confidence of clinicians who use it when breaking bad news to cancer patients[1] :

- **S**etting up the interview.
- Assessing the patient's **P**erception.
- Obtaining the patient's **I**nvitation, as shunning information is a valid psychological coping mechanism.
- Giving **K**nowledge and information to the patient.
- Addressing the patient's **E**motions with **E**mpathetic response.
- Having a **S**trategy and **S**ummarising.

Others have produced similar pathways designed to aid the clinician, such as the BREAKS protocol[9] .

Prepare for the consultation

- Ideally, bad news should be given in person and not over the telephone. It may be appropriate to ask a receptionist to call the patient and make an appointment.
- The patient may like to be accompanied by a spouse or someone close to them. Patients consider the news to have been broken more sensitively when it is suggested that someone accompany them, as it provides a warning that a serious discussion is planned[4] .
- 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 occurs during a surgery in which you are running late, run later. You may ask 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 work 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 - for example, the exact type of tumour and stage, as well as more general issues about the disease. This applies not just to cancer but to all illnesses that fall into the *bad news* category, including heart failure - a condition which patients report is particularly poorly communicated[4] .

- You may feel that this is such an intimate moment that you do not want a registrar or medical student present. However, if they can be unobtrusive 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. The need to train juniors must be weighed against the needs of individual patients[10] . Do what you feel is right for that person at that time.

Communication

- Structure the consultation, using one of the protocols referred to above if it helps.

- Find the patient's starting point. Establish what they already know and what they have been led to expect.

- 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 have spoken to them in language they did not understand.

- 'Chunk and check': give pauses and check understanding - eg, ask the patient if they would like to run through what they are going to tell their spouse.

- Thinking about how friends talk may be helpful. The "Would a friend have said that?" test may reduce anxiety and help you to develop a more sensitive communication style[11] .

- A warning shot to prepare them may be helpful: "I'm afraid that it is rather bad news." One study has shown that using a negative when breaking bad news has a lesser emotional impact, so it is better to say: "I'm afraid the news is not good."

- Consider how much detail the patient may want to know. Read the subtle signs. If in doubt, ask outright. Take level of education into account. One meta-analysis found that women, young patients and more highly educated patients wanted to receive as much information as possible[12] . In comparison with Westerners, when receiving bad news, Asian patients were shown to prefer that relatives be present. They were also shown to prefer to discuss their life expectancy less than Westerners[13] .

- Observe the patient and see how they are coping. There is emerging evidence that reducing the emotional response of a patient by only a few words of empathy can improve their recall of information, so address their emotional response before providing further medical information[14] . Specifically focus on reassurance and ongoing support with phrases such as: "Whatever happens, we won't let you down; you will not be left to face this on your own". "I will be with you all the way." "We will look at your options and work on this together."

- Patients will vary in the amount of honesty they want; an individual assessment will need to be made. Talking directly is perceived by patients to represent honesty and trustworthiness[4] . Be honest about what you don't know.

- As a GP you may not be able to give exact figures for survival rates but the patient may return to you after a specialist appointment asking about them. Make sure that they understand the nature of risk and probability and what these figures mean. 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. There is no certainty about the outcome.

- Ethical decision making and recognition of patient autonomy vary across different countries and cultures and may need to be taken into consideration for non-UK patients as well as by non-UK doctors[15] [16] .

Concluding the consultation

- If appropriate, explain what happens at the multidisciplinary (MDT) meeting, as this can otherwise seem to the patient to simply cause delay[17] .
- Finish with a summary and agree a plan for the next steps, including a further appointment. Do not expect to deal with everything in one consultation. If there has been a lot of information to impart this will need repetition or clarification in the future.
- If appropriate, inform other colleagues involved in care, including consultants.

'Breaking bad news' consultations don't happen often so are a good opportunity for reflective learning and identifying future learning needs.

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

Avoiding pitfalls

There are traps for the unwary that should be avoidable:

- Do not avoid seeing the patient or leave them anxiously waiting for news. Anticipation may 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 or disturbance.
- Be factual but sympathetic. Always be empathetic and non-judgemental, however you may feel regarding the person's lifestyle being responsible for their cirrhosis or lung cancer.
- If the patient does not appear to be coping, be prepared to end the consultation. Look for all the cues, verbal or otherwise. Establish with the patient whether they might want to leave more discussion for now and discuss it more when they 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?" be careful, as you're unlikely to be accurate.
- Saying that nothing can be done may cause the patient to lose all hope; be optimistic but do not promise success or anything else that may not be delivered.
- Written material may be useful.
- Be mindful of the legislation concerning consent. Do not be pressured by a relative saying, for example: "If it's cancer he mustn't know or it would kill him." It is your duty to impart the information to the patient and it is up to them to decide who, if anyone, they wish to tell. If you are asked to discuss the medical condition with a concerned third party - eg, relatives or carers other than the parent or guardian of a child - you must have the patient's consent if they are in a position to give it[18] .
- If the patient 'lacks capacity' under the terms of the the Mental Capacity Act, you must act in the best interests of the patient. You must take all factors into account, including the views of carers, persons with lasting powers of attorney, deputies appointed by the court and anyone whom the patient has previously indicated should be consulted about their views.
- People with learning disabilities may be inappropriately protected from bad news but may need to learn about it at home with their family or with non-medical care staff[19] .
- There are particular legal considerations when breaking the news of a sudden death.

Admitting adverse events[20]

Having to tell a patient or their relative that they have been the subject of an adverse event is a difficult conversation to have and to do well. Using the skills for breaking bad news, ensure a timely and genuine apology; this does not constitute an admission of liability. Provide the facts as they are known and reassure them that you are taking the situation seriously. Offer practical and emotional support and explain the next steps for keeping the person informed.

Be factual. Do not blame anyone. Keep full notes.

Further reading

- Dias L, Chabner BA, Lynch TJ Jr, et al; Breaking bad news: a patient's perspective. Oncologist. 2003;8(6):587-96.

References

1. Baile WF, Buckman R, Lenzi R, et al; SPIKES-A six-step protocol for delivering bad news: application to the patient with cancer. Oncologist. 2000;5(4):302-11.
2. Gilbey P; Qualitative analysis of parents' experience with receiving the news of the detection of their child's hearing loss. Int J Pediatr Otorhinolaryngol. 2009 Dec 28.
3. Schildmann J, Cushing A, Doyal L, et al; Breaking bad news: experiences, views and difficulties of pre-registration house officers. Palliat Med. 2005 Mar;19(2):93-8.
4. Hanratty B, Lowson E, Holmes L, et al; Breaking bad news sensitively: what is important to patients in their last year of life? BMJ Support Palliat Care. 2012 Mar;2(1):24-8. doi: 10.1136/bmjspcare-2011-000084. Epub 2011 Nov 25.
5. Brown R, Dunn S, Byrnes K, et al; Doctors' stress responses and poor communication performance in simulated bad-news consultations. Acad Med. 2009 Nov;84(11):1595-602.
6. Cialkowska-Rysz A, Dzierzanowski T; Personal fear of death affects the proper process of breaking bad news. Arch Med Sci. 2013 Feb 21;9(1):127-31. doi: 10.5114/aoms.2013.33353.
7. Barth J, Lannen P; Efficacy of communication skills training courses in oncology: a systematic review and meta-analysis. Ann Oncol. 2011 May;22(5):1030-40. doi: 10.1093/annonc/mdq441. Epub 2010 Oct 25.
8. Adler DD, Riba MB, Eggly S; Breaking bad news in the breast imaging setting. Acad Radiol. 2009 Feb;16(2):130-5.
9. Narayanan V, Bista B, Koshy C; 'BREAKS' Protocol for Breaking Bad News. Indian J Palliat Care. 2010 May;16(2):61-5. doi: 10.4103/0973-1075.68401.
10. Spafford MM, Schryer CF, Creutz S; Balancing patient care and student education: learning to deliver bad news in an optometry teaching clinic. Adv Health Sci Educ Theory Pract. 2009 May;14(2):233-50. Epub 2008 Feb 22.
11. Main DC; Communication in difficult situations: what would a friend say? BMJ. 2013 Aug 23;347:f5037. doi: 10.1136/bmj.f5037.
12. Innes S, Payne S; Advanced cancer patients' prognostic information preferences: a review. Palliat Med. 2009 Jan;23(1):29-39. Epub 2008 Oct 24.

13. Fujimori M, Uchitomi Y; Preferences of cancer patients regarding communication of bad news: a systematic Jpn J Clin Oncol. 2009 Apr;39(4):201-16. Epub 2009 Feb 3.
14. Sep MS, van Osch M, van Vliet LM, et al; The power of clinicians' affective communication: how reassurance about non-abandonment can reduce patients' physiological arousal and increase information recall in bad news consultations. An experimental study using analogue patients. Patient Educ Couns. 2014 Apr;95(1):45-52. doi: 10.1016/j.pec.2013.12.022. Epub 2014 Jan 13.
15. Slowther A, Lewando Hundt GA, Purkis J, et al; Experiences of non-UK-qualified doctors working within the UK regulatory framework: a qualitative study. J R Soc Med. 2012 Apr;105(4):157-65. doi: 10.1258/jrsm.2011.110256. Epub 2012 Mar 9.
16. Mobeireek AF, Al-Kassimi F, Al-Zahrani K, et al; Information disclosure and decision-making: the Middle East versus the Far East and the West. J Med Ethics. 2008 Apr;34(4):225-9. doi: 10.1136/jme.2006.019638.
17. Multidisciplinary teams; Macmillan Cancer Support
18. Consent guidance: patients and doctors making decisions together; General Medical Council, Sep 2020
19. Guidance on how to support people with learning (intellectual) disabilities in bad news situations; Breaking Bad News Website
20. Being open: communicating patient safety incidents with patients, their families and carers; National Patient Safety Agency Best Practice Guide (19 November 2009)

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