

# Breaking Bad News

GREGG K. VANDEKIEFT, M.D., Michigan State University College of Human Medicine, East Lansing, Michigan

Breaking bad news is one of a physician's most difficult duties, yet medical education typically offers little formal preparation for this daunting task. Without proper training, the discomfort and uncertainty associated with breaking bad news may lead physicians to emotionally disengage from patients. Numerous study results show that patients generally desire frank and empathetic disclosure of a terminal diagnosis or other bad news. Focused training in communication skills and techniques to facilitate breaking bad news has been demonstrated to improve patient satisfaction and physician comfort. Physicians can build on the following simple mnemonic, ABCDE, to provide hope and healing to patients receiving bad news: **A**dvance preparation—arrange adequate time and privacy, confirm medical facts, review relevant clinical data, and emotionally prepare for the encounter. **B**uilding a therapeutic relationship—identify patient preferences regarding the disclosure of bad news. **C**ommunicating well—determine the patient's knowledge and understanding of the situation, proceed at the patient's pace, avoid medical jargon or euphemisms, allow for silence and tears, and answer questions. **D**ealing with patient and family reactions—assess and respond to emotional reactions and empathize with the patient. **E**ncouraging/validating emotions—offer realistic hope based on the patient's goals and deal with your own needs. (Am Fam Physician 2001;64:1975-8. Copyright© 2001 American Academy of Family Physicians.)

**B**reaking bad news to patients is one of the most difficult responsibilities in the practice of medicine. Although virtually all physicians in clinical practice encounter situations entailing bad news, medical school offers little formal training in how to discuss bad news with patients and their families. This article presents an overview of issues pertaining to breaking bad news and practical recommendations for clinicians wishing to improve their clinical skills in this area.

## What Is Bad News?

One source<sup>1</sup> defines bad news as “any news that drastically and negatively alters the patient's view of her or his future.” Professional bicyclist Lance Armstrong's recollection of being diagnosed with metastatic testicular cancer exemplifies the impact of bad news on one's self-image: “I left my house on October 2, 1996, as one person and came home another.”<sup>2</sup> Bad news is stereotypically associated with a terminal diagnosis, but family physicians encounter many situations that involve imparting bad news; for example, a pregnant woman's ultrasound verifies a fetal demise, a middle-aged woman's magnetic resonance imaging scan confirms the clinical suspicion of multiple sclerosis, or an adolescent's polydipsia and weight loss prove to be the onset of diabetes.

How a patient responds to bad news can be influenced by the patient's psychosocial context. It might simply be a diagnosis that comes at an inopportune time, such as unstable angina requiring angioplasty during the week of a daughter's wedding, or it may be a diagnosis that is incompatible with one's employment, such as a coarse tremor developing in a cardiovascular surgeon. When the physician cares for multiple members of a family, the lines between the patient's needs and the family's needs may become blurred. Most family physicians have faced a conference room full of family members awaiting news about the patient, or have been pulled aside for a hallway discussion with the request to withhold the conversation from the patient or other family members.

## Why Is Breaking Bad News So Difficult?

There are many reasons why physicians have difficulty breaking bad news. A common concern is how the news will affect the patient, and this is often used to justify withholding bad news. Hippocrates advised “concealing most things from the patient while you are attending to him. Give necessary orders with cheerfulness and serenity...revealing nothing of the patient's future or present condition. For many patients...have taken a turn for the worse...by forecast of what is to come.”<sup>3</sup>

In 1847, the American Medical Association's first code of medical ethics stated, “The life of a sick person can be shortened not only by the acts, but also by the words or the manner of a physician. It is, therefore, a sacred duty to guard

*See editorial on page 1946.*

*Physicians need to individualize their manner of breaking bad news based on the patient's desires and needs.*

himself carefully in this respect, and to avoid all things which have a tendency to discourage the patient and to depress his spirits.”

In the past few decades, traditional paternalistic models of patient care have given way to an emphasis on patient autonomy and empowerment. A review of studies on patient preferences regarding disclosure of a terminal diagnosis found that 50 to 90 percent of patients desired full disclosure.<sup>4</sup> Because a sizable minority of patients still may not want full disclosure, the physician needs to ascertain how the patient would like to have bad news addressed. Qualitative studies about the information needs of cancer patients identify several consistent themes, but which theme is most important to any given patient is highly variable and few patient characteristics accurately predict which theme will be most important.<sup>5</sup> Therefore, the physician faces the challenge of individualizing the manner of breaking bad news and the content delivered, according to the patient's desires or needs.

Physicians also have their own issues about breaking bad news. It is an unpleasant task. Physicians do not wish to take hope away from the patient. They may be fearful of the patient's or family's reaction to the news, or uncertain how to deal with an intense emotional response. Bad news often must be delivered in settings that are not conducive to such intimate conversations. The hectic pace of clinical practice may force a physician to deliver bad news with lit-

tle forewarning or when other responsibilities are competing for the physician's attention.

Historically, the emphasis on the biomedical model in medical training places more value on technical proficiency than on communication skills. Therefore, physicians may feel unprepared for the intensity of breaking bad news, or they may unjustifiably feel that they have failed the patient. The cumulative effect of these factors is physician uncertainty and discomfort, and a resultant tendency to disengage from situations in which they are called on to break bad news.<sup>6</sup> Rabow and McPhee keenly describe the end result, “Clinicians focus often on relieving patients' bodily pain, less often on their emotional distress, and seldom on their suffering.”<sup>7</sup>

Several professional groups have published consensus guidelines on how to discuss bad news; however, few of those guidelines are evidence-based.<sup>8</sup> The clinical efficacy of many standard recommendations has not been empirically demonstrated.<sup>9,10</sup> Less than 25 percent of publications on breaking bad news are based on studies reporting original data, and those studies commonly have methodologic limitations.

Learning general communication skills can enable physicians to break bad news in a manner that is less uncomfortable for them and more satisfying for patients and their families.<sup>11</sup> Numerous investigators have demonstrated that focused educational interventions improve student and resident skills in delivering bad news.<sup>12-14</sup> Following traumatic deaths, surviving family members judged the most important features of delivering bad news to be the attitude of the person who gave the news, the clarity of the message, privacy, and the newsgiver's ability to answer questions.<sup>15</sup> As Franks observes, “It is not an isolated skill but a particular form of communication.”<sup>16</sup>

## How Should Bad News Be Delivered?

How can bad news be most compassionately and effectively delivered? Rabow and McPhee<sup>7</sup> developed a practical and comprehensive model, synthesized from multiple sources, that uses the simple mnemonic ABCDE (*Table 1*). The following recommendations are patterned after Rabow and McPhee's ABCDE mnemonic, with modification and additional material from other sources.<sup>16-21</sup> Although specific situations may preclude carrying out many of these suggestions, the recommendations are intended to serve as a general guide and should not be viewed as overly prescriptive.

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## The Author

GREGG K. VANDEKIEFT, M.D., is assistant director of the Palliative Care Education and Research Program at Michigan State University, East Lansing. Currently, Dr. VandeKieft is completing his masters in ethics and humanities at Michigan State University. He received his medical degree from the University of Iowa, Iowa City, and completed a residency in family practice at Phoenix Baptist Hospital and Medical Center, Phoenix, Ariz.

*Address correspondence to Gregg K. VandeKieft, M.D., Department of Family Practice, Michigan State University College of Human Medicine, B101 Clinical Center, East Lansing, MI 48824-1315 (e-mail: gregg.vandekieft@ht.msu.edu). Reprints are not available from the author.*

**A—ADVANCE PREPARATION**

- Familiarize yourself with the relevant clinical information. Ideally, have the patient's chart or pertinent laboratory data on hand during the conversation. Be prepared to provide at least basic information about prognosis and treatment options.

- Arrange for adequate time in a private, comfortable location. Instruct office or hospital staff that there should be no interruptions. Turn your pager to silent mode or leave it with a colleague.

- Mentally rehearse how you will deliver the news. You may wish to practice out loud, as you would prepare for public speaking. Script specific words and phrases to use or avoid. If you have limited experience delivering bad news, consider observing a more experienced colleague or role play a variety of scenarios with colleagues before actually being faced with the situation.

- Prepare emotionally.

**B—BUILD A THERAPEUTIC ENVIRONMENT/RELATIONSHIP**

- Determine the patient's preferences for what and how much they want to know.

- When possible, have family members or other supportive persons present. This should be at the patient's discretion. If bad news is anticipated, ask in advance who they would like present and how they would like the others to be involved.

- Introduce yourself to everyone present and ask for names and relationships to the patient.

- Foreshadow the bad news, "I'm sorry, but I have bad news."

- Use touch where appropriate. Some patients or family members will prefer not to be touched. Be sensitive to cultural differences and personal preference. Avoid inappropriate humor or flippant comments; depending on your relationship with the patient, some discreet humor may be appropriate.

- Assure the patient you will be available. Schedule follow-up meetings and make appropriate arrangements with your office. Advise appropriate staff and colleagues of the situation.

**C—COMMUNICATE WELL**

- Ask what the patient or family already knows and understands. One source advises, "Before you tell, ask... Find out the patient's expectations before you give the information."<sup>19</sup>

*A physician's attitude and communication skills play a crucial role in how well patients cope when they receive bad news.*

- Speak frankly but compassionately. Avoid euphemisms and medical jargon. Use the words cancer or death.

- Allow silence and tears, and avoid the urge to talk to overcome your own discomfort. Proceed at the patient's pace.

- Have the patient tell you his or her understanding of what you have said. Encourage questions. At subsequent visits, ask the patient if he or she understands, and use repetition and corrections as needed.

- Be aware that the patient will not retain much of what is said after the initial bad news. Write things down, use sketches or diagrams, and repeat key information.

- At the conclusion of each visit, summarize and make follow-up plans.

**D—DEAL WITH PATIENT AND FAMILY REACTIONS**

- Assess and respond to emotional reactions. Be aware of cognitive coping strategies (e.g., denial, blame, intellectualization, disbelief, acceptance). Be attuned to body language. With subsequent visits, monitor the patient's emotional status, assessing for despondency or suicidal ideations.

- Be empathetic; it is appropriate to say "I'm sorry" or "I don't know." Crying may be appropriate, but be reflective—are your tears from empathy with your patient or are they a reflection of your own personal issues?

- Do not argue with or criticize colleagues; avoid defensiveness regarding your, or a colleague's, medical care.

**E—ENCOURAGE AND VALIDATE EMOTIONS**

- Offer realistic hope. Even if a cure is not realistic, offer hope and encouragement about what options are available. Discuss treatment options at the outset, and arrange follow-up meetings for decision making.

- Explore what the news means to the patient. Inquire about the patient's emotional and spiritual needs and what support systems they have in place. Offer referrals as needed.

- Use interdisciplinary services to enhance patient care (e.g., hospice), but avoid using these as a means of disengaging from the relationship.

TABLE 1

**The ABCDE Mnemonic for Breaking Bad News****A**dvance preparation

- Arrange for adequate time, privacy and no interruptions (turn pager off or to silent mode).
- Review relevant clinical information.
- Mentally rehearse, identify words or phrases to use and avoid.
- Prepare yourself emotionally.

**B**uild a therapeutic environment/relationship

- Determine what and how much the patient wants to know.
- Have family or support persons present.
- Introduce yourself to everyone.
- Warn the patient that bad news is coming.
- Use touch when appropriate.
- Schedule follow-up appointments.

**C**ommunicate well

- Ask what the patient or family already knows.
- Be frank but compassionate; avoid euphemisms and medical jargon.
- Allow for silence and tears; proceed at the patient's pace.
- Have the patient describe his or her understanding of the news; repeat this information at subsequent visits.
- Allow time to answer questions; write things down and provide written information.
- Conclude each visit with a summary and follow-up plan.

**D**eal with patient and family reactions

- Assess and respond to the patient and the family's emotional reaction; repeat at each visit.
- Be empathetic.
- Do not argue with or criticize colleagues.

**E**ncourage and validate emotions

- Explore what the news means to the patient.
- Offer realistic hope according to the patient's goals.
- Use interdisciplinary resources.
- Take care of your own needs; be attuned to the needs of involved house staff and office or hospital personnel.

*Adapted with permission from Rabow MW, McPhee SJ. Beyond breaking bad news: how to help patients that suffer. West J Med 1999;171:261.*

- Attend to your own needs during and following the delivery of bad news. Issues of counter-transference may arise, triggering poorly understood but powerful feelings. A formal or informal debriefing session with involved house staff, office or hospital personnel may be appropriate to review the medical management and their feelings.

**Final Comment**

Despite the challenges involved in delivering bad news, physicians can find tremendous gratification in providing a therapeutic presence during a patient's time of greatest need. Further research is needed to provide empirical support for consensus-based guidelines. However, a growing

body of evidence demonstrates that physicians' attitude and communication skills play a crucial role in how well patients cope with bad news and that patients and physicians will benefit if physicians are better trained for this difficult task. The limits of medicine assure that patients cannot always be cured. These are precisely the times that professionalism most acutely calls the physician to provide hope and healing for the patient.

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