

Communicating Bad News to Your Patients



How you share the news can have a lasting effect on your patients and their families.

Communicating bad news to our patients is one of the most important things we do as family physicians – as important to our patients and their well-being as any other medical intervention. A growing body of evidence shows that the attitude, communication skills and empathy of the person delivering the bad news plays an important role in the coping and bereavement abilities of patients and their families.¹⁻⁶ >

It is also one of the hardest things we have to do. Most physicians have very little formal training or confidence when it comes to communicating bad news. Traditional medical training has emphasized curing and helping patients, which may make us reluctant to discuss a diagnosis or other information that will make the patient's life worse. Some physicians may feel they have failed the patient if a cure is not possible. Sometimes these feelings result in withdrawing from the patient or offering false hope in a dire situation. Add to these concerns the fear of the patient's reaction, time constraints, as well as the challenges of getting paid for these interactions, and communicating bad news becomes a burden.

But family physicians must be prepared to take it on. In part because of our aging population and a shortage of geriatricians, bad news discussions and end-of-life care are

increasingly becoming our responsibility. We are generally well suited for it. Our specialty's emphasis on understanding the psychosocial context of our patients' lives, and the trusting relationships we develop with our patients over the years, help us to determine more easily how bad news should be delivered and to predict how it will be accepted. We are in a unique position to ensure that the "bad news conversation" is not a one-time event but rather the beginning of an extended journey for the patient and physician.

Fortunately, providing a therapeutic presence at this time in a patient's life can be extremely rewarding, both professionally and personally, and taking an individualized, systematic approach to delivering bad news (like the one described in this article) can improve your confidence and reduce the patient's suffering.

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Delivering bad news is one of the hardest and most important things family physicians do.

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The aging population and shortage of geriatricians make the responsibility fall more on family physicians than ever before.

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The "bad news conversation" should not be a one-time event but the beginning of a patient-physician journey.

CROSS-CULTURAL COMMUNICATION

Discussing bad news is often further complicated when the patient is of an ethnic minority, which currently accounts for about one-half of the U.S. population. Understanding cultural norms related to medical care and death is important, but no one can be expected to know all the various taboos, traditions and expectations of every culture represented in our society today. For example, many cultures consider the U.S. model of "truth telling" to be disrespectful or cruel, particularly when older patients are involved. However, physicians must also be careful to avoid stereotyping patients based on their culture.¹¹

You can develop rapport with ethnically diverse patients by demonstrating an interest in their culture with a simple statement such as, "I know different people have very different ways of understanding illness and death. Please help me understand how you see things." Then allow the patient and family to serve as cultural educators. Never try to change a patient's cultural viewpoint; this will create distance between you and the patient and make the situation worse.¹²

If language is a barrier, arrange for a translator to be part of the discussion. If the translator is a native speaker of the patient's language, he or she may translate into the culture as well as into the language. For example, the word "cancer" may be translated into a more accepted cultural term like "mass" or "growth."

Preparing for the discussion

Sometimes communicating bad news must be done in less-than-ideal circumstances, such as in emergency situations that preclude preparation or planning. When possible, it is best to carve out ample time for the discussion and secure a private, quiet setting where you will be able to meet without interruption.

Under ideal circumstances, you should ask the patient who he or she wants present and consider whether the patient and family can comprehend the information you will give them. Does the patient have cognitive problems? Is the patient in severe pain? Are the patient and family too emotionally upset or overwhelmed to hear what you are about to say? Be sure the legal decision maker (or durable power of attorney) is present if the patient lacks capacity. Consider whether a spiritual adviser, social worker, interpreter (see "Cross-cultural

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communication,” left) or other professional is needed or desired. Be prepared to explain to the patient and family the relationships and roles of the people present.

Communication style has a significant influence on patients' and families' satisfaction with these encounters.¹⁻⁶ Important characteristics of bad-news communication include the attitude, sympathy and sincerity of the person giving the news, the clarity of the message and the attention to privacy. The news giver's knowledge and ability to answer questions are also important, so be sure to review the patient's chart and be prepared to offer at least basic information about the prognosis and therapeutic options.

Delivering the news

When it's time to deliver the news, face the patient, and speak slowly and deliberately, particularly to patients with hearing problems, who will also benefit from seeing your mouth movement and expressions. A systematic, step-wise approach as described below (see the summary on page 34) can provide a framework for the discussion and allow you to focus on the patient's comments and questions.

1. Find out what the patient knows. You might begin by asking, “What is your understanding of your present condition?” This question allows you to better understand the patient's perception of his or her condi-

tion, and it helps you determine a starting point by building on what the patient already knows. Depending on the patient's responses, consider providing a brief overview of the patient's history so that everyone has a common source of information.

2. Deliver a “warning shot.” This involves saying something that prepares the patient and family for the news you are about to deliver – something like “I'm sorry. I have some bad news.” Then pause. During the pause, the room will become quiet. At this point, essentially, the news has been delivered, but the emotional response has not yet come.

3. State the news or diagnosis succinctly in lay terms. Avoid medical jargon to reduce the potential for misunderstanding. Use words like “terminal” or “cancer.” Expect that once these emotionally charged words are used, the patient may not hear much else during your conversation.

4. Be quiet and listen. Let the patient make the next move. Avoid the temptation to talk; 10 seconds of silence will seem like an eternity when you're waiting for the patient's or family's reaction. If there is no response after a prolonged silence, you can gently say something like “Tell me what you are thinking.” Expect anger, fear and sadness, and be prepared for other cognitive coping strategies such as disbelief, denial and blame. It is OK to validate and normalize the emotional response by saying, “You must feel terrible” or “You must be shocked at this information.” Personal statements are valid if sincere and true. Avoid saying, “I know how you feel,” unless you really do. Even “I don't know what to say” can be beneficial. Be sure not to argue or criticize a colleague's medical care. This does not help the patient and can make the situation worse. It is better to say, “I don't know why that was done [or not done].” ➤

■ Carve out time for the bad-news discussion, and secure a private, quiet setting.

■ When delivering the news, face the patient and speak slowly and deliberately.

■ A systematic approach gives you a framework for the discussion and allows you to better focus on the patient's concerns.

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5. Provide additional information if requested. Many times, patients remember very little else after the news is given, so do not overwhelm them with information. Approximately 80 percent of patients now desire complete disclosure about their health and prognosis.⁷ However, this means that 20 percent do not want full disclosure. It is best to present information at the patient's pace – giving one layer of information at a time. “Peeling the onion” is a frequently used analogy that applies here.

It is important to give the patient “realistic hope” and avoid “false hope.” If you convey more optimism than is realistic, the patient and family might delay appropriate planning and feel betrayed when they find out that death is near. Many patients and their families will put their hope in a miracle. There is a delicate balance to maintain between not taking away the patient's hope for a miracle and not providing false hope. You could say, “Let's hope for the best [a miracle] but attend to the present [control pain and symptoms and maximize the quality of life] and prepare for the worst [address unfinished business, finances and advanced directives].”

What if the patient's family asks you not to reveal certain medical facts or the prognosis to the patient? What is your responsibility to the patient? One acceptable strategy is to simply ask the patient, “How much do you want to know?” If the response is “Talk to my kids,” then the answer is clear. However, it is suitable to tell the family, “I will respect

your wishes to not reveal this to the patient as long as that is his desire. However, if he asks for more information, I will not lie to him or withhold information that he desires.”

6. Develop a plan for follow-up care. Do not let your patient feel abandoned. The patient and family members will have questions after they have had time to think about the news, perhaps do an Internet search and talk to family and friends. Schedule a time to get together again, or encourage them to call when they're ready to talk further. Avoid making statements that sound distancing, such as “There is nothing more we can do.” You may not be able to cure the patient's disease, but there is always something you can do for the patient.

Be sure to assess the patient's risk of self-harm and continue to reevaluate the patient for despondency and suicidal ideations at follow-up encounters. As needed, write down resources and web sites for the patient and disseminate patient handouts. Make referrals to other professionals (e.g., chaplain, minister, social worker or hospice) if appropriate. It is imperative to be aware of appropriate community organizations, such as hospice, that you can partner with to provide quality end-of-life care and to understand the differences in services that various hospice organizations offer so that you can best match them to your patient's needs.

Explore the patient's goals and then consider what you can offer to help the patient meet them. For example, ask the patient,

“What goals do you have for the time you have left?” If his or her goals involve palliation and quality-of-life ideas, then you could start discussing hospice. You might introduce it this way: “There is an organization called hospice that can help you meet your goals.” (For more information, see “Discussing End-of-Life Care With Your Patients,” *FPM*, March 2008; <http://www.aafp.org/fpm/2008/0300/p18.html>.) It is important to talk about palliative care when the patient is still feeling well and cognitively intact enough to understand the significance.⁸ It may help to point out that hospice is more

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Begin the conversation by finding out what the patient knows about his or her condition.

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When you give the bad news, state it as clearly as possible in lay terms.

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Be prepared to give the patient additional information if requested.

A SIX-STEP APPROACH

1. Assess the patient's understanding: “What do you know about your condition?” or “What have the doctors told you?”
2. Give a “warning shot”: “I'm sorry. I have bad news.”
3. Present the bad news using words the patient will understand.
4. Be quiet and listen.
5. Give additional information in layers as requested by the patient or family (i.e., “Peel the onion”).
6. Follow up: This is the beginning of a journey with the patient.

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about quality of life than about death. Recent studies actually demonstrate that the average patient on hospice lives longer than his or her counterparts who continue aggressive care.⁹ Good end-of-life care requires an interdisciplinary team approach that ensures patients and their families have the necessary resources and support.

Finally, it is important not to overlook the patient's caregivers. Elderly care-giving spouses often die before the patient they are caring for.¹⁰ Other family members may ask you to provide counseling and resources to assist elderly caregivers.

Tending to your needs

Finally, you should tend to your own needs, whether for support or advice. Formal or informal debriefing with colleagues or other medical professionals can be very helpful. If you are unsure or uncomfortable with a patient's situation, don't hesitate to seek consultation (through palliative care or hospice, for example), as you would for any medical condition.

Getting paid for your services depends on accurate coding and documentation. The codes used for many end-of-life care services are the same as for other evaluation and management services (see "Discussing End-of-Life Care With Your Patients," *FPM*, March 2008; <http://www.aafp.org/fpm/2008/0300/p18.html>, for more information on billing for hospice care).

However, many end-of-life services may be best described by the time spent in counseling and coordinating care. Documenting accurately to support time-based coding can help to ensure appropriate reimbursement (see "Time Is on Your Side: Coding on the Basis of Time," *FPM*, November/December 2008; <http://www.aafp.org/fpm/2008/1100/p17.html>).

Moving forward

With an individualized, systematic approach and practiced communication skills, family physicians can successfully manage the difficult responsibility of communicating bad news to patients. Despite the challenges, family physicians can make a tremendous impact on the lives of their patients during this time of great need. **FPM**

Send comments to fpm@afp.org.

1. Butow PN, Kazemi JN, Beeney LJ, et al. When the diagnosis is cancer: patient communication experiences and preferences. *Cancer*. 1996;77(12):2630-2637.
2. Schmid MM, Kindlimann A, Langewitz W. Recipients' perspective on breaking bad news: how you put it really makes a difference. *Patient Educ Couns*. 2005;58(3):244-251.
3. Bertakis KD, Roter D, Putnam SM. The relationship of physician medical interview style to patient satisfaction. *J Fam Pract*. 1991;32(2):175-181.
4. Randall TC, Wearn AM. Receiving bad news: Patients with haematological cancer reflect upon their experience. *Palliat Med*. 2005;19(8):594-601.
5. Jurkovich GJ, Pierce B, Pananen L, Rivara FP. Giving bad news: the family perspective. *J Trauma*. 2000;48(5):865-870.
6. Bishop TF, Morrison RS. Geriatric palliative care – part II: communication and goals of care. *Clinical Geriatrics*. 2007;15(2):27-32.
7. Kaplowitz SA, Campo S, Chiu WT. Cancer patients' desires for communication of prognosis information. *Health Commun*. 2002;14(2):221-241.
8. Ngo-Metzger Q, August KJ, Srinivasan M, Liao S, Meyskens FL Jr. End-of-life care: guidelines for patient-centered communication. *Am Fam Physician*. 2008;77(2):167-174.
9. Connor SR, Pyenson B, Fitch K, Spence C, Iwasaki K. Comparing hospice and nonhospice patient survival among patients who die within a three-year window. *J Pain Symptom Manage*. 2007;33(3):238-246.
10. Schulz R, Beach SR. Caregiving as a risk factor for mortality: the Caregiver Health Effects Study. *JAMA*. 1999;282(23):2215-2219.
11. Kagawa-Singer M, Blackhall LJ. Negotiating cross-cultural issues at the end-of-life: "You got to go where he lives." *JAMA*. 2001;286(23):2993-3001.
12. Searight HR, Gafford J. Cultural diversity at the end-of-life: issues and guidelines for family physicians. *Am Fam Physician*. 2005;71(3):515-522.

It is important to develop a plan for follow-up care; you do not want the patient to feel abandoned.

Ask the patient what his or her goals are and consider how you can help meet them.

Be sure to code and document accurately to be paid for your services.