Commentary

Communicating Bad News

JEANNE MIRANDA, PhD, *and* ROBERT V. BRODY, MD, *San Francisco, California*

Communicating bad news in the clinical setting is difficult. Sometimes the patient, family members, and the physician telling the bad news feel upset and resentful for long periods thereafter. Yet research has emphasized the need for patients to be told bad news, or at least to be offered the opportunity to hear it.[1,2] Medical schools are attempting to incorporate teaching this communication into their curricula,[3,4] and specialty groups such as anesthesiologists,[5] oncologists,[6,7] and others[8-21] are beginning to address the issue as well. Despite the importance of this function, which falls to almost all clinicians, no clear research is available to guide this process, and little has been written to help practitioners deliver bad news in the most constructive manner possible. This article offers suggestions that we have found useful in helping physicians deliver bad news.

The physician's goal, not always attainable, is to fully inform the patient and family so that they are able to comprehend the clinical situation and make sound decisions consistent with their beliefs and ideals. Physicians can experience a great deal of personal satisfaction when the patient and family can be helped through a difficult time.

Bad news can involve a variety of things: a positive test for the human immunodeficiency virus, a heart attack, death of a family member, a recommendation for a surgical procedure, loss of a pregnancy, the need for a prolonged hospital stay. Anything that changes a person's view of the future in a negative way is bad news. For example, one of our most distraught and inconsolable patients had been given the diagnosis of herpes. The physician should remember that bad news, like beauty, may be "in the eye of the beholder."

Communicating Bad News to Patients

The setting and timing of the communication are important aspects of telling bad news. Unfortunately, the health care system often works against the physician in this regard. Specifically, physicians are often called on to deliver bad news to patients they have not previously met or do not know well, such as in an emergency department or a teaching hospital where house officer rotations may cause a trusted resident to leave the patient at a crucial time. Physicians often feel too busy to spend adequate time with a patient. Time spent counseling patients is not reimbursed at the same rates as time spent doing procedures. Although the system may work against it, we urge physicians to consider both the setting and timing when telling bad news.

The setting helps establish the tone of the interaction. We urge physicians to find a quiet place away from others to talk with patients. For example, leave a pager with a colleague for 10 to 15 minutes so that the talk will be undisturbed. Sit down and talk directly to the other person. What will be said is often among the most important communications the patient or family has ever heard, and they can feel slighted and uncared for if the physician is allowed to be distracted during this time. People find it comforting to receive their physicians' full attention and concern.

We strongly recommend that bad news not be given over the telephone. A recent study of patients hearing the news of cancer found that 23% were told over the phone.[22] Significantly, 76% of patients told in the office or hospital room rated their physicians as "helpful" in aiding them to understand their illness, while only 48% of those told on the telephone or in the recovery room rated their physicians in this way. For example, one patient told by phone reported that

> [The doctor telephoned to say] . . . "the bad news is you have a tumor. The good news is we think it's a meningioma which means it's easy to get to." But, meanwhile, I'm standing there with the phone and my mouth down to the floor saying, . . . "What do you mean?" and asking him if I could come in to meet with him. And he said, well he could see me next Tuesday. This was Thursday . . . . It still amazes me that a person could do that.[22(p586)]

In sum, we urge physicians to sit down with the patient and family members in a quiet setting, giving their full attention to conveying difficult and often painful information.

The timing of breaking bad news is also extremely important. If at all possible, a time should be chosen when the physician is feeling rested and emotionally able to deal with the situation. Avoid situations wherein the physician has been up all night or must rush off to finish rounds or to an appointment, meeting, or conference. Similarly, a time should be chosen when the patient is able to hear the news. For example, bad news should not be delivered immediately following a difficult medical procedure, when a patient's thinking may be clouded by medication, or when he or she is in pain or otherwise symptomatic, severely anxious, or depressed. If family members, counselors, or members of the clergy are involved with the case, a time should be chosen when they are available to support the patient after he or she hears the news. When possible, patients should choose who should be present when the information is divulged. Our recommendation is that the breaking of bad news should be timed to maximize the strength of all persons involved.

If there is a language barrier between the physician and the patient, a hospital or clinic interpreter should be used to translate, rather than a family member. We advise that physicians talk to the interpreter before the interview, making sure the interpreter understands the clinical situation and the physicians' goals for the discussion. The person doing the translating may have limited medical training, and precise communication may get lost in the emotions of the moment.

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From the Primary Care Medicine Residency Program, San Francisco General Hospital, University of California, San Francisco, and Visiting Nurses and Hospice of San Francisco.

Reprint requests to Jeanne Miranda, PhD, Dept of Medicine, 5H22, San Francisco General Hospital, 1001 Potrero Ave, San Francisco, CA 94110.

Also, translators have feelings, too, to which the physician must be sensitive.

Choosing what to say to a patient is perhaps the most important aspect of communicating bad news. First, the patient should be asked how he or she is feeling; the physician should not try to break bad news at a bad time for the patient. We suggest that the physician warn the patient that he or she has something serious to talk about. Often it is appropriate to say to the patient that this is going to be difficult for both. Then stop, monitor the effects of these words, and assess the patient's receptivity to the communication. We then suggest that the physician tell the patient the news in the most straightforward but compassionate way possible, using simple language, avoiding terms that the patient is unlikely to understand. The news should be told directly. Start with less emotionally charged words, but use the real words—cancer, AIDS, heart attack—at some point. Patients have been known to report later, "They told me I had a growth [or tumor or malignancy or adenocarcinoma], but nobody ever told me I had *cancer*." For example, a dialogue with a patient may proceed as follows:

PHYSICIAN: *Good morning, Mr Lee. How are you feeling today?*
PATIENT: Better than I did a week ago.
PHYSICIAN: *I'm glad of that. We have some very serious matters to discuss regarding your health. Do you feel ready for this discussion?*
PATIENT: Well, I want to know. I'll try to be ready.
PHYSICIAN: *It's hard to ever be ready for difficult news. This is not easy. It's going to be hard for both of us. I need to let you know that we got the results of your test back.* [pause] *As we had feared, the lump is a malignant tumor, cancer.*

Once bad news has been given, we suggest that physicians say they are sorry. We do not use this word in the sense of taking responsibility for the bad situation or apologizing for it, but rather to express sympathy and regret. It is often appropriate to respond on a human level, such as reaching out and touching the patient. It is acceptable to cry if feeling especially sad about the news; patients will not see their physician as weak or unprofessional but simply as a caring human being. For example, the conversation above may continue as follows:

PHYSICIAN: *I'm sorry about this. This is very hard news to hear. Are there any questions that I can answer for you now? We will be discussing this more in the next week.*

TABLE 1.—*Principles of Communicating Bad News*

Choose a quiet setting
Give the news in person
Choose a moment when patient and physician are rested and have adequate time
If an interpreter is used, talk to her or him in advance
Assess the patient's present physiologic and emotional state
Prepare the patient by saying there is a difficult topic to discuss
Use clear, simple language
Express sorrow for the patient's pain; be human
Give limited information; schedule time to talk again later
Be realistic; avoid the temptation to minimize the problem, but don't take away all hope
Explore how the patient feels after receiving the news
Reassure the patient of the continued availability of care no matter what happens

PATIENT: What does this mean? What do we do next?
PHYSICIAN: *We know this is very serious. Unfortunately, we don't know exactly how rapidly it will progress. For now, we need to run one more test that I will schedule, if you agree. You and I will keep talking about this as we know more.*

In choosing what to say first, the physician should avoid the temptation to give the patient too much information once the bad news has been delivered. Initial anxiety often blocks out everything else. A gradual process of changing the view of oneself and the future is better than attempting abrupt adjustments. Information should be spaced over several visits. The physician might say, "I know this is confusing; we can talk again tomorrow so that I can answer all your questions." When the discussion is taken up again, a careful assessment can be made of what has been retained; the physician should not be surprised if there were misunderstandings.

We recommend that physicians attempt to explore how a patient feels after receiving bad news and the reasons behind the feelings. The patient may say, "Just don't tell me I have AIDS. . . . " Ascertain the patient's conception of what it means to have the diagnosed disease or condition. Frequently the patient will relate a story of someone he or she knew or heard about with the condition, and specific fears may be elicited. Common fears, such as fear of pain, might be anticipated. We recommend that these concerns be validated, perhaps by simply saying, "I hear your worries about suffering." The physician might then decide which of these issues can be addressed and resolved at the moment and which can be dealt with later. Acknowledging personal and professional limitations here is crucial. For instance, pain can be managed by the physician with the assistance of nurses and pharmacists; a social worker might deal with disability issues, a member of the clergy with worries about death.

When talking about the prognosis of a terminal disease, physicians must become comfortable with uncertainty. Be hopeful without falsely leading patients on. For example, say, "This is a progressive disease, but we will certainly do what we can for you." Some estimate of remaining time is often important for planning, but the patient or family should be made to understand that it is impossible to be sure of the accuracy of such estimates. Physicians need to be aware of the tendency to err on the side of optimism when predicting the course of fatal diseases. Functional status is often a better predictor than pathologic staging in determining time remaining. Offer to keep the patient informed as changes occur or to help him or her recognize changes. Patients should be reassured, if possible, that they can contact the physician when things arise that are frightening. The patient will feel comforted knowing that their practitioner will be available no matter what events unfold.

What the patient has been told and how the patient reacts should be communicated to the nursing staff as soon as possible so that others can be prepared to offer emotional support and understand possible reactions, such as tears, anger, sleeplessness, or an increase in pain. A delay in communicating bad news to a patient can place nurses in a difficult position in their own relationship with the patient or family.

In summary, the effect of delivering bad news to patients can be improved by considering factors such as the setting, the timing, and the words used (Table 1). These principles can serve as a general guide. Specific situations, such as

knowing a patient well, may call for a different approach by the physician. Similarly, each physician will develop his or her own style for delivering bad news.

Communicating Bad News to Family Members

When it becomes necessary to notify family members of bad news, such as a death, the same principles of choice of setting and timing apply, as well as the advisability of stating the facts in a clear, simple manner. Again, physicians should say they are sorry the family must suffer this loss. Family members are probably not greatly interested in the technicalities of the death. Comforting information, however, can be useful. For instance, the physician might say, "I [or the nurse] was with your husband when he died. He looked peaceful and did not suffer." Technical details may be in order later, after the emotional impact has subsided.

Problems in Delivering Bad News

One problem that can arise when bad news is delivered is denial on the part of the patient or a family member. This denial can be extreme and may reach such proportions that the person can be considered delusional. Denial should be understood to mean that the truth feels too painful or too threatening to assimilate at this time. If the patient continues to cooperate with treatment, a period of denial may not be problematic. We recommend that the physician maintain the bond with the patient, who needs help desperately, while gently and slowly attempting to develop the patient's awareness. The patient should be asked how he or she understands what is happening. If the patient denies reality, the physician might ask if there may be a time when he or she might consider another explanation. The physician should keep assessing how the patient is coping, perhaps by saying, "How do you feel things are going?" With time, and perhaps with the progression of the disease, most patients and family members can bear to hear bad news.

Another problem that may arise when communicating bad news is a request for collusion to hide the news. Such a request may come from either the patient or the family. The request may be culturally based; in some societies it is traditional for older persons to give up decision-making powers to younger family members. It is important to realize that the request to hide the diagnosis or prognosis is usually made out of love, not out of denial of the seriousness of the situation. It is useful to acknowledge this, and then explore the reasons given for the request. Physicians often hear concerns that the other will "fall apart" or "just turn her face to the wall." In addition, when the condition may have a societal stigma, as with AIDS or even cancer, shame or guilt may play a role. A strategy that may be helpful in this situation is for the physician to present as an expert who knows that people want to be informed about their condition, or the condition of a loved one, even if it may be difficult, so that they can plan for the future, vent emotions, and take care of business. The person who has not been informed often "knows" anyway but is afraid to talk openly in the family. Serious illness is a time of change, physiologically, psychologically, and socially. Even when the physical changes are destructive, the psychological and social changes may be constructive, and some of the gratification in caring for the seriously or terminally ill comes from facilitating this positive change in patients and families.

A useful strategy for dealing with problems that arise while needing to deliver bad news is to enlist the aid of other health care professionals. Often nurses or social workers become particularly close to patients and family and can be helpful during the process of acceptance that must occur. By discussing the situation with the other health care workers before talking to the patient or family, others can deal with their own feelings and be supportive to the patient.

Physician Responses to Communicating Bad News

Communicating bad news can be difficult. The physician may have feelings of impotence, or even guilt or failure: "If only I'd done that mammogram/stool guaiac/Pap smear/got him to stop smoking." Some physicians attempt to block off their own feelings to be spared the continued pain of dealing with these sad situations. Unfortunately, this often results in the patient and family feeling bad as well as the physician feeling resentful, distant, and unfulfilled. We recommend that practitioners acknowledge and talk about their own involvement in these situations. Using the methods and strategies outlined in this article can transform these intense interactions from stressful, unpleasant confrontations into meaningful communications. The physician may be seen as representing the good things about humanity to the patient and family, helping them feel less alone at a difficult time. When responding in this manner, the physician may feel temporarily sad but also renewed.

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