Delivering bad news to patients

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When physicians lack proper training, breaking bad news can lead to negative consequences for patients, families, and physicians. A questionnaire was used to determine whether a didactic program on delivering bad news was needed at our institution. Results revealed that 91% of respondents perceived delivering bad news as a very important skill, but only 40% felt they had the training to effectively deliver such news. We provide a brief review of different approaches to delivering bad news and advocate for training physicians in a comprehensive, structured model.

The biopsy confirmed her fear: inflammatory breast cancer. Now Amanda, a second-year surgery resident, had to tell her patient the bad news. Overwhelmed and saddened by the task, she wondered how to tell a 62-year-old woman that she had a high risk of recurrence, even with chemotherapy, surgery, and radiation.

Delivering bad news is one of the most daunting tasks faced by physicians. For many, their first experience involves patients they have known only a few hours. Additionally, they are called upon to deliver the news with little planning or training (1). Given the critical nature of bad news, that is, "any news that drastically and negatively alters the patient's view of her or his future" (2), this is hardly a recipe for success.

Historically, medical education has placed more value on technical proficiency than communication skills. This leaves physicians unprepared for the communication complexity and emotional intensity of breaking bad news (3). The fears doctors have about delivering bad news include being blamed, evoking a reaction, expressing emotion, not knowing all the answers, fear of the unknown and untaught, and personal fear of illness and death (2). This can lead physicians to become emotionally disengaged from their patients (1). Additionally, bad news delivered inadequately or insensitively can impair patients' and relatives' long-term adjustments to the consequences of that news (4).

APPROACHES TO COMMUNICATING BAD NEWS

Given the negative results of delivering bad news poorly for both patient and physician, physician training in delivering bad news is needed. The best training will embrace a patient-centered approach that includes the patient's family. A patient- and family-centered approach not only keeps the patient at the center (5), but has also been shown to yield the highest patient satisfaction and results in the physician being perceived as emotional, available, expressive of hope, and not dominant (6).

In a patient- and family-centered approach, the physician conveys the information according to the patient's and patient's family's needs. Identifying these needs takes into account the cultural, spiritual, and religious beliefs and practices of the family (7). Upon conveying the information in light of these needs, the physician then checks for understanding and demonstrates empathy. This is in contrast to an emotion-centered approach, which is characterized by the physician emphasizing the sadness of the message and demonstrating an excess of empathy and sympathy. This approach produces the least amount of hope and hinders appropriate information exchange (6).

Additionally, the best training will include a protocol for delivering bad news (8). Several protocols have been proposed and tested in the literature. Buckman has written extensively on this subject (2, 9, 10), including his landmark 1992 book, *How to Break Bad News: A Guide for Health Care Professionals* (11). His criteria for delivering bad news include delivering it in person, finding out how much the patient knows, sharing the information ("aligning"), assuring the message is understood, planning a contract, and following through (2).

Fine proposed a protocol with five phases. Phase 1, preparation, involves establishing appropriate space, communicating time limitations, being sensitive to patient needs, being sensitive to cultural and religious values, and being specific about the goal. Phase 2, information acquisition, includes asking what the patient knows, how much the patient wants to know, and what the patient believes about his or her condition. Phase 3, information sharing, entails reevaluating the agenda and teaching. Phase 4, information reception, allows for assessing the information reception, clarifying any miscommunication, and handling disagreements courteously, while Phase 5, response, includes identifying and acknowledging the patient's response to the information and closing the interview (7).

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Baile et al proposed a protocol called SPIKES (10): S, *setting up* the interview; P, assessing the patient's *perception;* I, obtaining the patient's *invitation*; K, giving *knowledge* and information to the patient; E, addressing the patient's *emotions* with empathic responses; and S, *strategy* and *summary*. VitalTalk (www.vitaltalk.org) makes use of the SPIKES protocol and incorporates many articles and videos that describe and illustrate each step.

Rabow and McPhee also proposed a model for delivering bad news called ABCDE: A, advance preparation; B, build a therapeutic environment/relationship; C, communicate well; D, deal with patient and family reactions; and E, encourage and validate emotions (12). Additionally, numerous other published articles deal with communication skills relating to delivering bad news to patients.

Other factors to consider when delivering bad news include the physical and social setting and the message (13). Specifically, the location should be quiet, comfortable, and private. With regard to structure, bad news should be delivered when it is convenient to the patient, with no interruptions, with ample time, and in person. Ideally, those receiving the bad news should be given the choice to be accompanied by someone in their support network. With regard to the message being delivered, physicians should be prepared, find out what the patient already knows, convey some measure of hope, allow for emotional expression and questions, and summarize the discussion. The message should be delivered with empathy and respect and in language that is understandable to the patient, free from medical jargon and technical terminology.

As evidenced above, ample resources are available for improving one's skill in delivering bad news, from numerous published articles to online tools such as VitalTalk. However, there is no guarantee that these resources are being utilized by faculty and residents. We therefore asked whether a didactic intervention was needed in our department.

NEEDS ANALYSIS

To address this deficiency, we administered a preliminary questionnaire to gather baseline information about surgeons' experiences and attitudes when delivering bad news at our institution. The questionnaire was also used to evaluate the need for specific training to improve communication skills related to the delivery of bad news and gather pilot data for future research/intervention. The questionnaire was administered to 54 participants (17 women, 37 men) in the Department of Surgery at Baylor University Medical Center at Dallas. Thirty-four respondents were residents and 20 were attendings.

Results revealed that 93% of respondents perceived delivering bad news to be a very important skill and 7% a somewhat important skill; however, only 43% of respondents felt they had the training to effectively deliver such news. Furthermore, 85% felt they needed additional training to be effective when delivering bad news. Of the 85% of participants who felt they needed additional training, 59% were residents and 26% were attendings. No differences in reported preparedness were revealed across gender. As anticipated, participants with more experience (i.e., years in the profession) reported feeling better prepared to deliver bad news than those with less experience.

DISCUSSION

Based on these results, the need to implement an educational intervention to improve the communication skills of faculty and residents in the Department of Surgery has become evident. To address this gap in training, a follow-up study has been initiated to determine the effectiveness of Rabow and McPhee's ABDCE approach (12), with modifications and additional material from other sources including VitalTalk. Additionally, the study incorporates the use of standardized patients, three different bad news scenarios, video recording of the interactions, and individualized feedback. If this approach proves successful, it will form the basis of our department-wide educational intervention.

Professionalism and interpersonal communication skills are two of the six core competencies required by the Accreditation Council for Graduate Medical Education for all specialties. Unlike more concrete competencies, such as medical knowledge, which can be evaluated with in-training examinations, the assessment of professionalism and communication skills is more subjective and difficult. As opposed to continuing the tradition of implicitly learning professionalism by observing how attendings behave in a clinical setting, we believe that explicit, structured learning via formal curricula is necessary. It is our hope that by building communication skills training into our surgical education curriculum, residents and staff will feel better prepared to face this daunting task.

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