Breaking Bad News: Can We Get It Right?

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INTRODUCTION

The health service involves a spectrum of personnel working together towards achieving a common goal, namely the delivery of high quality health care. This involves a large volume of communication between members of staff and patients and their relatives. Doctors are trained to deal with various clinical situations but receive little or no training in communication skills and therefore their communication skills are predominantly instinctive. Patients and their relatives are understandably anxious and vulnerable and it is not surprising that things can go wrong if effective communication is not practiced. Although most doctors communicate effectively, there is increasing evidence that a large number of patients remain unhappy with the amount of information given and the manner of its delivery [1]. Maguire and colleagues found that when doctors use communication skills effectively, both they and their patients benefit [2]. Furthermore, ineffective communication is an important source of complaints and litigations. In a recent Japanese study 81% of litigation involved insufficient or incorrect explanations by the physician [3]. Moreover, in 26% of cases poorly delivered information was found to be the reason that prompted individuals to file a malpractice claim [4]. This article looks into a specific area of communication between doctors, on the one hand, and patients and their relatives on the other; namely "breaking bad news". It highlights the importance of equipping doctors to effectively communicate with patients and their relatives

How much information do doctors provide?

Bad news may be defined as any information that changes a person's view of the future in a negative way [5]. Until recently, withholding bad news from patients was, indeed, a common practice. In *Decorum,* Hippocrates recommended that physicians be leery of breaking bad news because the patient may "take a turn for the worse"[6]. Thomas Percival gave a similar warning in Medical Ethics in 1803 [7], as did the American Medical Association in its first code of medical ethics in 1847 [8]. A survey of 193 physicians revealed that 169 (88%) routinely withheld cancer diagnoses [9]. Furthermore, they often used euphemisms such as "growth" to describe cancer. The policy was "to tell as little as possible in the most general terms consistent with maintaining cooperation and treatment". However, the same study found that most patients desired the truth regarding their diagnosis. In fact, many recent studies have found that most patients want to know the truth about their illness [10]. The General Medical Council (GMC) 2006 guidance on relationships with patients is clear about the issue of providing patients with the information they want or need to know [11].

Delivering bad news; what is happening now?

Bad news in the hospital setting is delivered by one or more members of the team involved in the patient's care. Most often it is the responsibility of the treating specialist doctor. Delegating the task to an inexperienced junior team member is a recognised practice. At other times an experienced nurse takes on this mission as nurses can be seen to have developed a closer relation with the patient. One other practice seen in some parts of the world (including Libya) is breaking the news to the relatives and leaving them to decide when and how to tell the patient. Indeed, not uncommonly the patient is not told at all.

The manner in which bad news is delivered is, undoubtedly, the key to its efficiency. Mueller and colleagues concluded that how a clinician delivers bad news may affect patients' understanding of, and adjustment to, the news as well as their satisfaction with their physician [12]. Ineffective delivery of bad news by doctors to patients and relatives is becoming more easily recognisable partly thanks to the continuous growth of the strategic "patient-centred" approach to healthcare, which has emphasised the importance of quality communication practice.

Causes of ineffective delivery of bad news and proposals to improve the process.

Like any other communication process, delivering bad news is a *two-way process* between the doctor and the patient/relatives that must be underpinned and monitored by a feedback loop [13]. There are, however, many communication barriers that need to be recognised, considered and dealt with to facilitate effective communication. These barriers can be divided into three categories: Doctor related barriers, Patient/relatives related barriers, and Organisation related barriers.

Doctor related barriers

Lack of formal training

The first and perhaps the most important barrier is doctors' lack of training in communication skills. Epstein found that most clinicians have had little formal training in communication skills [14]. Doctors tend to rely on their intuition and experience, and contrary to the research evidence which shows that communication skills do not reliably improve with experience [15]; there is an assumption that communication skills will be acquired with time. Fallowfield stated that too many of our doctors are forced to rely on intuition to guide them as to what to say or how to say things to patients [16]. Lack of training leads to substandard skills. Doctors should be trained to recognise, first of all, that it is their *responsibility* to get the process of breaking bad news right. Doctors should also be prepared to *invest time* when delivering the news to minimise problems later. As professionals, they must

take responsibility for the development and improvement of their own communication skills. The GMC and other medical professional bodies have stressed the importance of doctors developing good communication skills [17]. Modernising Medical Careers (MMC) is a major reform of postgraduate medical education in the UK. It aims to develop demonstrably competent doctors who are skilled at communicating and working as effective members of a team. Ideally, training in breaking bad news should start at medical school. This can provide only theoretical and at best role playing models. The adoption of the Problem-Based Learning (PBL) approach for undergraduate education emphasises the importance of developing many generic skills including communication skills. Further knowledge can be gained at the early stages of the medical career by observing senior colleagues delivering bad news. Opportunities should be available for asking questions and giving opinions. More advanced levels of training should include doctors performing the task in real life under supervision. The Royal College of Physicians has recently introduced a list of assessment for trainees at different levels. One or more of these tools can be used for breaking bad news provided it is followed by the desired constructive feed back. In the UK, there are a number of available courses aimed at highlighting psychology, challenges, theories and mechanisms of breaking bad news. These measures will hopefully produce a future generation of doctors far more skilled in communication, generally, and in particular with patients and relatives.

Time constraints

A hospital doctor's working day usually stretches well beyond the contracted hours in order to carry out all tasks for the day. Although some doctors are better at managing their time more effectively than others, there is no doubt that hospital doctors generally work under considerable pressure as far as time is concerned. Doctors will need to prioritise these tasks and so it is not surprising that more pressing clinical situations often take priority over communication issues with patients and relatives. Effective time management, a skill that can be acquired by training and practice can minimise the time constraint barrier. Another way of effective time management is by appropriately delegating some tasks to trained colleagues such as other doctors, senior nurses, and nurse practitioners. Doctors need to choose the most appropriate time to communicate bad news. At the end of the ward round or at the end of the clinic if possible are good times as there is less pressure to see other patients. Without careful planning this may not be always achievable.

Human failings

Working out of hours is an essential part of a hospital doctors' duties. These are often continuous and long periods of on-call hours. This may precipitate tiredness and stress, which can compromise the doctors' ability to communicate effectively and breaking bad news is not an uncommon demand during out of hours. Careful planning can usually prevent this situation in most cases. In patients with chronic terminal diseases e.g. cancer, it is a good practice to prepare the patient and relatives for the potential prognosis well in advance. Certainly more open and detailed discussion needs to take place when the terminal stage is identified. This needs to be carried out by the appropriate team members at the appropriate time (i.e. routine working hours) if we are to avoid the situation of an on call doctor not familiar with patient's condition breaking the news out of hours.

Language competence

Because breaking bad news, in hospital settings, is almost always delivered in a face-to-face meeting with the patient and/or their relatives, a high command of the language is essential. Hospitals employ a large number of doctors whose mother language is not that of the patient. To work in the UK, it is mandatory for overseas doctors to be fluent and competent in English. For the European countries qualified doctors, who are not required to produce an evidence of English language competency, the local employment selection criteria should ensure that, and in the UK, it often does.

Historically in Libya the majority of front line health professionals were employed from neighbouring Arabic speaking countries. They share the same language as Libyan patients. However, there was a significant number from the Indian subcontinent and Eastern Europe who are not necessarily fluent in Arabic. Since the last decade there have been many more Libyan native frontline health professionals. Non Arabic speaking doctors make a small number in the Libyan health service now. Supporting these doctors by offering targeted language courses is one way to overcome this challenge. Another way is for doctors to work in teams to guarantee native language speaking members.

Organisation related barriers

Organisational barriers affect the process in an indirect manner and are usually outside the doctors' direct control. These include:

Communication climate

By this we mean the type of communication adopted and encouraged within the hospital, for instance if an open and supportive climate is promoted this will create a sense of worth and value among all members of staff including doctors. This of course can only be achieved by the organisation leadership commitment. By contrast, in a closed or defensive environment, effective communication is often the first casualty [18]. The organisation can improve this aspect of communication by promoting egalitarian communication climate where people communicate in a way that suggests that everyone is valued, regardless of their role or status. Doctors with high morale are more likely to recognise their responsibility to deliver the message properly. They are more likely to recognise and respond to the needs of others (patients, relatives and colleagues).

Statistical targets

Chasing statistical targets may be the primary concern of the hospital management and this is often demonstrated as an increase in patient turnover. This will in turn force doctors to devote less time for communication and will interfere with the desired quality of the process of breaking bad news performance of the organisation. These constraints affect the quality of individual consultations and can be counter-intuitive on the performance of the organisation. Statistical targets are likely to stay there. They are a strategic governmental choice necessary for driving as well as monitoring performances. There is, however, occasional conflict between achieving these targets and providing the highest

possible quality of care, for example when time is required to deliver bad news to patients and relatives effectively at the expense of delaying other patients' consultations. It is, also, the responsibility of the organisation to keep alive a feedback loop system by encouraging periodic surveys, audits, and research projects of patients' experiences and work towards empowering patients.

Patient/relatives related barriers

Differing needs of a **diverse range of patients and relatives**

Hospital doctors have to respond to the differing needs of a hugely diverse range of patients and relatives. Patients and relatives have different backgrounds, cultures, religions, languages, levels of intelligence, and ages. These variations put demands on doctors to adjust the manner of delivering bad news accordingly, which may influence the doctors' ability to effectively deliver the bad news. In some cultures it is believed that disclosure of bad news may cause patients to lose hope. In most of these cases, family members will act as bearers of the bad news. Whether the news is then communicated between the family members and the patient is another variation. Physicians in these cultures may be more likely to follow family wishes. A study from Turkey showed that the only significant factor behind not telling the patient the truth about a cancer diagnosis is the "do not tell" requests from relatives [19]. This issue is also reported in western societies. An Italian study showed that almost all physicians in the survey endorsed the involvement of family members when disclosing the diagnosis of cancer, but at the same time they also indicated that families usually prefer their ill relative not to be informed [20]. However, with training, planning, experience and knowledge of the local customs the physician will be able to accommodate the overall needs of the patient and family members in most cases. It is always worthy to discuss and negotiate with family members the potential benefits of professional disclosure of the condition with the patient. One will not expect all physicians to follow one hard rule in this matter. It is proven that the extent of communicating bad news to patients can be different in different parts of the world. Physicians from Western countries were less likely to withhold unfavourable information from the patient at the family's request, avoid the discussion entirely, use euphemisms, and give treatments known not to be effective so as not to destroy hope than physicians from other countries [21]. It is, however, vital to emphasise the fact that the interest of the patient is the primary duty of the physician if there is an unresolved difference between the patient and the family on the issue of breaking bad new. The GMC guidance stresses on the importance of keeping the patient informed of serious changes in their health. Discussion about the dying process allows patients the opportunity they may want to decide what arrangements should be made to manage the final stages of their illness, and to attend to personal and other concerns that they consider important towards the end of their life [22].

The SPIKES approach

Empathic communication is the key. This is particularly true in breaking bad news encounters. We found the work of Baile and colleagues [8] who organised recommendations into the mnemonic SPIKES: **S**etting up, **P**erception, **I**nvitation, **K**nowledge, **E**motions, **S**trategy and summary rather simple and a useful approach. This approach is intended to help clinicians break bad news to patients in a straightforward and empathic manner.

Setting up: Breaking bad news should be done in private. Only the patient, his or her loved ones, and members of the healthcare team should be present. The clinician should sit down, make eye contact with the patient, and may use touch appropriately. Sufficient time should be allowed to answer questions. Interruptions (eg, pagers and phones) should be eliminated. A general opening statement is an important link between the greeting and introducing the team and the process of breaking the news. This can be in the form of 'How have you been since you had the endoscopy' or 'Did you find the pain killers I prescribed last week helpful?'

Patient perceptions: Before breaking bad news, the doctor should find out what the patient knows about his or her illness. Questions that reveal patient perception include "What have you been told about your condition?" and "Do you recall why we did this test?" Assessing patient perceptions allows physicians to correct misinformation and tailor the news to the patient's level of comprehension.

Invitation to break news: Doctors need to get the patient's permission to share bad news. Getting permission may be especially important for patients from non-Western cultures in which autonomy of the individual may not be paramount and healthcare decision-making is shared with others. For example, the physician may say, "I'd like to share with you the results of your tests. Is that okay?" Before ordering tests or procedures, physicians need to inform patients about possible outcomes, which prepare patients for potential bad news. Physicians also should ask patients if they want only basic information or a detailed disclosure.

Knowledge: Patients need enough information to make informed healthcare decisions; thus, physicians should convey information at the patient's level of comprehension. For example, the word *spread* should be used in place of *metastasized*. To help patients adequately process bad news, small boluses of information should be given. Physicians can check for comprehension by asking, "Am I making sense?" or "Can I clarify anything?" Undue bluntness and misleading optimism should be avoided. Some physicians believe it is unhelpful to give specific time periods regarding prognosis.

Emotions: The empathic physician acknowledges a patient's emotional response to bad news by first identifying the emotion and then responding to it. "I can see that you are upset by this news" is an empathic statement. Deliberate periods of silence allow patients to process bad news and ventilate emotions.

Strategy and summary: After receiving bad news, a patient may experience a sense of isolation and uncertainty. Doctors can minimize the patient's anxiety by summarizing the areas discussed, checking for comprehension, and formulating a strategy and follow-up plan with the patient. Written materials (e.g. hand-written notes or prepared materials listing the diagnosis and treatment options) may be helpful. Physicians should

assure the patient of their availability to address symptoms, answer questions, and meet other needs.

The authors feel comfortable when adopting the SPIKE approach (Appendix 1) and recommend it to other healthcare professionals.

Conclusion

Delivering bad news to patients and their loved ones is a very sensitive task a doctor has to endure. It demands a sophisticated level of communication skills. Patients and relatives determine their satisfaction with their clinicians based on the manner in which the news is delivered. It is, therefore, vital to overemphasise the importance of doctors' competency in communication skills. Communication can be improved by various simple techniques like paying attention to barriers to communication and simple ways of removing barriers as well as consolidating the information communicated in a sympathetic way.

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