

# *Breaking Bad News to the Patient and Relatives*

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## **Introduction**

The word “Doctor” is derived from the Latin “DOCERE” which means ‘to teach’. A doctor in his capacity as a ‘healer’ should be able to teach his patient about health. Teaching skills will involve collecting information and efficiently communicating it to the patient. Sadly our medical curriculum lacks this aspect of ‘communication skills’. It is only when a medical graduate starts his clinical practice, then he realizes the lack of communication skills.

During the last 50 years, the subject of communication in health care has become a serious matter of study. Evidence is that healthcare fails without a conscious, informed effort of communication which is the professional responsibility of all concerned including nursing staff and doctors, pharmacist, health administrators etc.<sup>1</sup> It is the aim and mission of modern healthcare professional to provide care that is evidence-based and unconditionally patient centered. Communication styles that are patient centered provide a more complete clinical picture upon which diagnosis and treatment can be based and lead to improvement in health outcomes.

Breaking bad news to patients is one of the most difficult tasks in the practice of medicine. The usual problems encountered are:

- i. What constitutes a bad news?
- ii. Whether a patient should be informed about the news?
- iii. Whether any relative should be informed ?
- iv. What impact will the news have on the patient?
- v. What should be the way to carry out this unpleasant task?

## **What constitutes a bad news ?**

Bad news can be defined<sup>2</sup> as “any news that drastically and negatively alters the patient’s view of his or her future.” Bad news is usually associated with a terminal diagnosis of ‘cancer’ but a physician may encounter various situations that involve imparting bad news e.g. news of intrauterine fetal death to a pregnant mother, a diagnosis of multiple sclerosis etc. A diagnosis of a chronic illness such as Diabetes Mellitus or disability or loss of function of a limb or a part of limb can constitute a bad news. A diagnosis of AIDS to be conveyed to the patient, can be a difficult task. To me conveying a diagnosis of ‘pregnancy’ to the parents of a young unwed girl can also be difficult. A treatment plan that is painful, lengthy and costly can also have a negative impact. Thus bad news may be related to different diagnosis apart from cancer.

**Table 1**

- **Prepare** for the discussion.
- **Set** up a suitable environment.
- Begin the discussion by finding out what the **patient** and or family understand.
- Determine how they will comprehend new **information**.
- Provide new **knowledge** accordingly.
- **Share** plans for the next steps.

### Whether the patient should be informed?

In *Decorum*, Hippocrates advised<sup>3</sup> “Reveal nothing to the patient of his future or present condition for this has caused many patients to take a turn for the worse”. Unfortunately this tradition of silence persisted for centuries. In the past few decades, this has changed. A review of studies on patient preferences regarding disclosure of a terminal diagnosis found that 50-90% of patients desired full disclosure.<sup>4</sup>

Relatives may ask the physician to withhold the bad news from the patient. But, I feel the information belongs to the patient and not to the relatives.

Moreover it is observed that invariably, patients; (1) Know more about their illness than anyone’s guess or (2) May imagine things to be worse than they are (3) Welcome clear information about disease.

Thus it is clear that the bad news should be conveyed to the patient.

### Whether any relative should be informed?

The negative impact, the bad news can have, on the patient demands the presence of near and dear ones with the patient. But the ethical issues of the confidentiality and secrecy of patient information demands that this be discussed with the patient and his views need to be sought. Ask the patient who, if anyone, he would like to have with him. This need not be the official ‘next of kin’, but a same

sex friend, a confidant or a specific member of the health care team. But there may be exceptions to this general rule. If the patient is a child under 16 yrs., the information about the disease, prognosis and treatment belongs to the parents. If the patient has cognitive impairment or has impaired hearing faculty the presence of a relative is necessary. In case of a language barrier a suitable interpreter needs to be present. If the diagnosis has ethical issues attached, e.g. a diagnosis of ‘AIDS’, the doctor will have a social responsibility of discussing the diagnosis with the spouse. Thus the presence of a relative though not mandatory is advisable, but only with patient’s permission.

### What impact will the news have on the patient?

Rabow and Mcphee keenly<sup>5</sup> described the end result of communication “Clinicians focus often on relieving patient’s bodily pain, less often on their emotional distress and seldom on their suffering.” A physician should be aware of the possible negative impact of the bad news on a given patient. A reaction could consist of denial, blame, disbelief rather than acceptance or submission. This may result in meek surrender to the diagnosis and apathy towards further treatment or may result in hostility towards the doctors, relations or the hospital. A physician should be aware of such extreme reactions and be prepared for the same.

### What should be the way to carry out this unpleasant task?

Buckman<sup>2</sup> suggested an organized and effective procedure for communicating bad news. He outlined seven steps which goes by the acronym P-SPIKES.<sup>1</sup>

Table- 2 provides a summary of these steps along with suggested phrases.

Rabow and Mcphee<sup>5</sup> developed a practical and comprehensive model, from synthesized multiple sources, that uses acronym ‘ABCDE’.

**Table 2 : Elements of Communicating Bad News-the P-SPIKES Approach**

Acronym	Steps	Aim of the Interaction	Preparations, Questions, or Phrases
P	Preparation	Mentally prepare for the interaction with the patient	Review what information needs to be communicated. Plan how you will provide emotional support. Rehearse key steps and phrases in the interaction.
S	Setting of the interaction	Ensure the appropriate setting for a serious and emotionally charged discussion	Ensure patient, family and appropriate social supports are present. Devote sufficient time-do not squeeze in a discussion. Ensure privacy and prevent interruption by people or beeper. Bring a box of tissues.
P	Patient's perception and preparation	Begin the discussion by establishing the baseline and whether the patient and family can grasp the information.  Ease tension by having the patient and family contribute.	Start with open-ended questions to encourage participation.  Possible phrases to use: What do you understand about your illness? When you first had symptom X, what did you think it might be? What did Dr. X tell you when he sent you here? What do you think is going to happen?
I	Invitation and information needs	Discover what information needs the patient and/or family have and what limits they want regarding the bad information	Possible phrases to use: If this condition turns out to be something serious, do you want to know? Would you like me to tell you the full details of your condition? If not, then who would you like me to talk to?
K	Knowledge of the condition	Provide the bad news or other information to the patient and/or family sensitively.	Do not just dump the information on the patient and family. Interrupt and check that the patient and family are understanding. Possible phrases to use: I feel badly to have to tell you this, but..... Unfortunately, the tests showed..... I'm afraid the news is not good...
E	Empathy and exploration	Identify the cause of the emotions-e.g., poor prognosis.  Empathize with the patient and/or family's feeling.  Explore by asking open-ended questions.	Strong feelings in reaction to bad news are normal. Acknowledge what the patient and family are feeling. Remind them such feelings are normal, even if frightening. Give them time to respond. Remind patient and family you won't abandon them. Possible phrases to use: I imagine this is very hard for you. You look very upset. Tell me how you are feeling. I wish the news were different. I'll do whatever I can to help you.
S	Summary and strategic planning	Delineate for the patient and the family the next steps, including additional tests or interventions.	It is the unknown and uncertain that increase anxiety. Recommend a schedule with goals and landmarks. Provide your rationale for the patient and/or family to accept (or reject).  If the patient and/or family are not ready to discuss the next steps, schedule a follow-up visit.

**Table 3**

1. Advance Preparation.
2. Build a therapeutic environment.
3. Communicate Well.
4. Deal with patient and family reactions.
5. Encourage reliable emotions.

Though both these models are based on similar principles, these guidelines need to be modified to suit our health care set up. To provide an environment in a municipal or a government hospital may not be possible. The help of a counsellor may not always be available. Our country with its rich and varied heritage and traditions demands a different approach. Language barrier, cultural gap and existing customs do dictate the mode of breaking a bad news. The reactions of the In laws of a female patient may disrupt her social status. The stigmata attached even to a diagnosis of 'Tuberculosis' demands a more direct approach.

### Sharman Approach

I suggest a different approach 'SHARMAN' which in Sanskrit means 'protection' in relation to the "Sharir" (body). SHARMAN is a new concept in breaking the bad news to the patient.

#### A. Setting up

The doctor has to prepare himself for the interview. He has to ascertain the facts and confirm the diagnosis. A verbally conveyed report should not be shared with the patient. Documentary evidence is necessary before the diagnosis is revealed to the patient. Western literature talks about 'dress rehearsal' for the doctor. I feel this is far fetched and not necessary.

A proper environment setup is required. It can be the doctor's cabin or a patient's bed side. A separate interview room is not possible in our hospital set up and is not necessary as well. Make every effort to avoid interruptions. Usually in hospitals or clinics, the patient and relatives are advised to switch off their mobiles. But during such meetings, it is advisable that

**Table 4**

- Setting up
- His knowledge
- Active disclosure
- Reaction
- Modulate
- Attitude
- Next Step

the doctor also does not receive his mobile/landline phone calls.

Ensure that the persons present in the room are the ones which the patient desires.

#### B. Knowledge

Most patients will have some idea about their illness. Ascertain what he knows? by framing certain questions like.

- Have you any idea of what might be wrong?
- How would you describe your illness?
- What tests have you had?

Such questions prepare the patient mentally to accept a diagnosis of the illness. It brings his thinking process in the right direction. It starts involving the patient himself in the further discussions. Moreover it gives an idea to the physician, the extent to which he can reveal the diagnosis.

#### C. Active Disclosure

Now is the time to divulge the information to the patient. The doctor has to understand what information can the patient accept at that point of time. To give information at the patient's pace may mean accurate absorption of the message in manageable chunks. During the talk, the doctor has to take pauses to ascertain how the patient is accepting the information. The silence adds to the necessary creation of an environment. Phrases such as "Am I clear" or 'Are you understanding'? can help the doctor to check for patient comprehension.

**Table 5**

Do's	Don'ts
• Have the facts.	1. Assume patient's knowledge
• Have enough time.	2. Give too much information at one time.
• Clarify what patient knows.	3. Hurry the consultation.
• Observe patient's emotional reactions.	4. Give inappropriate reassurance.
• Check for patient's understanding of what you are saying.	

Avoid being unduly blunt but a definite message needs to be conveyed.

Absolute facts and truth about the diagnosis needs to be revealed to the patient in no uncertain terms.

#### D. Reaction

A patient's reaction to the news may vary. The diagnosis may be unacceptable or unbelievable. The patient may become unruly, abusive or may become mute and unresponsive. Reactions need to be acknowledged and handled in a sensitive way. Simple supportive measure such as touching, a glass of water work in a positive direction. Giving time to react helps in the patient realization and acceptance of the diagnosis.

Sometimes during discussion, patient goes mute. This silence can become very long. The doctor can interrupt it by saying "I guess you need some time to accept" or "You seem to be shocked" etc.

In a busy clinic, a long silence can disturb the routine. It may be advisable to suggest to the patient to sit outside the room for a while then talk to a nurse or an educator when ready. This team approach can be soothing to the patient.

#### E. Modulate

Manage the reactions of the patient effectively. This may involve a repeat explanation regarding the management of the case till then. If the

patient starts blaming the physician, there is no need to accept the blame but allow time for the patient to accept the reality. A counter argument with the patient at this juncture may have a negative impact.

If a patient seems too depressed, the meeting can be postponed to another suitable day.

#### F. Attitude

A physician needs to offer a ray of hope and encouragement to the patient. The patient should not develop a negative thinking. The physician should have an empathetic attitude. It may be prudent to attend to other needs in terms of referrals to other consultants, transfer of patient to another centre.

#### G. Next Step

If the information has gone well with the patient and is in a proper frame of mind, discuss with him what needs to be done further. If a diagnosis is made, what further tests need to be performed? What are the different modes of treatment available?, the duration of treatment and most important in our set up, the cost of treatment are some aspects of further management which need to be discussed.

A patient, when he leaves the cabin should be well informed about the diagnosis and treatment. If not, an assistant doctor or nurse can explain some of the procedures to be followed.

At the meeting itself a time frame should be set up to decide about further course of action. To this effect, a next meeting can be scheduled immediately.

It may be necessary to remember certain Do's and Don'ts.

Despite the challenges involved in breaking bad news, physicians can find satisfaction in providing soothing presence during a patient's time of greatest need. Further research is needed to provide empirical support for consensus based guidelines. But it is accepted that the physicians skills play a crucial role in how well

patient cope with bad news and that patients and physicians will benefit, if physicians are better trained for this difficult task. The fact is that medicine does not offer a cure for every disease situations. Hence these are the situations where professionalism most acutely calls the physician to provide hope and healing for the patient.

## References

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