

Breaking Bad News: A Practical Approach for the Hospitalist

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Communicating bad news to patients and their families is a difficult but routine responsibility for hospitalists. Most practitioners have little or no formal training for this task. Preparation for, delivery of, and follow-up to these conversations should be deliberately planned in order to meet patients' needs. In this article, we review the literature that guides this process and, with a case example, describe steps practitioners can take to effectively deliver bad news and pitfalls that should be avoided. As competency in this skill set is necessary for effective patient care, hands-on training should be part of the core curriculum for all health care practitioners. Hospitalists should be proficient in this area and may serve as role models and instructors for colleagues and trainees. *Journal of Hospital Medicine* 2007;2:415–421. © 2007 Society of Hospital Medicine.

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Broadly defined, bad news is any information that negatively alters a person's expectation about the present and the future.¹ Importantly, news is defined as "bad" based on the patient's perspective about the information. Providers must remember that it will not always be obvious what patients will interpret as bad news. Although all would agree that the diagnosis of a new cancer would qualify as "bad news," to some patients discovering hypertension would be deeply disturbing. Delivering bad news is difficult and stressful to all involved. Substantial data are now available describing patient preferences in these interactions, the impact on physicians who participate in these conversations, and specific recommendations for the delivery of bad news.

Hospitalists face additional challenges: lacking long-standing relationships with patients and dealing with discontinuity in patient care and patient handoffs on a regular basis. Using an actual case as an example, this article examines the patient/family perspective and the provider perspective and reviews practical advice, actual phrases, useful mnemonics, and communication techniques to make these conversations more successful and less stressful. Opportunities to increase training in this area of palliative care are discussed. Adequate preparation, effective communication skills, empathy, and planned follow-up are essential steps to assure that the goals for these difficult interactions are met.^{2,3}

CASE

The following scenario is based on an actual patient. The details and initials have been changed to maintain anonymity.

A 52-year-old Latino man, JR, was admitted with new-onset ascites. He had a known diagnosis of end-stage liver disease from

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prior alcohol use. Paracentesis revealed spontaneous bacterial peritonitis, and appropriate antibiotics were started. The fluid was sent for cytological analysis; the final diagnosis reported adenocarcinoma. A subsequent workup including PSA and CT of the abdomen/pelvis did not reveal the primary site of this malignancy.

JR had a supportive family and an established primary care physician. His spouse was no longer involved in his life, but his 2 daughters provided strong social support. His primary language was Spanish.

During the first 3 days of JR's hospital stay, he developed increasing abdominal pain, requiring escalating doses of narcotics. On the fourth day, the team received the cytology results, and the medical resident discussed the new diagnosis of cancer with JR. This conversation was not supervised by an attending, no interpreter was present, and no family members were in the room.

On entering the room, the resident said to the patient, "I have bad news for you, JR."

The patient turned and said, "Yes...."

The resident continued, "JR, you have cancer, and we don't know where it originated from."

The patient was silent and without expression. Unclear about how to proceed, the resident went on to say, "The oncologist will be coming by later to discuss options with you." As there was no response, verbal or otherwise, the resident exited the room. The resident reported that the patient was unexpectedly calm after the news.

Provider Perspective

The responsibility of breaking bad news to patients weighs heavily on clinicians. As in this case, most providers' first experience with breaking bad news occurs with patients they have known for only a few hours or days. Even for the more experienced, this part of the job is rated as at least moderately stressful. Notably, most also feel that this stress lasts beyond the encounter, despite their perceived ability to manage their own stress during these situations.⁴ Additional training on clinicians' own coping skills may alleviate some of the emotional burden.

Provider's awareness and management of distress may enhance ability to provide comfort to patients or to specifically address their needs. Medical providers may try to suppress personal thoughts and feelings in these situations, but they bring emotional attachments to almost all encoun-

ters with patients.⁵ Emotional preparation by the provider is an important step prior to delivering bad news. Self-reflection helps to identify personal emotions of sadness, anger, fear, or guilt and will help the provider not to disengage from the delivery of bad news.⁶ It is normal to have strong feelings, especially in difficult situations. Encouraging and validating these emotions personally will lead to a more therapeutic presence during a patient's time of need.⁷

Clinicians' perceptions of their interactions with patients when discussing bad news are probably more strongly influenced by the content of the discussion rather than the process itself. When asked to analyze their own videotaped consultations, doctors thought performance was worse when discussing palliative therapy than when discussing curative therapy.⁸

Traditionally, greatest emphasis has been placed on the acquisition and assessment of medical knowledge in medical training, and thus the focus on content is understandable. But more recently, efforts have been made at all levels of medical education to shift this focus toward encompassing many other competencies including professionalism and communication skills, which should translate into equal emphasis on the quality of these interactions.

As many hospitalists work closely with trainees, they are in the ideal position to serve as mentors and role models for communication. The case discussed in this article provides an example of a missed teaching opportunity. Ideally, the attending would have gone through the steps of preparation with the resident prior to the meeting, reviewed one or several of the suggested approaches discussed below, and observed the conversation and provided immediate feedback and a forum for processing afterward. It is especially helpful when first developing this skill to be familiar with helpful phrases to open the conversation, clarify patient preferences for communication, and convey empathy. It is also helpful to be aware of phrases that should be avoided (Table 1).

CASE

The following morning the attending physician, medical resident, and oncology fellow met with the patient and his daughter for a more extensive discussion. The goals of this discussion were to review the diagnosis and discuss the prognosis and future

TABLE 1
Phrases to Consider and Phrases to Avoid

Phrases to consider
<i>To start a conversation</i>
“I am sorry to have to tell you this.”
“I know this is not good news.”
“I wish I had better news.”
<i>To elicit patient preferences</i>
“Would you like your family here when we talk about this?”
“Would you rather I speak with you about this or your daughter?”
“Some people want to be very involved in making decisions about their medical care, and some people want their doctor to just give them a recommendation—how do you feel about that?”
<i>To facilitate empathy</i>
“I can see how upsetting this is.”
“Is it okay if I hold your hand?”
Phrases to avoid
“There is nothing more we can do for you.”
“I know what this must be like.”
“I understand what you are going through.”

approaches to care. The entire discussion was conducted via a professional Spanish interpreter.

The attending physician began the conversation by asking, “What do you remember about what the resident doctor told you, JR?” pointing to the resident.

JR replied, “I don’t remember,” and then went on to say, “Please talk to my daughter,” who was sitting across the room.

Family/Patient Perspective

As patient preferences for receiving bad news vary widely, it is these preferences that should determine the approach to the delivery, content, and context in which the news will be received. Some patients want information, and some do not; this needs to be clarified before beginning the discussion. The amount of detail should be negotiated in advance as well. As suggested by Back et al., soliciting patient preference prior to a discussion is important.⁹ These authors recommended using an approach called “ask–tell–ask.” This approach emphasizes the importance of asking questions to assess a patient’s needs, telling the patient the information that meets those needs, and asking again to assess the patient’s understanding.

Patients will rarely raise the issue of bad news with providers. In general, the provider must initiate the discussion.¹⁰ Surveys of patient preferences

for delivery of bad news lend insight into this process and help guide providers during this challenging time. Patients report poor delivery is often characterized by bluntness, a lack of hope, and initiation of this serious conversation at an inappropriate time or place.¹¹ Patients prefer providers to speak in clear, simple terms, being careful not to use technical jargon.¹² Clinicians often use euphemisms to soften the blow of bad news, but this can lead to ambiguity. In addition to the clarity of the message, privacy, the attitude of the doctor, and the ability to answer questions are most important to patients and families receiving bad news.¹³ Although most would encourage touching in these difficult situations, it has been reported that up to a third of patients surveyed do not want physical contact.

Contrary to what providers may believe, diagnostic disclosure is not the most important part of a bad-news discussion. Many patients believe it is most important to receive information on prognosis and treatment options. Often, patients want to discuss life expectancy. However, physicians are hesitant to address this issue. One study revealed that despite these requests, 22% of physicians would not provide any estimates at all, and when they did, 36% offered an overestimate.¹⁴ The authors hypothesized that how confident physicians are in this prognostic estimate and how much and what type of practice experience they have may influence their willingness to communicate a frank survival estimate.

The traditional dilemma of balancing hope with realism is reframed by Hagerty et al., who found that 98% of the patients they surveyed preferred a realistic and individualized approach.¹⁵ Use of euphemism and apparent unease of the provider actually decreases hope. Clayton et al. added that nurturing hope can also be facilitated by emphasizing what can be done, such as symptomatic management, emotional support, and practical support, particularly in terms of day-to-day living.¹⁶

In the case discussed in this article, preparation should have included asking the patient (1) whom he wanted present during the meeting, (2) how much information he and his family wanted to know, and (3) how involved he wanted his family to be. The informational needs of patients and their families will evolve over time as they process and accept the news. Thus, the ask–tell–ask approach remains a key concept to keep in mind as the dialogue continues beyond the initial encounter.

CASE

The attending physician attempted to continue the discussion by addressing both patient and daughter. He restated, "JR, you have cancer in the fluid in your belly, and it is likely widespread throughout your body."

At that moment, the daughter became very tearful and emotional. There were several minutes of silence. The patient began to sob as well. The oncology fellow broke the silence by adding, "Unfortunately, there is nothing that can be done when cancer is so widespread." The daughter broke into audible sobs; the patient looked away from the team and gazed through the window into the distance. The team fell silent and quietly left the room.

Importance of Empathy

The team failed in its inability to respond to emotion in this case. The emotional turmoil was apparent, but the team members made no attempt to acknowledge this emotion or to arrange additional emotional support. This could, at least in part, be a result of the providers' inability to process and manage their own emotions. A preparatory meeting beforehand and a debriefing session afterward for all the team members may have helped. Awareness of patients' coping strategies and various effective responses to these coping strategies may have better prepared the team to react and validate this patient's emotions. The role that psychology and emotion play cannot be overemphasized and clearly are important considerations. A useful mnemonic highlighting the components of the empathetic response is NURSE: naming, understanding, respect, supporting, and exploring.⁹ Using this technique, the provider starts by naming the emotion (anger, fear, disbelief); confirms a clear understanding of the patient's feelings; expresses respect verbally or nonverbally, letting the patient know the emotion is important; uses supporting statements that may express concern, reiterate understanding, or indicate a willingness to help; and closes by exploring additional concerns.

Certain phrases such as the one uttered by the fellow—"...There is nothing that can be done"—should be avoided.

Cultural Issues

Cultural diversity is increasingly common in contemporary medical practice in the United States. Some have suggested the Western value of auton-

omy is not embraced by all cultures. It has been suggested that non-English-speaking patients may receive less optimal end-of-life care than their English-speaking counterparts.¹⁷ Beyond the language barrier, this observation may be a reflection of associated cultural barriers as well. Effective strategies for key issues of truth telling, language, family involvement, and decision making may help effective cross-cultural communication and understanding and thus be effective patient-centered care.¹⁸

A study of Korean patients and family members revealed a marked discordance between family and patients in the desire for disclosure.¹⁹ Almost all patients wanted to be informed that they had terminal illness, whereas a quarter of family members did not want physicians to relay this bad news to the patient. Interestingly, this study found patients would prefer to be told by the physician, whereas their family members would prefer to be the ones to deliver the news.

In some cultures it is believed that disclosure of bad news may cause patients to lose hope and hasten death. Physicians in these cultures may be more likely to honor family wishes. Language barriers may make a difficult situation even more complex. It is important to ascertain early on in what language patients and their families want to hold discussions. A medical interpreter should always be utilized for discussions with patients and their families. Dependence on a family member to interpret is not advised because the objective point of view may be lost in the interpretation. In addition, this places an enormous burden on the family member to be the "bearer of bad news," which could have a lasting emotional impact. Although in the case discussed in this article, the patient's daughter was bilingual and could have translated, an interpreter should have been present for all discussions with this patient. Again, the importance of soliciting the patient's preference is critical.

Prior knowledge of the language requirement and of the patient's need for his daughter's involvement would also aid in the planning process. Because the patient's primary care physician (PCP) shared JR's Hispanic heritage, consultation with this PCP might have provided important insight, resulting in better preparation and planning.

TABLE 2
SPIKES 6-Step Approach to Delivering Bad News

Setting up interview	Maintain privacy, involve significant others, sit down, make a connection, minimize interruptions.
Assessing patient perceptions	"What have you been told about your illness?"
Obtaining patient's invitation	"How would you like me to give the information about your test results?"
Giving knowledge and information to patient	Begin with warning statement, avoid jargon, avoid excessive bluntness.
Addressing patient's emotions	Listen, observe, acknowledge the emotion.
Providing strategy and summary	Give prognosis and treatment options and address symptoms.

How to Deliver Bad News

A number of guidelines are available to help physicians structure their conversations.^{20–22} Baile and Buckman outline a 6-step approach (Table 2). Rabow and Mcphee recommend the ABCDE mnemonic to help providers remember techniques for delivering bad news (Table 3). These recommendations are largely based on the literature to date. Both these approaches first emphasize preparations and planning. A private and quiet space, the presence of significant others if desired, arrangement to minimize interruptions, and provider emotional preparations are all prerequisites for the success of this type of encounter before the actual dialogue begins. As the encounter begins, it is key to assess a patient's needs if not already done before conveying information. Unidirectional transfer of information most likely will fail to satisfy the patient. The resident's initial conversation suffered in this key aspect.

Armed with knowledge of a patient's individual preferences, it is then possible to effectively convey information in a clear manner without jargon, using a direct but not blunt style. Both the SPIKES and ABCDE approaches similarly emphasize the ask-tell-ask approach. The attending physician was fairly effective in applying this communication approach in the subsequent encounter. However, the team left the room without providing a summary and follow-up plan. Even though the patient and his daughter were quite emotional, acknowledging their reactions and appropriately ending the meeting with a summary and plans for the next steps would have been helpful in this continuing dialogue.

Hospitalist-Specific Issues

Hospitalists may face special challenges when delivering bad news to patients. Without the benefit of preexisting longitudinal relationships with their patients, they lack prior understanding of a

patient's values, family support system, and other cultural, spiritual, and social issues. Thus, preparation for these conversations is more difficult, and establishing rapport is more time-consuming. There are no data available to describe the impact that not having a previous relationship with a patient has on these encounters. It is possible that the newness of the hospitalist-patient relationship may allow more candid, transparent communication than would be possible with established providers, who may themselves be struggling with the news and how it reflects on their care or the emotional impact of the impending loss.

Handoffs are a frequent part of the care the hospitalist provides, but communicating bad news is often a longitudinal process. One hospitalist may have the initial conversation regarding the patient's disease and prognosis, but the follow-up often falls to a different hospitalist. Continuity of communication and awareness about what has been said previously are critical. It is important to explicitly document these conversations and their content in the medical record. In addition, summaries of pivotal conversations should be included in sign-out. At discharge, whether patients are transitioning to post-acute care or back to the outpatient arena, the hospitalist should carefully and vigilantly communicate critical conversations and predictions about patients' emotional needs.

Hospitalists do have some advantages when it comes to communication with patients. Unlike in outpatient practice, where clinicians are under pressure to keep up with a heavily loaded patient schedule, the hospitalist often has the flexibility and ability to allot time to each patient according to that patient's need. In addition, by definition, a hospitalist is in a hospital; this availability allows for more timely meetings, minimal delay in delivery of news, and accommodating the schedules of other people the patient may want included in any conversations.

TABLE 3
Techniques for Delivering Bad News Well: ABCDE

Advance preparation

Ask what the patient already knows and understands.
Arrange for the presence of a support person and appropriate family.
Arrange a time and place that will be undisturbed (hand off beeper).
Prepare emotionally.
Decide which words and phrases to use (write down a script).
Practice delivering the news.

Build a therapeutic environment/relationship

Arrange a private, quiet place without interruptions.
Provide adequate seating for all.
Sit close enough to touch if appropriate.
Reassure about pain, suffering, abandonment.

Communicate well

Be direct ("I am sorry, I have bad news).
Do not use euphemisms, jargon, or acronyms.
Do say "cancer" or "death."
Allow for silence.
Use touch appropriately.
Ask patient to repeat his or her understanding of the news.
Arrange additional meetings.
Use repetition and written explanations of reminders.

Deal with patient and family reactions

Assess patient reaction —
Physiologic responses: flight/fight, conservation/withdrawal;
Cognitive coping strategies: denial, blame, intellectualization, disbelief, acceptance;
Affective responses: anger/rage, fear/terror, anxiety, helplessness,
hopelessness, shame, relief, guilt, sadness, anticipatory grief;
Listen actively, explore feelings, express empathy.

Encourage and validate emotions

Correct distortions.
Offer to tell others on behalf of the patient.
Evaluate the effects of the news.
Explore what the news means to the patient.
Address further needs, determine the patient's immediate and near-term plans,
assess suicidality.
Make appropriate referrals for more support, provide written materials,
and arrange follow up.
Process your own feelings.

CASE

A subsequent meeting occurred between the patient, his daughter, and the team, this time including a social worker and a hospice nurse.

The social worker began this discussion by stating, "I understand you were quite upset last time and understandably so," and then inquired, "What questions can we help you answer?"

The patient and his daughter appropriately asked about alternatives to the usual aggressive treatment, and he made clear his desire to eventually spend his last days at home with family.

Through the translator, the hospice nurse succinctly explained the concept of palliative care with emphasis on symptomatic management as an alternative to aggressive curative therapy. JR and his daughter chose this palliative approach to care. This decision to focus on palliation was conveyed to JR's PCP. JR was eventually discharged to a short-term postacute facility for rehabilitation and palliative care.

The health care team was finally able to acknowledge and validate JR's emotions with the help of the additional expertise of a social worker and a hospice nurse. This multidisciplinary approach allows team members to complement each other's strengths and weaknesses. Further, the patient had time to process his feelings and articulate his questions, values, and desires. Time often is required for this type of news to be more fully understood and eventually accepted. Breaking bad news is not a single event but a continuing dialogue and ultimately a relationship. Thus, proper delivery of bad news not only requires planning, effective communication, and empathy, but also deliberate follow-up.

Training

What can be done to improve the effectiveness and satisfaction of these interactions for patients, providers, and families? Awareness of guidelines and effective strategies is a start but is unlikely to really change behavior or improve skills. Communication skills must be practiced, implemented, and observed with opportunity for feedback.²³ Graduate and postgraduate training is probably the best time to develop these skills, and formal training in this area should be incorporated in a curriculum. Workshops on communicating bad news are offered frequently to oncologists and oncology fellows at various regional and national meetings. Ideally, these workshops would be offered at CME meetings specifically designed for hospitalists already in practice. Comprehensive palliative care training and materials, including specific modules and live workshops for delivering bad news, are available via the Education in Palliative and End-of-Life Care Project (EPEC) and the End-of-Life/Palliative Education Resource Center (EPERC) at the University of Wisconsin.

Hospitalists and trainees fortunate enough to

practice in an institution with a palliative care service have the opportunity to learn from a multidisciplinary team, often including social workers, nursing staff, physicians and spiritual leaders. This interdisciplinary model is likely a more effective way to address the diverse physical, emotional, social, and spiritual needs of patients receiving difficult news and provides an ideal framework for this training.

CONCLUSIONS

Hospitalists are frequently called on to deliver bad news. A specific skills set is needed to be an effective communicator, especially in these stressful situations. Familiarity with an evidence-based approach to this process and incorporation of the key steps into each of these encounters will likely improve patient and provider satisfaction as well as patient care during these critical times. Patient and family preferences for communication vary; so communication should be adjusted for each patient using the ask-tell-ask approach. Providers must remember to respond empathetically to emotion expressed by the patient and family and should keep the NURSE mnemonic in mind to guide the discussion. Providers should seek hands-on training opportunities, which include supervision and feedback. Medical educators should incorporate training on the communication of bad news into curricula for students and trainees. Hospitalists may take a leadership role in teaching these skills at their institutions.

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REFERENCES

- Buckman R. Breaking bad news: why is it still so difficult? *BMJ*. 1984;288:1597-1599.
- Quill, TE, Townsend P. Bad news: delivery, dialogue, and dilemmas. *Arch Intern Med*. 1991;151:463-468
- Rabow, MW, McPhee SJ. Beyond breaking bad news: how to help patients who suffer. *WJM*. 1999;171:260-263.
- Ptacek JT, Fries EA, Eberhardt TL, Ptacek JJ. Breaking bad news to patients: physicians' perception of the process. *Support Care Cancer*. 1999;7:113-120.
- Baile, WF, Beale, EA. Giving bad news to cancer patients: matching process and content. *J Clin Oncol*. 2001;19:2575-2577.
- Rabow, MW, McPhee, SJ. Beyond breaking bad news: how to help patients who suffer. *West J Med*. 1999;171:260-263.
- Vanderkrieft, GK. Breaking bad news. *Am Fam Physician*. 2001;64:1975-1978
- Fallowfield LJ, Jenkins VA, Beveridge HA. Truth may hurt but deceit hurts more: communication in palliative care. *Palliat Med*. 2002;16:297-303.
- Back AL, Arnold RM, Baile WF, et al. Approaching difficult communication tasks in oncology. *CA Cancer J Clin*. 2005; 55:164-177.
- Lee SJ, Back AL, Block SD, Stewart, SK. Enhancing physician-patient communication. *Hematology Am Soc Hematol Educ Program*. 2002;464-483.
- Wenrich MD, Curtis JR, Shannon SE, Carline JD, Ambrozy DM, Ramsey PG. Communicating with dying patients within the spectrum of care from terminal diagnosis to death. *Arch Intern Med*. 2001;161:868-874.
- Lobb EA, Butow PN, Kenny DT, Tattersall MH. Communicating prognosis in early breast cancer: do women understand the language used? *Med J Aust*. 1999;171:290-294.
- Jurkovich J, Pierce B, Pananen L, Rivara F. Giving bad news: the family perspective. *J Trauma*. 2000;48:865-870
- Lamon, Christakis NA. Prognostic disclosure to patients with cancer near the end of life. *Ann Intern Med*. 2001;134: 1096-1105.
- Hagerty RG, Butow PN, Ellis PM, et al. Communicating with realism and hope: incurable cancer patients' views on the disclosure of prognosis. *J Clin Oncol*. 2005;23:1278-1288.
- Clayton JM, Butow, PN, Arnold RM, et al. Fostering coping and nurturing hope when discussing the future with terminally ill cancer patients and their caregivers. *Cancer*. 2005; 103:1965-1975.
- Chan A, Woodruff RK. Comparison of palliative care needs of English and non-English-speaking patients. *J Palliat Care*. 1999;15(1):26-30
- Kagawa-Singer M, Blackhall LJ. Negotiating cross-cultural issues at the end of life. *JAMA*. 2001;286:2993-3001
- Yun YH, Lee CG, Kim S, Lee S, Heo DS, Kim JS. The attitudes of cancer patients and their families towards disclosure of terminal illness. *J Clin Oncol*. 2004;22:307-314.
- Girgis A, Sanson-Fischer RW. Breaking bad news: consensus guidelines for medical practitioners. *J Clin Oncol*. 1995;13: 2449-2456
- Baile WF, Buckman R, Lenzi R, et al. SPIKES—a six step protocol for delivering bad news: application to the patient with cancer. *Oncologist*. 2000;5:302-311
- Rabow MW, McPhee SJ. Beyond breaking bad news: how to help patients who suffer. *West J Med*. 1999;171:260-263
- Fellowes D, Wilkinson S, Moore P. Communication skills training for health professionals working with cancer patients, their families, and/or carers. *Cochrane Database Syst Rev*. 2003;2:CD003751.