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Breaking bad news to patients: physicians' perceptions of the process

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Abstract The goal of this investigation was to gain a better understanding of the processes associated with communicating bad news to patients. A convenience sample of 38 physicians recalled a time when they delivered bad news and then answered a series of questions about what transpired. Data were also obtained about how well they thought the transaction had proceeded, how much stress they had experienced, and what they thought the experience was like from the patient's perspective. The majority of physicians reported following most of the published recommendations for delivering bad news. However, the number of recommendations followed was not correlated with self-reported stress and effectiveness in news delivery or with physicians' estimates of patients' distress. The number of recommendations followed could not be accounted for by the closeness of the relationship between physician and patient or by the gender composition

of the bad news encounter. Overall, physicians reported that the transaction was moderately stressful for themselves, that the stress lasted beyond the recalled transaction, and that they were effective in delivering the news in a way that reduced patient distress. These findings suggest that the sampled physicians are generally following a substantial number of published recommendations when delivering very stressful news to patients. The primary weaknesses in the delivery process occur while preparing for the encounter. The fact that many of the physicians reported that their stress lasted beyond the transaction itself suggests that training in the delivery of bad news should include guidance on cognitive and behavioral coping strategies to help physicians deal with their own discomfort.

Key words Bad news ·
Communication · Stress ·
Effectiveness

Introduction

One common experience among physicians is that of communicating bad news to patients and families. A series of recent publications on the topic is evidence of the interest researchers and clinicians have in obtaining a better understanding of the bad news process [14, 25]. Knowing what transpires in such transactions, how stressful they are, and whether these transactions have lasting emotional or physical effects is important to both the individuals receiving the news and the medical staff delivering it. Unfortunately,

the bad news literature has been dominated by articles that make recommendations about what should be done, with few or no data presented about what is done. The primary goal of this investigation was to document what physicians recall doing when communicating medically related bad news to patients or families.

Importance of the transaction

There is little doubt that receiving bad news about one's health or the health of a loved one represents the begin-

ning of a potentially stressful time in one's life. Additionally, receiving the news can itself be stressful [13]. Concern about how best to transmit such news emanates from the belief that not only might the content and style of news transmission serve to decrease long-term receiver distress, but that differences in content and style may account for different stress perceptions related to the transaction itself. Moreover, for some types of news delivered by workers in some clinical specialties, the bad news transaction may represent the beginning of a potentially lengthy relationship between the receiver and physician. It is likely that subsequent patient–physician interactions (and the overall quality of the relationship) will be colored by perceptions of the initial interaction.

From the physician's perspective, bad news transactions are potentially stressful, recurring events that have been shown to relate to physicians' well-being [4, 17]. The stress associated with a given transaction may influence subsequent interactions between that particular physician and other patients [28]. The challenge for physicians, it seems, is to communicate news in ways that are beneficial to the recipient – or at least cause no additional harm – and yet do not negatively influence the doctors themselves or other patients.

Current physician recommendations for providing bad news

According to recent reviews of this topic [14, 25] there are several important aspects of communicating bad news.

1. Provide a private and comfortable place in which to break the news.
2. Ensure that the timing of the transaction is appropriate.
3. Identify a patient's support network and have some member or members of it present.
4. Give the news in person while sitting close to the patient.
5. Prepare the patient for the news.
6. Find out how much the patient already knows.
7. Present the news in a thoughtful and caring way.
8. Show respect and empathy for the patient.
9. Use simple, non technical language without euphemisms.
10. Break the news at the patient's pace.
11. Explore patients' reactions and allow them to express emotions and ask questions.
12. Convey some measure of hope with the news.
13. Summarize the important information.

There are few examples in the literature of patients' and families' reports about their likes and dislikes regarding the way in which bad news was delivered [7, 24]. Published reports, however, suggest that patient preferences converge with the recommendations made by physicians [10, 14, 18, 24]. Specifically, patients prefer that the transaction occurs in a private and quiet location, that the news

is delivered in person, and that it is communicated at their own pace, free of jargon, and with some measure of hope. Receiving documentation at the conclusion of the transaction is also important [14, 24]. Despite the face validity of many of the recommendations offered by physicians and patients about communicating bad news, one outstanding feature of the majority of published work on the topic is that it is largely devoid of information about what physicians actually do during such transactions with real patients.

The bad news transaction as a process

An additional limitation of the medical literature on communicating bad news is a general lack of attention to the process-oriented qualities of such transactions. For physicians, the transaction itself occurs in the context of other job-related experiences and, perhaps, in the context of an ongoing relationship with the patient. How these contextual variables relate to what transpires while delivering bad news has yet to be adequately explored. For example, having given similar news in the past may make it easier to give news in the present. Repeated news delivery, alternatively, may result in delivery styles that protect the physician from emotional harm, while being less than optimal from the patient's perspective. Physicians and patients who have had lengthy relationships prior to the news are engaging in a specific interaction that is embedded in a history of other interactions.

The process of delivering bad news includes more than just the interaction with the patient or family. It also includes the strategies physicians use to prepare for the transaction and the steps they take following the transaction to reduce their own discomfort and to further assist the receiver of the news [9, 26]. Moreover, what transpires at one point in the transaction will impact on what happens later in that same transaction and on how subsequent behaviors are interpreted by both the physician and the patient.

To begin capturing the complexity of the bad news process in an empirical way, research is needed that assesses what transpires across the duration of such transactions. To obtain information about what physicians do – as opposed to what they should do – when delivering bad news, we asked physicians to respond to numerous questions about a time when they delivered bad news to a patient or family member. Questions were included that would not only allow us to assess what transpired while the physicians were preparing for and delivering the news but would also allow us to assess factors that may have impacted on what transpired (e.g., a physician's current experiences and past history of delivering bad news and a physician's relationship with the patient). We also obtained information about how stressful physicians thought these transactions were and about their perceptions of the patients' experiences. These self-report data allowed us to examine what typically happens in bad news transactions

(and compare what typically happens to what physicians recommend should happen), to explore the associations between what transpired and stress perceptions, and to assess whether factors external to the transaction itself relate to what transpired.

Subjects and method

Participants

The participants were 38 physicians from three clinics in the Midwestern and Eastern United States. The majority of physicians were male (82%) and Caucasian (90%). The average age of the sample was 45.42 years (SD 8.25 years). Seventy-five percent of the sample identified themselves as belonging to one of the following specialties: oncology, internal medicine, or family practice. The remaining 25% represented a variety of other clinical specialties, most notably surgery.

Procedure

Physicians whose specialties might involve oncology-specific issues, or who had referred patients for cancer-related treatment, were contacted in person by one of the authors and were invited to participate in a study on communicating bad news. As part of this invitation, the nature and goals of the project were explained. Those physicians willing to participate were given a survey to be completed and returned at their leisure. Because surveys were not completed in the presence of a researcher and because all data were anonymous, return of the survey served as implied consent.

Materials

Delivery of bad news

To assess physicians' recollections about the delivery of bad news, we generated 72 statements designed to assess distinct facets of the bad news process, which were subsumed under four main headings: (1) the life experiences of the physician, (2) the nature of the relationship between physician and patient, (3) preparation by the physician for delivery, and (4) delivery. Our goal in generating these items was to be overinclusive, allowing us to obtain the richest self-reported account possible of the bad news process. Items were drawn from an extensive review of the medical literature [25] and our interviews with physicians, nurses, and patients. During the latter stages of statement generation, several physicians and a cancer support group examined the survey and were invited to make comments about any additions needed and possible deletions.

Physicians in this study were asked to recall, and describe on a cover sheet, a time when they communicated medically related bad news to a patient. With that particular transaction in mind, physicians indicated whether each statement was true of the recalled transaction and then indicated the extent to which the behavior described in the statement made the news harder to deliver (ranging from 1=much harder, through 4=no impact, to 7=much easier). Because these difficulty ratings proved to be confusing, particularly when items were "false" with respect to the recalled transaction, and because a notable portion of the sample did not complete these ratings for all items, we elected to focus only on whether the statement was endorsed as "True" or as "False."

Stress and effectiveness perceptions

We obtained reports about the stress/anxiety experienced by the physician during preparation and during bad news delivery (ranging

from 1=none to 5=a great deal) and an estimation of the length of time the physician's stress lasted (ranging from 1=until the transaction ended to 5=more than 3 days). Physicians also rated how effective they thought they were at delivering the news in a way that reduced their own distress as well as the distress of the receiver (ranging from 1=not at all to 5=very much). Physicians reported on their perception of the stress experienced by the receiver (ranging from 1=none to 5=a great deal) and also provided ratings of the stress that they thought the news caused for the patient in eight life areas: family, friends, romantic relationships, other social interactions, school, health, work, and finance; other types of stress were all subsumed under other.'

Results

Our intent in analyzing these data was to answer four questions. First, what typically transpires in bad news transactions? This question was addressed by focusing on those statements that 80% or more of the sample endorsed in a given way. Second, how stressful are these transactions for physicians and how effectively do they believe they handle them? This question was answered merely by examining the response patterns to several survey questions. Third, can individual differences in the number of statements endorsed in the preparation section of the survey and the number of positive statements endorsed in the delivery section of the survey predict either stress or effectiveness perceptions? This question was addressed via correlational analyses, following the construction of preparation and delivery summary scores designed to capture the quality of physicians' efforts at communicating the news. Finally, can delivery and preparation summary scores be predicted by situational or interpersonal factors? Here we conducted a series of independent group *t*-tests.

Over 75% of those individuals who agreed to participate returned completed packets. Of those returning packets, 87% reported having given news directly to a patient, while an additional 13% reported having given news to parents or families. Seventy-nine percent of the sample recalled news that had been given within the preceding 4 weeks.

Ninety-two percent of the sample reported giving cancer-related bad news, including the initial diagnosis of cancer, the recurrence of cancer, the lack of responsiveness to treatment, and the imminence of death associated with the cancer. Three physicians (8% of the sample) gave news involving kidney failure or informed patients or families of impending death (without specifying the cause on the questionnaire).

The typical bad news transaction

In an attempt to describe the typical transaction, we focused on those statements for which 80% or more of the sample made the same response (e.g., either indicated that the statement was "True" with respect to the recalled transaction or indicated that the statement was "False" with respect to the recalled transaction). These statements

Table 1 Statements to which 80% or more of the sample endorsed a given response (either 80% “True” or 80% “False”)

Life experiences	I knew of other people who had given similar bad news.
	I could have done something to prevent this situation from occurring. ^a
Relationship	I was in part responsible for bringing about the news I delivered. ^a
	I have given other bad news at least once in the past.
	I believed I was the proper person to give the news.
	I respected the person to whom I delivered the news.
	I was an authority figure to the person receiving the news.
Preparation	At the time I delivered the news, I believed the receiver trusted me.
	I believed I was respected by the person receiving the news.
	I knew that the person receiving the news would be able to turn to me for help and guidance after the news was delivered.
	I talked to others about how to best deliver the news. ^a
Delivery	I thought the receiver would consider this to be bad news.
	I feared being blamed by the receiver. ^a
	I thought about the needs of the receiver prior to the transaction.
	I tried to prepare myself for the receiver’s response.
	I tried to use direct, simple language while giving the news.
	I tried to take into account what the receiver already knew about the situation the bad news entailed.
	I tried to break the news such that the receiver understood the news and its implications.
	As I delivered the news, I tried to convey some measure of hope.
	I tried not to rush through the news.
	I delivered the news in person.
	I thought I was believable when I gave the news.
	I took into account the personality and emotionality of the receiver when I delivered the news.
	I tried to ease the tension in the situation by using humor. ^a
	I gave the receiver an opportunity to express his/her feelings while the news was being delivered.
	I tried to choose my words carefully when delivering the news.
	I sat close to the receiver.
	I gave the receiver a chance to ask questions.
I tried to deliver the news in a warm and caring manner.	
I let the receiver know in words that bad news was forthcoming.	
I kept myself from showing how I was truly feeling during the interaction. ^a	
Someone accompanied me while I gave the news. ^a	
I gave the news in a quiet place.	
The place where I gave the news was comfortable.	
The receiver took the news harder than I expected. ^a	
I had the ability/knowledge to answer questions that the receiver asked.	
I thought about my own needs during the interaction. ^a	
As I was giving the news, it was clear that I was blamed by the receiver. ^a	
Rather than sticking to a plan, I allowed the receiver’s reaction to dictate the flow of the transaction.	
I tried to empathize with what the receiver was asked.	
I gave the news in private.	
I thought about the needs of the receiver during the interaction.	
I pressured the receiver to respond in a certain way during the interaction. ^a	

^a 80% or more of the sample indicated that the item was “false” in relation to the recalled transaction

are listed in Table 1 and are organized according to the stage of the process during which they occurred. When their statements were compared with the list of suggestions presented earlier, these physicians reported following much of the advice that has appeared in the medical literature. In the typical transaction physicians gave the news in a private and comfortable place, gave the news in person while sitting close to the patient, prepared the patient for the news, attempted to find out what the patient already knew, presented the news thoughtfully and with empathy, used simple language, proceeded at the patient’s pace, explored the patient’s feelings, and conveyed hope.

Several statements were not included in the typical transaction that, based on recommendations appearing in

the medical literature, perhaps should have been. Physicians *did not* identify members of the patient’s support network and suggest that they be present, make a plan of action, develop a script, consult with other physicians, or think about their goals for the transaction. In addition, using nonverbal cues to let the receiver know that bad news was forthcoming, letting the other events in the receiver’s life influence how the news was delivered, and having someone accompany the physician as she or he delivered the news were also not included in the typical transaction. Stress and effectiveness perceptions

We next examined the effectiveness, stress, and anxiety perceptions of the physicians by conducting a series of de-

Table 2 Means, standard deviations, and ranges for the major study variables. The preparation and delivery quality scores were based on 14 items and 30 items, respectively. In all cases, higher scores represent more of the construct being measured. (*Patient life stress* physician's ratings of how much stress the news would cause in each of eight life areas)

	M	SD	Range	Possible range
Physician perception of patient stress				
During delivery	4.08	0.88	2–5	1–5
Patient life stress	30.37	9.86	4–45	0–45
Physician stress				
While preparing	2.83	1.08	1–5	1–5
During news delivery	2.95	0.94	1–5	1–5
Time stress lasted	2.64	1.07	1–5	1–5
Transaction				
Preparation summary score	7.79	3.14	2–14	0–14
Delivery summary score	25.76	1.58	22–29	0–30
Effectiveness at lowering own distress	3.79	0.84	2–5	1–5
Effectiveness at lowering patient distress	3.58	0.92	2–5	1–5

scriptive and correlational analyses. Means, standard deviations, and ranges can be found in Table 2. Stress recalled during preparation and stress recalled during delivery were, on average, below the midpoint (“Some”) on their respective scales. However, a notable percentage (30.6%) of the sample recalled preparation-specific stress as being above the midpoint on that scale. In addition, 29.7% of the sample rated the stress associated with delivery as above the midpoint on that scale. Regarding the length of time stress was perceived to last for the physicians, 86% of the sample indicated that their own stress lasted beyond the transaction, with 20% of the physicians indicating that the stress lasted for more than a day.

In terms of lowering their own distress level, the mean effectiveness rating was above the midpoint on the scale, and the median effectiveness rating equaled 4.00 on the 5-point scale. Descriptive statistics also suggest that on average physicians believed that they were effective in delivering the news in a way that lowered the discomfort of the receivers. The mean and median (again median equaled 4.00) scores on this variable were above the midpoint on the scale, and the modal response was a 4.00. Overall, physicians perceived that patients experienced stress while the news was delivered, with 71.1% of physicians entering either a 4 or a 5 on the 5-point rating scale. All physicians indicated that patients experienced at least some stress while the news was being delivered. Although there was a considerable range in perceptions (from a low score of 4 to a high score of 45), on average physicians reported that the condition they disclosed to patients caused a substantial amount of stress in the patients' lives.

Predicting stress and effectiveness ratings from other study variables

One goal of this investigation was to examine the associations between what physicians do when delivering bad news and certain stress and effectiveness appraisals. However, given the large number of statements to which physicians responded, the true-false response scales employed, and the relatively small sample size, focusing analyses at the individual statement level was inappropriate. We therefore created two transaction-specific scores: one based on

the preparation statements and one based on the delivery statements. Our intent in creating these scores was to identify transactions for which physicians were more or less well prepared and during which physicians made use of a greater or smaller number of positive strategies while delivering the news.

Of the 19 preparation statements, 14 involved actively planning for the upcoming transaction and were thus used to compute the preparation score. In constructing the delivery summary score we focused on those behaviors, thoughts, and feelings that, based on recommendations appearing in the medical literature or on common sense, should have been associated with more effective news delivery from the *receiver's* perspective. Six of the 36 statements were excluded because it was unclear whether engaging in the behavior described by the statement would generally be perceived positively (or negatively) by the patient (e.g., “I struggled to find the right words” or “The receiver took the news harder than expected”).

Table 2 includes the means and standard deviations for these two summary scores, under the “Transaction” sub-heading. Regarding preparation, the mean (7.79) number of statements endorsed was at the midpoint of the possible range of scores. The range of statements endorsed (2–14) suggests that some physicians prepared quite thoroughly while others did not. On average, physicians endorsed in the more effective direction over 80% of the delivery statements. The mean number (25.76) endorsed, which was well above the midpoint on the scale, combined with the relatively small range (22–29) suggests that these physicians reported engaging in many potentially effective strategies while delivering the news in the transaction they selected.

Table 3 displays correlations among the study variables. Those physicians who recalled transactions that had occurred in the more distant past also reported that the delivery of the news was more stressful. As would be expected, physicians' stress scores were moderately to strongly interrelated. Specifically, more stress experienced during preparation was associated with more stress during delivery, each of which was associated with stress that lasted longer. Physicians who reported experiencing more stress at each stage of the transaction and those who reported stress that lasted longer also tended to believe that

Table 3 Correlations among major study variables (*Length* rating of time since the news delivery, on a scale ranging from 1 within the past week to 4 more than 6 months ago); all ratings were provided by physicians

Item	1	2	3	4	5	6	7	8	9	10
1. Length	–	0.16	0.35 *	0.32	–0.01	0.(16)	–0.11	0.19	–0.10	–0.12
2. Stress preparation		–	0.78 **	0.53 **	–0.03	–0.01	0.57 **	–0.01	0.46 **	0.20
3. Stress delivery			–	0.74 **	–0.08	–0.06	0.53 **	0.15	0.43 **	0.01
4. Duration of stress				–	–0.02	0.06	0.40 *	0.24	0.21	–0.001
5. Lower self stress					–	0.58 **	0.02	0.28	–0.16	–0.11
6. Lower receiver stress						–	–0.12	0.18	–0.24	0.08
7. Receiver stress							–	0.33 *	0.26	–0.03
8. Receiver life stress								–	–0.17	–0.07
9. Preparation summary score									–	0.29
10. Delivery summary score										–

* $P < 0.05$, ** $P < 0.01$

the patient himself or herself experienced more stress. Higher preparation summary scores were associated with reports of greater stress during preparation and delivery. However, higher preparation summary scores were not significantly associated with higher delivery summary scores. Finally, the delivery summary score was unrelated to all other variables in the study.

Predicting preparation and delivery summary scores from other study variables

The relationship-related statements were included in the study to provide information about the context in which bad news transactions typically occur and to allow us to examine, in a more process-sensitive fashion, whether differences in the nature of the patient–physician relationship would relate to what physicians do when delivering bad news. We were able to identify four relationship-specific statements that, based on the pattern of “True/False” responding, allowed us to construct naturally occurring groups of roughly the same size. The four items used were as follows: “I was the same sex as the person to whom I delivered the news” (54.1% endorsed “True”), “I had strong positive feelings about the receiver prior to the news being delivered” (61.1% endorsed “True”), “I recognized that the news would impact on the relationship I had with the receiver” (59.5% endorsed “True”), and “I knew the person receiving the news quite well” (37.8% endorsed “True”). We then examined whether the groups (two groups for each variable) differed in their preparation summary scores, delivery summary scores, stress ratings, and effectiveness perceptions. The critical alpha for these analyses was set at 0.01 to partially control for type I error rates. In no instance did the group who indicated the statement was true of the transaction differ from the group who indicated that the statement was false of the transaction.

Discussion

The primary goal of this investigation was to obtain descriptive information about bad news transactions from the

physician’s perspective. In doing so, our aim was to fill an empirical gap in the existing literature, a literature dominated by practical advice about giving bad news. Our findings indicate that the majority of sampled physicians reported following most of the published advice on breaking bad news. Patterns of responses suggest that these physicians were particularly skillful during the delivery stage of these transactions. Only two notable exceptions arose during this stage: physicians did not consistently allow the other events in the receiver’s life to influence how the news was delivered, and it was not typical for physicians to have someone accompany them as they delivered the news. This group of physicians appeared to do somewhat less well, as defined by following published advice, in preparing for the upcoming encounter. Not only did several preparation items fail to typify the bad news transactions recalled by this group, but there was also a greater range in response to these items, as revealed by the preparation summary scores.

There are undoubtedly numerous reasons why several preparation items failed to typify the bad news transactions that were recalled. Time and resources are, however, possible institutionally related factors. Given tight patient scheduling (or situations involving death due to trauma or unforeseen procedural incidents), it is likely that many physicians have no more than 3–5 minutes to prepare themselves for bad news delivery. Limited time to prepare may preclude attempting to discover more about the lives of the receivers, a situation that is exacerbated when the physician has had minimal or no contact with the receiver prior to the transaction itself. The ability of physicians to tailor news delivery to a patient’s life circumstance may be one reason why patients have reported that they would prefer that the news came from a physician they know well [18]. Scheduling may also make it impractical, in many circumstances, to have more than one person deliver the news. Moreover, it might not be practical to have more than one physician present during news delivery, even when multiple providers have participated in the medical procedure that preceded the news itself (as might happen in surgery).

One implicit assumption in much of the medical literature on conveying bad news to patients and their families

is that the nature and quality of these interactions will impact the deliverers and receivers in important ways and that negative outcomes are not inevitable [18]. We imagined that allowing receivers to take control over the flow of the transaction, encouraging them to vent their emotions and to ask questions, and having other family members present would be more taxing for physicians than if the information were merely presented in a quick, cool, clinical fashion, and would thus place physicians at an increased risk for personal stress [8]. The use of more such strategies would, it was thought, be related to less stress in the receiver. This assumption, however, was not supported by the current self-report data. Despite the general tendency of the physicians to follow many of the published recommendations, individual differences in this tendency were unrelated to stress in physicians or to their perceptions of stress experienced by the receiver. This pattern of findings may have arisen because physicians generally believed that the transaction was stressful for receivers regardless of what they did, a possibility that elicits questions about the utility of focusing on “correct” ways to communicate such news [23]. Focusing on the number of strategies employed is but one way to operationally define quality. How many strategies a physician uses, and how well those strategies are implemented may be distinct, and in the present investigation we obtained no information regarding the latter. From a statistical perspective, we also note that the delivery summary score was associated with low variability and a restricted range of responding, both of which probably attenuated the magnitude of correlations that could be observed.

Physicians believed that they were effective in transmitting the news in ways that reduced both their own stress and the stress of the receiver. These perceptions about the efficacy of their delivery were made despite the recognition that the transaction *was* stressful for the receiver. Perhaps the goal of transmission should not be to reduce the patient’s discomfort, but rather to communicate the necessary information without further exacerbating the patient’s distress.

The communication of the bad news recalled by this sample was associated with moderate levels of stress. Although the experience was not uniformly highly stressful, the range of stress experienced suggests that at least some physicians are vulnerable to the negative effects of stress. We also found that for the majority of physicians the stress experienced transcended the bounds of the transaction itself. To the extent that this negative affective state is carried away from the transaction, the quality of subsequent transactions with other patients may be compromised. This particular finding suggests that the training of residents or practicing physicians in the delivery of bad news should include material on coping skills.

Limitations and future directions

The present investigation had several limitations that should be addressed in subsequent work, the most impor-

tant of which involved the relatively small sample. The question remains as to whether our findings and the conclusions drawn from them will be replicated when a larger, more diverse sample is assessed. At the very least, a larger sample will allow for a more detailed examination of responses. Most notably, we would be able to assess how response patterns differ as a function of clinical specialty, years in practice, type of news, characteristics of the receiver, and the nature of the physician–patient relationship. To our knowledge, however, the present sample is one of the largest samples of *physicians* so far investigated in a study on the issue of communicating bad news. Moreover, given the number of responses obtained per physician, these data are some of the richest we have encountered.

A second limitation of the work was the reliance on physicians’ reports of a transaction they themselves had selected and the assessment of only physicians’ views of what transpired and of how effectively the news was delivered. A notable literature has accumulated suggesting that physicians are relatively poor at recognizing the emotional states of patients [12, 15, 22]. The most frequent bias appears to be that physicians underestimate the emotional distress of their patients. Thus, had we asked patients what transpired and how they felt, a very different picture of bad news transactions might have emerged. Although one might suspect that this different picture would be less favorable, it is noteworthy that several studies indicate that patients are generally satisfied with the bad news transactions they experienced [16, 27, 29]. Additional work is clearly needed in which both physician and patient (and perhaps nurses and other family members) make ratings of the *same* transaction [21].

By allowing physicians to select, without restriction, the bad news transaction on which to report, we may have obtained information on a restricted set of transactions, at least with respect to how well the transactions proceeded. A less positive picture of the bad news delivery process may emerge when physicians are asked to report on an interaction that went particularly poorly. Indeed, interesting differences may be revealed by a study in which some respondents recall a self-defined successful transaction, while others recall a self-defined unsuccessful one.

The transactions that these physicians recalled had occurred days, weeks, or months earlier. Because we relied on retrospections, we cannot ignore the possibility that the passage of time contributed to our pattern of findings [3, 31]. Our results suggest that transactions that had occurred in the more distant past were remembered as having involved more stressful deliveries. However, none of the other summary scores or stress or effectiveness measures we examined were related to the length of time that had passed since the transaction. One might also suspect that the reports we obtained were more unreliable than might be expected based merely on the passage of time because of the stressful nature of the transaction being recalled [4, 30]. However, the role stress plays in retrospective recall is poorly understood and is subject to debate, with some work suggesting that high stress undermines the accuracy

of retrospective reports [6] and other work suggesting that stress enhances recall [2].

Finally, we attempted to define what is typical by summarizing individual responses across a range of specific transactions. Because we did not ask physicians to indicate how typical the transaction was, we were unable to determine the generalizability of a given transaction to all the transactions a given physician has. Assuming that the interactions recalled were unique, we risk forming generalizations about the delivery of bad news from numerous atypical encounters. Conversely, focusing on construction of the typical transaction (coupled with a sufficiently limited sample size to preclude examining subsets of data) we glossed over potentially important environmental and social determinants that may lead to variations in what does transpire and, perhaps, what should transpire. An alternative approach to this research would be to inquire about styles of communicating bad news by asking physicians to provide information about what they typically do in such encounters. Some authors have speculated that physicians do develop styles of communicating bad news, perhaps in part to protect themselves from the pain and suffering they

encounter [19, 29]. However, focusing on what a physician typically does would limit the ability of researchers to explore how situation-specific factors influence the process.

In conclusion, the present investigation provides basic empirical information about the process of delivering bad news. Although somewhat limited because of a small, selective sample, these data are nonetheless informative in their own right and suggest several avenues for future research that will more completely illuminate the nature of this potentially important and frequently occurring transaction. Moreover, these data can be added to the empirical work that has focused on training physicians to communicate bad news more effectively. Published training research is unique in that it is typically more empirical than the general bad news literature and it has attempted to document objectively how residents and practicing physicians convey bad news [1, 5, 11, 20]. We believe that clinicians and researchers interested in developing and administering training programs will benefit from a deeper theoretical and broader empirical foundation on which to base their programs.

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