

Breaking Bad News: An essential skill for doctors

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SUMMARY

Breaking bad news is a process of delivering news, which may negatively affect a patient's view of the future, however is an essential skill for doctors. There are a multitude of benefits if doctors can execute this task well, and will improve the disease journey for the patient. There are several published models including the SPIKES and ABCDE models to help guide the doctor to break bad news effectively. This important skill can be taught through various methods but the most effective may be actually observing a session by senior clinicians.

KEY WORDS:

Breaking bad news, communication skill, patient-physician communication

INTRODUCTION

The late renowned oncologist and eminent person in interpersonal communication, Dr Buckman,¹ once defined bad news as "any information, which adversely and seriously affects an individual's view of his or her future". Breaking bad news well is therefore a very important communication skill for us doctors, particularly when we will be doing it hundreds if not thousands of times in our careers. However, from the time of medical school to looking after actual patients, breaking bad news may not be a procedure that some doctors are particularly eager to perform.

The importance of breaking bad news cannot be underestimated for both the patient and the healthcare team looking after the patient. More so in this day and age where patients are living longer and having more illnesses, recognising the importance of this skill is crucial. Breaking bad news is not reserved exclusively for cancer or terminally ill patients as most believe, but also for other significant life changing conditions including mental health illnesses, chronic infections or neurological disorders.

Many physicians may feel uncomfortable about breaking bad news, some perceiving that by shielding patients from the truth, they are protecting them. This is the opposite of what several surveys and studies have showed. A survey done in 1982 showed that the majority of patients would like to be told not only whether they faced a diagnosis of cancer, but also how long their prognosis was.² Another more recent survey also showed that almost all patients in the survey in an oncology centre in Scotland wanted to know their diagnosis, prognosis and treatment options.³

It is important to deliver truth and consistency when breaking bad news, as uncertainty in one's condition will undoubtedly impact the patient's quality of life by causing stress and anxiety of the unknown. Inconsistency in delivering bad news can also cause distrust and suspicion among the patient and family members.⁴ By giving accurate and wholesome information, the doctor actually empowers the patient to become involved in decision making about their condition, treatment options and in some terminally ill cases allows the patient to plan ahead and put their affairs in order.

While breaking bad news, the doctor can use the session with the patient to probe the information that the patient has and complete their understanding about their condition. Doctors can also take the opportunity to explore the patient's feelings and discuss treatment options, sometimes allowing the doctor to avoid subjecting the patient to treatment that they may not have wanted anyways.

A FRAMEWORK FOR BREAKING BAD NEWS

There are multiple models of breaking bad news that have been proposed and utilised effectively over the years. These models help guide and improve breaking bad news among doctors. Probably the most utilised models are the SPIKES and ABCDE models, however there are several others that have been described and used including the BREAKS protocol and the Kaye 10 Step Approach.⁵⁻⁸

The common themes across all these models and guides are described below:

1. Preparing for the breaking bad news session.

It is advised that prior to the session, the doctor who will take the role of delivering bad news to fully review the case including previous treatments and results. It is also useful to note any previous discussions with other healthcare staff to gain an idea of how much the patient already knows and their expectations. Mental preparation, scripts and anticipation of difficult questions about prognosis and treatment failure are also suggested steps to prepare for the session.

2. Preparing the setting/environment.

Ideally the session should be conducted face to face in a private consultation room, away from the rest of the patients. Doctors should ask the patient whether they would like anyone else present during the session, which could include

This article was accepted: 15 December 2015

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their family members or friends. The presence of a nurse or caregiver who has been involved with the patient may offer emotional support to the patient. An environment free from interruptions should be achieved by setting out time constraints on the session, and also by handing over mobile phones or bleeps to colleagues during the duration.

3. Exploring the patient's knowledge, perceptions and expectations.

The doctor should be able to probe the patient regarding what they understand about the condition, their perceptions and expectations by using open-ended questions. By doing this, the doctor is able to identify the deficiencies of information and any misconceptions and address them in the discussion. It is important to note any unrealistic expectations with treatments or prognosis. Exploring how much information the patient wants to know is also essential because although most patients would be receptive and want to know all available information, some would not be as keen. It has been shown that avoidance of bad news is a valid psychological coping mechanism in patients with cancers and other health threats.⁹

4. Clear and direct communication to the patient.

All the models emphasise the importance of clear communication. The usage of medical jargon should be avoided, with layman terms used as much as possible. Information should be delivered in the amount expected by the patient in a clear, truthful and direct manner, avoiding vague terms and sentences that may be misunderstood by the patient later. Any concern about information being misunderstood by language barriers should be addressed by the use of professional translators who could be brought in for the session, or fellow healthcare professionals who may speak the language. The doctor may invite the patient to ask questions for clarity and allow time for important points to be absorbed by allowing pauses and silence.

5. The emotional aspect of the discussion.

Patients receiving bad news are likely to experience a multitude of emotions such as denial, anger and sadness. By recognising these emotions via verbal or non-verbal cues, the doctor can acknowledge and address these concerns. Simple gestures like handing over a tissue, or saying “I can see that you are very upset with the news” are effective. By showing empathy towards the patient, the patient is more likely to trust the doctor and become more receptive during the discussion. It also facilitates the progress of the discussion, as a highly anxious and upset patient is less likely to want to absorb information compared to a calm one.

6. Summarising the session.

It is helpful to regularly ask the patient whether they have understood the information discussed so far and to invite them to ask questions. The doctor and patient can then participate in planning ahead and share decision making about treatment options and further care. In some instances the sessions may end with unanswered questions or concerns, and in these situations, further sessions with the patient or arranging family conferences might be useful.

Breaking bad news is an essential skill for doctors, however it is a skill that many medical schools allocate little formal

teaching to. This complex communication skill, if taught well, will increase the confidence and effectiveness of the doctor delivering information to the patient. Didactic lectures, small group teaching and role-playing are among the methods used to teach communication skills in medical schools. However, the one method that we thought was most effective was being allowed to sit in and observe an actual session of breaking bad news conducted by senior doctors and consultants followed by a debriefing session. We therefore encourage fellow senior clinicians to include medical students and junior doctors into these sessions to help them correlate the theory and practical aspects of this skill better.

CONCLUSION

Breaking bad news is a complex yet important communication skill that all doctors must be able to execute well. There are many benefits of breaking bad news, not only for the patient, but also for the medical team managing the patient. It empowers and informs the patient and allows them to plan ahead. There are multiple models and guides that help doctors to break bad news, all commonly promoting the importance of preparation prior to the session, gaining an understanding what the patient knows, how much they want to know, clear communication and addressing their concerns and emotions. Breaking bad news should play a more prominent role in communication skills teaching in medical school and the formative years as a junior doctor. As more senior clinicians we should encourage the participation and exposure of our juniors in these sessions.

COMPLIANCE WITH ETHICAL STANDARDS

Funding: This article has not been funded.

Conflict of Interest: Both authors declare that they do not have any conflict of interests.

Ethical approval: This article does not contain any studies with human participants or animals performed by any of the authors.

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