

## Giving bad news

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### Remember

- The patient's illness experience has physical and emotional elements, and the management of issues in each area is part of the responsibility of medical carers.
- In the community, widespread fears of illness and dying inhibit communication. Elements of these include:
  - lack of close experience of death in the modern community
  - high expectations of health
  - fears about severe symptoms of physical illness and about treatment
  - fears about psychological breakdown and 'going crazy'.
- In some cultures there is a belief that to tell someone of a terminal illness will cause them to 'go crazy'. Some families, therefore, may be vigorously opposed to 'telling' interviews, and there may be a need to deal (gently) with the denial of the family first.
- Health care practitioners have a number of anxieties about breaking bad news and about serious illness. These include:
  - fear of being blamed (i.e. blaming the messenger for the message)
  - fear of upsetting the patient
  - fear of saying 'I don't know'
  - fear of 'opening a can of worms' of emotions
  - fear of admitting inability to cure a patient's illness
  - fears of one's own illness and death.
- In the face of advanced illness, many professionals experience a sense of helplessness, powerlessness and failure. As a protective coping strategy, the doctor may use excessive denial, suppression of feelings and retreat into authoritarian relating styles, or unrealistic therapeutic zeal doomed to disappointment.
- The 'health beliefs' of some patients are idiosyncratic and may be quite distorted from medical reality. Such distorted ideas may include beliefs about physiological processes, conventional medical treatment, alternative medical treatment, and other ideas circulating in the community, often in popular magazines. There is frequently a need to clarify what these beliefs are before one can effectively interact about the illness.
- It was observed many years ago that since many seriously ill patients are aware of their situation the question 'should the doctor tell?' loses much of its force. The problem becomes



### Seven step protocol for breaking bad news

- Assess the patient's interest in, and capacity for, detailed information.
- Establish the patient's beliefs about the illness, and what he or she wants to know.
- Provide accurate information in small doses, checking regularly what has been understood.
- Monitor how the patient feels about what has been said.
- Repeat the dialogue as the illness progresses, especially after each new step of investigation, deterioration or major treatment.
- Involve family members as much as the patient wants.
- Plan for continued involvement. An assurance of continuing contact between doctor and patient is important.

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rather more ordinary and resolves itself into discovering what the patients know about their illness and how much more they really want to know, then providing that information in a quiet unhurried conversation, while monitoring the reaction.

## Assessment

- It is important to get the physical context right. Many conversations breaking bad news are conducted in corridors or over the phone – this is unacceptable. Patients and relatives resent a lack of attention to the importance of these conversations.
- How much the patient knows and his or her level of partial denial can be clarified by asking direct questions, such as ‘I wonder what doctors have said so far to you about your illness?’ or ‘I wonder what you understand is wrong?’.
- How much the patient wants to know can be clarified from the style of interaction with the patient in earlier conversations and by asking some specific questions, such as ‘To help most in managing your illness I need to know how you want to handle information – are you the kind of person who wants to know exactly what is going on, or would you prefer just to hear about treatment recommendations?’.
- By their responses, patients indicate how much they are using partial denial of what is happening. Partial denial is a normal coping strategy, and it should not be demolished but rather nudged gently in the direction of reality.
- Most people will indicate if they want a full clear version, or if they want to be protected for a while by using partial denial. They may of course need a fuller explanation later, as their use of denial diminishes.

## Management

- At the heart of all good medical care is good communication and open dialogue. Many of the emotional problems and anguish encountered by patients with advanced disease and their families stem from poor communication at an early stage of the illness.
- Establish the patient’s main concerns about what has been communicated, before explaining proposed treatment and likely outcome.
- Use stepwise dialogue, rather than hurried bold statements, to slow down the speed of transition of the patient’s perception of him or herself as a well person to that of someone with a life-threatening disease.
- Conversations about sharing information need to be held repeatedly during the course of an illness. It is not a ‘once only’ conversation to ‘give the bad news’. People will absorb only a limited amount of information at a time.
- ‘Breaking bad news’ consists of not only giving medical information but also checking what has been understood and discussing the person’s feelings about it.

- There is a need to clarify the person’s emotional reaction to bad news because the management of grief, anxiety and depression is an important part of ongoing medical care.
- ‘How long do I have to live, Doc?’ It seems best to answer this question in terms of weeks, months or years without trying to be overly precise, because it is just an educated guess. People often interpret such time estimates very literally.
- Family members will often need to be involved in these dialogues. They may need to see for themselves that their family member already knows he or she has a serious illness, and that the doctor is not forcing unwanted information on the patient.
- Giving bad news about a child to his or her parents can follow similar principles (i.e. first enquiring what the parents might think is wrong, or what they understand that doctors have said about the illness previously).
- When talking with a child, establish what the child thinks is wrong with him- or herself, and give age-appropriate information, particularly about what can be done to relieve any distress, and what ongoing management is planned.
- Remember, especially in dealing with children, that one has two ‘patients’: the identified patient and the family. Parents may feel guilt that they have ‘caused’ a problem by giving birth to a child who is not normal or becomes ill.
- Plan for continued involvement. One of the fears that patients have when hearing bad news is that they will be abandoned by their medical practitioners under the guise of ‘there is nothing more I can do for you’. One of the important issues is combating a feeling of helplessness. Patients need to hear that their doctors will continue to be involved with them, even if the disease cannot be cured, in order to manage the illness experience and give good palliative care. Ongoing appointments and plans are important. It is almost never true that ‘nothing more can be done’.
- Patients also need an unhurried atmosphere, where they have the undivided attention of their doctor, rather than the perception that the doctor has to rush off. **MT**

## Reference

1. Doyle D, Hanks GWC, Macdonald N, eds. Oxford textbook of palliative medicine. Oxford: Oxford University Press, 1993: 54.

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