

## Breaking Bad News – Pointers and Pitfalls

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### ABSTRACT

Breaking bad news (BBN) is a frequent and challenging task for clinicians, with the majority of consultants reporting that they do so at least once a week. Whilst discussing a cancer diagnosis or approaching end of life situations is probably foremost in the mind of a medical student or junior doctor, it is unlikely that you will be asked to lead in this type of consultation at this point in your career. However, the definition of BBN is much broader. In this article Dr Mandy Barnett notes a few key pointers that will help you approach BBN consultations in your role as a junior doctor.

**Key Words:** breaking bad news; communication skills

### Introduction

Breaking bad news (BBN) is a frequent and challenging task for clinicians, with the majority of consultants reporting that they do so at least once a week<sup>1</sup>. Whilst discussing a cancer diagnosis or approaching end of life situations is probably foremost in the mind of a medical student or junior doctor, it is unlikely that you will be asked to lead in this type of consultation at this point in your career. However, the definition of BBN is much broader, as set out by Ptacek and Eberhardt<sup>2</sup>

“..pertaining to situations where there is either a feeling of no hope, a threat to a person's mental or physical well-being, a risk of upsetting an established lifestyle, or where a message is given which conveys to an individual fewer choices in his or her life”.

It is information that “...results in a cognitive, behavioural or emotional deficit in the person receiving the news that persists for some time after the news is received.”

Clearly this definition covers a wide range of possibilities; a study of hospital consultants produced a long list of clinical scenarios ranging from heart failure to hearing loss and also of indirect situations e.g. cancellation of operations due to bed shortages<sup>1</sup>. Hopefully, throughout your undergraduate and foundation training, you will have had the chance to practise breaking bad news in a protected (i.e. simulated patient) environment, and to have observed senior colleagues carry out consultations in practice. This may have given you some ideas about what does and doesn't work.

In this article I would like to focus on a few key pointers that I hope will help you approach BBN consultations in your role as a junior doctor:

### Preparation

Irrespective of the situation, preparation is fundamental – this means preparing:

- 1) Yourself
- 2) The patient
- 3) The environment

The first point encompasses both intellectual and emotional factors. To break bad news, you need to first make sure you have the facts so that you are able to give the patient correct and consistent information. However you also need to prepare yourself; this involves practical points like ensuring your bleep is turned down or handed over and that you have a clear time window; it also involves clearing your head to focus on the task; occasionally it may mean recognising that you are not the right person (for example if the situation mirrors something in your personal life) and finding a colleague instead.

If you feel out of your depth, do be prepared to ask a senior colleague for help. In palliative or end of life situations (irrespective of diagnosis), the Palliative Care Team is a valuable resource<sup>3</sup>.

Preparing the patient is often an on-going task in the hospital setting, as they may be undergoing a series of tests or procedures to build up the overall picture both diagnostically and prognostically. What is important is trying to ensure that the patient can exercise a degree of choice regarding the timing of a consultation, and also with regard to who hears it. Some may wish to have a significant other present; whilst others will prefer to receive news initially on their own. Remember that family members will have their own concerns and agendas and although they can be supportive they do not have a right to receive confidential information without the patient's permission. This can be a delicate path to tread, especially when the predominantly North European-North American model of patient autonomy clashes with other cultural norms. However there is increasing evidence that individual patients value honest information irrespective of their culture<sup>4-5</sup>. If in doubt, try to establish early on with the patient on their own, using a professional interpreter if language barriers exist, if the patient is content for the family to receive information on their behalf.

Finally, preparing the environment in the hospital setting is not always easy – not all wards have private areas, and if a patient is very unwell it may not be possible to use a separate space<sup>6</sup>. However little things like getting the cleaners to start in another bay (!), turning the TV off and making sure everyone has a chair all help. Above all, make sure that the patient is comfortable so they can concentrate (and have their glasses on and hearing aid in place!) and that you are sitting near them – this helps them to hear you, creates a more private space and conveys compassion<sup>7</sup>. If at all possible, take another member of the ward team with you, so that there is a witness who can reinforce support and/or clarify information subsequently.

## Starting and Listening

Having introduced yourself (and any colleagues) and established who any other people are if you have not met them before (never make assumptions about relationships!), how do you start? If you already know the patient and have been involved with their care to date, your opener is likely to be checking what they understand and have remembered so far. If you are meeting the patient for the first time, it is sensible to take a similar approach, but with a more open question, although it helps to guide the patient to a suitable starting point. E.g. 'I have read a bit about you in your notes, could you tell me what has happened/what you have been told/what you understand about...since you ..went to your GP/were admitted/had your operation?' Then listen carefully to their answer, as it will tell you a great deal about where they are up to, what they have actually heard (as opposed to what they have been told) their understanding of information received, their grasp and interpretation of what this means. This will set the tone for the rest of the consultation, so giving the patient uninterrupted time is important.

You can then move on to what you have come to talk about now, checking at this point that they are ready to do so. E.g. 'we have the results of your scan/blood test/MDT meeting/OT assessment, would you like to go through them?' Be aware that individual preference for information will vary with time and illness trajectory, not just between individuals<sup>8</sup>.

There is also evidence that whilst patients with a cancer diagnosis seek and prefer information on treatment and prognosis<sup>9-11</sup>, patients with other life-limiting diagnoses such as chronic obstructive pulmonary disease (COPD) may view their illness more as a way of life than as a terminal disease and may resist attempts to broach this possibility<sup>10</sup>.

## **Explaining**

If and when you move on to explaining a diagnosis or discussing management options, remember to Keep It Simple, and less is definitely more if you want your main points retained. Tailor your language according to the patient's own – some patients will have learning difficulties and a very basic vocabulary<sup>13</sup>, whilst at the other end of the spectrum you may meet patients with long-standing chronic or progressive conditions who know more about it than you do.

The key is to give information in small chunks and to allow time for the patient to process it and respond – this may involve sitting in silence for a time that feels long to you, but is rarely perceived as such by the patient.

## **Answering Questions – Know Your Limitations**

Always invite questions, and try to answer them as clearly as possible, but don't get drawn into discussing areas that you either don't know about (such as specialist treatment options) or timeframes that are speculative (such as when they can start treatment/go home). It is not being evasive to say that you don't know, as long as you indicate who will provide answers and/or when that information will be available. One of the major underlying causes for complaint is when patients receive inconsistent or contradictory explanation. Ironically it is more likely to occur when the patient is more anxious and the clinical team are trying hardest as this may lead to information being presented early when it is incomplete or the picture is changing.

## **Handling Emotions – yours and the patient's**

Emotional reactions are often the area doctors feel least adept at handling<sup>14</sup> (Cantwell & Ramirez, 1997). If the discussion is more emotional, try to avoid talking to cover any discomfort on your part. If a patient or relative becomes tearful, allow time and don't be afraid to offer silence. If it feels appropriate, a supportive touch such as patting a hand may be appreciated, but don't do it if you feel uncomfortable<sup>15</sup>. It is alright to express sadness 'I am so sorry...' as long as your feelings are genuine<sup>16</sup>. Equally, it is important to remain professional and not to allow your sadness for the patient's situation to become confused with your personal feelings.

A potentially more difficult situation to handle is if the patient or relative becomes angry in response to the news. The key here is not to take it personally, and, unless you perceive a real physical threat, try to allow the person to vent their feelings while you listen. If you are not already seated (which you should be if you have prepared your environment), sit down as soon as you can. It is difficult for someone to maintain aggression if they are sitting down and talking to someone who is listening calmly. In most BBN scenarios anger usually reflects someone's fear or frustration with a situation beyond their control. If there are genuine

grounds for complaint, apologise for the failings of the system, but do not assume individual fault. If you think the person concerned is likely to make a formal complaint, let your consultant know.

### **Finishing the BBN consultation**

When it comes to closing the consultation, how you do so will clearly vary enormously with the situation. If the patient and/or family are calm, you may wish to recap on what you have talked about, check for any questions and agree on what happens next. If the situation is more emotional, you may need to state gently that you are finishing at this point ‘...I am going to have to leave shortly...’ if they are in a private area, make it clear that they can stay ‘...please take your time’ and check if they want anyone to remain with them (this is when an accompanying colleague is invaluable) or to be alone for a while.

### **Documentation and Follow-Up Action**

Ensure you update relevant clinical colleagues verbally but most importantly, document your conversation in the medical records and check that an entry goes into the nursing Kardex if this is maintained separately. Documentation of significant conversations is key to good professional care but is often inadequate<sup>17-18</sup>. If you need to put other plans into action as a result of the meeting e.g. referring to the Discharge Co-ordinator, try to address this while it is still a priority.

### **Self-Awareness**

Once you leave the room or area, pause for a moment to check on yourself. Breaking bad news is stressful for juniors<sup>19</sup>, but it remains emotionally draining no matter how experienced you become<sup>20-21</sup>. It may be helpful if you can debrief with colleagues<sup>22</sup>.

An easily overlooked point is to be aware around the hospital too. Hospital canteens are often public areas, so take note of who is around you if you go for a break with colleagues shortly after a BBN consultation – uproarious laughter may be a release for you but will appear at odds with your previous professional demeanour to a family member standing behind you in the lunch queue.

### **On-Going Patient and Family Support**

Breaking bad news is often a continuing process. Whilst it is important not to offer unrealistic hope (whether that relates to prognosis, treatment options or the likelihood of coping safely at home) it is equally important that patients and families can discuss and consider options and come to terms with limitations without feeling abandoned by the health professional team<sup>23</sup>. If you are involved with the patient’s on-going care, be sure to indicate when you will be back to see them again, especially if they have decisions to make. If they are being handed over to another team, make sure the patient knows you will document your meeting and any outcomes from it. If a patient is going home and has unstable medical needs, try ringing the GP directly, not only to update them on the medical situation, but also to let them know what the patient and/or family has been told, as the GP is likely to be the first point of contact once the patient is home.

### **Conclusion**

Bad news is what the hearer perceives it to be, and conditions or situations that become routine to you during your career will still be unique to the individual patient and family. You will not always find it easy to deliver patient-centred care within the constraints of busy

departments, pressurised team members and less supportive senior colleagues<sup>24</sup>. However, remember that patients will forgive you for not knowing all the facts (as long as what you do tell them is consistent), but they will always remember your attitude and whether or not you cared<sup>16</sup>.

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