

BREAKING BAD NEWS: A PATIENT-CENTERED APPROACH TO DELIVERING AN UNEXPECTED CANCER DIAGNOSIS

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Dr. Cho, a senior internal medicine resident, is rounding with his team when the pathologist calls with lung biopsy results for Mrs. Campbell, a 68-year-old woman admitted 1 week ago for community-acquired pneumonia. The biopsy, which revealed non-small cell lung cancer, was done after a CT scan ordered to follow up a suspicious chest x-ray revealed a mass. Upon hearing the biopsy results, Dr. Cho orders a PET scan and consults the hematology-oncology service, then proceeds to complete his rounds.

Two hours later, Dr. Cho receives a page that Mrs. Campbell refused to have the PET scan until she sees her doctor. Dr. Cho suddenly realizes he forgot to discuss the need for the test with Mrs. Campbell. He had intended to visit her after rounds but was distracted by a page from the emergency department. He immediately goes to see Mrs. Campbell and finds her asleep, with a man sitting beside her.

Dr. Cho gently wakes the patient. "Hello, Mrs. Campbell. I'm sorry to wake you, but I need to speak with you about some test results. Your biopsy was positive. I'm afraid it looks like you have lung cancer. The test I ordered today, called a PET scan, is important to see how far it has spread. The nurse told me you refused to go for the test, but we really need to get it done. I asked the cancer doctors to come and see you as well. Do you have any questions?"

Mrs. Campbell looks bewildered but remains silent. Her visitor, however, speaks up, "I thought she had pneumonia. Now all of a sudden she has cancer?" Before Dr. Cho can respond, Mrs. Campbell suddenly bursts into tears and exclaims, "I don't want any more tests! I just want to go home!"

This remark catches Dr. Cho off guard. Didn't Mrs. Campbell hear what he just said about the bi-

opsy results? Suddenly he is unsure what to do next. He has 3 patients to see before clinic in 40 minutes. He tries to calm Mrs. Campbell down and persuade her to have the test, but she again refuses. He suddenly notices the silence in the room and becomes uncomfortable as he realizes that another patient and a nurse are listening. He tries to hide his frustration as he leaves to find the oncologist.

Breaking bad news is difficult, and the process is often distressing for both physician and patient. Although communicating bad news is a necessary part of clinical practice [1-4], many physicians are unprepared for this task [2,4,5]. Inadequate communication skills [6-8], fears and emotions [9], and time constraints [10] lead many clinicians to adopt counterproductive ways of conveying bad news. Poor delivery of bad news can increase the distress of the patient receiving the news [4,5], impede how the patient comprehends and adjusts to the news [11,12], decrease satisfaction with the doctor-patient relationship [13], and increase the risk of litigation [4,14].

Few empiric studies are available to guide clinicians on how to break bad news effectively [4,15-17]. In the absence of such evidence, international experts developed consensus guidelines in 1995 to assist with this important task [15]. These guidelines, along with others, have been synthesized into various recommended approaches that have in common 4 chronologic steps: (1) preparing to disclose information identified as bad news, (2) disclosing the news to the patient, (3) responding to the perceived patient reactions, and (4) making further plans. Observation of actual interactions with patients, however, suggests that these approaches may be too linear to reflect the full complexity of real clinical settings [1,18]. In an empiric study by Eggly et al [18], 25 of 35 randomly selected videotapes of interactions between oncologists, patients, and companions were found to contain information that could have been perceived

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by patients and/or their companions as sad and new. Rather than flowing predictably as one central piece of information from doctor to patient, these bad news topics often emerged as clinicians, patients, and their companions engaged in complex conversations. The authors noted that patients often reacted differently to similar information. How news is perceived depends on the individual patient's expectations, previous experiences, and general disposition [4].

To be effective in delivering bad news, physicians must be competent in gathering information that allows them to understand the unique characteristics of their patients and to manage patients' reactions and address their expectations. These are *patient-centered* communication skills. A patient-centered approach to physician-patient interactions is rooted in the biopsychosocial model, which acknowledges the person with the disease (eg, the unique personal features of the patient, the doctor-patient relationship, the family, the community, and the spirit) as well as the disease [19]. Smith [20] has synthesized the literature on effective patient-centered communication skills to develop stepwise, behaviorally defined models for (1) gathering information and responding to emotion and (2) providing difficult information to patients (Table 1). It has been shown that these skills can be learned and applied effectively and efficiently to improve patient satisfaction with the physician-patient relationship [21]. This article presents a patient-centered approach to giving bad news that integrates these skills (Table 2) and illustrates how this approach might be applied in the case of Dr. Cho and Mrs. Campbell.

Step 1: Prepare for the Encounter

A common recommendation in how to deliver bad news is to prepare in advance [3,20,22]. This advice is reasonable, as advance preparation may reduce stress, increase confidence, and improve performance of the task [2-4,9,23]. However, some recommendations, such as to mentally rehearse the bad news delivery [3], assume that clinicians can accurately predict which information patients will perceive as negative. There is likely to be a broad range of information that has the potential to cause cognitive, behavioral, and/or emotional distress in the recipient of the news [1]. Therefore, to be patient-centered, physicians should take the "universal precaution" of preparing for all interactions in which information will be discussed—no matter how benign [18]. The following steps will help to ensure one is maximally empathic while addressing the patient's informational needs, protecting the pa-

tient's privacy, and helping the patient to understand and recall vital information.

Prepare Emotionally

A range of emotions—guilt, sorrow, identification, or a sense of inadequacy—might cause a physician to withhold bad news or to deliver it inappropriately [23-25]. Qualitative studies of interviews of students, residents, and fellows suggest that unrecognized emotions, such as fear of addressing psychological matters or of harming the patient, are common in all types of interactions and can result in potentially harmful physician behaviors such as excessive control, superficiality, and passivity [26-28]. These negative reactions are especially prominent in physicians working with cancer patients [4,5,25,29,30]. Making self-awareness a specific objective may help one recognize and avoid such inappropriate behavior [4,23,28]. Before delivering bad news, the clinician can take a few minutes to consider how he feels about the news and the upcoming interaction. Mindfulness about one's own emotions and attendant behavior has been identified as a core professionalism competency for clinicians [31].

Gather Relevant Information

In a study of breast cancer patients, oncologists, and oncology nurses, Girgis et al [14] found that all 3 groups ranked the patient's legal and moral right to accurate and reliable information as the highest principle to guide bad news delivery. In another study of cancer patients' preferences regarding delivery of news about their diagnosis and treatment, physician expertise and adequate information about the disease and treatment options were the most-endorsed areas of interest [32]. Although patients differ in the level of detail they desire, most expect information about further testing, therapeutic choices, and/or prognoses when they are given news of a bad diagnosis [14]. A review of all relevant laboratory and other diagnostic tests prior to meeting with a patient will help the physician prepare to provide what the patient needs. Details about prognoses, treatment options, approximate time frames for next steps, and other logistics (eg, which consultants or surgeons are available or on call) also may be important to have at hand.

Arrange an Adequate Setting and Time

Most guidelines recommend conveying bad news in a private setting, with ample time allotted [3,4,16,22]. In the study by Girgis et al [14], ensuring privacy and allowing enough uninterrupted time to adequately deliver the news were among the 10 top-ranked steps by all 3 groups (patients, doctors, nurses). Giving the news

Table 1. Core Patient-Centered Communication Skills

Skill	Description and Examples
Open-ended nonfocusing skills	
Silence	Remaining silent while encouraging the patient to talk by maintaining eye contact
Nonverbal encouragement	Using nonverbal actions (nodding, leaning forward) that signal the clinician's attention and encourage the patient to keep talking broadly
Neutral utterances	Using sounds that encourage the patient to keep talking broadly ("uh-huh," "hmm")
Echoing	Prompting the patient to talk about a topic by repeating the patient's words or phrases about that topic ("frustrating and scary")
Open-ended focusing skills	
Open-ended requests	Prompting the patient to talk about a specific topic by asking directly ("Tell me more about your chest pain")
Summarizing	Providing a brief summary of what has been discussed, typically at a transition ("You'd like to know how the diagnosis of pneumonia is related to your biopsy. You are also frustrated, scared, and ready to go home. Anything else?")
Emotion-seeking skills	
Direct	Inquiring directly about emotions ("How does that make you feel?")
Indirect	Offering statements that encourage the patient to divulge emotions, in the event the patient does not respond to direct requests about emotions
Self-disclosure	Statements about one's own emotional reaction or other patients' emotional reactions in similar situations ("I would be scared in your situation." "Many patients become depressed when they learn they have cancer.")
Impact on life or others	Questions about how an experience affects the life of the patient or significant others ("How has it affected your life?")
Belief about the problem	Questions about the patient's explanatory models for problems or experiences ("What were you thinking might have caused it?")
Emotion-handling skills (NURS = empathy)	
Naming	Repeating an expressed emotion to signal that the patient was heard ("You were afraid")
Understanding	Legitimizing the emotion with a statement of understanding; may need to first probe about the emotion to genuinely understand ("I can see how that would scare you")
Respect	Acknowledging the patient's plight and/or value or accomplishments ("You have been through a lot." "Your family is lucky to have you.")
Support	Assuring that the patient will not be abandoned and that the clinician will work with the patient to find a solution ("We will work together with you to minimize your suffering")

Adapted with permission from Smith RC. Patient-centered interviewing: an evidence-based method. 2nd ed. Philadelphia: Lippincott Williams & Wilkins; 2002:17.

in a place that is quiet and private was more important to patients (who ranked it second) than to nurses (who ranked it fifth) or doctors (who ranked it eighth). Thus, to be patient-centered, the clinician should attempt to ensure quietness and privacy. Additional preparations (eg, asking a colleague to hold a beeper, proper scheduling) may help the clinician to provide the undivided attention and time that most patients desire [3].

Prepare to Provide a Summary

Patients often do not understand or remember much of what they are told when the news is bad [4]. Recordings or summaries of consultations have been shown to help cancer patients to recall important details of these interactions [33]. The clinician can be prepared to offer to tape the interaction if the patient desires a recording of the conversation.

Table 2. Patient-Centered Approach to Delivering Bad News

Prepare for the encounter

- Prepare emotionally to be maximally empathic with the patient
- Gather all relevant information to meet the patient's needs
- Arrange an adequate setting and time that protects the patient's privacy and ensures undivided attention
- Prepare to offer a summary of the interaction to help the patient recall vital information

Use patient-centered interviewing to prepare the patient for the news

- Set the stage
- Set the agenda
- Open the interview
- Elicit the patient's story and address emotions
- Summarize and transition to giving the news

Tell the news in a way the patient understands

- Use simple language to present and discuss the first topic
- Answer questions and allow the patient to express emotions
- Once emotions have subsided, probe for patient comprehension
- Repeat steps 1 through 3 with each new topic

Identify next steps

- Develop a plan
 - Arrange specific follow-up
 - Provide a summary of the information discussed
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• Dr. Cho prepares for the encounter •

After hearing the biopsy results, Dr. Cho resists the urge to immediately order a PET scan and instead pays Mrs. Campbell a visit. As he mentally rehearses the encounter, he reflects on his emotions. He realizes that he is still numb from the death of a similar patient with stage IV lung cancer. He also is aware from discussions with colleagues and his mentor that he often blames himself unrealistically for the deaths of his patients. At times this has led him to be aloof in similar situations. He resolves to remain aware of his emotions and try to avoid harmful behaviors when he speaks with Mrs. Campbell.

In preparing for the discussion, Dr. Cho reviews the implications of the results of Mrs. Campbell's workup as well as recommendations for staging and management of non-small cell lung cancer. He

prints patient education material on the diagnosis and sketches a diagram of the lung showing the infiltrate and mass. Finally, he checks on the identity and availability of the oncologist on call, reserves a conference room, and asks the internal medicine resident on call to hold his beeper. On his way to Mrs. Campbell's room, he stops by the library to borrow a tape recorder. He is anxious as he enters the patient's room, but he feels prepared.

Step 2: Prepare the Patient for the News

While accurate and specific information is necessary, blunt delivery may heighten shock and impede information processing [3]. Preparing the patient to receive bad news may lessen the shock and allow the patient to brace for what is coming [34]. By creating a patient-centered atmosphere, the clinician may uncover and address immediate concerns and eliminate potential barriers to communication. This step, which can be completed in 2 to 3 minutes [21], adapts and incorporates patient-centered communication skills (Table 1).

Set the Stage

Like patient-centered interviewing, most guidelines for delivering bad news start with setting the stage [3,22]. After greeting the patient by name, the clinician introduces himself, identifies his role, and ensures privacy (eg, by moving to a prearranged room, respectfully excusing a health care assistant, or shutting a door). Any other barriers to communication are removed (eg, by drawing a chair close to the bedside or turning off a loud television). The clinician then may ask questions to ensure comfort and put the patient at ease (eg, "Is that a comfortable chair/bed for you?" or "Is the light bothering your eyes?" or "How has your care been so far?"). Finally, the clinician ascertains patient readiness, for example by asking if the time and place are convenient. It may be necessary to postpone or delay the interview if the patient is not ready or must take care of pressing needs.

Guidelines for delivering bad news typically focus on physician-patient dyads [18], and doctors, nurses, and patients agree that the clinician's primary responsibility is to the patient [14]. However, physicians often must communicate with patients in the presence of concerned and active companions. Thus, to remain patient-centered, the clinician may need to build rapport with multiple participants while attending to the confidentiality and privacy of the patient [35]. If companions are present, the clinician should learn who the third parties are and ask whether the

patient wants these individuals present and whether the individuals themselves desire to be present [20].

Set the Agenda

After ensuring patient readiness, the clinician indicates the time available and the need to discuss a topic with the patient. Although there are no data on patients' opinions about agenda-setting in bad news encounters, clinician experts recommend agenda-setting because it provides an opportunity to inform patients of time constraints or expected interruptions and to warn them that bad news is coming [3].

In general interviewing, indicating available time is followed by obtaining a list of all issues concerning the patient, summarizing these concerns, negotiating the number and priority of items to be discussed, and then finalizing the agenda items [20]. In the setting of giving bad news, where the patient may have no other specific agenda, inquiring about the patient's expectations and specific needs for the interaction will position the clinician to meet those patient needs. Agenda-setting may be especially helpful in creating a patient-centered atmosphere in the event of unexpected bad news [20].

Open the Discussion

Most guidelines recommend assessing the patient's understanding of the clinical situation pertaining to the pending bad news [3,4,16], and patients agree that this is important [14]. The clinician uses open-ended nonfocusing skills to get a picture of what the patient and/or companion perceives (eg, "What is your understanding of your current medical situation?") and then remains silent, using neutral utterances and/or nonverbal signals (eg, nodding) to encourage the patient to talk. During this step, the clinician is actively listening for verbal clues about the patient's circumstances, values, beliefs, and emotions and observing for nonverbal cues (eg, patient appearance, autonomic changes such as sweating or shaking) and for the presence or absence of evidence of social support [20,21].

Elicit the Patient's Story and Address Emotions

In this step, the clinician focuses actively on important themes introduced by the patient. In the setting of bad news delivery, patients and/or their companions may have inaccurate health beliefs and negative emotions that can interfere with assimilating new information [3,22,36]. Using focusing skills (Table 1), the clinician can follow patient cues to uncover these attitudes and to activate the patient (ie, get the patient to open up).

The typical activated patient mixes personal context with descriptions of physical problems (eg, "I came in with a very bad cough 1 week ago. At first, they said it was pneumonia, and then I had to have a biopsy for a spot on my x-ray.") Because most patients expect it, the clinician should initially focus on a physical problem (eg, "Very bad cough" [echoing], "Tell me more about the pneumonia" [making a direct request], or "First pneumonia, then spot on x-ray, then biopsy" [summarizing]). Any of these focusing techniques will likely elicit more description of the immediate context in which the physical problem occurred (eg, "The cough is much better now," "I don't really know whether I had pneumonia," or "Yes, it seems like my pain got worse after the biopsy"). The clinician then uses focusing skills to develop the general personal/psychosocial context (eg, "Don't know whether you had pneumonia" [echoing]), which might evoke the response, "Well, first I was told I would get better with antibiotics, and I did, but then they did a biopsy and now I don't feel so well").

As the patient's story unfolds, physical, personal, and psychosocial data usually are associated with emotions. If a patient is not showing or expressing emotion, the clinician can use emotion-seeking skills, the simplest of which is asking directly about how the patient feels at that moment. Once an emotion is expressed, the clinician uses open-ended focusing skills to better understand the emotion (eg, "Tell me why you feel confused and worried"). This usually leads to more clarification (eg, "I don't know whether my doctors know what they are doing"). The clinician then addresses the emotion(s) elicited with an empathic response. For example, "Sounds like we're not doing a good job of explaining what is going on and that is diminishing your trust and leaving you confused and worried" (naming), "I can see how that would be stressful" (understanding), "Thanks for letting me know" (respect), and "We will work on communicating better with you" (support). The mnemonic NURS is useful for recalling the elements of an empathic response. NURS skills usually expand the patient's story further by prompting new personal information, which leads to further use of open-ended focusing skills, emotion-seeking skills, and so on.

Transition to (Doctor-Centered) Discussion of the News

Finally, the clinician briefly summarizes the information obtained thus far, checks for accuracy, and obtains permission to proceed in presenting the news. This brief, transitional step prepares the patient for the more doctor-centered communication style to

follow and allows the doctor to gauge the patient's readiness to hear the news [34].

• **Dr. Cho prepares Mrs. Campbell for the news** •

Dr. Cho finds Mrs. Campbell asleep. Sitting by her bed is a man Dr. Cho presumes to be her son, although he checks to be sure.

"Hello, I'm Dr. Cho, and you must be Mrs. Campbell's son," he says as he shakes the man's hand. The visitor confirms his identity and gently wakes his mother. Dr. Cho then addresses Mrs. Campbell.

"Hi, Mrs. Campbell. I'm sorry to wake you from what looked like a restful sleep. I wanted to discuss the results of your biopsy, but I can come back if this isn't a good time."

"That's alright, Dr. Cho. I was hoping you'd drop by this afternoon."

Dr. Cho offers to talk in the conference room, but Mrs. Campbell prefers to stay in her room. After verifying that both parties want the son to remain for the discussion, Dr. Cho closes the door, draws the curtain around Mrs. Campbell's bed, and pulls up a chair. The following conversation ensues.

Dr: We have 20 minutes together before my colleague returns my beeper. Before we talk about your results, is there anything else you'd like to discuss?

Pt: Well, everyone has been very nice, but to be honest with you, I'm tired of being here. I'm afraid I'll just get worse if I stay here. And, it's frustrating ... every time I try to get some sleep, someone comes to take more blood or take me for some test.

Dr: Frustrating and scary—yes, I can imagine. I'll ask the nurse to help us minimize unnecessary visits and tests, and we'll work hard together with you to get you out of here soon.

Pt: That would be great. Thanks.

Dr: Okay. To begin, it would help me to know what you understand so far about your medical condition.

Pt: Oh, okay... Well, when I came in a week ago, you thought I had pneumonia. Then I had a biopsy... (*doctor nods silently*) ... and I'm very curious to see what that shows because I was feeling so much better. My fever was gone and my cough had improved, but it came back after the biopsy.

Dr: So you were feeling better, but you got worse...

Pt: (*interjects*) Yes, it makes me worry something went wrong with the biopsy. They said it could cause a punctured lung. To be honest with you, I really didn't think I needed it.

Dr: I can see why that would be a worry. Thank you for

sharing that with me. The x-ray after the biopsy was normal, but we'll continue to monitor you to make sure that the biopsy did not cause any damage.

Pt: (*with perceptible relief*) Thank you.

Dr: I'm surprised to hear you say you didn't think you needed the biopsy.

Pt: Well, I know you said you saw a spot and wanted to make sure it wasn't cancer. I went along with it, but I really didn't think it was necessary because I was feeling so much better...

Son: I'm sorry I wasn't here when you initially talked with my mom. If the chest x-ray showed pneumonia, why would she need a biopsy?

Dr: It sounds like you both are confused about the diagnosis of pneumonia and the need for the biopsy. I understand why this would be upsetting. I'll try to explain the connection.

Pt: Yes, that would help.

Dr: To summarize, you'd like to know how the diagnosis of pneumonia is related to your biopsy. You are also frustrated, scared, and ready to go home. Is there anything else?

Pt: That's about it.

Dr: (*brings out diagram*) I've made this sketch to help you understand what we think might be going on in your lung. (*pointing to infiltrate*) This abnormality showed up on the x-ray and told us you had an infection in your lung. The infection is pneumonia. (*pointing to mass*) As I told you before, we also found this spot, which looked like a tumor. Sometimes tumors can interfere with the normal defenses of the lung and lead to pneumonia. Just like you, many patients get better when we treat the pneumonia, but they still have the tumor. We did the biopsy to find out the nature of this possible tumor.

Pt: Oh. Okay. I understand better now why the biopsy was necessary.

Dr: Is it okay if I talk about the results of the biopsy now?

Pt: Yes, please do.

Step 3: Give the News in a Way the Patient Understands

Research shows that patients want doctors to deliver bad news in a way that is understandable, honest, and unambiguous [14,4]. In addition to speaking as plainly as possible, giving the information in small chunks, with appropriate transitions and explanation about how different parts of the conversation relate to each other, may help to enhance patient understanding [4,18]. Finally, although having ample time and not

feeling rushed are also important to patients [14,37], having a clinician's undivided attention and being heard and understood are likely more important to patients than the actual time spent with them.

Use Simple Language

Experts advise clinicians to deliver bad news in a brief, clear, and direct message [20,21]. Patients often do not understand common medical terms such as "mass" or know basic anatomy, such as the location of the lungs or liver [38]. Therefore, a brief statement (eg, "Your biopsy shows you have lung cancer") may need further explanation or clarification with illustrations, diagrams, or pictures. Frequently used phrases such as "The test is positive/negative" or "The disease is progressing" should be avoided, as they have different connotations in nonmedical settings and might alarm or falsely reassure patients [38].

Answer Questions and Allow for Emotions

Upon hearing bad news, a patient may react with silence, questions, crying, denial, or anger. After delivering the first piece of news, the clinician should allow the patient to set the pace by accepting questions and observing for emotion [20,21]. The clinician can provide support and reduce the patient's sense of isolation by gently using emotion-seeking and NURS skills when appropriate. In responding to questions, one should continue to avoid jargon and seek to clarify misperceptions.

If companions are present, the clinician should monitor these individuals and their interactions with the patient. Companions may interrupt or prolong the interaction without benefit to the patient. If this occurs, the clinician should try to redirect the individual(s) or negotiate common ground [35]. In rare cases, it may be necessary to respectfully excuse and thank persistently disruptive companions after briefly focusing on them to obtain any data they may have [20]. Once the patient's reactions to the initial news have been addressed, the clinician asks for permission to continue.

Assess Understanding

In the setting of shocking or upsetting news, patients often do not absorb the information they receive and overestimate what they understand [20]. Assessing the patient's comprehension of the information presented allows the physician to check for lapses in recall and understanding and to address further misconceptions. To avoid confusing the patient, the clinician should first provide a rationale for probing

the patient's understanding (eg, "It is easy to get confused about news like this. Can you tell me what you understand so far?"). It may be more effective to verify understanding by asking *what* is understood, rather than asking *if* the patient understands [38]. Sometimes one can best establish understanding by asking the patient to restate core information [36]. New information is given only when it is clear that the patient understands the information presented thus far and is ready for more [36].

Repeat the Process with Each New Topic

Eggle et al [18] found that rather than focusing on one central piece of information, such as an unexpected diagnosis of cancer, bad news interactions typically include multiple topics, for example necessity and consequences of further testing, staging, availability of and eligibility requirements related to various treatment options, adverse effects and logistic complexities of treatment, and/or prognostic probabilities related to diagnosis and treatment. Each topic can be potentially distressing, and the patient may not understand how the topics are interrelated. For example, a patient may erroneously expect therapeutic benefits from a recommended diagnostic test. Based on their findings, the authors suggested that current guidelines for delivering bad news be revised to emphasize clear transitions and explanations between pieces of information [18].

Thus, to remain patient-centered, the clinician repeats the process of giving information, responding to questions and reactions, and probing for comprehension for each new topic that emerges in the interaction. This allows the clinician to address not only diagnoses, tests, treatments, and prognoses but also patient hopes, expectations, fears, and goals. After giving all information and answering questions, the clinician checks to see whether the patient is ready to proceed with identifying next steps.

• Dr. Cho delivers the news •

Dr: Some patients find it useful to have a tape recording to refer to later if they have questions. Would you like me to tape our conversation?

Pt: I don't think so.

Dr: Okay. (*brief pause*) I'm afraid I have some bad news. Your biopsy shows you have lung cancer.

Pt: Oh my God! (*silence*)

Dr: (*pause*) It looks like the news is shocking to you.

Pt: I was feeling so much better...I never thought it was something that serious.

Dr: That serious. You said earlier that you were afraid.

Pt: (*silence, then sobbing*) I'm not ready to die... I want to see my daughter get married and my grandkids grow up... I just can't bear for my kids to go through this again!

Dr: (*puts hand on patient's arm*) Go through this again?

Pt: Yes, I saw how everyone suffered last year when my husband was sick and died.

Dr: I'm sorry to hear about your husband. It sounds like the whole family went through an ordeal.

Pt: Yes, it was terrible... It was awful to see him suffer and to be so helpless to do anything.

Dr: I understand why you would be scared. We will do our best to ease your suffering and to help you and your family cope with what lies ahead.

Son: How far along is the cancer?

Dr: We need more testing to know, which I'll talk about in a moment, but I want to make sure we're all on the same page. (*addresses patient*) Can you tell me in a few sentences what you understand so far?

Pt: You said they found cancer. The pneumonia probably happened because of it. The reason I was feeling better is because the medicine helped the pneumonia. But now... (*sobbing*)...now (*struggling to speak*)...I guess we need to know how bad it is...the cancer...we need more tests to see how far it has gone.

Dr: (*pauses until patient stops sobbing*) Yes, that's right. We need to order a PET scan to see whether the cancer has spread to other parts of your body.

Pt: A PET scan?

Dr: A PET scan is an imaging test that helps us see how the tissues and organs in your body are functioning. It can detect cancer in the cells of the body at an early stage. A small dose of radiation will be injected into your vein. Then you will be passed into a doughnut-shaped scanner for imaging.

Pt: When can we have this done?

Dr: This afternoon. I've already spoken to the radiologist about it. Will you agree to have it done?

Pt: Sure. I just don't want to have to wait 2 days like I did with the CT scan. That was so frustrating.

Dr: I can understand that, especially with all you've been through. Unfortunately, delays sometimes are unavoidable, but I'll let the radiology department know it's important for us to have the test as soon as possible.

Son: What about treatment?

Dr: Well, that will depend on the results of the PET scan. Before I talk about treatment, are there any more questions about the cancer or the PET scan?" (*patient and son shake their heads*) Okay, again, to

make sure we're on the same page, could you tell me what we've talked about to this point?

Pt: I'll get a PET scan, hopefully this afternoon. My treatment will depend on the results.

Dr: Great. Yes, depending on the results of the PET scan, treatment options may include surgery, chemotherapy, radiation, or some combination of the 3.

Pt: (*looks overwhelmed*) That sounds like a lot. I don't think I want surgery.

Dr: Surgery frightens you?

Pt: We haven't had very good luck with surgery in my family. The thought that I might need surgery is frightening.

Dr: I see. That's good to know. Again, we need more information before we can determine your treatment options, but we'll definitely consider your concerns as we come up with treatment plans together with you and your family. This may be a good point to talk about other specific next steps. Is that okay with you?

Step 4: Identify Next Steps

Develop a Plan

Doctors, nurses, and patients agree that having a clear plan for the future is helpful to most recipients of bad news [14]. Future plans often include further testing, referral, and/or treatment [20]. Even when no testing or treatment is indicated or possible, it is important to avoid the notion that nothing can be done, as something almost always can be done to ease the patient's suffering [2,20,22]. Simply sitting with a patient who is in distress and being empathic can be therapeutic. Patients benefit when clinicians offer hope while avoiding false reassurances [4,20]. The clinician can help the patient to gather resources and obtain support (eg, from medical and/or psychological professionals, family, friends, community members, support groups). Often, the clinician can change a hopeless patient's attitude by getting the patient to talk about her strengths, specific values, and prior coping strategies [20,22].

Arrange Specific Follow-up

Ensuring a plan for follow-up has been identified as one of the desired outcomes of bad news communication [2]. Patients with a new diagnosis may want to know that they will be seen regularly and updated about their condition [37]. The clinician can conclude the bad news interaction by arranging to be in contact via appointment or telephone in the very near future. In the inpatient setting, the clinician might arrange to have a sitter for the patient who is suicidal

or to visit the less distressed patient later that evening. Arranging for close follow-up provides support and allows the physician to detect any further psychological impact of the news [2].

Provide a Summary

Summaries of bad news interactions that contain elements of hope and reassurance have been helpful in alleviating some later fears [37]. Furthermore, in the setting of shocking news, many patients do not know what questions to ask initially; questions often arise later as the news settles. In addition to a verbal summary, a tape-recorded or written summary of the information discussed will give the patient the opportunity to review the discussion afterward [2]. Reports of diagnostic tests and information leaflets may answer questions that arise later and offer the patient some control over how much information to learn [37].

• Dr. Cho identifies next steps in Mrs. Campbell's care •

- Dr: To help us understand the options better, I'd like to consult the oncologist, Dr. Brent. Is that okay?
- Pt: Is that who you would recommend?
- Dr: Well, he's the oncologist on call, but he is very good. I'd be quite happy to see him if I were in your shoes.
- Pt: Oh good.
- Dr: I'm sure you'll have questions later. Write them down. I have clinic this afternoon, so I won't be able to see you again until tomorrow morning. We can talk about any questions you have at that time. I've also asked my colleague to check in on you later this evening. If you have more pressing questions, my colleague can address them when you see him.
- Pt: Thanks. Let me make sure I understand what happens now. This afternoon I'll have the PET scan and see your colleague and the oncologist?
- Dr: Well, you will hopefully have the PET scan and will definitely see my colleague. You probably won't see the oncologist, Dr. Brent, until tomorrow afternoon. I'll see you tomorrow morning.
- Pt: Oh. Okay.
- Dr: (*hands patient the educational material*) Here is some literature on the kind of cancer you have. You can read as much of it as you want to. Write down any questions you think of, and we can talk about them tomorrow. (*pause*) This is a lot to throw at you. How are you doing with all this?
- Pt: I guess I'm not quite as scared as I was when we

first started. I'm nervous about what the PET scan shows. But, maybe I'll be luckier than my husband. One can only hope, right? (*doctor nods*) Thanks for taking time to explain everything and answer our questions. I feel like I'm in good hands.

Dr: You're welcome, Mrs. Campbell. I know this isn't easy. But, I'll be right here to make sure the process is as smooth as possible. Do either of you have any more questions?

Pt: Not at this time. (*son shakes his head*) Thank you, doctor.

Conclusion

Many clinicians feel unprepared to deliver bad news effectively. This article offers an approach physicians in the inpatient setting can use to prepare themselves and their patients for interactions that involve bad news and to deliver the news in a way that their patients can understand. This approach incorporates evidence-based, patient-centered communication skills for gathering and delivering information and addresses some of the criticisms of current guidelines for bad news interactions, such as inadequate attention to patient preferences. Taking a patient-centered approach, regardless of the nature of the information presented, can help clinicians to better anticipate, elicit, and respond to patient reactions and lead to less distress and better patient choices in the setting of bad news. As with all communication skills, acquiring the skills to deliver bad news is most effective when learning is experiential [6,8]. The steps outlined in Table 2 can serve as a checklist to teach, observe, and critique residents using actual or simulated clinical scenarios; likewise, residents can use this checklist to critique audio- or videotapes of their own performances [39].

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