ABSTRACT

Objective: To describe the impact of culture on delivering bad news to patients and to describe a patient-centered approach physicians can use when delivering bad news.

Methods: Descriptive report and discussion utilizing an illustrative case.

Results: Physicians often find it challenging to deliver bad news in a culturally sensitive manner. Patients vary in their preferences for how they receive bad news, both within and across cultural groups. A strategy to address these preferences is presented that integrates the ethnographic Kleinman model and the SPIKES model.

Conclusion: Delivering bad news is a challenging endeavor for many physicians. Strategies are available to guide clinicians through these conversations in a manner that is culturally sensitive and patient-centered.

A 52-year-old patient from Mexico is seeing his physician because he has been experiencing some fatigue and abdominal pain. The doctor asks the patient about his symptoms with the aid of an interpreter (in all the dialogues, a Spanish interpreter is present).

Doctor: How can I help you today?
Patient: I think it’s probably nothing, but my wife is worried and wanted me to see you. I don’t quite feel myself, just a little more tired than usual.
Doctor: Do you have any other symptoms?
Patient: Well, I have been having some pain in my stomach, just a little crampy feeling down low. My wife says I have lost some weight and she wanted me to see a doctor. I haven’t been eating as much as I usually do. I just don’t have much of an appetite, especially when I get the pain.

The doctor goes on to ask some additional questions and conducts a physical examination. He discovers the patient lost 20 pounds since his last visit 8 months ago. He is worried that the patient may have something serious going on, possibly colon cancer. He recommends some testing to the patient.

Doctor: I would like to do some tests to see what is going on.
Patient: What kind of tests?
Doctor: A few blood tests and a colonoscopy. Do you know what that is?
Patient: Yes, my brother had one a few years ago.
Doctor: Ok, my nurse will set that up and explain what you will need to do. We’ll schedule another appointment for you to come back to discuss the results. You mentioned your wife. Would you like her or anyone else to be with you at that appointment?
Patient: Yes, my wife and son. My son knows a lot more about medical things than I do, and I know he would want to come.

The Need for Culturally Sensitive Care

The concept of one’s culture encompasses a host of components including how an individual identifies oneself as well as the language, customs, beliefs, and value system one utilizes. Culture, in turn, profoundly affects patients’ belief systems regarding health and wellness, disease and illness, and the delivery of health care services, including the use of healers and alternative providers [1]. In order to provide culturally sensitive and high-quality care to diverse patient populations, it is important for providers to gain an understanding and sensitivity to the influences of culture on patients’ beliefs and behaviors [2].

The ability to provide care to people of different cultures is more important than ever before. In 2011,
the number of legal and unauthorized immigrants in the United States rose to 40.4 million (13% of the population) and between 2007 and 2011 alone, this number rose by 2.4 million [3]. According to a 2010 census bureau report, in the last 30 years the number of individuals over the age of 5 who spoke a language other than English in their home more than doubled, an increase that was 4 times greater than the rate of population growth [4]. In addition, in 2009 the United States resettled more refugees than any other nation (60,000+) and this number reached almost 70,000 in 2013 [5,6]. Patient populations in the United States are becoming increasingly diverse, and providers must have the skills to communicate effectively with these groups. A one-size-fits-all approach is not sufficient for our changing population.

**The Challenges of Delivering Bad News and the Impact of Culture**

Perhaps one of the most challenging communication scenarios faced by physicians is the need to deliver bad news to a patient. “Bad news” can be described as any information that adversely alters one’s expectations for the future [7]. Clinicians from nearly all specialties are confronted with the task of giving bad news [8], and this is particularly true regarding cancer care. Among oncologists, 60% reported the need to break bad news to patients between 5 to 20 times per month, with 14% reporting greater than 20 times per month [9]. The concept of giving bad news is often viewed as stressful by clinicians [10], and clinicians must be able to balance a myriad of elements, including patients’ emotional responses, information needs, uncertainties of disease progression and treatments, patients’ preferred level of involvement in decision making, patient expectations, involvement of family members, and how to maintain hope, among others [9,11]. Indeed, it seems that clinicians find it difficult to take into account the full spectrum of patient needs [8]. While the descriptive literature indicates that patient satisfaction and psychological well-being is improved when a patient-centered approach is utilized that attends to the emotional needs of patients [12], clinicians often focus on biomedical information, with less focus on patients’ psychosocial needs and their level of understanding [13–15].

Further, the interaction of patient culture and context with the complexity of the “bad news” interaction can be daunting, and clinicians have noted their diminished level of comfort in adjusting to these cultural preferences [16]. The ability of clinicians to “match” the patient’s preferred level of involvement in decision making is associated with higher patient satisfaction with decision making and lower depression after 3 months [11], yet clinicians often find it difficult to determine which patients want to be involved in the decision making to a greater or lesser extent [12]. In addition, words have different meanings when used in medical settings or in lay contexts [8], not to mention the challenges of translation when dealing with non–English-speaking patients. Yet, the manner in which clinicians deliver bad news can affect patients’ understanding of their disease, treatment options, and patients’ adjustment to the diagnosis [8], as well as patients’ expected quality of life and intentions to adhere to recommendations [17].

**Information Disclosure**

One of the key areas impacted by culture relates to preferred disclosure of medical information. Walsh et al noted in their review that the majority of patients in English-speaking countries wanted relatively full disclosure regarding their illness in comparison to individuals from other countries [18]. As a further distinction, Blackhall et al noted that African Americans and European Americans were more likely to believe that a patient should be told of a terminal diagnosis than Mexican and Korean Americans [19]. In addition, Mexican and Korean Americans were more likely to believe that clinicians should not discuss death and dying with patients, as it could be harmful. Fujimori noted that Asians are less likely to prefer discussions of life expectancy in contrast to Westerners [20]. In a survey of Albanian nationals, < 50% of patients wanted to know their true diagnosis; however, individuals who were male, urban, and educated demonstrated a significantly greater preference for disclosure [21]. In the Middle East, the concept of disclosure is highly variable in terms of both provider and patient preferences [22].

**Involvement of Family Members**

A second important area relates to the involvement of family members. Fujimori noted high variability of patient preferences for having family members present when discussing bad news. Of Japanese patients, 78% preferred to be told with family members present, with the number decreasing for Portugal (61%), Australia (53%-57%), and Ireland (40%). Eighty-one percent of the US patients
did not want anyone else present. However, almost all
placed high value on physician expertise and honesty [20].
Blackhall noted that Mexican and Korean Americans
were more likely to favor a family-centered approach to
decision making [19]. In addition, Orona indicated that
Mexican-American and Chinese-American families felt it
was their duty to protect their relatives from a cancer di-
agnosis to keep the patient’s remaining time free of worry
[23]. Haggerty found mixed evidence for patient prefer-
ences regarding disclosure of cancer prognosis to family
members [24].

Given these variations and complexities, it is natural
to try to develop a system for managing them, eg, a list
of traits or attributes one can apply to certain groups.
For example, patients of Asian origin prefer _______.
However, there is an inherent danger in doing this, as it
leads to stereotyping [25]. Cultural factors also may be
given inappropriate meaning. Specifically, a well-meaning
clinician might attribute certain characteristics to a
patient when in fact it has little bearing on the patient’s
perspective [25]. In addition, given the nature of com-
munication, travel, and the fact that many individuals
identify with more than one cultural group, it may be
inappropriate to attribute a singular cultural identity to a
group in contemporary society. As a result, Kleinman [25]
proposed an ethnographic approach as opposed to a cul-
tural approach. Specifically, this involves understanding a
patient and his/her illness from an individual’s perspec-
tive as opposed to the cultural collective.

Communication Skills to Help Deliver Bad
News

Two models can be particularly useful as communication
guides when the need arises to deliver bad news. The
Kleinman model, as previously mentioned, incorporates an
ethnographic approach and focuses on understanding the
individualized influence of a patient’s culture and context
[25]. The “SPIKES” model was developed in reference to
cancer patients and guides the clinician through a 6-step
communication process with patients [9]. An integrated
approach that incorporates both models can be found in
the Table. When combined, these 2 approaches provide a
framework to help the clinician communicate in a way that
is patient-centered, humanistic, and culturally responsive.
These approaches provide practical guidance and identify
specific questions one can use to better understand the
patient’s perspective of his diagnosis and treatment prefer-
ences. Additionally, the specific steps may be used over
several sessions with the patient and are not necessarily
meant to be done in a linear fashion.

Set Up the Interview

Before meeting with the patient, it is important to review
the medical data and have a plan in mind for delivering
the bad news. Schedule adequate time for discussion
and avoid interruptions. Meet in a quiet, private room
that is large enough to accommodate family members or
friends whom the patient may have brought. In our case
example, the patient has brought his wife and son to the
appointment.

Doctor: Hello, Mr. Ruiz. (Turning to the patient’s wife
and son) I am Dr. Simon.

Patient: Hello, Doctor. This is my wife, Maria, and son,
Alejandro.

Doctor: Please have a seat. Are you comfortable?

Patient: Yes. We are anxious to hear the results of the tests.

Son: My father doesn’t always understand medical terms
and I wanted to be here to help. I am very worried about
him.

Doctor: I understand your concern and I will explain
everything to you.

Assess the Patient’s Perception of the Problem

Before telling the patient the diagnosis, it is important to
gain an idea of the patient’s understanding of the problem,
including what he calls it, what he thinks caused it, and
how severe he thinks it is.

Doctor: Before I tell you the results, I would like to get
a sense first of what you think is going on.

Patient: Well, I really don’t know for sure, but I know
the pain is getting worse and I have been feeling weaker.
The pain started right after my son’s wedding. There was
a lot of food and I ate more than usual. Maybe it was
something bad that I ate?

Doctor: (Turning to the wife and son) Do you have any
thoughts about the illness?

Wife: I can see he is in pain a lot, even though he tries
to hide it from me. I want to know what’s wrong. I am
worried it could be something bad.

Obtain the Patient’s Invitation to Disclose the
Information

It is important to know if the patient wants to be told
the information about his or her diagnosis. Ideally,
Table. Integrated Model for Delivering Bad News

**Step 1: Set Up the interview**
- Review your plan for delivering the news
- Arrange for privacy (an interview room or the physician's office, if available)
- Involve significant others (patient's choice)
- Allow the patient to dress first if (s)he was examined
- Sit down
- Make a connection with the patient. Note: eye contact and touch may not always be preferred, depending on the patient
- Obtain a sense of the patient's ethnic identity and whether it is an important part of the patient's sense of self (assumptions lead to stereotyping). Note: this may be done during a prior session, particularly if it is a continuity patient
- Manage time constraints and interruptions, eg, set pager on “silent” or ask a colleague to respond to it

**Step 2: Assess the patient's Perception**
- Before you tell the diagnosis, ask the patient about his/her understanding of the illness. This provides opportunity to discuss cultural meanings that may have implications regarding the patient's care
- Sample questions include:
  - What do you call your problem?
  - What do you believe is the cause of this problem?
  - Why do you think you got sick when you did?
  - What do you think this problem does inside your body?
  - How severe is your sickness?
  - What kind of treatment do you think you should receive?
  - What are the most important results you hope to receive from this treatment?
  - What do you fear most about your problem?
  - How do your family members and close friends feel about this problem?

**Step 3: Obtain the patient's Invitation**
- Ask about the patient's preferences regarding disclosure (this may be best done at the time of ordering tests or ideally early in the relationship before a bad situation even arises)
- If the patient does not want to know, offer to talk to a relative or friend

**Step 4: Give Knowledge and information to the patient (or relative/friend)**
- Consider utilizing a warning statement, eg, “I'm sorry to tell you,” or “Unfortunately, I've got some bad news”
- Provide medical information at the patient's level of comprehension and vocabulary
- Avoid jargon (metastasized vs. spread)
- Don't be excessively blunt, eg, “You are going to die unless you get this treatment”
- Give the information in small “chunks”
- Check the patient's understanding
- Avoid phrases that take away hope, eg, “There is nothing more I can do for you”

**Step 5: Address the patient's Emotions with empathic responses**
- Demonstrate empathy
- Ask exploratory questions
- Validate the patient's emotions

**Step 6: Strategize and Summarize**
- Ask the patient if (s)he is ready for a discussion about treatment options
- Share responsibility of decision-making with the patient
- Consider the influence of culture on the clinical relationship (this may include the patient's cultures and the physician's culture, eg, physician bias, use of interventions, use of technology, institutional norms, stereotyping)
- Explore the patient's knowledge, expectations, and hopes
- Allow patients to express fears and concerns
- Explore the patient's goals, eg, symptom control, treatment
- Are there possible interventions to improve treatment results? These may include:
  - Self-treatment
  - Family assistance
  - Alternative/complementary medicine

Physicians should discuss this in general terms as part of routine care, before any bad news needs to be delivered. For example,

**Doctor:** There may come a time when I will need to tell you something bad about your health. Hopefully, that time will never come, but I want to know your preferences so I can honor them if the time does arise. Would you want to be told about this, or would you want someone else, perhaps someone in your family, to be told?

**Patient:** I appreciate your asking, Doctor. I haven’t really thought about it, but I get kind of nervous and upset when I hear bad news. I would rather you tell me when my wife and son can be there too.

### Give Knowledge and Information to the Patient

It is important to provide information that is at a level that the patient can understand. Avoid the use of medical jargon. When speaking through an interpreter, the clinician may need to have a conversation with the interpreter before meeting the patient to explain the situation and the need to be sensitive. For example, if the clinician does not use the word “cancer” after determining from the patient or family the preference for an alternative word, be sure to inform the interpreter not to use the word “cancer.” Provide the information in small chunks and check in frequently to make sure the patient understands. Avoid language that takes away hope. If there is a family member who speaks English, there is a tendency to speak to that person rather than the patient directly. Avoid doing this unless the patient explicitly requests that the clinician speak directly to that individual. This is often the case with older patients. The following might take place at a subsequent appointment:

**Doctor:** Mr. Ruiz, you told me previously that you would like me to tell you the results of your tests, along with you wife and son. Unfortunately, I have some bad news to tell you. (Pause) The colonoscopy showed that you have a tumor in the colon, also called the large intestine. It is located in the part that we call the ascending colon (draws a picture to show them where this is). We will need to do some other scans to make sure that the tumor is just in the colon and has not spread. I am hopeful, though, that we have caught it fairly early and it has not spread. That would be the best situation. (Pause) Do you understand what I have told you so far?

### Address the Patient’s and Family’s Emotions

Every patient will express their reactions to bad news differently, and their reactions may be different from what the physician might experience in a similar situation. Thus, the clinician should be self-aware and be prepared to respond to a variety of responses. It is important to express empathy and validate the patient’s and family reactions and emotions. If the patient does not express any emotion, the clinician should explore this carefully. It may require more than one visit for the patient to open up with his feelings.

**Doctor:** I am so sorry. I know that this must be a big shock for you.

**Patient:** I kind of figured it might be something bad, but it is still a shock. Even so, I am a religious man and I believe that I will get through this with the help of my wife and family.

**Doctor:** It sounds as if you have a great support system and get strength from your faith. You are lucky to have such a wonderful family and that will be a big help as we move forward.

### Strategize and Summarize

Ask the patient if he or she is ready to have a discussion about treatment, including his or her goals of treatment. Continue to explore the patient’s knowledge, expectations and hopes. Always allow the patient to express his fears and concerns. Most importantly, let the patient know that you will share the responsibility of decision making with the patient and be there to support him.

**Doctor:** This is never easy and it’s a lot to take in. Would you like to discuss the next steps and possible treatments at this time or should we make another appointment after your CAT scan?

**Patient:** My wife is pretty upset and I think it might be better if we stop here for now. Is that ok?

**Son:** We want to come back as soon as we can after the CAT scan. In the meantime, can you provide me with some information or a good website to check out?

**Doctor:** Yes, of course. That sounds like a good plan.

### Conclusion

The task of giving bad news is a necessity for physicians of most specialties and is often viewed as challenging and even stressful to some. However, the manner in which information is discussed with patients can impact patients’
satisfaction, understanding of their illness, adjustment to the diagnosis, expected quality of life, and intentions to adhere to recommendations [8,17]. Providing bad news in a culturally sensitive manner adds an additional level of complexity to an already challenging encounter. While an individual’s culture can strongly influence patient belief systems and utilization of care, there is an inherent danger when clinicians make assumptions about individuals’ culture and the role it plays in their lives. Instead of focusing on creating a mental list of cultural attributes, we recommend a patient-centered approach where few assumptions about the patient are made and instead, the clinician gains an understanding of each individual patient through queries and adjusts his/her approach and language according to each individual’s needs.

Corresponding author: Lisa K. Rollins, PhD, Dept. of Family Medicine, Univ. of Virginia, PO Box 800729, Charlottesville, VA 22908-0729, lkr2h@virginia.edu.

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References