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Practice Point

Let's Sit Down and Talk: The Art of Breaking Bad News

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Abstract

Physicians often are uncomfortable when communicating bad or difficult news. In the absence of much effective training, many doctors find that breaking bad news is one of the most difficult, demanding, and stressful tasks. A significantly negative relationship can form between the patient and their medical staff if poor communication is used. Most patients want the truth, but how bad news is delivered can substantially influence a patient's emotions, satisfaction, subsequent psychological adjustments, and attitudes toward treatment. Moreover, values in certain cultures can become barriers that can limit or pressure a physician in ethically approaching the patient. Disclosing bad news is a complex communicational task that requires time, compassion, and empathy. Although breaking bad news will never be easy, communicating well is a skill that can be learned. The SPIKES protocol provides a simple and easily learnable strategy for communicating bad news.

Keywords: Breaking bad news, communication skills, empathy, SPIKES protocol

Introduction

Woody Allen wrote that the most beautiful words in the English language are not "I love you" but "It is benign."[1] Physicians are responsible for delivering bad news, but they are generally poor at it. Breaking bad news is an art and an essential skill for all doctors; however, no one particularly enjoys it or finds it easy. It is not what you say but how you say it that matters, and therefore care must be acquired when choosing how to communicate bad news. Naturally, the severity of how bad the news is depends on several specific factors for each patient. No two patients or relatives of the patients will respond in the same way to the same news.[2,3] Often, clinicians focus primarily on relieving a patient's bodily pain and may neglect their emotional distress and suffering.[4,5] The doctor must be emotionally conscious of what is going on and cannot simply break the news directly or abruptly, as this can be damaging to the patient's mental health. Shock, horror, anger, disbelief, and denial are all possible reactions, and anyone with the responsibility of breaking bad news needs to cope with these

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emotions. What physicians say and what the patient may hear or interpret can be very different, leading to misunderstanding and occasionally, to harboring bitterness and resentment against the bearer of the bad news. Patients who complain that the "doctors did not tell me anything" were they may not have heard, understood properly, or were hoping to be given better news.

Bad News

What is bad news?

Many physicians define "bad news" as a worst-case scenario; this can include telling patients that they have cancer or that their loved one has died. Ironically, merely no available hospital bed or a postponed surgery may be considered bad news for a patient. Buckman defines bad news in a manner that matches the patient's perspective by stating it as "any news that drastically and negatively alters the patient's view of his or her future."[5,6] Examples of bad news may include death, diagnosis of serious or terminal illness as cancer, failure of treatment or disease recurrence, and disability, loss of limb function, or amputation.[3] The impact of bad news is directly related to the gap between a patient's expectation and the reality of their medical condition. Therefore, a physician cannot tell how bad any news is and how badly it may affect the patient unless they already have some idea of the patient's perception, an expectation of the situation, previous medical experiences, and their general personality. Therefore, before you share any news, ask and determine what the patient knows and thinks first.

Why is it important?

Most patients want the truth, and by sharing information, patients start to show a greater degree of adaptation to reality. How bad news is delivered can substantially influence a patient's emotions, satisfaction, subsequent psychological adjustments, and treatment adherence.[2,7-9] Moreover, physicians who are comfortable breaking bad news may be subject to less stress and burnout.[8,10] Good communication is the foundation of trust between medical staff and patients and families. In contrast, poor communication is the single largest cause of complaints against medical staff, leading to anger and an increased risk of litigation.[6,8,9,11] Not breaking the truth may convey unjustifiable optimism to the patient and encourage them to participate in difficult or uncertain treatment options.

What is difficult about giving bad news?

Nobody likes to be the bearer of bad news. One of the factors that most interfere with bad news communication is the health professional's stress, which is usually related to a lack of specific training.[7] Medical education in the past has placed more emphasis on technical competency rather than placing value on communication skills.[10-12] This leaves physicians unprepared for the communication complexity and emotional intensity of breaking bad news.[11] Ptacek *et al*. showed that 42% of physicians experience stress after breaking bad news, and the effect lasts from several hours to 3 days or more.[13] Before sitting with patients and families, clinicians must identify the different barriers that may come in the way of breaking the bad news [Table 1].[12,14] Clinicians should make a conscious effort to overcome these barriers and be mentally prepared for any potential outcomes. These potential outcomes can cause physicians to communicate poorly and cause them to avoid communicating as well.[14] The first potential outcome is an adverse emotional reaction from the patient such as denial, blame, disbelief, or submission.[4] The second is an adverse emotional reaction from the doctor including feeling responsible and fearing blame.

Should hope and reassurance be given along with bad news?

A physician may reassure patients that their fears are probably worse than reality. Conveying hope and reassurance is a common form of emotional first aid, as it results in an immediate decrease in the patient's anxiety and distress. However, it is often considered

Table 1: Barriers to delivering bad news

Fear of being blamed
Fear of the unknown and the untaught
Fear of unleashing a reaction
Fear of expressing emotion
Fear of not knowing all answers
Personal fear of illness and death

inappropriate as it may serve to sweep fear under the carpet that will resurface later. If false hope is offered, physicians run the risk of colliding with the patient's denial of the severity of their problem.

Who should give bad news?

Since the task of breaking bad news is one to be treated with great caution, it should not be given to junior staff or residents, aside from exceptional circumstances of sudden death where the most senior member available should break the news. Ideally, bad news should be delivered by the lead consultant whom the patient is familiar with or trusts. Once the news is broken to the patient, other team members should note what has been said to remain in the same framework of communication with the patient. It is poor practice to delegate the task to a colleague because you do not want to confront the patient yourself.[7] Occasionally, however, it may be more appropriate for another physician to break the bad news. For example, suppose a patient was sent to another hospital for a particular test. In that case, they may still expect their primary physician to reveal the results rather than the hospital consultant since the referring physician usually has an established relationship with the patient and is better at analyzing the medical issue and/or other issues that can potentially arise.

When should bad news be given?

Options do exist regarding when is the optimal time to share the news, and these options all depend on the patient's unique medical and emotional situation. Informing the patient of the news as soon as it is confirmed is the ideal option that clinicians should regularly practice. Note that there are situations where a clinician has no option but to share the news straight away such as if a hazardous medical risk exists (e.g., HIV) or informing relatives of a patient's death.[5] There is the second option of delaying breaking the news until a later stage. For example, suppose a patient has a chronic medical condition with no urgency to tell right away. In that case, withholding the information provides the advantage of being able to break the news gradually. This will give the patient and their relatives' time to adjust emotionally. The disadvantage of this approach is that it may deny them the opportunity to face up to the whole picture and begin to make the necessary adjustments in their personal lives.

Where should bad news be given?

Choosing the right environment can help the patient feel more comfortable and that they are in a safe space to react to the situation in a manner they feel necessary. With the patient's prior permission, try to ensure that a relative or friend is present for support. The ideal place is a private consultation room as every effort should be made to avoid breaking news in nonprivate rooms such as emergency departments, in the corridor, or during ward rounds. More information on where to share bad news will be discussed in the upcoming SPIKES protocol section.

Cultural Difficulties Involved with Informing Patients

Whether the patient should be informed?

Over the years of medical practice, the most common questions among doctors have always been Should we break the bad news? what should the patient be told? and what does the patient want to know? Hippocrates advised against breaking bad news because the patient may "take a turn for the worse."[5,11,12] Thomas Percival gave a similar warning in 1803, as did the American Medical Association in 1847.[12] This attitude of silence existed for centuries but has fortunately changed in most contemporary medical practices. A review of studies on patient preferences regarding the disclosure of a terminal diagnosis found that 50%–90% of patients desired full disclosure.[11] In Oken's survey of 1961, 90% of physician did not routinely discuss a cancer diagnosis with their patients,[9,15] Two decades later, Novack *et al*. repeated this survey to show a complete reversal of attitude as 97% of participants indicated a preference for telling a cancer patient his diagnosis.[9,16]

To Whom to Give Bad News?

Responsibility to the relatives of patients is important but secondary compared to the doctor's primary responsibility to the patient. The patient, not the family, should be the first person to be informed of the news, and it is essential to obtain the patient's permission to discuss his/her care with family or friends.[8,11] These considerations are per a patient's

given rights [Table 2]. However, there are exceptions where the family may be told before the patient, for instance, if the patient is a minor or has an intellectual disability or cognitive impairment.[5] These patients still have a right to information regarding their health. They should be approached with special preparation and sensitivity as involving people who can support the individual (e.g., family members, peers, and care workers).

Cultural Difficulties

Despite cultural differences, most patients would like to be aware of their medical conditions, even if it is something as severe are a chronic illness.[7] Although many studies have indicated that most physicians from Western societies tell their patients the truth about cancer diagnosis and prognosis, it is not the practice in many eastern cultures.[17,18] Physicians should be aware of cultural differences as some cultures are opposed to sharing bad news with the patient themselves out of fear that they will be significantly impacted by the news and lose hope. Hence, the patient's relatives may pressure the doctor not to share the news or demand to break the news themselves.[17] However, this is not ideal as it may be difficult for them to convey serious and distressing news due to their emotional involvement. Information could be miscommunicated or even not shared to begin with, which can lead to misunderstandings later. Due to societal pressure, physicians in these cultures may be more likely to follow the family's wishes.[17,18] Unfortunately, this supportive attitude from physicians may evolve into a dominating attitude that hijacks the patient's fundamental right to confidentiality, knowledge, and involvement in decision-making. Interestingly, a recent study indicated that most cancer patients (87%) in Saudi Arabia prefer to know the diagnosis of cancer or any related poor outcomes and prefer to be involved in decision-making throughout their illness. Furthermore, 83% of these researched patients wanted to be the first to know of any bad news, and more than half of patients want to be involved even in the end-of-life discussion. There was no statistically significant effect of age, sex, education level, professional status, diagnosis, and stage of disease on this preference.

Table 2: Patient's rights

Accurate and true information
Receive or not receive bad news
Decide how much information they want or don't want to know
Decide who should be present during the consultation, (family members and friends)
Decide who should be informed about their diagnosis and what information they should receive?

When the family says, "Do not Tell."

Relatives may pressure the physician not to tell the patient the diagnosis, prognosis, or other vital information to protect the patient out of fear that they would be hurt. However, this is not a justifiable reason and is unethical for the physician. In reality, it is observed that invariably patients know more about their illness than anyone's guess or may imagine things to be worse than they are.[5] Although the physician's legal obligation is to obtain informed consent from the patient, he/she does not want to risk a meaningful relationship and alliance with the family. Instead of confronting families by stating, "I have to tell the patient," ask the family why they do not want the physician to tell the patient, what are they afraid that will be said, or what their experience has been with prior bad news? If they continue to resist, suggest that you go together to the patient and ask the patient in front of the family how much he/she wants to know about his/her health and what questions he/she might have? Even though this goes against one of the patient's rights of receiving their permission to allow anyone to be included in their discussions, it may be a necessary step if the family is entirely unwilling to follow standard protocols. In challenging situations, ethical rules may need to be altered wisely and mindfully to prevent the potential outcome of a more unethical situation (i.e., family taking the patient to another doctor who will allow them to deal with the bad news themselves). The patient's medical situation requires a significant negotiation as this can pull families apart when they most need to be close to each other.

How to Break Bad News?

Buckman suggested an organized and effective strategy for communicating bad news. He outlined a six-step protocol which goes by the acronym SPIKES [Table 3].[5,6,9,10,11,14] In addition, the

pearls and pitfalls of disclosing bad news are summarized [Table 4].

Set up the interview

Giving bad news is a sensitive task, thus ensure privacy and allow adequate time for discussion. The ideal setting is a quiet and private room with adequately comfortable and chairs of even height. A conversation such as this may require a long duration of time. Hence, to avoid unnecessary interruptions, try scheduling it at the end of a working shift, place a "Meeting in Progress" or "Do not Disturb" notice on the door, and switch off phones and other devices of possible disturbance. Before meeting the patient, review medical information and familiarize yourself with the relevant clinical information, and mentally rehearse how you will deliver the news. Start by introducing yourself and then take a seat, as this conveys the message that you intend to remain for a length of time and not rush the discussion. No furniture should be between the two parties. While talking, keep your focus on the patient, maintain eye contact, and try not to get distracted by things such as fumbling through clinical notes, fixing drips, and looking outside the window, etc., Should the physician be incapable of getting a private room and/or, the discussion needs to be conducted by the patient's bedside, check with the patient that he/she is comfortable with this environment for the conversation. Ensure the curtains are drawn for some privacy and do not stand far from the patient but rather as close as the patient deems okay; this helps enhance humanness.

Table 3: Six-step (SPIKES) protocol for breaking bad news

Set up the interview
Perception: Assess patient's perception by finding out how much the patient knows already?
Invitation: Obtain a patient's invitation by finding out how much the patient wants to know?
Knowledge: Give knowledge and information
Emotions and empathy: Address patient's emotions with empathic responses
Strategize and Summarize

Perception: What does the patient know?

Most patients will have some idea about their illness, therefore, ask the patient to mention what they know or suspect about their medical problem. As the patient replies, listen to the level of comprehension, language, and vocabulary used and attempt to match their level when responding. This means noting anything that the patient does not have sufficient knowledge of and explaining it. In addition, noting any words not to use because they may be overly complicated or overly simplistic to use. If the patient is in denial, then accept it and do not confront it further at this stage. This means that the patient requires time to process the heavy news. Confrontation at this early time will most likely unnecessarily raise the patient's anxiety or set up an antagonistic relationship. Denial may come in the form of the patient giving the impression of knowing very little about their medical condition despite previous consultations. They do not want to believe the bad news they were given before and hope to receive news that contradicts what was previously heard.

Table 4: Pearls and pitfalls for breaking bad news

Do	Do not
Have the facts	Assume patient knowledge
Allow enough time	Give too much information at one time
Ensure privacy and confidentiality	Distort the truth
Use simple language	Withhold information
Clarify what patient knows	Give false reassurance
Let the patient talk	Feel obliged to keep talking all the time
Listen to what the patient says	Assume that you know what is concerning the patient
Be sensitive to the nonverbal language	Criticize or make judgments
Observe patient's emotional reactions	Hurry the consultation
Allow for silence, tears and other patient reactions	
Check for patient's understanding of what you are saying	
Document and liaise with the multidisciplinary team	
Ensure that colleagues know what the patient has been told have the facts	

Invitation: How much does the patient want to know?

While most patients express a desire for complete information about their diagnosis, prognosis, and details of their illness, some patients do not. Start by asking the patient if they want to involve other people when disclosing their medical information. If the patient wants someone else to be present, ask them to choose 1 or 2 companions. Subsequently, find out what the patient wants to know; this way, he/she feels a sense of control and management over their medical condition. Different people handle information differently, and they have the right to voluntarily decline to receive any information or designate someone else to communicate on their behalf. A physician can never be sure about what a patient wants until he/she asks.

Knowledge: Give knowledge and information

Before you break bad news, give your patient a warning that bad news is about to be told. When breaking bad news, always consider the educational and sociocultural background of the patient and their current emotional status. Give positive aspects first and avoid excessive bluntness. Provide information slowly and in small segments using clear and easily understandable language. As you discuss, frequently pause to allow silence and time for understanding and to encourage asking questions. Remember to acknowledge the patient's emotions and reactions as they occur and respond accordingly. Focus on what can be done to meet the patient's expectations and hopes and at the end, conclude with your opinion on what all the information you shared means.

Explore emotions and empathize

Responding to the patient's emotions is one of the most challenging challenges of breaking bad news. Try to adopt an empathetic characteristic during these discussions, as this situation can be emotional for the patient and their family. Try not to introduce new information too quickly, but instead establish a rapport first and earn some of the patient's trust. Afterward, information should be given incrementally while avoiding being defensive or criticizing colleagues. There is a high potential that the patient and relatives will have outbursts of strong emotions, such as denial, anger, anxiety, shock, sadness, or blame. These outbursts usually make physicians uncomfortable. However, rather than immediately trying to limit these emotions, give the patient and family time to react and express their feelings. Being empathetic entails acknowledging and addressing their emotions as they arise.

In addition, be prepared to support and comfort patients and families; small acts such as handing over a box of tissues can go a long way! Remind them that their responses are normal and natural, and let them have an outlet for their inner feelings by not rushing them. Once the emotion is "released," most people will carry on in the discussion.

Strategy and summary: Planning and follow-up

After giving bad news, it is tempting to assume that the patient and family have retained and understood what was told. However, that is not always the case since they may have misinterpreted some information or were too shy to admit they did not understand it. Therefore, it is good practice to ask the patient or family to summarize what they have understood so that any misunderstood information can be corrected. Ask for their expectations and assess their readiness to move on to discuss the treatment plan. At the end of the interview, summarize and suggest realistic treatment goals and how they can be achieved. Reassure them that you will be with them and give them written information that includes a follow-up meeting.

Conclusions

The way bad news is given affects how people cope and adjust. Giving bad news requires time, setting free from distractions or interruptions, empathy, and active listening. Keep an open mind as to what is bad news. Before giving bad news, consider who should be given, who should give it, when it should be given, what are the likely consequences of giving it? During the process, provide support for the patient's relatives and ensure that colleagues know what the patient has been told. In addition, the patient's cultural background should be considered, as the physician may need to adjust their approach to the patient due to this. Overall, a conscious effort should be made to adhere to the patient's rights as much as possible and to provide them with exceptional medical treatment.

Authors contribution

All authors have substantially contributed to the conception, drafting, critical revision for important intellectual content, and final approval of this manuscript for publication. In addition, the authors agreed to be accountable for all aspects of the work.

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Compliance with ethical principles

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