Introduction

One common experience among physicians is that of communicating bad news to patients and families. A series of recent publications on the topic is evidence of the interest researchers and clinicians have in obtaining a better understanding of the bad news process [14, 25]. Knowing what transpires in such transactions, how stressful they are, and whether these transactions have lasting emotional or physical effects is important to both the individuals receiving the news and the medical staff delivering it. Unfortunately, the bad news literature has been dominated by articles that make recommendations about what should be done, with few or no data presented about what is done. The primary goal of this investigation was to document what physicians recall doing when communicating medically related bad news to patients or families.

Importance of the transaction

There is little doubt that receiving bad news about one’s health or the health of a loved one represents the begin-
ning of a potentially stressful time in one’s life. Additionally, receiving the news can itself be stressful [13]. Concern about how best to transmit such news emanates from the belief that not only might the content and style of news transmission serve to decrease long-term receiver distress, but that differences in content and style may account for different stress perceptions related to the transaction itself. Moreover, for some types of news delivered by workers in some clinical specialties, the bad news transaction may represent the beginning of a potentially lengthy relationship between the receiver and physician. It is likely that subsequent patient–physician interactions (and the overall quality of the relationship) will be colored by perceptions of the initial interaction.

From the physician’s perspective, bad news transactions are potentially stressful, recurring events that have been shown to relate to physicians’ well-being [4, 17]. The stress associated with a given transaction may influence subsequent interactions between that particular physician and other patients [28]. The challenge for physicians, it seems, is to communicate news in ways that are beneficial to the recipient – or at least cause no additional harm – and yet do not negatively influence the doctors themselves or other patients.

Current physician recommendations for providing bad news

According to recent reviews of this topic [14, 25] there are several important aspects of communicating bad news.

1. Provide a private and comfortable place in which to break the news.
2. Ensure that the timing of the transaction is appropriate.
3. Identify a patient’s support network and have some member or members of it present.
4. Give the news in person while sitting close to the patient.
5. Prepare the patient for the news.
6. Find out how much the patient already knows.
7. Present the news in a thoughtful and caring way.
8. Show respect and empathy for the patient.
9. Use simple, non technical language without euphemisms.
10. Break the news at the patient’s pace.
11. Explore patients’ reactions and allow them to express emotions and ask questions.
12. Convey some measure of hope with the news.
13. Summarize the important information.

There are few examples in the literature of patients’ and families’ reports about their likes and dislikes regarding the way in which bad news was delivered [7, 24]. Published reports, however, suggest that patient preferences converge with the recommendations made by physicians [10, 14, 18, 24]. Specifically, patients prefer that the transaction occurs in a private and quiet location, that the news is delivered in person, and that it is communicated at their own pace, free of jargon, and with some measure of hope. Receiving documentation at the conclusion of the transaction is also important [14, 24]. Despite the face validity of many of the recommendations offered by physicians and patients about communicating bad news, one outstanding feature of the majority of published work on the topic is that it is largely devoid of information about what physicians actually do during such transactions with real patients.

The bad news transaction as a process

An additional limitation of the medical literature on communicating bad news is a general lack of attention to the process-oriented qualities of such transactions. For physicians, the transaction itself occurs in the context of other job-related experiences and, perhaps, in the context of an ongoing relationship with the patient. How these contextual variables relate to what transpires while delivering bad news has yet to be adequately explored. For example, having given similar news in the past may make it easier to give news in the present. Repeated news delivery, alternatively, may result in delivery styles that protect the physician from emotional harm, while being less than optimal from the patient’s perspective. Physicians and patients who have had lengthy relationships prior to the news are engaging in a specific interaction that is embedded in a history of other interactions.

The process of delivering bad news includes more than just the interaction with the patient or family. It also includes the strategies physicians use to prepare for the transaction and the steps they take following the transaction to reduce their own discomfort and to further assist the receiver of the news [9, 26]. Moreover, what transpires at one point in the transaction will impact on what happens later in that same transaction and on how subsequent behaviors are interpreted by both the physician and the patient.

To begin capturing the complexity of the bad news process in an empirical way, research is needed that assesses what transpires across the duration of such transactions. To obtain information about what physicians do – as opposed to what they should do – when delivering bad news, we asked physicians to respond to numerous questions about a time when they delivered bad news to a patient or family member. Questions were included that would not only allow us to assess what transpired while the physicians were preparing for and delivering the news but would also allow us to assess factors that may have impacted on what transpired (e.g., a physician’s current experiences and past history of delivering bad news and a physician’s relationship with the patient). We also obtained information about how stressful physicians thought these transactions were and about their perceptions of the patients’ experiences. These self-report data allowed us to examine what typically happens in bad news transactions.