The Good News About Giving Bad News to Patients

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BACKGROUND: There are few data available on how physicians inform patients about bad news. We surveyed internists about how they convey this information.

METHODS: We surveyed internists about their activities in giving bad news to patients. One set of questions was about activities for the emotional support of the patient (11 items), and the other was about activities for creating a supportive environment for delivering bad news (9 items). The impact of demographic factors on the performance of emotionally supportive items, environmentally supportive items, and on the number of minutes reportedly spent delivering news was analyzed by analysis of variance and multiple regression analysis.

RESULTS: More than half of the internists reported that they always or frequently performed 10 of the 11 emotionally supportive items and 6 of the 9 environmentally supportive items while giving bad news to patients. The average time reportedly spent in giving bad news was 27 minutes. Although training in giving bad news had a significant impact on the number of emotionally supportive items reported (P < .05), only 25% of respondents had any previous training in this area. Being older, a woman, unmarried, and having a history of major illness were also associated with reporting a greater number of emotionally supportive activities.

CONCLUSIONS: Internists report that they inform patients of bad news appropriately. Some deficiencies exist, specifically in discussing prognosis and referral of patients to support groups. Physician educational efforts should include discussion of prognosis with patients as well as the availability of support groups.

KEY WORDS: communication; bad news; end-of-life care.

Studies have shown that physician communication skills can affect patient satisfaction,1,2 compliance with treatment,3 quality of life,3 and health outcomes.4,5 Poor communication skills have been linked with physician burnout,6,7 professional dissatisfaction, and increased litigation.8,9 Giving a patient bad news, for example, that he or she has cancer, poses a special challenge in patient–physician communication.

For patients, receiving a diagnosis of cancer or other bad news causes great stress and can lead to psychological morbidity.10–12 Studies have suggested that physician communication can affect the psychological well-being of patients being given a diagnosis of cancer.13–19 Many patients prefer a patient-centered style of communication.20 Authors stress the importance of giving information that is perceived as adequate and eliciting and responding to the emotional reaction of each patient.11,13,21 Patients may be more likely to develop psychiatric disorders when they do not receive the information that they want or do not receive sufficient attention to their emotional responses.11,21

In the last decade, several authors have published recommendations and guidelines for breaking bad news.22–34 There is little evidence about the best methods for giving bad news, so most guidelines are based on opinion.27,35 The guidelines generally recommend individualized disclosure, i.e., tailoring the interview to the individual patient.28 Nondisclosure is no longer considered ethical. However, complete disclosure without regard for the patient’s readiness for the information is also inappropriate. Patients differ in their reactions to being given bad news and in their needs during this emotional time.

Buckman22 developed a 6-step protocol including the following: 1) giving the news in person, in private, with enough time and without interruptions; 2) finding out what the patient knows about the diagnosis; 3) finding out what the patient wants to know; 4) sharing the information, which includes giving a warning shot and then a small amount of information in simple language at a pace the patient can handle, with a caring and honest attitude; Buckman includes eliciting and listening to the patient’s fears and concerns in this fourth step; 5) responding to the patient’s feelings, which includes identifying, acknowledging, and validating his or her reaction; 6) planning and follow-through, which includes planning the next steps, summarizing what has been said, identifying sources of support, and making an early follow-up appointment.

There are relatively few data on how physicians actually give bad news. Ford et al.36 in the United Kingdom have analyzed oncologists’ interactions with their patients. In Ford’s analysis of audiotaped interactions, she found little psychosocial exchange compared to biomedical exchange, few empathic responses of physicians to their patients, and high physician control over the interviews. Several studies have shown that physicians do not detect or they under-rate distress in their patients. For example, Fallowfield et al.13 found that surgeons did not detect emotional distress in women with breast cancer in 70% of
cases. Ford et al.\textsuperscript{36} found that oncologists under-rated distress in their cancer patients. Other authors\textsuperscript{37–41} also have found that oncologists do not detect or assist patients well with their psychosocial issues.

There are even fewer data on how physicians in the United States give bad news. Eggly et al.\textsuperscript{42} analyzed videotapes of general internal medicine residents giving the diagnosis of lung cancer to simulated patients. They found a mean rating of 3.42 on informative items out of a possible 5 and a mean rating of 3.45 on affective items out of a possible 5. They found that the residents had the most difficulty in eliciting the patients’ perceptions of the problem before giving bad news, exploring whether the patient wanted to receive the news, and eliciting the patient’s emotional reaction to the news.

The purpose of the current study was to survey practicing internal medicine physicians in the United States on their self-reported practices in giving bad news. We also collected data on demographic factors and prior training in communication skills or personal experience with illness that could impact how these physicians give bad news.

**METHODS**

We conducted a cross-sectional mail survey of 1,000 randomly selected practicing interns in the United States, identified through the American Medical Association (AMA) master file, a comprehensive list of U.S. physicians, not limited to AMA members. Students, residents, and non-practicing physicians were excluded. To test the hypothesis that there is a difference in how specialists and general internists deliver bad news, the study, which was approved by the Institutional Review Board of Christiana Care Health System, included 500 general internists and 500 medical subspecialists.

Each physician received an anonymous questionnaire along with a $5 incentive. A second questionnaire was mailed to all nonresponders. All responses received before June 1, 2000 were included in the analysis.

The survey presented a hypothetical patient with metastatic carcinoma of the liver and lungs with an unknown primary. Items in the survey were developed from a study\textsuperscript{28} that used a consensus panel consisting of 28 medical oncologists, general practitioners, surgeons, nurses, social workers, clergy, and human rights representatives, along with 100 patients diagnosed with cancer within the previous 6 to 12 months. Items recommended by the panel and indicated as essential or desirable by more than 70% of the patients were included.

Eleven questions ascertained information about how internists give bad news and the emotional support that they provide to patients and their families. These questions included providing support to the family when giving bad news, finding out how much the patient wants to know, avoiding the use of specific statistics on survival, touching the patient on the hand or arm while giving bad news, giving an indication that things are serious before giving the details about the bad news (“warning shot”), conveying some kind of hope to the patient, avoiding giving the patient a specific amount of time that he/she will live, inquiring about the patient’s worries, fears and concerns, starting the process of giving the bad news by first assessing the patient’s understanding of his/her condition, encouraging the patient to express his/her feelings, and avoiding telling the patient that “everything will be all right” when conveying bad news.\textsuperscript{22,28,31} These items are referred to in this paper as emotionally supportive items.

Nine questions addressed the physical and social aspects of giving bad news in the office setting. These questions included ensuring that the bad news is given in a private setting, picking a time for giving bad news that is convenient for the patient and his/her family, sitting in a chair next to the patient (rather than behind a desk) when giving bad news, avoidance of a white lab coat when giving bad news (this item was included on the basis of suggestions during pretesting), referral to a cancer support group, ensuring that a support person is present when giving bad news, asking the receptionist to hold all phone calls when giving bad news, turning off the beeper or having someone hold it when giving bad news, and the avoidance of giving bad news by telephone.\textsuperscript{22,23,28,31} These items are referred to in this paper as environmentally supportive items. Respondents were asked to indicate how often they would perform each behavior, based on a 4-point Likert-type scale (always, frequently, rarely, never).

Items were framed so that a mix of positive and negative responses were deemed optimal (Appendix A). Demographic questions about the respondents were also included. The survey was pretested for face and content validity among 25 practicing physicians at Christiana Care Health System. Respondents in the pretest completed the questionnaire, and were then questioned about their understanding of each of the items on the survey instrument.

Data were entered for analysis manually by 2 individuals. In a cross-check of 30% of the entered data, no errors were detected. The effects of the demographic data on the number of activities indicated as being performed by respondent physicians always or frequently for each of 2 broad aspects of giving bad news (emotionally supportive items and environmentally supportive items) were analyzed by analysis of variance. Demographic variables included age, gender, marital status, life-threatening illness in the respondent, life-threatening illness in a spouse, year of medical school graduation, prior training in giving bad news, location and type of practice, percent of time seeing patients, specialty/subspeciality, and percent of practice in primary care. Demographic variables demonstrating a significant association ($P < .05$) with the outcome in a univariable regression model were entered into multivariable models. The dependent variables in these models were the number of emotionally supportive