



Mid Trent Cancer Network

Guidelines for Communicating Bad News with Patients and their Families

Information for Staff

2nd Edition - September 2008

COMMUNICATING BAD NEWS WITH PATIENTS AND THEIR FAMILIES

FOREWORD

The first editions of these guidelines were produced in March 2006 as part of Peer Review of the Mid Trent Cancer Network. We wanted to produce a set of guidelines that would be helpful to health care professionals working at the coalface of clinical practice, whether it be a busy outpatients department, GP surgery, hospital ward or patients home. They were designed to be looked at shortly before seeing a patient. They tell you not just what you should do but also what you could say which is why the guidelines contain useful phrases. For the second edition we've slightly altered the layout and in the reference section we've added a website address where electronic copies of the guidelines can be found. The flowchart at the end of the guidelines should be laminated and made accessible to staff involved in the process of breaking bad news.



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INTRODUCTION

As health care professionals the majority of us, at some time, will have to break bad news to a patient, relative or carer. Breaking bad news involves tailoring information to the patients needs, attempting to understand the patient's perspective and working in a collaborative partnership¹. The psychological sequelae of breaking bad news in an abrupt and insensitive way can be devastating and long lasting.

Although it is a fairly common part of our working lives, very few of us will have been taught or guided in how to break bad news effectively, consequently we may do it badly. Therefore these guidelines are intended to help all health care professionals to improve their skills and confidence in this difficult area. They are intended for use in busy clinical practice but it should be stressed

that these are just guidelines and not a rigid protocol. It is advised that all levels of staff have appropriate training in breaking bad news.

Teams should ensure that the communication of significant news is normally undertaken by a senior clinician. In addition to having expertise in the disease and treatment options, he or she should have received advanced communication skills training and been assessed as being an effective communicator. This may not always be practical, however as patients and carers often ask less experienced staff searching questions about their condition and care².

Bad news should not be broken over the phone. It's best to arrange a meeting. When breaking bad news the facts may not be remembered but the way they are given will be³.

There are eleven well-recognised steps to breaking bad news.

ELEVEN STEPS TO BREAKING BAD NEWS

1. Preparation
2. What does the patient know?
3. Is more information wanted?
4. Give a warning shot
5. Allow patient to refuse information at that time
6. Explain if requested
7. Elicit and listen to concerns
8. Encourage ventilation of feelings
9. Summary and plan
10. Offer availability and support
11. Communicate with the team.

**"Best Practice"
recommendations are
added to this stepwise
process**

STEP ONE - PREPARATION

Know all the facts

Before seeing the patient, check their healthcare records. Talk to the other healthcare professionals caring for the patient. For example, a patient may lose confidence if you don't know which side of their body the cancer is on.

- **The consultant has lead responsibility for discussing the news**
- **All staff conveying information will have received appropriate training in breaking bad news**
- **Whoever gives the news will have clarified the information to be discussed**

Who should be present?

It is often best for a doctor and a nurse to see the patient and relative(s) together. The patient should be given a chance to invite a spouse, relative, or friend as appropriate.

- The patient should be given the opportunity to bring the person of their choice to the interview

Set time aside

Set time aside and avoid interruptions. Sit down and avoid giving bad news when standing.

Ensure privacy and set the scene

Before starting, it is worth getting the physical context right or as right as possible. Patients should be seen in a private room within the clinical setting. If this is not possible, simple measures to ensure privacy should be undertaken, e.g. drawing curtains around a bed. Introduce yourself and your colleague clearly. You may need to check that the patient can hear you. Interviews should take place sitting down with a doctor and patient at the same level with no obstruction between them, such as a desk.

- Sit down at the same level as the patient with appropriate eye-to-eye contact
- Offer information in keeping with physical and emotional maturity
- Ensure appropriate time has been allocated and avoid disturbance

STEP TWO - WHAT DOES THE PATIENT KNOW?

At first many patients will deny knowing much about their condition but in fact often have good insight into what's going on. It's important therefore to find out what they know.

'It would help me to know what you understand about your illness-how did it all start?'

'What happened next?'

'What did the previous doctors tell you about your illness?'

'What have you made of the illness so far?'

'When you had the first symptom what did you think it might be?'

As the patient replies, you get not just factual information but you also get an understanding of what the experience has been like for the patient. You also get an understanding of their impression of the illness and how close their ideas are to the reality.

- Clarify current understanding

STEP THREE - IS MORE INFORMATION WANTED?

This is a critical step in the interview⁴. Without a clear invitation or declination from the patient to share information, you will feel unsure of the amount of information to impart. The key task for the health care professional is to establish a patient's information needs⁵.

'Would you like me give you more detail about your illness?'

'If this condition turns out to be serious, are you the kind of person who likes to know exactly what is going on?'

The level of information the patient prefers can be clarified even before results are available and this should be documented in the patient's notes.

If the patient expresses a wish not to discuss information, then this decision must be honored. Fear prevents people asking for more information and thrusting unwanted facts onto a patient can cause emotional damage. Therefore, further appointments should be made available and the patient made aware that they are free to request more information later.

By giving the patient control over the amount of information they want, it increases their trust in you. Even if a patient wants to know everything it's still best to go gently.

- An assessment is made of what the patient wishes to know at this time

STEP FOUR - GIVE A WARNING SHOT

The warning shot lets the patient know that you've got some important news for them.

'I'm afraid it looks more serious than we had hoped'

A pause after this sort of phrase gives time for your warning shot to sink in and also allows time to study the patient's reaction.

The patient's response sets the stage for the rest of the interview. They have control over whether more information is given to them. The decision to carry on is in the patient's hands.

- Prepare the way by advising some difficult news is coming

STEP FIVE - ALLOW PATIENT TO REFUSE INFORMATION AT THIS TIME

Refusal of offered information is a form of personal care that protects the individual from threats to the self⁶. This 'denial' is specific to the time of the interview and is not necessarily permanent. It isn't necessarily maladaptive and should be respected as a coping strategy.

'It must be very hard to accept this'

It is vital that you confirm with the patient that they can always ask for additional information in the future.

Few patients adopt a stance of denial permanently, most start to ask for more information once they start to feel more secure.

- Allow the patient to decline information at that time
- Breaking bad news is a process rather than an event

STEP SIX - EXPLAIN (IF REQUESTED)

A narrative of events can be a useful technique in explaining things.

'When you had a cough your GP arranged a chest x-ray for you. This showed a shadow. The shadow looked suspicious which was why a sample was taken from it. I'm afraid the results of the tests are more serious than we had hoped. The tests unfortunately show that the shadow on your lung is in fact a cancer'.

A hierarchy of euphemisms³ is helpful before mentioning cancer. Allow time for pauses and time for denial.

When explaining anything to the patient the following should be kept in mind:

- Use clear, simple and unambiguous language.

- Information should be given in small chunks.
- Avoid information overload.
- Avoid medical jargon.
- Premature reassurance doesn't reassure.
- If you can't answer a question be honest with the patient
- Use silence. It gives the patient time to let things sink in, gives them a chance to recover and gives them some control over things.
- Check understanding 'Does that make sense?'
- Repeat important points
- Use any written material available.

- Use language appropriate to the individual
- Avoid excessive information, which may "dilute the important message"

STEP SEVEN - ELICIT AND LISTEN TO CONCERNS

'What are the main things that you are worried about?'

After breaking bad news, eliciting and listening to concerns is essential. You find out what the patients agenda is. This list of concerns is often quite different to the professionals concerns. Listing the concerns, acknowledging them and prioritising them, clarifies things and is therapeutic in itself.

- Demonstrate you are willing to discuss concerns

STEP EIGHT - ENCOURAGE VENTILATION OF FEELING

'How does that news leave you feeling?'

'I can see that the news I've given you has distressed you a lot'

This is the key phase. The verbalisation of feelings is therapeutic in its own right. It's important to acknowledge the patients feelings. It can also be helpful to explore the underlying reasons for the patient's distress.'

'Can you bear to tell me why you're so upset?'

- Support the patient showing their feelings in response to the news

STEP NINE - SUMMARY AND PLAN

'Your main concerns at the moment seem to be...'

'Have I left any thing out?'

'Is there anything else important that we should discuss now?'

Making a summary and plan involves listing the patients concerns and combining this with the health care professional's knowledge of the options available. It's about making a plan, explaining it and distinguishing between the fixable and the unfixable. It acknowledges the support already available, especially from family and friends.

- Summarise the news and offer a permanent record
- Encourage questions

STEP TEN - OFFER AVAILABILITY AND SUPPORT

'We can see you again next Wednesday at 2 pm, is that alright with you?'

A clear follow up appointment that the patient is happy with is important. Most patients need further explanation after being given bad news, as they often cannot think of anything to ask at the time. It also takes time to adjust emotionally to bad news.

'We will work on this together'.

'You will not be left to cope with this on your own'.

Support for the patient is essential. Offer contact numbers for the clinic/surgery and the specialist nurse. Offer appropriate written information.

- Offer a follow up telephone call
- If the patient wishes follow up - ensure a person is nominated to make the call

STEP 11 - COMMUNICATE WITH THE TEAM

It's important to communicate with the rest of the team including the patients GP, as they will have to support the patient after you've left. Document details of the conversation in the patient's notes and if you're sending a letter make a note of the breaking bad news session in the letter. Consider offering a copy of the letter to the patient.

- Document the communication clearly including quotes for key words and phrases used
- Communicate with Primary Care Team and secondary Care Multidisciplinary Team
- Consider offering a copy of letter to patient

REFERENCES

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2. NICE Improving Supportive and Palliative Care for Adults with Cancer, P58, 2004.
3. Kaye P, Breaking Bad News-A ten step approach, 1996.
4. Buckman R. How to break bad news. Pan, 1992.
5. Faulkner A, Maguire P. Talking to cancer patients and their relatives. Oxford, 1994.
6. Russell G.C. The role of denial in clinical practice Journal of Advanced Nursing 18 938-940, 1993.
7. <http://information4u.org.uk/> Contains a copy of these guidelines.

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Breaking Bad News Flowchart

