

## Breaking Bad News: A Patient's Perspective

LAUREN DIAS, BRUCE A. CHABNER, THOMAS J. LYNCH, JR., RICHARD T. PENSON

Department of Medicine, Division of Hematology-Oncology, Massachusetts General Hospital,  
Boston, Massachusetts, USA

**Key Words.** *Oncology · Support · Psychosocial · Communication · Care*

---

### LEARNING OBJECTIVES

After completing this course, the reader will be able to:

1. Explain the importance of compassionate care and clear communication in oncology.
2. Recognize the advantages and limitations of good communication.
3. Communicate better with patients and families who face life-threatening illness.

CME

Access and take the CME test online and receive one hour of AMA PRA category 1 credit at [CME.TheOncologist.com](http://CME.TheOncologist.com)

---

### ABSTRACT

Shortly before his death in 1995, *Kenneth B. Schwartz*, a cancer patient at Massachusetts General Hospital (MGH), founded The Kenneth B. Schwartz Center at MGH. The Schwartz Center is a nonprofit organization dedicated to supporting and advancing compassionate health care delivery that provides hope to the patient, support to caregivers, and encourages the healing process. The Center sponsors the Schwartz Center Rounds, a monthly multidisciplinary forum where caregivers reflect on important psychosocial issues faced by patients, their families, and their caregivers, and gain insight and support from fellow staff members.

Clinicians in the field of oncology are unavoidably forced to break bad news. The Schwartz Center Rounds

focuses on issues of communication between patients and their caregivers, one of the most difficult aspects of which is breaking bad news. The invited patient, a woman who had been living with a low-grade cancer for many years, spoke about her experiences both as a person living with cancer and as the daughter of a patient diagnosed with cancer. Her father's suicide, precipitated by being told his diagnosis, puts the horror of receiving bad news into stark relief. She provides a fascinating account of how she proactively adjusted to her diagnosis, and fought for optimal quality of life. This article discusses issues of support, abandonment, and how hope is conveyed, and reviews the literature that informs good clinical practice in breaking bad news. *The Oncologist* 2003;8:587-596

---

### PRESENTATION

Details of the patient's history have been changed to protect her anonymity.

*Patient:* Let me take you back to the start. I was completely well. I was toodling along with two little kids and a husband. He is a physician. I was teaching school

*Correspondence:* Richard T. Penson, MRCP, M.D., Instructor in Medicine, Hematology-Oncology, Cox 548, 100 Blossom Street, Boston, Massachusetts 02114-2617, USA. Telephone: 617-726-5867; Fax: 617-724-6898; e-mail: [rpenson@partners.org](mailto:rpenson@partners.org) Received October 20, 2003; accepted for publication October 20, 2003. ©AlphaMed Press 1083-7159/2003/\$12.00/0

and one day I found a football-sized mass in my abdomen. It frightened me, but because it was so huge, I felt it had to be benign. After all, something that big could not possibly be a cancer, and the word cancer just never even entered my mind. I was too young, I thought. Anyway, I went into surgery not having a clue. The doctors really did not prepare me for it except to say I had a mass. I remember exactly what he said. I woke up from surgery to hear my surgeon say, "I have good news and bad news. I didn't have to remove any of your organs, but (pause) you do have cancer." It just blew me away.

During that year I had four surgeries and was in and out of the hospital. I had a lot of time to think about what I was going to do with the rest of my life, which is something you say when you have cancer. "Now what am I going to do? I don't know how long I am going to live." No one was sure of the prognosis, and I said to myself, "What I do know is

*During that year I had four surgeries and was in and out of the hospital. I had a lot of time to think about what I was going to do with the rest of my life, which is something you say when you have cancer.*

that I don't like what I am doing now. I do not want to teach school anymore. I want to do something health care related because I don't even know where any of my organs are and I need to know more about my body if I am going to interact with my doctors intelligently."

While some people who interacted with me were really truly wonderful, others were horrendous, just horrendous. I thought I could make a difference. I stopped teaching and went into the medical field, which is actually one of the best things that could have happened to me.

Subsequently, I have had 13 abdominal surgeries, 4 months of chemotherapy, and 6 weeks of radiation therapy. I have a tumor right now. I have not been tumor-free in years. I have always had some tumor that is being watched. The tumor in my abdomen that we're watching now will have to be operated on, or I will get experimental therapy. I am having a computerized tomography (CT) scan next Tuesday, and so I am sort of on edge. I am very well aware of the size of the tumor because I feel it. So, I am very realistic about where I am at and about how things might go for me, and that's why I need to act.

Through my care, I have been in three different hospitals. I think my medical care has always been excellent. I left the two previous ones, not because I was unhappy

with the medical care, but because I was unhappy with the communication with the doctors. After one complication, the surgeon did not speak with me for the whole admission. He would come into my room each day to check my chart and examine me, but he never sat down to say, "This is what I found. This is what happened. This is what is going to happen. This is what we're going to do." I don't think he could deal with a bad result and I really was a bad result. So I left that hospital. Another doctor made me feel like things were just hopeless. Now I have found somebody who lifts my spirits and who is always going to tell me he's got something to pull out of

his hat for me. I am realistic and I know that the hat is getting a little bit shallow, but the communication is there and I am part of a team, and that's very important. Patients really want to feel that they're part of a team.

I didn't have my cancer in isolation. I was married, was raising children, and I had two parents who were very distressed about my cancer. They were

from an older generation where they couldn't talk about cancer. I took it upon myself to educate them. I remember one time we sat down in my living room and I said, "Okay now, on the count of five we are all going to say the word 'cancer'." They literally could not say it. They lived far away and tended to only see me during times when I was ill. Never when I was well. There were a lot of times when I was ill. And when I was ill, I was really ill. What they apparently were learning from my experience was not that you can survive cancer, but that it could be really horrible.

My father was 86 years old, a very healthy man, very robust, very active, didn't look a day over 70, never had a health problem, and was uncomfortable in a hospital setting. He was just so scared for me, and would say, "I will never suffer like that. I think what you're going through is just torture," and at times, it really was. Some of those times were really horrible and there was no hiding it from him. He would say, "This isn't fair, people shouldn't suffer. Somehow you have the strength to do it, but I could never do that. If I had to suffer at the end of my life, I would be active."

My parents were becoming more frail and my mother suffered from depression. My father then had some rectal

bleeding. He dismissed it for ages but finally he went to the doctor. The doctor sent him for a barium enema that showed an irregularity in his colon and suggested that he probably should have a colonoscopy. I said, "Irregularity is not a word that a radiologist uses. What does that mean? Call him back and ask him for a copy of the report." He said, "Oh, the doctor doesn't sound alarmed. It doesn't sound like it's anything major. I am feeling fine. Just let me be. The colonoscopy is just a precaution." Meanwhile he had no contact with his doctor. All the contact he had with his internist was one telephone call to be told he had an irregularity. So I was thinking, maybe it's a polyp.

He finally went for the colonoscopy, and the gastroenterologist took one look at the barium enema and said to him, "I don't know why you're here. You clearly have a blockage. You should have gone to a surgeon 3 weeks ago." My father was understandably startled by that. That was the first time he had heard "blockage." He said, "You go home." It was a Friday afternoon. "I will call your internist, and tell him

that you really need to be admitted because you need surgery." My father went home, called me immediately, related the story, and said, "Are they trying to tell me I have cancer?" This was the first time he had brought it up. I said, "Dad, let me get off the phone," and I had my husband call the gastroenterologist. So my husband called the gastroenterologist who said, "Your father-in-law clearly has colon cancer. He should have seen a surgeon weeks ago. He is almost completely obstructed. He really needs to have surgery tomorrow." I called my father back. He said, "Well, what did the doctor say?" I said, "Well, the doctor said you really need to go to the hospital to talk to a surgeon." He asked, "Is it cancer? Am I going to need a colostomy?" I said, "Dad, first of all, it's not that low down. Number two, we don't know if it's cancer, but it's an obstruction, and an obstruction has to be removed. You just can't live like that." He said, "I can't do it. I don't want to do it." I could hear the distress in his voice. Evidently he got off the phone, didn't say a word to my mother, walked right by her, walked into another room where he had a gun, which nobody knew about, walked out of the house, and shot himself in the head.

His suicide has changed everybody's life. It's the most extraordinary experience. I had 16 years of cancer

and my father couldn't deal with the possibility of it for an hour. I was so upset that he couldn't turn to me and have me or his doctor say, "Let's talk about this. Ask me your questions." My mother was also completely in the dark. My father hadn't verbalized any of his concern to her. But, 2 days before he committed suicide, he said to my mother, "Well, I am having the colonoscopy on Friday and then I will know if I have cancer or not." What he was saying to her was, "I will know if I am going to kill myself or not," because that same day he went to the bank, took out \$5,000 and sent me a check for \$5,000 that arrived in my mailbox the day after he killed himself with a little note that said, "Darling, here's a gift and mum's the word. Love, Dad."

After we buried my father, I made an appointment to see the internist, and I said, "Why didn't you pick up the phone and call me? You knew how concerned

I was." And he said, "Because your father never told me to call you." I said, "But my father didn't know what he had. You didn't even give him the opportunity." I asked the internist, "How many times a month do you have

a patient who has just been diagnosed with cancer?" He said, "Maybe once or twice a month." I was furious. "Did you ever think of how serious it is telling somebody that they have cancer? How much thought have you given it?" He said, "Maybe I never gave it any thought."

I am here today, because if only one person hears this story and understands just how traumatic giving a cancer diagnosis is, it will be worth it.

#### DIALOGUE

**Patient:** This is a wonderful forum for me because a very important part of my cancer experience has been becoming an advocate for cancer survivors. A friend of mine said to me, "After your 16 years of cancer you really ought to write a book and you should call it 'How I Found My Voice'." I am definitely a different person than before my cancer, when I was a very quiet, docile, passive, submissive person. Cancer gave me my voice and made me very active and, honestly, there is nothing I won't say at this point.

**Nurse:** Did you and your father have very different attitudes toward both life and death?

*If only one person hears this story and understands just how traumatic giving a cancer diagnosis is, it will be worth it.*

**Patient:** I know that my father read *Final Exit* when it came out in 1991 [1]. He and I discussed it. To him, cancer meant death. When you think about that age group, it really was different. For younger, proactive patients, it means survivorship. For that age group it was death. And years ago it was death. Part of me says he did what he wanted to do.

**Physician:** What are the things you can remember about times you've been told devastating news and yet felt supported?

**Patient:** With the team that I have right now, there is the sense that, if my latest treatment doesn't work, there'll be something else. We're going to try it. There's always something more. The relationship I have with my doctors is really very close and warm. They know me very well. I know them very well. I feel very comfortable sharing anything with them and it's just the idea that there's always something more to be done. And I talked about end-of-

life issues with my doctor and I said, "You know, one thing that a lot of cancer patients fear is that they'll be treated by their oncologist for a number of years and then be abandoned." And I said to him, "When you no longer have any tricks in your hat, am I no longer going to be part of your patient pool?" I have a very close relationship with him, and he said, "No, we don't do that to patients." I hope that's true. But it's a scary thing. I know. I have many friends with cancer. I have a huge cancer world that I am living in now. We talk about things like that, and we all find it very scary.

**Patient:** I had to learn the lesson personally. I made a serious mistake when I was first diagnosed. We decided to protect the children. Four years later, my older son, who was then a teenager, said to me, "Mom, I have something to ask you. You have cancer, right? Mom, you know, I've known this all these years. Other mothers don't go to the doctor every 3 months for CT scans and other mothers don't get agitated right before tests. I just knew, but I was waiting for you to tell me, and I

felt that you didn't think that I could be of help to you." It really broke my heart and it really taught me a lesson. He said, "Please don't ever do that again, because I could have been supportive. I could have been helpful." The older one is very outgoing about it. He is married now and lives in New York. He's very up-front with questions. We discuss it all the time. The younger son, who is 25 and also lives out of town, can't talk about it at all. I said to him once, "Why don't you ever talk to me about my disease? You never ask me questions." He said, "Mom, I love you and I am very concerned about you, but I am afraid I am going to say something to you that's going to make you cry and I don't want to see you cry. And I know, I talk to my older brother, so I know everything that's going on. I know everything,

but I am just afraid to hurt your feelings and make you cry, and then I am going to cry." He's a very sensitive kid. It's hard on my husband, and it's very hard to comfort him. It's harder to be the spouse of the patient than the patient. I am involved, I am with the doctors, I am having the test, I am doing the things. He feels helpless, and especially because he's a doctor, he feels like

maybe there were things he could have done to prevent all this, which he obviously never could. It's very difficult. I've become a different person. I am not the person he married.

**Facilitator:** I wonder if it's changed the way your husband delivers news to patients?

**Patient:** Well it's interesting. He actually wanted to engage more with patients, and started spending more time with them. But with me, it's just too scary. He doesn't want to talk about it. He doesn't look at my CT scans. I don't really blame him. They're really pretty horrible.

When I was first diagnosed and this whole thing was a big surprise, I was very impressed with a young nurse who came into my room one day. She was just kind of doing her little things around my room and she just turned to me very casually and she said, "So the doctor told you your diagnosis." I said, "Yes," and she said, "Do you want to talk about it?" It was wonderful. She

*I live my life in little bitty segments. My goals are very short-term goals. I have enough friends with cancer and I've seen things that have happened to them and I am very realistic. I am not going to be around forever.*

was very comfortable with it, and we talked about it.

In my experience, the surgical nurses have a lot of problems with cancer, and the worst thing for a cancer patient is to have a nurse be uncomfortable with your cancer. I am just like anybody else.

**Nurse:** How do you cope? How do you maintain hope?

**Patient:** I live my life in little bitty segments. My goals are very short-term goals. I have enough friends with cancer and I've seen things that have happened to them and I am very realistic. I am not going to be around forever.

**Social Worker:** I heard a patient advocate speak recently. She was very critical of physicians being paternalistic, but she also slammed physicians who used statistics to explain prognoses. She seemed to have a "tell me everything, but not the bad bits" attitude. Any advice for us?

**Patient:** When I sit around with my cancer friends and we compare notes, what

becomes very apparent is that patients are very different. I like to be hugged by my oncologist. Some people don't want that. A friend of mine was hugged by her oncologist and she felt she was going to die the following week. She said, "Why would he have hugged me if he didn't think that I was about to die?" It broke my heart. I said, "If my doctor doesn't hug me I am insulted." Patients are very different. A lot of us don't like to hear statistics. When I was first diagnosed, I said to the first doctor who gave me my diagnosis, "What are the chances for my living 5 years?" and he said, "They don't mean anything, so I won't even give them to you." That afternoon my husband went to the library and spent the afternoon researching my disease and in his head decided that I wasn't going to live 5 years, according to the statistics. He didn't tell me that until 10 years later, which was excellent. Even if my chances of surviving 5 years are only one in 100, well why couldn't I be that one?

**Facilitator:** When he told you that, were you upset?

**Speaker:** No. I need a doctor who is going to say, "You know, you're looking great, we're going to do it,"

rather than, "You're going to live another 10 years." My doctor never says "You're going to live to be an old lady." He says, "You're doing fine. Look how well you're doing now. You're doing well now. There are more things. There are so many things on the horizon." And then I am realistic, too.

**Physician:** A patient is not just looking for the facts, but for some belief in themselves, because they've got a fight ahead of them, and you'd better be on the side of the patient.

**Patient:** There are words that hurt and there are words that heal. A lot of it has to do with the way your doctor relates to you as a human being. I want to see my doctor as a human being.

*A patient is not just looking for the facts, but for some belief in themselves, because they've got a fight ahead of them, and you'd better be on the side of the patient.*

**Nurse:** I think that when you relay bad news or sad news to patients, one of the key ingredients is that you come with a plan, not just the news, but what you are going to do about it.

**Patient:** Yes, clearly. But when he comes with a plan, he doesn't say to me, "This is what you are going to do," he says "This is what you could do... you could do this and this is what it will entail." Then it is my decision. He is very respectful of my wishes, which I think is just as important.

**Physician:** I have had some patients tell me that I don't smile enough or joke enough. I am often giving them very serious information. I am happy to joke with patients. But how much and when?

**Patient:** Cancer is very grim and a lot of people look at us in a very grim way... Somebody called my doctor a cheerleader, because he is very upbeat. Cancer is his life, and it was my life too.

## DISCUSSION

Open communication between a physician and patient is critical for developing a therapeutic relationship, gathering data, and implementing a treatment plan (Table 1). This level of communication requires mutual trust and respect as well as strong listening skills. Communication is often defined as "to impart" or "make known," but its Latin derivation is helpful

**Table 1.** Communication skills

1. Improve the accuracy of diagnosis and quality of management.
2. Improve the eliciting and imparting of information.
3. Improve patients' understanding, retention of information, and compliance.
4. Reduce anxiety, uncertainty, and litigation.
5. Improve doctor and patient satisfaction.
6. Can be learned.

From *Penson and Slevin* 2002 [27].

in emphasizing the “sharing” of information; *communis* means “in common.” Though the main aim of communication is to elicit and impart information, the way that it is accomplished can have a profound effect on the relationship between the doctor and the patient, and on a patient’s approach to his or her disease and treatment. Many aspects of communication are obscured by myths and moralizing, but communication remains one of the most important influences on the quality of medical practice. Good communication improves the accuracy of diagnoses, enables better management decisions, and reduces unnecessary investigations and inappropriate treatment. For the doctor, good communication is professionally rewarding and personally satisfying. For the patient, it reduces anxiety and uncertainty [2]. There is evidence that good communication improves compliance [3], and that improving doctor-patient communication may be the most effective way of reducing the incidence of litigation [4]. The patient’s easier adjustment to the diagnosis of cancer is a cited, but as yet unproven, independent prognostic factor [5].

### Barriers to Good Communication

Some barriers to open communication are obvious: major disconnections over social status, race, age, or gender. Other barriers are more subtle, such as when embarrassment, guilt, or fear limits a patient’s ability to discuss a concern [6]. Defining and exploring barriers is often the best first step toward overcoming them. For example, a lung cancer patient may be overwhelmed with feelings of guilt about a smoking history. A physician who recognizes this may ask about this emotional burden, empathize with the patient’s concerns, and explore ways to find self-forgiveness.

All too often, patients and doctors collude to limit communication. More than one-quarter of patients are not told of the incurable nature of their illness, more than one-third of patients with incurable metastatic cancer believe that their palliative regimens are meant to be curative, and approximately one-quarter are not told of treatment side effects. Rarely do physicians ask patients if they understand the information presented [7]. Many patients feel that they have not been given adequate information, yet many patients fail to ask questions or ask for clarification. However, both sides are reforming. Medical schools routinely teach communication skills [8], and there are resources available (e.g., the website Ask Me 3; <http://www.askme.3.org>) that encourage patients to ask three simple questions each time they see a health professional: What is my main problem? What do I need to do? Why is it important to do this?

Multiple studies have shown that patients generally

want to know their cancer diagnoses and prognoses. Despite this, more than 40% of oncologists withhold prognoses if they are not specifically asked or if family members request that the patient not be told [7]. In the U.S., the law has clearly defined a clinician’s obligation to pro-

vide as much information about a disease course and treatment as the patient desires [9].

A lack of time is often blamed for limiting good communication, and rightly so. Lack of privacy, interruptions, and distractions compound stress. The more subtle, and yet potentially more difficult, aspects of giving bad news include responding to patients’ emotions, giving hope when the situation is bleak, and handling difficult family issues [10]. When patients are asked to identify factors that contribute to poor delivery of bad news, they cite excessive physician bluntness, location or time not conducive to serious discussions, and lack of maintenance of hope. They also stress the importance of balancing honesty and realism with sensitivity and support [11].

Denial in cancer patients, which can vary in degree based on a number of factors, is often a very reasonable defense mechanism. Age and level of depression may limit what patients want to know. Older patients tend to want less information and less involvement in decision making [12]. Caregivers should take account of this, both by offering to go into more detail with younger patients and by offering “escape clauses” to older patients. That is, physicians may tell the truth but not the whole truth. Though this older

*It is, thus, extremely important  
to separate the message from the  
messenger, in order to achieve  
clinician self-preservation.  
The cancer is to blame.*

group may offer fewer “signposts” (flags, cues) to the doctor hoping to steer a successful course through difficult issues, they tend to be more easily satisfied [13].

Bad news may be defined as “any information which adversely and seriously affects an individual’s view of his or her future” [14]. In an informal survey conducted during a communications symposium at the 1998 Annual Meeting of the American Society of Clinical Oncology (ASCO) (64% medical oncologists, 38% practicing in North America), 31% of participants reported breaking bad news 10-20 times per month, while 14% did so greater than 20 times per month [9]. Other sources report averages as high as 35 times a month [7]. Physicians frequently report difficulty in explaining a lack of curative options and negotiating the transition to hospice [9]. Yet, in one recent study, 42% of physician responders reported no formal training for breaking bad news and 53% felt their ability to break bad news was good to very good while 47% reported it to be fair to poor [9].

However, there are multiple barriers to and concerns about breaking bad news. Physicians feel anticipatory stress prior to an encounter, and their stress peaks during the clinical session. Many oncologists find it extremely stressful and have difficulty dealing with patients’ emotional responses. In the ASCO survey, 67% of participants rated their comfort in dealing with patient’s emotions as “not very comfortable” to “uncomfortable.” The stress of breaking bad news is greater when the clinician is inexperienced, when the patient is young, when the doctor and patient have a long-standing relationship, when strong optimism for a successful outcome had been previously expressed, and when the prospects for effective treatment are limited [15]. Many caregivers become quite anxious around delivering bad news and feel a tremendous burden of responsibility. They may avoid sensitive topics, such as prognoses, and thereby contribute to a patient’s false sense of hope. It has been suggested that physicians who have difficulty breaking bad news may be more apt to offer and provide harsh treatments that are not expected to help [15]. Many practitioners feel guilty or to blame for the bad news. It is, thus, extremely important to separate the message from the messenger, in order to achieve clinician self-preservation. The cancer is to blame.

### Breaking Bad News

There are many views on the right way to break bad news [16]. There are, however, a number of helpful essential

**Table 2.** Breaking bad news

Ideally, confirm bad news.

1. Be prepared. What do they know and want to know?
2. Warn that you have serious news.
3. Be simple and clear. Tailor the information to the patient.
4. Has the message been understood? If not, check how much more information the patient wishes to know.
5. Pause to let it sink in then respond to their reaction and to difficult questions.
6. Summarize and establish a plan for how to move on.

From *Penson and Slevin* 2002 [27].

elements common to each school of thought [17, Table 2]. Two important factors in effectively breaking bad news include a physician willingness to discuss dying and physi-

cian sensitivity to the difficulties of the topic [11]. The ability to break bad news effectively and compassionately involves not only delivering the information clearly, but also providing emotional support, responding to patient and family reactions, assuaging any fears

*A patient should never hear  
“there is nothing more to offer,”  
as this ignores the importance of  
symptom management and creates  
a sense of abandonment.*

of provider abandonment, participating in group decision making, and maintaining a sense of hope.

More effective communication happens in a quiet, private, and comfortable location. The space should allow the physician and patient to sit face to face without physical barriers, and should be large enough to accommodate the patient’s support network (i.e., appropriate family and friends). Maintaining eye contact is critical, and occasional physical contact, such as touching the patient on the arm or hand, may be appropriate and comforting. In order to avoid interruptions, turn off cell phones and sign-out beepers when possible. Schedule ample time and communicate any time constraints you may have at the beginning of the conversation.

The presence of friends and relatives can inhibit the disclosure of difficult issues that patients may wish to discuss. In these situations, the patient may also retain little of the information and may benefit from going over what was said again with the spouse, friend, or relative that was present. Physicians should consider providing a tape recording of the interview, written information, and illustrations [18].

Discussing ahead of time how an individual patient would like to receive test results, and how much detail he or she would like about clinical course and prognosis, can help

guide future conversations. Asking a patient for his/her perception of their situation can help to establish how much the patient knows or wants to know. Questions such as “what is your understanding of your illness?” may help elucidate a patients’ perspectives of their clinical situation and allow the oncologist to identify misinformation. This also creates the opportunity to confirm bad news rather than deliver it. It may also bring to light the use of different forms of denial that may need to be addressed.

The doctor should prepare the patient to receive serious news. Some physicians advocate “forecasting” or “firing a warning shot” in order to prepare the patient for the news to come. For example, a discussion might open with “I am afraid I have some difficult news.” Giving the details about the diagnosis, stage, and prognosis in a sequence of acceptably small “packets” can enable a doctor to tailor the delivery of the information according to a patient’s readiness to accept it. What the patient says and asks, and how he or she reacts to each bit of information, should determine how much is said at any one time. One drawback to giving information incrementally, as a “ladder” leading up to the bad news, is that patients may be reluctant to ask questions, unable to interact, or prematurely opt out of hearing important information.

Doctors must inform patients of the facts and assess their emotional responses. Doctors should reinforce the elements that the patients perceive correctly and gently educate in areas of misunderstanding. Physicians should continually probe patients’ understanding and have the confidence to ask them how they feel. Rarely is a patient’s reaction to bad news purely dependent on the news itself. Everyone has “personal baggage” that colors how they respond. If the patients feel that doctors understand their distress, then reassurance will be more effective.

Language should be simple and free of jargon and euphemisms. The patient should not be inundated with complicated technical terms. Rather, the information should be conveyed clearly and slowly around key issues, leaving time for questions. There are three particularly helpful ways to proceed when discussing difficult or distressing topics.

- *Reflection*: Repeating back key words that the patient said can give patients the opportunity to say more, if they wish. Reflection is especially helpful in emotionally charged interviews. Paraphrasing (reformulating

what is said, or unsaid) the underlying emotion may provide very helpful insight.

- *Clarification*: Checking that you understand correctly what the patient said aids precision and avoids errors. Gut feelings that you have about the link between a particular cause and effect should be explored, for example, “because of the... you felt...?”
- *Summarizing*: Summarizing what has been said fundamentally improves understanding while bringing some order to the confusion that a cancer diagnosis causes. Repeating key points is often helpful and necessary. Providing diagrams, lists of treatment options, or written material that can be referred to later can help to clarify complicated matters. These treatment

options have to be clearly explained including outlining what can be, and what might not be, achieved.

Empathizing with a patient involves making a connection with him or her and experiencing his

or her emotions as an extension of your own, and communicating an understanding of his or her position and feelings. An empathic response makes clear to the patient that you’ve understood how they feel. When further chemotherapy, surgery, or radiation are not options, it is important to emphasize therapeutic goals such as pain control and maximizing quality of life. A patient should never hear “there is nothing more to offer,” as this ignores the importance of symptom management and creates a sense of abandonment.

Doctors should identify and address emotional responses. Patients may express shock, denial, sadness, frustration, fear or anger; each of these emotions deserves attention, yet physicians often fail to address them. The clinician should recognize and validate the patient’s feelings as best as he or she can. In a qualitative study of five oncologists, the physicians were frequently ineffective in identifying a patient’s distress while delivering bad news. In the same study, this sharply contrasted with physician self-assessment. Doctors overestimate their efficacy [11].

Bad news inevitably raises a considerable, if not overwhelming, number of problems for patients and families. Encourage patients to prioritize these problems to ensure that they are addressed in an appropriate order. It may be more productive to tackle most of them during a later visit. Nurses and social workers provide invaluable support. Establishing the next appointment and the ground rules for

*It is important to remember  
“a physician need not fully share a  
patient’s hopes or fears to respect,  
learn about, and respond to them.”*

how discussions might proceed, giving a telephone number through which you can be contacted, and fostering realistic hopefulness are investments toward success. Addressing emotionally laden issues and helping patients navigate through their distress is undoubtedly a skill to be cherished.

Initial or additional training in breaking bad news may be very useful in enhancing patient-doctor communication, improving job satisfaction, and benefiting patient quality of life. A study from the United Kingdom showed that the communication difficulties of senior oncologists were not resolved with time and clinical experience. In fact, an intensive 3-day training course did significantly improve those physicians' skills [17]. An increasing number of resources are available to help oncologists learn effective communication. These include formal courses [11, 19, 20], guidelines [15], symposia, and workshops [21].

### Lending Hope

Hope is a critical component of coping with a cancer diagnosis, yet the diagnosis of cancer cannot always be softened in the same breath with talk of cure. Doctors expect their patients to hope for the best, and prepare for the worst, and patients expect their doctors to "advocate for their health and longevity" [22]. In order to maintain a healthy practice, physicians must also be optimistic about their patients' treatment plans and course. By sharing a sense of hope, doctors align themselves with the patient and provide critical support [11]. Hope includes not only successful treatment, but freedom from pain and support in facing death.

It is important to remember "a physician need not fully share a patient's hopes or fears to respect, learn about, and respond to them" [11]. Honest information, rather than unduly negative or falsely reassuring information, offers the safest path for patients to establish their hopes (Table 3).

Viktor Frankl eloquently recorded his experience in the concentration camps during the Second World War [23]. He observed that prisoners who felt that life had real purpose and meaning were able to cope with the atrocities and the almost certain threat of death, while others, for whom life had lost all

meaning, quickly succumbed to malnutrition and infection. However, this latter group could be helped to regain the meaning in their lives with consequent improvement in its quality. Frankl's observations reinforce the notion that information fills voids that people might otherwise fill with despair. Positive and practical information banishes the fear of the unknown. Simply categorizing issues can chop up overwhelming distress into manageable worries. Although at least 85% of patients would want a "realistic estimate" of how long they had to live if their life expectancy was less than 1 year [24], fixed life expectancies can discolor remaining time, and it has been suggested that uncertainty as to when life ends is a prerequisite for life to have meaning and value [25].

Achieving realistic hopefulness is hard. While most oncologists try to remain hopeful and enthusiastic throughout a patient's course, they must balance this with realism. Exclusive emphasis on hope can rob patients of the opportunity to explore their wishes and fears, discuss dying, and engage in life review. The patients may be unaware of a limited prognosis and may choose to engage in ineffective therapies instead of spending quality time with their loved ones. When a patient is dying, the physician may regret not being completely honest and may withdraw from the situation and create a sense of abandonment. By striking the balance between hoping for the best and preparing for the worst, clinicians can help their patients address emotional and spiritual issues, focus on symptom management, and cultivate a deeper and more satisfying patient-physician relationship. The public is intensely interested in improving the bedside manner of physicians, and that desire has now been heard at several levels of organized medicine [26].

### CONCLUSION

Good communication potentially offers the most rewarding aspect of total patient care. The way in which patients are involved in their care and the way in which oncologists elicit and impart information contribute to the quality of patient treatment.

### POSTSCRIPT

The patient described in this paper has subsequently died. She did not write her book but leaves an enduring legacy.

### FURTHER READING

Buckman R. I Don't Know What to Say. London: Papermac, 1988:1-272.

Simpson M, Buckman R, Stewart M et al. Doctor-patient communication: the Toronto consensus statement. *BMJ* 1991;303:1385-1387.

Baile WF, Buckman R, Lenzi R et al. SPIKES—a six-step protocol for delivering bad news: application to the patient with cancer. *The Oncologist* 2000;5:302-311.

**Table 3.** Communication with the cancer patient

1. Have clear objectives, assume nothing, and be flexible.
2. Introduce yourself and establish rapport.
3. Listen and ask open, but directive, questions.
4. Question and summarize until you have the whole picture.
5. Acknowledge and address issues.
6. Summarize and screen for other issues.
7. Be simple and clear, tailor the information to the patient.
8. Reinforce realistic hopefulness.

From *Penson and Slevin* 2002 [27].

## REFERENCES

- 1 Humphrey D. *Final Exit—the Practicalities of Self Deliverance and Assisted Suicide for the Dying*. Third edition. New York: Delta 2002:1-256.
- 2 Fallowfield LJ, Baum M, Maguire GP. Effects of breast conservation on psychological morbidity associated with diagnosis and treatment of early breast cancer. *Br Med J (Clin Res Ed)* 1986;293:1331-1334.
- 3 Davis H, Fallowfield L. *Counseling and Communication in Health Care*. Hoboken, NJ: John Wiley & Sons Ltd, 1991.
- 4 Shapiro RS, Simpson DE, Lawrence SL et al. A survey of sued and nonsued physicians and suing patients. *Arch Intern Med* 1989;149:2190-2196.
- 5 Greer S, Watson M. Mental adjustment to cancer: its measurement and prognostic importance. *Cancer Surv* 1987;6:439-453.
- 6 Quill TE. Recognizing and adjusting to barriers in doctor-patient communication. *Ann Intern Med* 1989;111:51-57.
- 7 Gropman JE. *The measure of our days*. New York: Penguin USA, 1998:238.
- 8 Laine C, Davidoff F. Patient-centered medicine: a professional evolution. *JAMA* 1996;275:152-156.
- 9 Baile WF, Lenzi R, Parker PA et al. Oncologists' attitudes toward and practices in giving bad news: an exploratory study. *J Clin Oncol* 2002;20:2189-2196.
- 10 Adenis A, Vennin P, Hecquet B. What do gastroenterologists, surgeons and oncologists tell patients with colon cancer? Results of a survey from the Northern France area. *Bull Cancer* 1998;85:803.
- 11 Back AL, Arnold RM, Tulsky JA et al. Teaching communication skills to medical oncology fellows. *J Clin Oncol* 2003;21:2433-2436.
- 12 Cassileth BR, Zupkis RV, Sutton-Smith K et al. Information and participation preferences among cancer patients. *Ann Intern Med* 1980;92:832-836.
- 13 Blanchard CG, Ruckdeschel JC, Fletcher BA et al. The impact of oncologists' behaviors on patient satisfaction with morning rounds. *Cancer* 1986;58:387-393.
- 14 Buckman, R. *Breaking Bad News: A Guide for Healthcare Professionals*. Baltimore: Johns Hopkins University Press, 1992:15.
- 15 Baile WF. Breaking bad news. Report of the NCCN Task Force on Physician-Patient Communication. Presented at the Annual Meeting of the National Cancer Center Network. Fort Lauderdale, Florida, March 18, 2000.
- 16 Ptacek JT, Eberhardt TL. Breaking bad news: a review of the literature. *JAMA* 1996;276:496-502.
- 17 Fallowfield L. Giving sad and bad news. *Lancet* 1993;341:476-478.
- 18 Hogbin B, Fallowfield L. Getting it taped: the "bad news" consultation with cancer patients. *Br J Hosp Med* 1989;41:330-333.
- 19 Fallowfield L, Lipkin M, Hall A. Teaching senior oncologists communication skills: results from phase I of a comprehensive longitudinal program in the United Kingdom. *J Clin Oncol* 1998;16:1961-1968.
- 20 Parle M, Maguire P, Heaven C. The development of a training module to improve health professionals' skills, self-efficacy and outcome expectancies when communicating with cancer patients. *Soc Sci Med* 1997;44:231-240.
- 21 Baile WF. Communication at the end of life. Walking the darkness together. Special session of the Annual Meeting of the American Society of Clinical Oncology. San Francisco, California, May 14, 2001.
- 22 Back AL, Arnold RM, Quill TE. Hope for the best, and prepare for the worst. *Ann Intern Med* 2003;138:439-443.
- 23 Frankl VE. *Man's searching for meaning*. Washington, DC: Washington Square Press, 1946:1-221.
- 24 President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *Making health care decisions: the ethical and legal implications of informed consent in the patient-practitioner relationship, Volume 2, Appendices*. Washington, DC: Government Printing Office, 1982:245-246.
- 25 Harris J. *The Value of Life. An Introduction to Medical Ethics*. London: Routledge and Kegan Paul, 1985:87-110.
- 26 Lurie SJ. Raising the passing grade for studies of medical education. *JAMA* 2003;290:1210-1212.
- 27 Penson RT, Slevin ML. Communication with the cancer patient. In: Price P, Sikora K, eds. *Treatment of Cancer, Fourth Edition*. New York: Arnold, 2002:1187-1198.