CME Case Study

Delivering Bad News

What to do, what to say

By Sophie Laflamme, MD, FRCPC

This text refers to delivering bad news in the pediatric field, the author's field of expertise. The format is equally applicable to adult medicine.

Delivering bad news is an integral part of a physician's responsibility. It is one of our most difficult tasks.

Imagine what it would be like to receive news that your child has cancer, or worse, that he/she has died in an accident? It is the most stressful situation that an individual can experience in his/her lifetime. We have a duty, as health-care professionals, to deliver bad news in observance of, and in concurrence with, a patient-oriented interview format. The physician has an ethical and legal obligation to tell patients the truth.[1,2] One of the most common problems is *how* to deliver the truth.[2-5]

Physicians' Uneasiness

Physicians are very uncomfortable with having to deliver bad news to their patients.[2,4,5] There are several factors that explain this uneasiness. First of all, bad news generates distress and pain. Health-care professionals are accustomed to trying to ease their patients' pain and make them comfortable.[1] Moreover, physicians have received little or no training on the subject, and are not familiar with patient-oriented interview formats.[1]

In addition to their fear of admitting ignorance and provoking negative reactions from patients, physicians are often afraid of expressing their own feelings.[1,2] It is common for physicians to identify with the patients' distress. Imagine, for example, that you have to tell the parents of a five-year-old little girl that she has acute myeloid leukemia. If you also have a five-year-old daughter at home, how can you help but relate to the situation? A physician's fear of crying with patients is very tangible and well-founded. It is not wrong for physicians to share their feelings with parents. Parents actually appreciate it. But physicians cannot let their emotions interfere with their judgment and

Cases 1 and 2

Case 1: It is the weekend and you are doing your medical rounds on the pediatric floor. You see a family whose child has just been diagnosed with neuroblastoma. Despite everything, the atmosphere in the room is good.

Case 2: You check in on the child in the next room. That patient is recovering from gastroenteritis. When you tell the mother that the child should be discharged the next day, she is in tears, discouraged and fed up. She is a single mother and has two other children at home.

Question: How do you handle these two situations?

must revert back to their roles as professionals. That is why it's important to be familiar with, and master, a good interview format.

Definition of Bad News

Before describing a medical consultation format, it is important to briefly review the definition of bad news.

Bad news is information that abruptly and negatively changes how the parent and/or the child visualize their future.[1,3] Some news is universally perceived as bad news, such as the death of a child. There are some events that may require health-care professionals to make a judgment call.

Dr. Laflamme is assistant professor, Université de Sherbrooke, and pediatrician, Pediatric Intensive Care Fellowship, Sherbrooke, Quebec.

Patients' Dissatisfaction

When meeting with patients to deliver bad news, it is important to be aware of some issues that cause dissatisfaction for patients and to try to avoid them. The main two issues that parents have with health-care professionals are their poor listening skills and their too frequent use of medical jargon.[1,6,7]

Poor listening skills. Research done on the medical consultation process actually showed that, on average, physicians interrupt their patients within the first 18 seconds of a discussion.[1] Consequently, few patients get the opportunity to express themselves properly. If patients were given the opportunity to finish what they have to say without being interrupted, it would not take more than 150 seconds for them to finish speaking.[1] By really listening to patients, physicians increase the level of patient satisfaction and are better able to adapt to the patient's needs.

Use of medical jargon. The too frequent use of medical jargon is also a problem. Patients retain less than 50% of the information given to them during a medical consultation.[1,6,7] Half of the patients do not repeat the facts correctly when they verbalize them. It is not easy for patients to retain

Table 1

Medical Consultation Steps

• Preliminaries.
• Start with the patient's knowledge.
• Provide information.
• Verify the comprehension.
• Be aware of patients' feelings/ needs.
• Close.

Table 2

Preliminaries (Step 1)

• Private environment (quiet room).
• Be available.
• Sit down to talk.
• Introduce and identify yourself.

bad news. The parents and/or child are already very upset and in distress. The physician can save time and energy by using simple terms.

Steps to Take During the Medical Consultation

Physicians are very well-trained on the diagnostic and therapeutic approaches of various medical entities (patient history, case history, structured system review, physical examination, *etc.*) They can refer to this solid structure even in difficult times. The same format should apply when the physician has to deliver bad news. There are six steps involved in the medical consultation process (Table 1):

- Creating a situation scenario;
- Finding out what the parent already knows about the situation;
- Providing the parent with new information;
- Making sure parents have understood the information properly;
- Responding to parents' feelings and needs; and,
- Concluding the medical consultation.

Step 1: Preliminaries (Table 2). Ideally, delivery of bad news is done in an *appropriate place* — a room that allows for some privacy.[3,5,8] If there is no room available, the curtains around the patient's bed should be drawn for privacy.

The physician should also *set aside some time* for the medical consultation.[2-4] Sometimes the physician does not have any time available (*i.e..,* in the emergency room). Keep in mind that patients don't necessarily expect a long consultation. They would like physicians to dedicate 100% of their attention to them. Out of respect for the parents, it is up to the physician to find some time when he/she will not be interrupted.

It is important that the physician *introduce and identify him/herself.*[1,3] It is good to greet the parents with a handshake. The health-care professional must also meet everyone who is present at the medical consultation and be aware of their relationship to the sick child.[1] In light of the significant number of extended families, this step allows physicians to properly identify the child's legal guardians. They will probably provide support for the child's parents and siblings later on.

Lastly, it is important to *sit down when speaking.*[1,2] The physician can sit on the child's bed, if necessary. A study comparing medical consultations of equal periods of time has shown that patients will perceive a medical consultation to last longer if the physician takes the time to sit down.[1,9]

Step 2: What the patient already knows. Once the introductions have been made, a good way to

Table 3

Providing Information (Step 3)

• Conveying a little bit of information at a time.
• Use simple terms.
• Repeat and restate.
• Write information down/draw.

start the consultation is to let the parents speak. The physician wants to know their current understanding of the situation.[1,3,8] What do they know? This approach uses open-ended questions. For example: "What have you understood from what the other doctors have told you?" and "What do you think will happen to your child?" Health-care professionals can then confirm or correct the information. This process also allows physicians to determine the parents' emotional state.[1] They can then tailor the way they provide information to the parents.

Step 3: Providing information (Table 3). It is up to the physician to provide the parents with information. The physician must *use simple everyday terms* and avoid using medical jargon.[1,3,6,7]

It is a good idea to repeat the terms used by the parents in order to get them more involved in the discussion.

You must *provide little bits of information at a time*.[2,5,8] We know the retention rate is low and the parents' state of mind is not conducive to retaining information. The information should be restated and explanations need to be repeated regularly. At this stage, the physician should let the parents know they can ask questions anytime during the medical consultation.[3] This gesture will make parents more comfortable about interrupting the physician, if they need to do so.

Parents like to have sketches drawn, when possible, and especially appreciate having the diagnosis, as well as more complex terms, written out.[1] For example, parents understand the term "head trauma" if it is explained well. Nonetheless, they often have difficulty remembering the exact terms, which is why they like to have them written out. Knowing the correct terms used to explain a diagnosis when they communicate the information to their families gives them some sense of control at a time when they feel they have no control. This step also gives the physician the opportunity to *adapt to the level of information* that the parents wish to receive.[1,7] Some parents want to know all the details while others do not.

Step 4: Verifying patients' comprehension. The next step is too often neglected. Physicians should confirm the information they have just provided to their patients. They have to verify what the parents have understood, as well as whether their interpretation of the situation is adequate.[1,8] The delivery of bad news is always emotionally difficult. There are misunderstandings in too many cases. I witnessed a medical consultation where the physician was telling parents that their child was afflicted with a type of leukemia that has an 85% to 90% survival rate. When the physician wanted to confirm what the parents had understood, the father replied: "It's simple, my daughter has cancer and will die soon." This step of the medical consultation allowed the physician to correct the father's information analysis.

This part of the medical consultation is extremely important because the physician's ultimate goal is to make sure that the patient and/or parent has properly understood the diagnosis. It is, therefore, imperative to confirm that the facts are provided and to ensure the facts are understood. When the parents have adequately interpreted the facts, it is important to tell them that they have understood the information provided. This is called reinforcing comprehension.[1]

Step 5: Responding to patients' feelings/needs

(Table 4). Before ending the medical consultation, physicians must ensure they respond to the parents' feelings and needs.[1,3,8]

They must also ask them, using an open and clear question, if they can do anything to help. Hearing bad news is always a very intense moment in a person's life. It is sometimes surprising to realize that some of the parents' requests are easily met and may help to ease the painful moments. Some examples include being allowed to spend time alone with the child or to bring the child's siblings to the hospital, to have a priest present or take photographs (especially of newborns, as it may be the only souvenir of them). A mother once told me that she would have liked to have spent more time alone with her dead baby. She had been too shy to ask and no one had offered.

This part of the medical consultation is critical for the parents and may influence the mourning process. If the parents have any remorse or regrets pertaining to their child's last days, the mourning process will be more difficult.

It is recommended that physicians express their sympathy by saying, for example, "I understand your pain," or "I know this is an extremely difficult time."[1-3,8] It would seem obvious that, as physicians, we share in our patients' pain. Nonetheless, bereaved parents still feel the need to hear us tell them.

Lastly, you must make sure that the action plan proposed to the parents meets their concerns.[1,3,6]

Step 6: Concluding the medical consultation. To conclude the medical consultation, physicians should present a brief summary of the situation, going over the child's reversible and irreversible problems, as well as the implications involved. A good way of ending the consultation is by asking the parents if they have any other questions.[8] If they don't have any, the physician must remind them that they may ask any questions at a later date.[1] It is also important to guide parents with a short-term plan. The physician may lead the parents to the child's bedside, for example, and talk about the surrounding premises and equipment, inform them of any plans to transfer the patient to another institution and how to get there. When possible, it is important to deliver a positive message and to have a treatment plan prepared while hoping for the best.

Table 4

Be Aware of Feelings/Needs (Step 5)

- Ask an open-ended question: "Is there anything we can do for you?"
- Verbalize empathy: "I understand your pain."
- Make sure that the action plan is in concurrence with the patients' concerns.

There may be moments of silence during the medical consultation process. These moments must be respected, as they are important. To quote Camille Belguise (*Écho du silence*): "It is in silence and solitude that we hear nothing more than what is essential."

It is also important to remember that the sick or deceased child's siblings must always be involved in the medical consultation process with the family.

Follow-up

After completing all the steps of the medical consultation process, the next step is parent and sibling follow-ups, which are pivotal. I work within a milieu where we meet parents who have recently lost one or more of their children. We see them two weeks after the child's death, six to eight weeks later and again later on, depending on their needs. Bereaved parents view the follow-up as essential. The family and relatives spend a lot of

time at the hospital, especially around the last days of the child's life. Parents are lonely after their child's death. It is during this time that they need follow-up.

Medical consultations allow them to ask questions about their child. It is an opportune time for the physician to make sure that the mourning is not pathological. A review of the autopsy, when applicable, often raises questions and provides many answers to these questions. If you cannot provide this service, you should refer your patients to a physician or other health-care professional who can be of assistance and will offer follow-ups. There is an enormous need for parental follow-up in our health system which, unfortunately, is not currently being met.

Discussion of Cases 1 and 2

It is obvious to the physician that the parents' emotional reactions are not proportionate to the diagnosis each child was given. The second child's parent saw the news of an additional hospitalization day as very bad news. It is important to be careful with value judgements when we are providing a diagnosis or informing parents. The physician cannot foretell the patients' reactions, nor can he/she generalize about them.[1]

In the cases presented, the physician must take time to sit down with the mother in Case 2. The physician must make her understand the cause of the problem and must calmly explain why it is necessary to keep the child in the hospital an extra day. The physician should also ensure that the mother understands the reasoning behind this decision. In such a case, it is necessary to be sympathetic even if the parent seems to be overreacting. Ideally, the physician should ensure that the parent agrees with the plan of intervention. Despite her initial disappointment, the mother is satisfied with the medical care her child is receiving.

Conclusion

Delivering bad news is part of a physician's function. Physicians must understand and use the medical consultation format in order to communicate properly with their patients. Using the format becomes automatic and makes the physician's job easier. It also ensures that all of the essential steps for the parent/sibling consultation process are followed.

Following-up with a deceased child's family is vitally important. If the physician is not able to provide this service, he/she must refer the family to a resource person. CME

References

1. Buckman R: *S'Asseoir Pour Parler*. Editions du Renouveau Pédagogique, 1992, pp. 13-24, 36-7, 59-90.
2. Bigonnesse J-M, Martel, G: L'annonce d'une mauvaise nouvelle. Le Médecin du Québec 1993; 28(5):55-9.
3. Buckman R, Sourkes B, Lipkin M, Tolle S. Strategies and skills for breaking bad news. Patient Care Canada 1998; 9(2):33-40.
4. Brody H, Tomlinson T: On truth telling and the diagnosis of Alzheimer's disease (commentary). J Fam Pract 1988; 26(4):404-6.
5. Buckman R: Breaking bad news: Why is it still so difficult? Br Med J 1984; 288:1597-9.
6. Quill TE, Townsend P: Bad News: Delivery, dialogue, and dilemmas. Arch Intern Med March 1991; 151:463-8.
7. Miranda J, Brody RV: Communicating Bad News. West J Med January 1992; 156:83-5.
8. Garg A, Buckman R, Kason Y: Teaching medical students how to break bad news. Can J Med Asso 1997; 156(8):1159-64.
9. Mount B: Communication personnelle.