Communicating sad, bad, and difficult news in medicine

Lesley Fallowfield, Valerie Jenkins

In every medical specialty bad, sad, and difficult information must be given to patients and their families. An insensitive approach increases the distress of recipients of bad news, may exert a lasting impact on their ability to adapt and adjust, and can lead to anger and an increased risk of litigation. Many doctors also find these interactions stressful, and in the absence of much effective training they may adopt inappropriate ways of delivering bad news and coping with the emotional fall-out. Recognition of these difficulties has led to many initiatives, ranging from increased communication skills training to the development of guidelines and protocols. We review some of the research on the impact that giving sad, bad, and difficult news has on doctors and patients, and assess whether interventions are helping. We focus mainly on difficulties encountered involving parents in an obstetric or paediatric setting, people in acute trauma situations such as accident and emergency departments, and patients with cancer.

John Diamond, a journalist in the UK who died in 2001 of throat cancer, expressed surprise that many doctors who have to give bad news to patients for much of their careers, had not yet found a way “ . . . somewhere between the mawkish and the unnecessarily brusque, which would serve them comfortably in the majority of cases”. 10 years ago we showed that despite the fact that virtually every clinical specialty requires doctors at some stage to be the bearers of sad, bad, and difficult news, a woeful lack of training existed. This gap in medical education is bad for the patients and their relatives and for the doctors themselves. Doctors’ first clearly remembered experiences of giving bad news are frequently harrowing and may haunt them for years to come.2,3 We wished to see whether things have improved in the past decade.

Substantial education and research data are now available, in various medical specialties, on the communication of bad, sad, and difficult news.4–8 Many reports deal with the impact that bad news has on the deliverers9 and the recipients,10 and others contain useful guidelines and recommendations about what to do and say.6,12–14 Although many of the recommendations seem sensible, worthy, and helpful, there is little evidence that such encouragement alone can substantially improve behavioural styles of health-care professionals, nor has much research assessed the implementation of or the adherence to the guidelines. Likewise, little work has been published that shows whether or not guidelines on breaking bad news have led to increased satisfaction among patients.

Recognition that doctors may require further training to help them improve communication skills has led to the development of countless courses and workshops on breaking bad news for undergraduates15 and postgraduates.16–18 Although most participants report them to be helpful, few empirical data show that these courses lead to improvements that successfully transfer into practice or that any measurable improvements are sustained over time.19

We have reviewed examples of research done in different parts of the world, looking at the impact that giving sad, bad, and difficult news has on the giver and receiver. We focus mainly on problems encountered from three areas of research involving parents in an obstetric or paediatric setting, people in acute trauma situations such as accident and emergency departments, and patients with cancer. We choose these areas from the vast amount of studies available since they provide good examples of settings in which: most people expect good news; health carers might have to give sudden, unexpected, bad news to people with whom they have formed no relationship; and in which patients and relatives receive news about life-threatening disease. Finally, we review some of the interventions such as guidelines and training courses aimed at helping doctors to communicate more effectively in such stressful situations.

What is bad news in medicine?

Any information that produces a negative alteration to a person’s expectations about their present and future could be deemed bad news.20 Ptacek and Eberhardt21 define bad news as information that “ . . . results in a cognitive, behavioural or emotional deficit in the person receiving the news that persists for some time after the news is received”. Bad news does, of course, have gradations, which to a certain extent are subjective, dependent on an individual’s life experiences, personality, spiritual beliefs, philosophical standpoint, perceived social supports, and emotional hardness. Obvious examples that might be universally accepted as bad news include telling a mother that her baby is stillborn, telling parents that their only

Search strategy

We identified relevant studies for possible inclusion by searching standard computer databases, including MEDLINE, EMBASE, and CINAHL (1993–February, 2003), and The Cochrane Library. Searches were restricted to papers published in English. Keywords used were: “receiving bad news”, “breaking bad news”, “breaking bad news effect on patients”, “breaking bad news effects on doctors”, “communication skills”, “training guidelines”, “truth disclosure”, “physician/patient”, “doctor/patient”. “disability and communication”, “accident and emergency and communication”, and “cancer/oncology and communication”.

Lancet 2004; 363: 312–19

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child involved in an accident has irreversible brain damage, or informing a person that they have motor neurone disease. However, consider the following examples: explaining the need for a hip replacement that will prevent a woman from flying to Australia to see her first grandchild born, or telling a window cleaner with no other skills that he has mild epilepsy. To the impartial observer these situations might not be classified in the same category of bad news as the first examples. Nevertheless, they would have many distressing consequences other than medical for the affected patients and their relatives. Health-care professionals sometimes find it hard to step back and take into account the spectrum of physical, social, occupational, and emotional issues that may affect what information is classified as bad news by the recipient.

**Difficulties faced by health-care professionals**

Table 1 shows several studies of health-care professionals’ views on breaking bad news from 1993 onwards.\(^1,3,13,22-25\) The disparity between physicians in opinion about truthful disclosure, the stress experienced when giving bad news, and the desire for more training is notable. Talking about distressing subjects is unpleasant, but responsibility for giving sad, bad, and difficult news may come early in training and with little experience. Few doctors receive adequate guidance and help during their initial formative experiences.\(^1,25\) Many doctors also have difficulty handling their own emotions—sorrow, guilt, identification, and feeling a failure are just part of the range of emotions reported. There is little evidence that these difficulties get easier as doctors become more experienced. Inadequate training in communication skills was acknowledged by senior hospital doctors as a major factor contributing to their high rates of burnout and psychological morbidity.\(^\) The content of a consultation may influence a doctor’s ability to assess how well they communicated with a patient. In a comprehensive study of videotaped consultations with more than 3000 patients, doctors thought interviews and their performance were worse when palliation was being discussed than when they discussed potentially curative treatment. Their self-analysis bore little relation to the objective analysis by trained observers of their communication skills.\(^20\) In only one published retrospective study of 73 physicians did doctors recall only moderate degrees of stress after breaking bad news.\(^21\)

Doctors frequently censor information they give to patients about outlook on the grounds that what someone does not know cannot harm them. Such traditional paternalistic attitudes can still be seen despite moves towards increased autonomy and empowerment for patients. In one US study of physicians working in five hospices, even if patients requested survival estimates, physicians said that they would provide frank disclosure only around 37% of the time, favouring instead either no disclosure or a conscious overestimate.\(^28\) Doctors are unaware that a failure to disclose information honestly to patients might be an attempt to protect their own emotional survival as much as to help protect the patient. Prognostic errors are nearly always made in an overly optimistic direction, but they increase the better the doctor knows the patient.\(^30\)

**Patients’ and families’ needs**

A summary of some of the research eliciting patients’ and relatives’ views on receiving bad news is shown in table 2.\(^27-42\) How bad, sad, or difficult information is received depends on many factors, including expectations, previous experiences, and general personality disposition. Shock, horror, anger, stoic acceptance, disbelief, and denial are all possible reactions and anyone charged with breaking bad news needs to be able to cope with these emotions. No two patients or relatives will respond in the same way to the same news, but the way in which bad news is conveyed can substantially influence their emotions, beliefs, and attitudes towards the medical staff and how they view their future. Thus, understanding what is important to patients when sad or upsetting news is given can help doctors redefine how this task is best done.

Although many personal and moving anecdotal reports have been published in the medical\(^6\) and lay press,\(^9\) few researchers have systematically assessed how patients or the families felt immediately after having received bad news. The shortage of such research stems from worries that the burdening of distressed people with semi-structured interviews and questionnaires is unethical. Although not impossible, asking the recipients of bad news questions immediately after the event can be impractical. Consequently, many reports have been based mainly on retrospective recall several months or years after the event. Nevertheless the observational and qualitative data generated from research identifying the
specific positive and negative features of communicating an unhappy diagnosis or prognosis provides invaluable material for people attempting to develop guidelines and training initiatives.

**Bad news in different specialties**

**Obstetrics and paediatrics**

When parents conceive a wanted child they generally experience several months of excitement and nervous anticipation, hoping for an uneventful pregnancy, a safe delivery, and a normal, healthy baby. For most parents there is a happy outcome, and health-care professionals have the pleasurable experience of confirming that all is well. When things do not follow the anticipated pattern and a baby is born damaged or dead, it is therefore extremely distressing to all concerned. Sometimes everything seems well during pregnancy and delivery, but as time passes a serious disability becomes obvious. Health-care professionals need to be able to handle responses such as disbelief, distress, recriminations, and anger. The way in which parents are informed about their child’s disability can affect the parent-child relationship and the ability of parents to adjust psychologically to the reality of the situation. After disclosure of any sad and bad news, parents are frequently very clear many years later about communication that helped them, and that which left them still feeling upset and angry. For instance, in a study of the impact that disclosure had on parents that their child had died, police officers were praised as being good informants rather than nurses or doctors. Specifically, the bereaved parents recalled that the most appreciated characteristics were the informants themselves showing some concern and distress at the news rather than cold professional detachment.

In one US study, 18 families in which a child had neurofibromatosis were interviewed about their experiences of being told the diagnosis. Despite the availability of guidelines for breaking bad news, disclosures about the diagnosis were made in a haphazard way, leaving 16 of the 18 families feeling shocked and upset. This reaction led to depression. These findings underline the importance of providing experiential training in the actual behavioural skills needed, not just a list of guidelines about what to do.

Although parents’ complaints about poor communication service in many other studies, including children with cerebral palsy and other life-limiting disease, these reports also show some of the more positive experiences. Parents were asked to comment on their experiences when receiving news that their child had a chronic disorder such as Down’s syndrome, congenital heart disease, or both. The parents were clear that they could distinguish between their personal reactions to the diagnosis itself and their reactions as to how doctors had informed them. About two-thirds of the families reported

<table>
<thead>
<tr>
<th>Author</th>
<th>Number of participants and country</th>
<th>Type of study and objectives</th>
<th>Findings</th>
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<tbody>
<tr>
<td>Garwick et al.</td>
<td>43 families of children with Down’s syndrome, congenital heart disease, or both, UK</td>
<td>Interview; to identify factors that influenced caregivers’ reactions to learning the child has a chronic condition</td>
<td>Positive experiences noted for two-thirds of families but there were negative reactions by those provided with outdated and inadequate information</td>
</tr>
<tr>
<td>Strauss et al.</td>
<td>100 parents of children with cleft lip, cleft palate, or both, USA 84 breast cancer patients, 64 oncologists, 140 oncology nurses, Australia</td>
<td>Questionnaire to parents; to rate dimensions of doctors’ communication when giving diagnosis and parents’ preferences</td>
<td>Many reported positive experiences but differences between what parents experienced and what they desired in informative interview 70% rated 7 of 15 principles and 6 of 12 steps as essential. Differed on relative importance of other items</td>
</tr>
<tr>
<td>Girgis et al.</td>
<td>Parents of 107 children with cerebral palsy, UK</td>
<td>Survey; to rate importance of element when receiving bad news</td>
<td>Dissatisfaction with how diagnosis had been disclosed was greater if children premature, developed more severe degrees of disability, and diagnosis made later. Dissatisfaction shown by later self-reported depression</td>
</tr>
<tr>
<td>Baird et al.</td>
<td>30 patients with advanced cancer in Sweden</td>
<td>Semi-structured interviews; to assess how patients experienced information about their incurable state</td>
<td>All patients described their doctors as experts with six subcategories: inexperienced messenger, emotionally burdened, rough and ready expert, benevolent but tactless expert, distanced doctor, and empathic professional</td>
</tr>
<tr>
<td>Friedrichsen et al.</td>
<td>54 family members of 48 patients who died in accident and emergency department or intensive care, USA</td>
<td>Interviews; parents’ perceptions of disclosure of diagnosis and questionnaires to measure depression and coping styles</td>
<td>Importance attributed to attitude and knowledge of news bearer, clarity of message, and privacy when receiving news</td>
</tr>
<tr>
<td>Yardley et al.</td>
<td>131 newly diagnosed malignant melanoma patients 4 months after diagnosis, Australia</td>
<td>Survey to identify any disparities between published guidelines and patients’ preferences for communication practices, and to document patients’ preferences and recollections of communication experiences</td>
<td>Factor analysis revealed three categories: content, facilitation, and support</td>
</tr>
<tr>
<td>Schofield et al.</td>
<td>351 patients with various cancers, USA</td>
<td>Questionnaire: to assess preferences for how patients would like to be told news of their cancer</td>
<td>Patients did not strongly endorse doctors helping tell others of diagnosis or telling patients about cancer support services. Very few expressed a preference for presence of another health professional</td>
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<td>Yardley et al.</td>
<td>13 patients with lung cancer, UK</td>
<td>Semi-structured interview; to document patients’ views on delivery of lung cancer diagnoses and ideas for improvement</td>
<td>Five key areas: communication, family issues, reaction to diagnosis, views on treatment, and prognosis</td>
</tr>
<tr>
<td>Friedemann et al.</td>
<td>120 patients with cancer, USA</td>
<td>Descriptive statements; to document patients’ recollections of what doctor did while communicating bad news</td>
<td>Patients reported similar experiences with doctors behaving according to medical practice advice. Satisfaction with interview was related to what was said and how doctors broke news</td>
</tr>
<tr>
<td>Barnett et al.</td>
<td>20 family members of patients with cancer, Sweden</td>
<td>Semi-structured interviews; to explore relatives’ experience of receiving bad news</td>
<td>Different types of family role types: demander of truth, the secret-keeper, Controller, surrendering, considerate listener, and excluded outsider 69% patients neutral or positive about consultation, 20% negative, 6% very negative</td>
</tr>
<tr>
<td>Parker et al.</td>
<td>43 families of children with cerebral palsy, UK</td>
<td>Survey to rate importance of element when receiving bad news</td>
<td>All patients described their doctors as experts with six subcategories: inexperienced messenger, emotionally burdened, rough and ready expert, benevolent but tactless expert, distanced doctor, and empathic professional</td>
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</tr>
<tr>
<td>Barnett et al.</td>
<td>106 patients with advanced cancer, UK</td>
<td>Interviews to assess patients’ perceptions of doctors involved in care</td>
<td>All patients described their doctors as experts with six subcategories: inexperienced messenger, emotionally burdened, rough and ready expert, benevolent but tactless expert, distanced doctor, and empathic professional</td>
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Table 2: Patients’ views on receiving news
positive experiences, especially when doctors had tried hard to present accurate information in a sensitive way. In another study of disclosure about non-life-threatening deformity, such as cleft palate and harelip, 100 parents were asked to rate different features of their doctors’ communication and preferences for different types of information. Parents most appreciated doctors who were confident, showed concern, and were caring, but who also allowed them plenty of time to talk and ask questions. A severe breakdown in communication between health-care professionals and parents can lead to distressing and stressful situations that may result in long-term investigation, for example the Bristol Inquiry. This public inquiry into the management and care of children receiving complex heart surgery between 1984 and 1995 resulted in a final report and recommendations presented to the UK Parliament by the Secretary of State for Health. In the report parents described their experiences, in particular their dissatisfaction with the communication of health-care professionals, especially after their children had died. Many were critical about the way in which the bad news was broken, citing a lack of privacy and a perception of being hurried out of the way from other parents. Recommendations to improve the service included giving clear verbal and written information to parents, including the provision of copies of letters to family physicians about patients’ own or their children’s care, and the need for clear communication between doctors and parents and between multidisciplinary team members.

An exemplary model of how to change practice for the better when communicating bad news can be seen in the work done over the past decade by SCOPE, a UK organisation that campaigns for equality in society for people with cerebral palsy. The organisation investigated the experiences of parents when told their child had a disability and found that an overwhelming proportion spoke of how distressing it had been. In response a working party was set up that included SCOPE and other voluntary organisations, such as MENCAP, the Royal National Institute for the Blind, and professional bodies such as the Royal College of Paediatrics and Child Health. Together they published a report on the way the diagnosis and disclosure of disability in children was presented to parents and ways to improve the practice. The Right From the Start resource pack offers information and support for developing and training in the communication of a disabled child’s needs. The resources available include a template for developing local policies based on valuing the child and respecting the parents. Also provided are background reading materials, videos, a website (http://www.rightfromthestart.org.uk), and, with negotiation, the society will support conferences, workshops, training, and the development of local policies all aimed at promoting good communication. Unlike many other organisations, SCOPE has continued to update its materials and, importantly, to audit the results. Unfortunately the audit of one large health authority who had used the template to develop their own good practice manual of guidelines showed that around a third of key professionals had no knowledge of the guidelines or training opportunities available. This finding shows not only how difficult implementation of training initiatives can be but also the importance of monitoring adherence and change.

**Acute trauma**

Staff in accident and emergency departments frequently have to tell families bad news and the experience can be especially stressful for all concerned since there is little or no opportunity to develop a trusting relationship with the family. In a questionnaire survey, researchers asked 54 family members of 48 patients who had died to rate the importance of 14 items relevant to being given bad news. Among the most important attributes for these family members were privacy when receiving the news, the attitude and knowledge of the news bearer, and the clarity of the message.

The suboptimum care that patients receive in critical-care units has been receiving increasing attention. Along with poor clinical features of treatment and care, inadequate communication can lead to complaints by patients and their families. In response to this situation, a National Health Service Trust in Portsmouth, UK, developed a workshop based on advanced life-support courses designed for trainee surgeons called the Acute Life threatening Events—Recognition and Treatment course. The format of the 1-day workshop for all professionals working with critically ill patients includes precourse reading (a 70-page course handbook), informal and interactive seminars, practical demonstrations, role play, and discussion, with specific sessions on breaking bad news and communication between professionals. Although the course has been running successfully since 2000, there is no objective evidence of its effectiveness to date.

Another example of a delicate situation in which good communication is essential is the seeking of permission from recently bereaved families for organ donation. A request for a postmortem has to be made at a time when relatives will be in the acute phase of grieving, displaying emotions such as shock, denial, and anger. Asking for donation requires personal insight into and awareness of the needs of bereaved relatives as well as good communication skills. Some clinicians do not believe it is their role to discuss donation with relatives. To address the problems that relatives report and to meet the training needs of clinicians and nurses who feel uncomfortable approaching bereaved relatives about donation, the European Donor Hospital Education Programme was devised (http://www.edhep.co.uk/our.htm). This programme consists of two parts: part 1 is a hospital-based lecture to raise awareness and understanding among health-care professionals of organ and tissue donation; part 2 is a 1-day grief response and donation request workshop. The workshops are led by two experienced communication-skills trainers, and are attended by a maximum of eight doctors and eight nurses working in critical care. The workshop includes reflection of personal feelings aroused by loss and separation, role play with actors playing bereaved relatives, and discussion on ways of setting up in-hospital protocols for dealing with the bereaved.

The programme was introduced into the northwest of England in 1995 as part of a randomised controlled study to assess the effects of workshop attendance on the competence of intensive-care-unit doctors and nurses. For ten experimental and ten control nurse-doctor pairs the researchers reported positive changes in the communication skills of nurses after the course. Clinicians in the experimental group also showed notable improvements when breaking bad news and requesting donation, but unfortunately most of the improvements were not maintained over time.
munication is frequently thwarted by the pressures of time constraints in some health-care systems, together with political imperatives to meet targets and contain costs. Therefore, the communicating of bad news about diagnosis or recurrence, or discussion of transition from active curative treatment to palliative care with ill and anxious people are not simple tasks. A doctor may also have to explain the need for further diagnostic tests, complex therapeutic options and their side-effects, describe the uncertainty that exists about optimum treatments, and the possibility of trial participation and randomisation.

Patients’ perceptions of the way in which doctors deliver bad news alter understanding, decisions about treatment options, and later adjustment. The emotional experience of receiving bad news does not seem to overwhelm a patient’s ability to distinguish the effective communicator from the less effective. Qualitative analysis of interviews with 30 Swedish cancer patients who were given the news that their treatment was to change from curative to palliative identified six classifications of clinicians.58 All were described as experts who had various characteristics and qualities: the inexperienced messenger, the emotionally burdened, the rough and ready, the benevolent but tactless, the distanced doctor, and the empathic professional.

There is a broad consensus of opinion about how patients want to hear news and what they need to hear. The need for an empathic delivery was reported in an Australian survey, in which patients with breast cancer wanted to be given the diagnosis and prognosis honestly and in simple language but not too bluntly.33 Some studies have been done of cancer patients’ interpretations of the meaning of words included in bad news and the importance attached to them. Swedish patients interpreted information conveyed to them about ending active tumour treatment as either emotionally trying or as fortifying and strengthening. The relevant words had focused the patients on treatment, quality of life issues, or towards threat and death.41 The difficulty for most doctors is getting the balance right, of being honest but at the same time encouraging, hopeful, and supportive. When the preferences of 351 patients with cancer about being given bad news were assessed, although the setting and the need for emotional support were deemed important, content received the highest rating from patients.37 If patients are to make appropriate decisions about their treatment the content of discussions needs to speak in simple terms, and to use unambiguous language.57 Ambiguity is common in cancer consultations. We know that euphemistic expressions are commonly used in an attempt to soften the blow,58,59 but sometimes they can misunderstand the therapeutic intent of treatment.62 Some frequently used words such as “positive” and “negative nodes”, and phrases such as “the disease is progressing” have different connotations when used in a medical rather than layperson context and might alarm or falsely reassure patients.63

Too much emphasis is perhaps placed on the communication of bad news by one individual. Cancer care is frequently delivered by multidisciplinary teams and, therefore, demands excellent continuity of communication and awareness about what has been said within the team and between individual team members, patients, and families. Team members frequently have little awareness about each other’s informational roles and responsibilities.64 Furthermore, what has been communicated about the diagnosis and prognosis is not well documented in hospital records,65 and collusion with relatives to deceive patients about the reality of their situation is still evident. The content of future training initiatives may need to include more about ethics and team approaches to the delivery of bad news to ensure appropriateness and consistency of the message being delivered.

**Interventions to help communication**

**Guidelines**

There are many guidelines and recommendations as to how doctors should prepare themselves before imparting bad news, about what constitutes an optimum supportive environment, and how difficult information should be given. Examples of such guidelines are summarised in table 3.6,12,50,66 The empirical basis for guideline development is important, in particular checking that guidelines have some face validity, are ethical, practical, and address patients’ needs. A good example can be seen in Australia, where researchers did a survey of 131 newly diagnosed patients with melanoma to assess preferences for information and memory for how they were told news.38 The findings were compared with the current guidelines. Overall the guidelines were relevant and supported by the patients’ expressed preferences, but there were some disparities highlighting the importance of getting feedback from patients about the areas that make a difference to them. In another excellent Australian survey involving patients with breast cancer, a reasonable degree of consensus was reported between patients, oncologists, and oncology nurses about their published guidelines for breaking bad news.39

Some congruence exists between guidelines and the views of patients and relatives as to how unpleasant news should be delivered, but significant evidence for their implementation in a clinical setting without further

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**Table 3: Examples of guidelines**

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<thead>
<tr>
<th>Study and country</th>
<th>Guidelines</th>
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<tbody>
<tr>
<td>Baile et al,6 USA</td>
<td>SPIKES: Setting up interview, assessing patient’s Perception, obtaining patient’s Invitation, giving Knowledge and information, addressing the patient’s Emotions, Strategy and Summary</td>
</tr>
<tr>
<td>Girgis and Sanson-Fisher,12 Australia</td>
<td>Ensure privacy and adequate time, assess understanding, provide information simply and encourage patients to express feelings, give broad time frame, arrange review, discuss treatment options, offer assistance to tell others, provide information about support services, document information given</td>
</tr>
<tr>
<td>SCOPE,66 UK</td>
<td>Preparation, who should be present, tuning in to parents, effective communication</td>
</tr>
<tr>
<td>Rabow and McPhee,68 USA</td>
<td>Advance preparation, build therapeutic relationship, communicate well, deal with patients’ and families’ reactions, encourage and validate emotions</td>
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</table>
training is lacking. In a qualitative study of first-year and second-year medical and surgical residents in Canada, despite an ability to identify several important guidelines pertinent when breaking bad news, many did not practise them. The barriers cited included a lack of support from other health-care professionals, time, and personal fears. The lack of supervision and opportunities to discuss feelings after difficult interviews were also seen as barriers to implementation, personal growth, and confidence. Nevertheless in some reports staff who work with clear guidelines teams’ roles in breaking bad news development were significantly altered and improved performance.13

Communication skills courses and workshops

Many training courses on breaking bad news have been reported, but many of these initiatives use a wide variety of models and approaches, some devoid of any clear educational theory or attempts to elucidate specific objectives and outcomes that could be assessed. Examples of such courses from the past few years are shown in Table 4.11,13,16,68 Most courses and workshops rely heavily on self-report of confidence ratings before and after course and acceptability of the training as their outcome measures. These measures are generally positive but provide little hard evidence of effectiveness for transfer of good skills into practice and improvements in patient-rated outcomes.

Moreover the preponderance of training courses in breaking bad news might suggest that generic communication skills of health-care professionals in other areas do not need improvement. This is manifestly not the case. As breaking bad news appropriately is only one element of interacting well with patients, perhaps the content and methods of courses aimed at improving communication in general should be assessed. The most successful methods, according to one systematic review,77 seem to be learner-centred approaches similar to those pioneered by Lipkin and colleagues in the USA. The essential characteristics are provision of a cognitive component or evidence base for suggested skills, a behavioural component allowing participants to rehearse the actual communication skills required through role play with patient actors playing patients, and an affective component permitting participants to explore the feelings that communicating about difficult issues evoke. For example, in a large randomised controlled trial, an intensive 3-day training course that used a modified Lipkin model significantly altered and improved oncolgists’ communication skills.76 The course also significantly altered attitudes and beliefs about the importance of psychosocial issues and communicating well.91 The improvement in skills was still evident 12 months later when assessed in the clinical setting despite no further intervention.91 Such courses are resource intensive and expensive but are probably necessary if changes are to be made to communication behaviours and if skills are transferred and maintained in a pressured clinical environment.

Conclusion

The delivery of sad, bad, and difficult news will always be an unpleasant but necessary part of medicine. In the past decade recognition has grown of the need to integrate appropriate communication skills teaching into undergraduate and postgraduate education. Research has shown that if bad news is communicated badly it can cause confusion, long lasting distress, and resentment; if done well, it can assist understanding, acceptance, and adjustment. Training health-care professionals how to do the task more effectively will produce benefits for them as well as their patients, but this training needs to be based

Table 4: Training courses on breaking bad news

<table>
<thead>
<tr>
<th>Study</th>
<th>Participants and country</th>
<th>Type of study and content</th>
<th>Measures</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Farrell et al18</td>
<td>45 health-care professionals in paediatrics, UK</td>
<td>Five 1-day workshops (10 people); role play, reflection and discussion, develop own breaking bad news guidelines</td>
<td>Assessment questionnaire with qualitative questions subject to content analysis</td>
<td>High praise for workshops, Promotion of self-awareness and multidisciplinary awareness of teams’ roles in breaking bad news</td>
</tr>
<tr>
<td>Faulkner et al19</td>
<td>80 nurses and doctors, UK</td>
<td>Four residential workshops; observational study, learner centred, role play, feedback, discussion</td>
<td>No pretest measures</td>
<td>91% gave a warning of distressing information, 85% gave information at the patient’s pace, 5% attempted to “pick up the pieces,” Increase in confidence</td>
</tr>
<tr>
<td>Baile et al16</td>
<td>29 oncology faculty, USA</td>
<td>Postgraduate two half-day workshops: breaking bad news and problem situations, didactic and role play, used SPIKES</td>
<td>Self-efficacy and satisfaction questionnaires</td>
<td></td>
</tr>
<tr>
<td>Greenberg et al71</td>
<td>Paediatric residents in accident and emergency, USA</td>
<td>Role play with actors</td>
<td>Assessment of counselling and informing skills, trainee feedback</td>
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</tr>
<tr>
<td>Vetto et al72</td>
<td>First-year and second-year medical students, USA</td>
<td>Formal instruction in breaking bad news</td>
<td>Compared old curriculum students with those taught via the OSCEs</td>
<td></td>
</tr>
<tr>
<td>Vaidya et al73</td>
<td>Seven paediatric intensive-care fellows, USA</td>
<td>1-day workshops: videotaped role play with volunteer standardised parents</td>
<td>Given feedback through objective analysis by trained observers</td>
<td></td>
</tr>
<tr>
<td>Garg et al74</td>
<td>359 third-year medical students, Canada</td>
<td>Two half-day teaching sessions: video presentation, discussion, role play with actors</td>
<td>Questionnaire before and after course to measure attitude changes, plus questionnaires given over 5 years</td>
<td>High ratings of acceptability</td>
</tr>
<tr>
<td>Ungar et al75</td>
<td>40 family-medicine residents over 4 years, Israel</td>
<td>Mandatory training; group work (four 10-people groups), role play with actors, video feedback, peer consultation, self-awareness group</td>
<td>12-item Likert scale, satisfaction questionnaires, instruction techniques, teachers’ skills, open-ended feedback</td>
<td>High satisfaction, deemed relevant to work, decided to use OSCEs for objective measure in future</td>
</tr>
<tr>
<td>Rosenbaum and Kreiter76</td>
<td>341 third-year medical students, USA</td>
<td>Small group practice of delivering bad news with actors</td>
<td>Surveys before and 4 weeks and 1 year after course, rating of comfort with scenarios</td>
<td>Became more comfortable and rated course highly</td>
</tr>
</tbody>
</table>

OSCE=objective structured clinical examination.
on sound educational principles, informed by evidence, and assessed and monitored adequately.

Conflict of interest statement
None declared.

Acknowledgments
LF and VJ have received funding from Cancer Research UK for communication skills work.

References
64 Jenkins VA, Fallowfield LJ, Poole K. Are members of multidisciplinary teams in breast cancer aware of each other’s informational roles? *Qual Health Care* 2003; 10: 70-75.