

## Communicating Bad News in Oncology Practice

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### Abstract

A good attitude, fine communication skills, and empathy of the oncologist play an important role in the coping and bereavement abilities of patients and their families. The present article explains the role of oncologists in communicating bad news to patients and their care providers. Breaking bad news is an emotionally difficult and unpleasant task for an individual. In the practice of oncology, bad news includes diagnosis of cancer, poor prognosis, recurrence of disease, unsuccessful treatment, irreversible side-effects or complications, or a sudden unexpected event leading to death. A number of factors like time constraints, inadequate experience, spiritual and cultural beliefs, personal attitudes, burn-out, and the fear of harming the patient or being blamed by him or her influences an oncologist's communication skills when delivering bad news. Hence, any communication between an oncologist and the patient should be able to lessen the patient's uncertainty for the future, improve the ability of the patient to act, and strengthen the relationship between the two. A six-step approach, called the SPIKES Protocol, which is the most popular and acceptable method of giving bad news has been described in detail in this article.

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Bad news is any news that seriously and adversely affects the patient's view of his or her future (Buckman, 1992). In the practice of oncology, bad news can be a diagnosis of cancer, a poor prognosis, recurrence of disease, unsuccessful treatment, irreversible side-effects or complications, or a sudden unexpected event leading to death (IPOS, 2005). Most of the seriously ill patients with cancer lose control over their lives, have diminished energy and a future filled with uncertainties. The key word in such a state is 'pain'. Pain not only makes them physically miserable, but also psychologically vulnerable.

Breaking bad news is an emotionally difficult and unpleasant task. The messenger of such news has to face strong emotions, both from the patient's side and from within himself or herself. A good attitude, fine communication skills, and empathy of the oncologist play a significant role in the lives of patients and their families impacting their coping and bereavement abilities. This is one of the hardest tasks that oncologists are required to take part in as part of practice (Butow et al., 1996).

Communication of bad news requires a balancing act between informing patients and sustaining their hope. It has to be realized that this is an ongoing process, and cannot be carried out as a one time activity. Also, this is dependent on a good foundation of a trustworthy professional relationship. Truthfulness is the beginning of a relationship towards such trust. Communication is always a two-way process. This fiduciary relationship becomes more important at the time of withdrawal of specific therapy and introduction of palliative care. Further, communication needs to be done face to face. Bad news should not be given over telephone or through other means in absentia (Lind, Good, Seidel, Csordas, & Good, 1989).

Good communication facilitates the patient's choice of management and promotes high quality patient-centered care. Poor communication leads to psychological distress, poor compliance, and increased dissatisfaction with care. At the same time, it can cause stress and emotional burn-out in healthcare professionals.

Patient satisfaction pays. In this context, it is imperative that we do not forget the family, friends and caregivers. Their satisfaction also is an important factor, especially when the patient is suffering from an incurable progressive illness, and you are the only source of information, medical care and psychological support (Brown, Nelson, Bronkesh, & Wood, 1993). The ultimate goal of any communication in this context is to make certain that the patient and the family are fully aware of the truth, and the entire truth. Telling the truth is a moral imperative (Cassel, 2015).

A number of factors influence an oncologist's communication skills when delivering bad news. Some of these include time constraints, inadequate experience, spiritual and cultural beliefs, personal attitudes, burn-out, and the fear of harming the patient or being blamed by him or her (Zolnierek & Dimatteo, 2009). Despite these challenges, oncologists have the potential of making an enormous impact on not just the lives of their patients but also their families, during this immensely challenging period.

Conversations with patients and caregivers usually revolve around two goals in palliative care—improving survival and improving quality of life. In most situations, only one of them is possible. Logically and ethically, the tilt is towards improving the quality of life. Ethics is a personal thought process where values and evidence are carefully balanced, and action taken thereupon. It is a debate between several pros and cons. Many questions have to be simultaneously answered. Who is the beneficiary? Will it adversely affect anybody? Is it legally and morally justifiable? Also, such an action considered ethical has to pass the test of public scrutiny and be applicable to others in similar situations (de Caestecker, 2012).

Decision making is difficult for both patients and caregivers in an illness with a poor prognosis. Oncologists are expected to help and guide them towards reasonable logical conclusions, but at the same time not make decisions for them. The main objective is to separate the messenger of bad news from the message, so that even though the message is bad, the

messenger can be viewed as a part of the support system.

Any communication between an oncologist and the patient should try to lessen the patient's uncertainty for the future, improve the ability of the patient to act, and strengthen the relationship between the two (Cassel, 2015). Medical professionals spend a lot of time in gaining expertise, yet the need of the hour is the ability to talk and communicate with the patient. The implication is that what you say matters. Every word matters (Brown et al., 1993). The reward of putting the patient and family first is loyalty. In addition, it serves as a booster for improved productivity, better compliance and lesser malpractice suits (Cassel, 2015). Before communicating bad news, the patient has to be briefed with the nature of news. It's a Truth or Dare situation. Thereafter, we have to respect both the patient's right to know, and the right not to know.

Family presence is an important variable. While receiving bad news, a patient can be assisted by a relative to aid comprehension and decision making. But the relative does not have the right to keep the news away from the patient. The family can be both a facilitator and a barrier. The presence of family could accelerate the process of information delivery. Alternatively, oncologists sometimes perceive friction in the acceptance of palliative care (Buckman, 1992).

A six-step approach, called the SPIKES Protocol, is the most popular and acceptable method of giving bad news. The first step is the *setting-up* of the interview. It is vital to respect the patient's privacy and dignity during all meetings. The goals here are to create rapport, put the patient at ease, and facilitate exchange of information in an uninterrupted manner. Maintaining good eye contact develops rapport and is a bridge to communication.

While preparing for a discussion, it is necessary to assess whether the patient has any cognitive problems, is in distress, or in any considerable pain. Also, is the patient or the family already emotionally upset, and do they require the presence of a legal decision maker or interpreter (Jurkovich, Pierce, Pananen, & Rivara, 2000).

The second step is to learn the patient's *perception* of illness. The goals here are to determine if there are any information gaps, to assess if there is an element of denial, and to understand the patient's expectations and concerns. Use of open-ended questions is of benefit in this scenario. One can evaluate the patient's understanding with questions like, 'What do you know about your condition?', or 'What have the doctors told you?' That should be followed by a cautionary sentence like, 'I am sorry. I have bad news.' Saying 'sorry', as part of the conversation, is in order, although the meaning of the word 'sorry' here does not connote any shortcoming or guilt from the doctor's end. It is an expression of empathy (Miranda & Brody, 1992).

The third step is to solicit an *invitation* from the patient to give the requisite information. The goal here is to acknowledge whether the patient needs any change over the procedure. Any information provided has to be tailored to the listener's ability to understand and comprehend. It should be provided in a comfortable relevant place, in optimum privacy.

Step four deals with giving the patient optimum *knowledge*, checking each time for the patient's understanding. This is the actual presentation of bad news, in a language that the patient understands. It is recommended that the doctor face the patient, speak slowly with the right body language and expression. Patients often want all the information and a complete understanding of their medical condition. Ideally, the discussion should cover the following—What is it? What does that mean? What is that we are going to do about it? (Cassel, 2015).

Some patients are aware, but have questions to ask, as they do not understand the how and why of it. They need an explanation which should be free of scientific jargon, clear and concise. Information is to be provided in small chunks. Speaking more about information related to treatment is more likely to induce hope, rather than giving information related to prognosis. Consequently, it is essential to be quiet and listen to what the patient or the family has to say. Finally, we allow the patient to make the next move.

The fifth step is an important one as it deals with patient's *emotions*. Exploring the patient's mental status and understanding after the delivery of bad news is a vital part of the process. Questions should be solicited and doubts cleared. The oncologist should have a plan of action ready to deal with the diagnosis, and discuss the same as soon as the patient or the family feels ready to comprehend (Souhami, 1978).

The goal here is primarily to facilitate emotional recovery. At this level, one should anticipate feelings of anger, fear and sadness, and be ready for other coping strategies (cognitive) such as disbelief, denial and blame. Next, additional information should be provided in parts, as and when requested by the patient or family. Some of the questions put forth by patients can be quite uncomfortable. These are the questions generally oncologists would like to answer later, armed with more certain information, and when the patient is more emotionally adaptable. Difficult questions, in addition, should be answered to the point, and no more than needs to be said. When confronted with the future in mind, it is better to answer specifically as to the plan of management. It is essential to let the patient have a "realistic hope", wherein all the optimism expressed is true. The nature of the disease and finding out about the impending death might lead to the patient and the family feeling betrayed and delaying appropriate planning.

The last step is to devise a *strategy*, and summarize the meeting. The goal thereon is to ensure that there is a clear, negotiated plan for the future, with a mention of recommendations and an understanding of barriers. All recipients of bad news should be provided with a realistic palliative care plan. Such a plan of action should be in accordance with the principles of Beneficence (To do Good) and Non-Maleficence (To do no Harm).

A follow-up to the breaking of bad news is critical. A charted follow-up practical plan has to be put in place which, following this meeting, leads to the beginning of a journey with the patient. What is pertinent here is that it provides patients and caregivers an opportunity to raise issues of concern or clarify doubts and expectations, as and when they arise. Caregivers care for attention more than the time oncologists spend with them. This also ensures that the patient does not feel abandoned. Further, exploring the patient's goals, and a sincere offering to help the patient meet them to a feasible extent strengthens the oncologist-patient bonding and relationship (Ngo-Metzger, August, Srinivasan, Liao, & Meyskens, 2008).

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