

Giving Bad News to Cancer Patients: Matching Process and Content

By Walter F. Baile and Estela A. Beale

HERE'S THE CASE

MRS E, A 36-year-old woman with three young children, was referred to Dr T, a young female surgeon, for an opinion about treatment for a lung mass that her primary physician strongly suspected of being malignant. The patient had never smoked and she was shocked and angry about the diagnosis, but hoped that Dr T could offer treatment. Dr T reviewed the pertinent studies and concluded that Mrs E had metastatic, inoperable disease. Aware of the inevitable consequence of the illness, Dr T was troubled by the thought of telling the patient the bad news, having occasionally speculated on the fate of her own young children if she were to become incapacitated and die. Naturally a warm and caring person, Dr T reacted to these unsettling thoughts with detachment and aloofness toward the patient, and Mrs E received a blunt and factual opinion: "Your doctor was right. The studies show that you have advanced lung cancer. It's inoperable and there's nothing I can do for you. You could see a medical oncologist to determine whether he/she has anything to offer. I know several in town." On hearing this, the patient burst into a tirade, exclaiming, "I came all the way here for a second opinion and some hope and you give me none! How dare you stand there and tell me these results. Are you aware that I am only 36 and have three small children and no relatives to look after them?" Dr T, initially dumbfounded by the intensity of the patient's anger, later wondered what went wrong in this encounter. What had she done to upset the patient so much? What could she have done differently?

Giving bad news is a stressful and unavoidable aspect of caring for the patient with cancer. It is even more challenging when the doctor knows that the news is unexpected or when the patient directs an angry reaction at the doctor. However, distancing oneself or attempting to make the bad news more palatable by encouraging unrealistic optimism or avoiding discussion of the life-threatening, unfavorable aspects of the disease often eventually results in the patient reacting adversely or distrusting the physician. Understanding the dynamic interaction that takes place during the delivery of the bad news and applying some key interpersonal skills will enable the clinician to make the process as bearable as is possible in such an exchange. In fact, learning the skills needed to deliver bad news is not unlike learning

skills to handle other distressing situations in oncology. When the clinician has a sense of mastery of the task, he/she feels more confident and is less likely to experience it as something to be avoided.

SHIFTING GEARS

Receiving bad news usually creates a crisis for the patient, often manifested by intense anxiety, uncertainty, confusion, helplessness, and fear of losing control over one's life.¹ Because patients regard their oncologist as an important source of emotional support,² a compassionate approach based on the oncologist's interpersonal skills, as well as his or her self-reflection can help both the doctor and the patient.³ Seen in the framework of crisis intervention,⁴ the application of these skills may reduce the emotional trauma associated with receiving bad news and help the patient to mobilize his or her own coping ability. It also helps the oncologist with a framework for the professional helping role in delivering bad news.

RECOGNIZING OUR BAGGAGE

Telling bad news is an inherently aversive act. The doctor may feel sad for the patient, helpless, afraid of being blamed for the bad news, or may wish to shield the patient from the unpleasant reality.^{5,6} Such emotions, although valid, may thwart the clinician's ability to assist the patient because they create emotional detachment from the patient, arouse unrealistic expectations, or, conversely, hopelessness, all of which may be transmitted to the patient. Dr T was deeply disturbed by her patient's plight. Given an opportunity to reflect on the encounter, she acknowledged feeling beleaguered by her patient's predicament, especially the uncertain fate of her children. Her medical training had taught her to suppress her own thoughts and emotions, and she had not been taught an approach to the disclosure of the bad news in the same ways she had been taught other skills. Conse-

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quently, overwhelmed by her identification with the patient's situation, she could not express empathic feelings that might have opened a door of support to the anxious patient. Her recourse was to distance herself, while coldly and quickly delivering the information. The patient, feeling alone and without support to face the prognosis of her illness, reacted by blaming the messenger.

How could an introspective approach have helped Dr T? In preparing to give bad news, Dr T could have reflected on several questions: am I troubled by giving the bad news to the patient? Will it be more difficult than usual? How do I think the patient will respond? How will I respond? Acknowledging her thoughts about the patient might have helped Dr T to consider several strategies. She may have recruited support by asking another member of the treatment team to attend the meeting, requesting that the patient bring a family member to the meeting, or discussing the case with a colleague. She might even have acknowledged to the patient how difficult it was for her to tell the bad news. In this way, the physician's strong emotions could be neutralized as a factor in deciding how to give the news.

HEARING THE PATIENT'S STORY

Patients sometimes engage in wishful thinking about the severity of their illness or harbor unrealistic expectations of treatment success.⁷ In desperation, they may project magical, curative powers onto the doctor. This seems particularly true in referral settings where patients come for a second opinion. These attitudes often hide fearful and pessimistic thoughts. A patient's knowledge about the illness may be incomplete because assimilating information without distortions or omissions takes time. Receiving unexpected information may intensify the patient's crisis and his or her emotional reaction to it. A strategy of finding out how much patients know about their illness, and what they expect from their physician, gives clinicians an opportunity to assess and close the gap between the patient's understanding and wishes and the current information about the illness. This may prevent misunderstandings and disappointment later on.

To better understand the patient's perspectives, at her first encounter with Mrs E, Dr T could have asked, "What were you told about your illness? What treatment options were discussed at that time? What do you hope your visit with me will accomplish?" Thus Mrs E's hopes, expectations, and worries could have been expressed and discussed.

BREAKING THE BAD NEWS

In giving bad news, preparing the patient for it may enhance the patient's ability to accept and process it.⁸ In discussing the test findings, Dr T might have reflected on the

patient's own knowledge by stating, "I understand you doctor told you that you have a serious problem. Unfortunately this is true. I had hoped that I would be able to offer you surgical treatment, but regrettably I can't."

Introducing the bad news and pausing may allow the patient to come to her own conclusion about the message, actually breaking the bad news to herself. This then allows the physician to make a confirmatory statement, as well as a statement of support, such as, "Nonetheless, I will help you get the best care available by asking that a medical oncology specialist see you."

Giving bad news bluntly, as Dr T did to distance herself from her own sorrow for the patient, may cause intense shock and resentment and, as happened in this case, may cause the patient to hold the messenger responsible for the bad news.⁸ Expressions of futility ("there's nothing more we can do for you") may create hopelessness in the patient. Using medical terminology (eg, your disease is widely disseminated) or euphemisms or holding out false hopes for treatment ("we can't operate, but if Dr X can reduce the tumor with some chemotherapy, we will look again"), may temporarily allay the patient's anxiety but later cause her to feel she has been deceived. Offering assistance in finding treatment options that incorporate achievable goals for care is an empathic response to the patient's anxiety and an honest and realistic expression of hope.⁹

RESPONDING TO EMOTIONS

When patients hear bad news, clinicians should be prepared for the expression of a wide range of emotions, including sadness, anger, despair, or gallows humor. Such expressions may make the doctor feel uncomfortable, but they should not be discouraged, as they are a part of the normal process of reacting to threat and loss. The relatively short period of intense emotion is as expected as nausea after chemotherapy. Once the clinician learns the patterns, and the helpful responses, it is also as easily managed. In this case, when the doctor shows understanding of the patient's emotions, it can validate the patient's feelings and reconnect the patient to the doctor, allowing the interview to continue.

The physician might best show understanding by following these steps:

- Listen for and observe the patient's emotional reaction. Sometimes this is very obvious, such as when the patient cries, but may at times be less apparent, such as when the patient is silent in disbelief. If you are not sure about what the patient is experiencing, ask the patient. For example, when a patient is silent, ask "Can you tell me what you are thinking right now?"

- Identify the cause of the emotion. In most cases this is the bad news, but again, if you are not sure, ask the patient.
- Make an empathic statement that shows you understand and acknowledge the patient's suffering.

If Mrs E had begun to cry when she talked about her suspected diagnosis, Dr T might have best responded with a moment of silence and then a statement such as, "I can imagine how devastating it is to hear this." If the patient had been silent, she could also have shared a few moments of reflective silence and then could have asked, "Can you tell me what you're thinking?"

REDUCING ANXIETY

Bad news is almost always accompanied by intense distress. A treatment plan may reduce uncertainty, and specific recommendations often help to reduce the patient's anxiety. Examples of these include recommending that the patient discuss the illness with a veteran patient or attend a support group for patients with similar diagnoses. A treatment plan, designed for the patient, may allow patients to make practical arrangements to organize their lives. One patient, for example, tacked to her kitchen wall the treatment steps her doctor outlined on the paper covering the

examination table. A treatment plan also allows the patient to ask questions,¹⁰ further reducing uncertainty and confusion.

Patients often have worries they are reluctant to discuss. Mrs E's concerns for her children were probably number one. Eliciting and addressing them is part of treatment because such a process begins to remove obstacles to understanding and accepting the information. When concerns are unspoken, patients tend to remain preoccupied, fearful, and shut down. At times, these difficulties lead to such psychiatric problems as chronic anxiety, panic attacks, posttraumatic stress disorder, or clinical depression.¹¹ It would be beyond the abilities of most oncologists to know what to do about Mrs E's children. But identifying the problem and helping guide the patient to support, such as a counselor or social worker, is part of the role of the doctor.

In conclusion, patients depend on their oncologist for information, guidance, and support. Although bad news should not be made better than reality, addressing the emotional issues that may cloud the process will allow the physician to support the patient and facilitate the patient's ability to progress from a position of despair to one of acceptance.

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