

Guidelines on the Breaking of Bad News

i Document Control

Title	Guidelines on the Breaking of Bad News
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Owner	YCN Psychological Support Sub Group

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Contributors to current version		
Contributor	Author/Editor	Section/Contribution
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ii Information Reader Box

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Contact details	Yorkshire Cancer Network 21 Wetherby Road Harrogate HG2 7RY Tel: 01423 555705 Email: info@ycn.nhs.uk

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1 Background

Breaking bad news is one element of patient-professional communication. Ideally all communications with patients (and their relatives/carers) should be delivered sensitively and in a manner and at a time that fits with their needs. The aim should be to establish a dialogue between the professional and the patient (and relatives/carers). The following statements reflect the particular issues that need to be incorporated into a 'bad news' interview.

Breaking bad news is one of the more difficult tasks that health professionals have to undertake. However well it is done, there is no getting away from the fact that bad news is bad news. What is clear, however, is that the manner in which bad news is broken can have a profound effect on both the recipient and the giver. To do it badly may affect all of a patient's (and their relatives') future contact with the health care professionals involved in their treatment and may impair their quality of life and well-being. It may also result in a formal complaint. If done well, it can form the basis for a helpful and constructive partnership between patients, relatives and their healthcare staff.

The objective of this document is to provide an accessible and practical set of guidelines for all healthcare professionals involved in giving 'bad news' or in other challenging and difficult consultations with patients, relatives and others. Each of these situations will have its own particular characteristics and individuality. Guidelines are not rigid constraints upon decision-making and do not stop health care professionals using clinical judgement.

The evidence base for these guidelines is derived from a variety of different sources including academic cognitive psychology, clinical and health psychology and extensive surveys of the experiences of people with cancer and their relatives. While the majority of these findings arise from conventional experimental studies some do not (and could not, given the ethical issues involved). Some guidelines will be based on consensus from users and practitioners about best practice.

A small selection of key references is noted at the end of this document and more information may be obtained from the Yorkshire Cancer Network Psychology Group. It should be noted that the Department of Health published major Guidance on Cancer Services in 2004 entitled Improving Supportive and Palliative Care for Adults with Cancer. Included in this guidance is a clear set of standards for both face-to-face communication and information needs of patients. This is supported by a separate extensive review of the evidence-base, which will include many of the studies on which this policy is based.

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2 Scope

Whilst the impetus for the development of these guidelines comes from oncology, 'bad news' and other challenging and difficult consultations occur in all clinical specialities and in all settings. Bad news or significant information encompasses different scenarios including diagnosis of a serious illness, disease progression, change in functional status and where medical expectations are different to patient expectations. These guidelines therefore are applicable to all clinical conditions in adults. Whilst many of the issues identified here will be applicable to sick children and their families, when working in a child health setting, health professionals will need additional guidance within a developmentally appropriate framework.

As any health care professional may have to deal with challenging and difficult consultations, these guidelines have wide applicability and should not be seen as profession-specific. It is important to note however, that those using these guidelines must be aware of the limits of their own competence and skills and always work within the governance of their own profession.

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3 Guidelines

3.1 Professional accountability

A skilled senior member of the clinical team who has read all the relevant information about the patient before the consultation begins should break bad news.

If the task is to be delegated to a junior member of the team, it is essential that this person is fully briefed and has the necessary clinical skills to manage the situation safely and sensitively (see section 3.2). It is important to emphasise that if this person is not able to answer all the questions that a patient or relative may put to them, they must find out the answers rather than try to 'bluff it out', and tell the patient/family that they will find out and get back to them.

3.2 Key skills

Any health care professional who is responsible for breaking bad news should demonstrate the following key skills:

- Ability to elicit the patient's main problems, their perception of these and their emotional, social and physical impact on the patient and their family.
- Ability to tailor information to the patient's needs.
- Ability to check patient's understanding.
- Ability to elicit and explore patient's reactions to the information given.
- Ability to determine how much the patient wants to participate in decision-making.
- Ability to discuss treatment options so that the patient understands the implications.
- Ability to enable the patient to follow agreed decisions about treatment.
- Ability to identify, offer, discuss and signpost relevant further support (e.g. Psycho oncology, counselling, information resources, support groups) that the patient and relatives/carers might find helpful.

3.3 Ethical issues

For guidance on the ethical issues around breaking bad news, each practitioner should refer to their professional Code of Conduct.

3.4 Pre interview

3.4.1 Patient support

An assessment of the patient's communication needs should be undertaken prior to the breaking of bad news. Where necessary, arrangements, such as the provision of an interpreter booked via the interpreting service, should be made well in advance.

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It may be helpful for a relative and/or another member of the team to be present. It should be checked with the patient who they might want to have with them. The very fact of making a special effort to ensure that the patient is accompanied can itself act as a warning, especially if this has not been done before.

Check who the accompanying person is and what their relationship is to the patient. Treat them politely and respectfully in the same way as you do the patient. Include them in the interview as they may remember more than the patient and check whether they have any questions.

3.4.2 Supporting families/carers.

Working with families/carers can add a layer of complexity to an already difficult situation. It is important to try to ensure that they are involved as far as they can be without compromising the patient's care or interfering unduly with the patient's autonomy.

Include all the relevant family members/carers where possible. Where the patient is able this must be done with their agreement.

In general, collusive arrangements with families about 'not telling' should not be entered into. Patients have a right to know, have a right to expect not to be lied to and may pick up on the non-verbal cues from their families and the health care professionals. However, the fears of families need to be addressed sympathetically and their knowledge of the patient can be helpful in guiding your approach. Listen to the family's views (and these themselves may be contradictory) and explain the position and responsibilities of the health care professional in this situation. Try, as far as possible, to attain a sensible balance of views about what information should be given to whom and when. Ultimately the lead should be taken from the patient. Reassure the relatives that information will not be forced onto the patient if it is not wanted.

3.4.3 The setting

When breaking bad news it is particularly important to maximise privacy. Use a private and quiet room whenever possible. The health care professional should take appropriate actions to prevent interruptions, for example diverting mobile phones, delegating bleep devices to a colleague and informing other members of staff that you are not to be interrupted. Allow enough time for the interview so neither you nor the patient feel rushed or pressured. If at all possible do not try to 'fit it in' at the end of a busy clinic.

Sit at the same level as the patient where possible. This avoids literally 'talking down' to them. Minimise the distance between you and the patient; so for example do not talk from the end of the bed or with one hand on the door handle.

3.5 The interview

3.5.1 Language

When breaking bad news it is best to keep it simple by using words and language that are appropriate for people without complex technical knowledge. Do not be concerned about making it too basic. A patient's emotional state will limit the complexity of the information that they can take in and remember, particularly in a 'bad news' consultation.

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Non-verbal communication can be as influential as verbal communication. Posture, style and manner will affect the progress and outcome of the interview.

Do not use euphemisms that are misleading or ambiguous, for example, use the word cancer rather than growth or tumour (if appropriate).

Always check that the patient and carer/relative have understood what you have told them. Give them a chance to ask any questions.

3.5.2 The scope of the interview.

Always attempt to give information that is appropriate for the individual patient's needs at that particular point in time. There is no hard-and-fast rule about how much to tell. It is not good practice to have inflexible rules about 'telling', such as 'Everybody must be told everything at once' or 'Nobody must be told anything'.

If there is a lot of information to give it may be better to cover it in a number of short conversations rather than one long one. Do not overload patients and carers/relatives with too much information at any one time.

The vast majority of patients want to know the truth and welcome honesty from a health care professional they trust. Never tell lies or actively hide the truth, as this will lead to a breakdown of trust later on.

The truth can be presented gently and humanely. It does not have to be the 'bitter truth' or presented with bluntness and inhumanity.

3.5.3 Managing the interview

The person leading the interview should always introduce themselves and any other member of the team who is present. It is not good practice to break bad news with too many other people in the room.

Listen to what the patient is saying or asking, so that you can find out the patient's view of the problem and how much she/he already knows. Watch for non-verbal behaviours that may act as pointers for concerns or worries that the patient may have.

Give a warning signal to help the patient to prepare for the next stage of information. This can include statements such as, "I'm afraid it could be more serious than we thought". Break the news using simple but clear language.

Expect to have to repeat some information both in this interview and in subsequent ones. The initial shock of hearing bad news tends to block out the processing of further information. A patient's awareness of the full implications of the news may come gradually rather than all at once.

Do not assume that a patient who does not want to know things is 'in denial'. Patients will deal with as much information as they can at the time, which means that they may seem to be listening selectively. People will often need to come back to things at some time in the future.

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Pace the interview and follow the patient's lead, as they will have to take in and digest a great deal of information and handle some powerful emotions. Never give the impression of being in a hurry.

Not all-direct questions have to be answered with a direct answer. While this is often appropriate there will be occasions that you will need to ask 'I wonder why you are asking that question?' as it may uncover some other concerns which you need to know about.

Patients and/or carers can be very upset and distressed on hearing bad news. This is to be expected and may not be anything to do with the way you have told them. It is important to acknowledge and accept their reactions and allow them to happen. Avoid premature reassurance in an attempt to comfort.

3.5.4 Closing the interview

Check whether the patient or carer/relative has any unanswered questions.

Let the patient know whom to contact for further information or clarification. Give written information about local and national information and support services for both patients and relatives/carers, if available. Let the patient know that it is very common to ask for further clarification, support and advice.

Ask if the patient would like any further support (e.g. specialist nurse) and arrange for this to be set up. In doing this make sure that the patient has the name of the person whom they can contact and how (and when) this contact can be made. It is good practice to let that person know what you have told the patient.

Allow the patient time and privacy to assimilate the news and to collect their thoughts and feelings.

Give the patient and/or relative time to compose themselves (as far as they can) before they leave the room. It can be additionally distressing for them to emerge from a difficult consultation into a crowd of people whilst they are visibly upset. Ideally, there should be a way of them being able to leave without passing through a busy waiting room.

Check whether the patient can get home safely.

It may be helpful and is good practice for someone from the team to follow the patient up after a 'bad news' interview to check how he or she is feeling. Where possible, arrange for the patient to have a follow-up visit or telephone call, patients do not always feel able to call if they have further questions. This should be done within about a week or so from the interview.

3.6 Patient support/ information

3.6.1 Documenting and recording the interview for the patient.

Because of the amount, detail and emotional significance of the information in a 'bad news' interview offering the patient a physical record should be considered.

In some centres, all interviews are audio taped routinely with the patient taking the recording away both for their own recollection and for sharing information with others.

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A written summary, either done then and there or in the form of follow-up letter to the patient, may be effective if audio recording facilities are not available. There is no one correct way of doing this. Always ask the patient what they would like and then try to achieve this within the particular context of your service.

3.7 Documentation and communication with the Multi Professional Team

Always document exactly what you have said to the patient in their notes and record their reactions. The following may be used as a minimum: person(s) present; actual diagnostic words used; actual prognostic words used, treatment intent (curative or palliative); response of patient and supporter; understanding by patient; treatment plan.

Inform staff on duty and members of the team what has been said and how the patient reacted.

Inform the patient's GP of the diagnosis, what the patient has been told and their reaction as soon as possible. Clarify with the team who will do this task and record when it has been done. Always tell the patient who else you are communicating with and check out any concerns the patient may have regarding confidentiality.

3.8 Post interview

It is good practice to review difficult interviews soon after you have done them to allow yourself the opportunity to reflect on your performance.

Be prepared to ask any staff present to give you feedback on how well you handled the interview. They will have had a chance to observe with less emotional involvement than you. Ask what was done well and what could be done differently/better. This can be a reassurance as you may not be aware of how well you have done it!

The breaking of bad news may occasionally be particularly difficult. It is recommended that initially you seek the support of a trusted friend or colleague to talk over your feelings in this case. Further support can be arranged via your line manager.

4 Provenance

Record: 340

Policy/Guideline number (Nursing, Midwifery and Health Visitors only) 01 12 03

4.1 Author/s:

This document was primarily written by Dr Peter Harvey, former Lead Consultant Clinical Psychologist for Oncology, Leeds Teaching Hospitals Trust (LTHT) at the request of the LTHT Oncology Communications Forum. This Group was multi-professional. The additional sources from which material has been derived are noted in the document itself.

All members of the Forum reviewed and commented on early drafts of the document. It was reviewed by the Yorkshire Cancer Network User Group (which includes a majority membership of current and past patients and carers), the Leeds Cancer Centre Steering Group and the LTHT Clinical Management Team for Non-surgical Oncology.

Trust Nursing Policy and Practice Guidelines group appraised and suggested a revised structure that encompassed ethical issues, training, and provision of information to patients with communication difficulties.

4.2 Objective:

The objective of this document is to provide an accessible and practical set of guidelines for all healthcare professionals involved in giving 'bad news' or in other challenging and difficult consultations with patients, relatives and others. Each of these situations will have its own particular characteristics and individuality. Guidelines are not rigid constraints upon decision-making and do not stop health care professionals using clinical judgement.

Clinical condition: N/A
Target patient group: N/A
Target professional group(s): Allied Health Professionals
Nurses Secondary Care
Secondary Care Clinicians Health Visitors
Adapted from: N/A

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5 Evidence base

5.1 Selected references and sources

5.1.1 Reviews

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Maguire, P. (1999). Improving communication with cancer patients. *European Journal of Cancer*, 35 , 1415-1422.

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5.1.2 Patient preferences and needs.

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5.1.3 Training

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5.1.4 Communicating about clinical trials

Cox A, Fallowfield L, Jenkins V (2006). Communication and informed consent in phase 1 trials; a review of the literature *Supportive Care in Cancer* ,14 (4): 303-309

Jenkins V, Fallowfield L, Solis-Trapala I, Langridge C, Farewell V (2005). Discussing randomised clinical trials of cancer therapy: Evaluations of a Cancer Research Training Programme. *British Medical Journal* 330 (7488): 400-06

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5.1.5 Audiotaping interviews

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Recording minimum data set.

Kirwan, J. M., Tincello, D. G., Lavender, T. & Kingston, R. E. (2003). How doctors record breaking bad news in ovarian cancer. *British Journal of Cancer*, 88, 839-842.

5.1.6 Useful web-sites

<http://www.breakingbadnews.co.uk>

www.skillscascade.com/badnews.htm

<http://bmj.bmjournals.com/cgi/content/full/321/7270/1233>

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