"I've Got Some Bad News"

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By Elizabeth Heubeck [2]

Advice on physician-patient communication

Long before the advent of techniques such as cardiopulmonary resuscitation and mechanical ventilation, the extended hand of a bedside physician — not a tangle of tubes connecting the patient to machinery — served as the patient's primary source of hope.

Now, the opposite is often true. Medical schools train students to become highly skilled at aggressive life-extending measures. But how well does medical school prepare physicians to handle the difficult task of delivering bad news, or managing the spectrum of patients' psychosocial needs that follow? Not very well, say some young physicians. When asked if he recalls his professors in medical school ever formally addressing the topic of how to deliver bad news to patients, Kenneth Williams, a Baltimore internist, responds "never." He and countless others had to wing it, and many still do. But now that he is an instructor of residents, Williams makes sure he covers the topic. And although it's never easy to deliver bad news, he says 14 years of practice has made him much more adept at handling it.

Williams also says the established relationships he shares with many of his long-term patients eases the difficult task. "I don't use a generic 'you've got cancer' approach. Every patient's an individual. I try to identify how I think they're going to respond to the news, be it the stoic patient or the histrionic. Some people really don't want to know more than the bare minimum. Others are very sophisticated, and want a lot of detail. I try to find out what the patient's needs are," says Williams.

A course, of course

Williams' lack of exposure during medical school to the "art" of delivering compassionate care — from bad news to what lies beyond — is not unusual. Fortunately, that's changing. Although courses that teach medical students how to communicate effectively with patients may not be found under the "requisite" section of every medical school's curriculum, select schools are beginning to offer, and in some cases require, students to gain competency in this vital aspect of delivering care.

Johns Hopkins University is one such school. Ten years ago, Leon Gordis, MD, professor of epidemiology and pediatrics and associate dean of academic affairs at Hopkins, codeveloped "Physician and Society," a four-year required course for medical students that focuses on patient-physician communication. Why? "The medical administration felt there was something missing," explains Gordis.

The course, which delves into issues such as death and dying, draws from the expertise of more than 70 of the medical school's faculty who are involved in running the course's small discussion groups. "We focus on actual clinical experiences, both the satisfying and the dissatisfying. That serves as the basis of discussion," says Gordis. The course, which delves into issues such as death and dying, draws from the expertise of more than 70 of the medical school's faculty who are involved in running the course's small discussion groups. "We focus on actual clinical experiences, both the satisfying and the dissatisfying. That serves as the basis of discussion," says Gordis.

With the help of standardized patients — actors trained to play the role of patients confronting difficult situations, such as hearing bad news — course participants practice within simulated, challenging clinical experiences. "It has been a very effective and well-received piece of the curriculum," says Gordis. Not to mention long overdue.

While some schools have developed and are now offering courses that address challenging patient-physician communication issues, others need assistance in adopting them. That's where initiatives like Last Acts, a communication campaign established in 1997 by the Robert Wood Johnson Foundation, come into play. The campaign was a direct response to findings from studies published in JAMA and the Annals of Internal Medicine that revealed a lack of communication between dying patients and their physicians about important end-of-life preferences. Out of Last Acts grew the Task Force on Spirituality, Cultural Issues, and End-of-Life Care. The task force, chaired by Christina Puchalski, MD, assistant professor of medicine and director of the Institute for Spirituality at George Washington University School, develops medical school curricula addressing the psychosocial aspects of end-of-life care.

"Often physicians are trained to look only at the biomedical perspective. Our patients want to be
able to connect with us," says Puchalski. "When you deliver bad news, there's a person who's suffering and anxious." The curricula she develops offer physicians practical communication strategies to use during these challenging medical encounters. To date, 70 medical schools have adopted the courses. "We've made some progress, but we're far from there," says Puchalski.

Skills that help
When it comes to getting better at delivering bad news, nothing takes the place of practice. The following strategies were developed with input from physicians practiced in the art of delivering bad news and patients with experience in receiving it.

Create the right environment
According to Ronald E. Waldridge, a family physician in Kentucky who recently lectured at the National Congress of Family Practice Residents on how to impart bad news to patients, creating an appropriate atmosphere in which to deliver the information is critical. "Good news is spontaneous: 'Mr. Brown, you have a bouncing baby boy.' Bad news requires planning," says Waldridge. Before meeting with a patient or the patient's family, Waldridge recommends that the physicians find an appropriate, private setting (complete with a box of tissues) for a face-to-face meeting. Sort out the medical events that led to the diagnosis, and translate medical jargon into layman's terms.

Balance candor with hope
No one knows better than a patient how it feels to receive bad news. That's why one group of researchers turned to patients with chronic and terminal illnesses and their family members to identify communication areas of central importance. Overwhelmingly, participants identified a strong desire for physicians to deliver news with a mixture of candor and hope.

One family reported that their physician managed to do just that: "He was honest with us, but he never did anything to our hope ... he didn't belittle it and he didn't build it up." In the face of a terminal illness, it may take creativity to deliver hope — but it can be done. "If cure is not an option, then hope may be oriented toward maximizing quality of life and making the patient comfortable," explains Marjorie D. Wenrich, dean of the School of Medicine at the University of Washington, and author of the study, which was later published in the Archives of Internal Medicine.

Elicit patients' preferences
In most cases, a patient-physician relationship does not end with the delivery of bad news. In some instances, it is only the beginning. Just as thriving patients have goals, so do those who are dying. According to Howard Brody, MD, principal author of an article on compassionate clinical management published in the *New England Journal of Medicine*, the goals of a dying patient and his or her family — not available technology — should dictate that patient's plan of care. Physicians should find out what's important to the patient and family members, such as whether they wish to maintain the patient's ability to communicate, whether interventions judged to be particularly burdensome should be avoided, and how best to maximize the patient's and family's comfort.

Make yourself available
In any medical situation that involves delivering bad news to a patient, a physician's tendency to avoid that patient is extremely common. Says one physician respondent in Wenrich's study, "I didn't really involve myself with the patient. And I still, to this day, regret my level of involvement with that patient."

Avoidance, of course, is the exact opposite of what many patients want and need at such a time. Instead, they long for physicians who are willing, and who take the time, to listen. Just how well a physician listens is sometimes hard to gauge; one way is to note how frequently physicians ask their patients open-ended questions, as opposed to those that require just a "yes" or "no" response. Says another study participant, the daughter of a terminally ill patient, "What I found helpful was the doctor really made herself available to the family as well as to my mother and said, 'Please, please, ask questions.'"

No one likes to deliver bad news to a patient. But when it's done with foresight and followed up with an equal amount of care and compassion, it can actually help ease a patient's anguish — and the physician's.

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