



For Debate . . .

Breaking bad news: why is it still so difficult?

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No one seems to find it easy to talk about bad news with a patient and, although much has been published about patients' reactions, there is very little written (other than in specialist journals) about doctors' reactions and feelings. In this article, I try to identify some of the major difficulties and show that they may arise partly because we are (properly) taught to deal systematically with organic medical states in a way that makes it difficult to know how to behave when different services are required by our patients. I venture to suggest that, with relatively minor changes in the medical school curriculum, we can in future produce junior doctors who are better at coping with this awkward (but important) part of clinical medicine.

By "bad news" I mean any information likely to alter drastically a patient's view of his or her future (whether at the time of diagnosis or when facing the failure of curative intention). Naturally, how bad the news is will depend to some extent on the patients' expectations at the time, on how ill they actually

feel, and on whether or not they already know or suspect their diagnosis or current state. I have based many of the ideas on my own reactions and experiences as a medical student and junior doctor. In the past four years I have given and participated in many tutorials and seminars with nurses, students, and doctors. From their reactions I have begun to think that the fears and feelings I describe below are fairly common, though not often talked about.

I consider under two headings the major problems that face us as doctors in breaking bad news: the anxieties and fears that we have, which make it difficult for us to start the conversation; and those factors that drive us into taking responsibility for the disease itself, making it even more difficult once the conversation has been started.

Some of the fears that doctors may have

FEAR OF BEING BLAMED

The worst fear for doctors—particularly junior doctors—is that the patient will blame them personally for the bad news that they bring. Of course, the phenomenon of identifying the bad news with

the bearer of it is not new, nor is it unique to doctors (after all, the execution of bad news messengers was quite common in ancient times). At the heart of it is the identification of the target for the blame: the easier it is to identify the official authority by which means the news arrives, the easier it is to fix the anger aroused by the news itself on to the bearer. That's why it's so easy, for example, to get angry with a traffic warden—the real anger is at getting the ticket, but with a rapid bit of spurious rationalising it is very easily transferred to that particular warden (who is quite obviously enjoying it, or who doesn't seem to care at all, or who could just as easily have gone around the block again or waited just two minutes—"that's all I ask . . .").

Perhaps it is generally easier to personalise bad news to help deal with it. Whatever the prime cause, my point is that the transferring of a reaction on to the bearer is not uncommon or aberrant behaviour. This means that as doctors we can naturally expect (and thus fear) this kind of reaction from our patients when it's our turn to wear the badge of authority and hand out the bad news.

Worse still, the closer we are to our patients the easier we make it for them to blame us—we are (usually) easily identifiable, often in uniform, and we hand out the essential day to day information that actually makes an enormous difference to our patients ("... the bone scan is booked for Tuesday, we've fixed the marrow sample for Wednesday, and we should have the results by the ward round on Friday"). It's easy to see how patients come to regard doctors as the source and origin of everything that happens to them and not just of the scans and the blood tests. The more authority we have the more we select ourselves as targets.

Not every patient responds to bad news by blaming the doctor, but it is clearly common and well known enough for many doctors to fear it before they start the conversation and possibly to avoid the conversation because of it. Even doctors with many years of experience may find themselves relieved when a patient says "actually I knew it was cancer anyway" and they realise that the moment has passed without blame.

I don't wish to make too much of the sense of blame, but I believe that it is very off putting to doctors and nurses early in their training and that it requires a great deal of care and attention to remind them (and often ourselves) that the patient's disease is not our fault and therefore that the act of blaming is a reaction (to be taken into account as we would inflammation or haemorrhage) and not to be taken personally. This is easier said than done, but perhaps it needs saying more often even so.

FEAR OF THE UNKNOWN AND UNTAUGHT

By the time of qualification all doctors should have been trained (in theory at least) in the management of common medical crises. Nevertheless, unless they qualified in the past few years (and in only certain medical schools, even then) they will not have had any specific training in communication skills in general, nor in talking to dying patients in particular. Plainly it is vital that the doctor should be able to cope efficiently with a diabetic coma or cardiac arrest, and it is in the patients' interests that doctors should know the standard routine approach so that things get done properly and in the right order. That way, if the resuscitation attempt fails at least the doctor may be reasonably certain that he did his best and that nobody else could have done much better.

As we get better at doing the things that we have been trained for, however, the more awkward we feel in situations that we have not been trained for (such as talking to dying patients) and the more we will avoid them. Not only do we miss the comfort and the security of following the course of action that we've been taught but if it all seems to go wrong we have no idea whether it is because we are peculiarly crass or whether this is what happens all the time. This simply means that areas that are out of bounds while we are being trained tend to stay out of bounds once we are trained. It is as if a subject that is not on the curriculum is not a "proper" subject, and the feeling of venturing out beyond the pale of standard medical practice into an uncharted and unfamiliar area adds to the insecurity and anxiety.

FEAR OF UNLEASHING A REACTION

There is also the problem of what may happen once the conversation actually starts—what happens if the patient has a "bad reaction"? What happens if the patient starts crying—right in the middle of the ward, or in a busy clinic while the nurses are trying

to get the next patient into a cubicle and the clinic is 50 minutes behind already?

Not knowing how to deal with the consequences of what we do breaks one of the most important rules of accepted medical behaviour. It makes us inadequate in our own eyes and those of others. There is also the embarrassment of being known as the doctor who goes around making the patients cry. It is generally regarded as better for all concerned if dealings with patients go "smoothly"; and if patients burst into tears many doctors feel that it is because they failed to do the right things to prevent it. It is not easy to suggest that a patient's crying is not in itself a disaster (for the doctor or the patient) or that the tears may actually have done the patient some good, when confronted by nurses or other doctors who, from the kindest motives, don't want the patients to be "disturbed."

FEAR OF EXPRESSING EMOTION

We are trained to behave calmly in emergencies, to suppress any panic that we may be feeling, and also to suppress any antagonism that we may occasionally feel towards any individual patient. These principles are plainly unarguable and fit in with the accepted idea of proper professional conduct. Adopting the model of the calm and composed efficient doctor, however, does make it difficult to learn how to express sympathy and other emotions that might be helpful to the patient at the right moment. I do not wish to imply that doctors are unsympathetic—but merely that having learnt how not to show panic or anger it is necessary to relearn, as a conscious effort, a way of showing human sympathy. I've often heard doctors say how much easier it is to talk to a friend or a neighbour about the way a disease is affecting them than it is to talk to a hospital patient with the same condition. Perhaps in the clinical setting it's easy to get bogged down by the weight of clinical responsibility and to use authoritative language that disguises both therapeutic failure and underlying sympathy.

There is also a most unfortunate semantic quirk that makes this difficulty even worse—and that is the ambiguity of the word "sorry." In general use it has two quite distinct meanings. It may be used as in "I am sorry *that I did this*," which implies responsibility; or it may be used as in "I am sorry *for you*" to express sympathy. This makes it even harder to express sympathy, for even if he overcomes his medical reserve the doctor will feel that in saying sorry in the usual way he is inviting the patient to blame him. The knack of expressing sympathy clearly without covertly accepting responsibility is difficult and needs to be taught and demonstrated.

FEAR OF NOT KNOWING ALL THE ANSWERS

The more junior the doctor the more difficult it is to maintain self confidence while saying "I don't know." Perhaps it's to do with the way we are taught to behave in exams early in our careers, when "I don't know" is expected to earn failure. In practice, it seems as if only the most senior and respected doctors are able to earn applause for confessing ignorance. It is a common enough sight at a symposium or case conference. The consultant is asked for his opinion after the juniors have staggered through a morass of guesses and theories, and his reply "I simply don't know" is so redolent of experience and authority that it gets the audience muttering "of course, that's it—the diagnosis is not known." I would suggest that it is almost a universal law that you must be seen to know a very great deal before you are allowed to confess to not knowing it all.

At first, talking to dying patients does seem a bit like taking an exam, and it's only after some experience that it becomes apparent that many patients may not want The Answer (and may already know that there isn't one) but may simply want somebody to listen to the problem.

PERSONAL FEAR OF ILLNESS AND DEATH

The personal fear of illness and death is too large a subject to deal with in detail here, and in any case I am not qualified to talk about it in depth. There seem, however, to be two very important factors that come into play. One is the general taboo of death (and talking about death), which is a fairly recent and much discussed social phenomenon and needs no further comment. The other concerns the denial of illness and death by the doctor. Some psychiatrists suggest that among the many reasons for which people want to become doctors is the feeling of invulnerability that comes

from working among the sick while being healthy. Whether this is a major or a minor motive, it is much easier to defend the illusion of invulnerability by keeping at a distance from the patient and avoiding the discovery that patients are often very similar to us ("There but for fortune . . .").

I don't know how important this factor is. From the many articles written by doctors about their personal experience of illness and from the descriptions of how surprised and even affronted they were, I would guess that doctors are just a little more inclined than the general public to believe that it can't happen to them. It's easier to keep this illusion alive by staying at a distance from someone to whom it clearly can happen and has happened.

Taking responsibility for the bad news itself

If (despite all the anxieties and fears) a doctor begins to talk about the bad news, other factors begin to operate which push him into assuming responsibility for the disease itself, making him more and more identifiable as the target for blame, rather than as the ally and supporter of the patient.

SHIELDING

Some people are more inclined than others to pat a seriously ill patient on the shoulder and reassure him that all will be well. Those who do this most readily are not uncaring or insensitive or unaware of the patient's true state—in fact, the opposite is more likely to be so. Usually they simply want the news to be good—all the more if they have begun to identify with the patient in any way—and think that an optimistic picture, by heartening the patient, is a self fulfilling prophesy.

Wishing for a successful outcome, however, doesn't produce it; and by shielding the patient the doctor removes the opportunity for him to react and behave in his own way to the news or take any intelligent part in his own care. That may seem like a rather trifling and insignificant aspect of being ill, but I believe that it's actually very important, although difficult for healthy people to understand. A man who was not told that he had multiple sclerosis until after seven years of symptoms put it very well to me. He said that it was like worrying about his bank balance and then going to the bank to find the cashier in whispered conference with the manager, who comes forward and refuses to give the current balance but smilingly reassures him that the balance isn't anything to worry about, really.

I do not say that shielding should never take place (roughly half of the patients in two studies indicated that they would rather not be told the exact diagnosis and would prefer to be shielded), nor do I believe that every gloomy detail and possible horror must be spelt out. But I do think that shielding should not go on by default, as a matter of course and without even considering the possibility that the patient may want to make up his own mind. If it does then at least half of the patients will (justifiably) see the doctor as assuming total command of things, and they will identify him with the disease instead of with the fight against it.

TAKING THE CREDIT FOR REMISSION

Talking about the possibility of future relapse (for instance, in the common solid tumours) is an unpleasant experience and there is always a great temptation to dismiss it altogether ("we got it in time"; "it's all gone"). This is one of the most common examples of shielding and patients often overtly encourage us in it, making it difficult not to go along with it. They may be just recovering from primary surgery or treatment and be feeling well and optimistic for the first time since diagnosis and ask us for encouragement to speed their recovery. It seems churlish and cruel to sound a cautious note at that time, and it's very easy to agree, even tacitly, that the patient is cured. Doctors pushed into that position find that their ward rounds and clinics go smoothly and quickly and that their patients are happier—for a time. The problem is that if a cure is promised (when it's not possible) any future relapse will be seen as the personal failure of the doctor. The patient will (probably) see it that way, and the doctor may also feel—even subconsciously—that the relapse is a failure to fulfil the promise and may subsequently avoid contact with the patient for this reason. Ward rounds at that stage tend to be much stickier, with a great deal of hedging round the subject and much anxiety in the patient.

EXERTING CONTROL OVER THE INFORMATION

We are trained to try to control disease processes, and it's very frustrating when that can't be achieved. This frustration may lead to a search for some aspect that can be controlled—and often this is the information given to the patient and relatives. Exerting control over this information may not alter things clinically, but it does offer the chance of behaving in a sort of doctorly way. This disguised therapeutic impotence originates from the very best of motives, and it's very difficult to realise while you are doing it that you may not be helping the patient and family at all.

What can be done?

Training in oncology, I have met many doctors who are good at talking to seriously ill or dying patients and a few who are absolutely superb at it and from whose example I have learnt a great deal. Only one or two of them, however, had the time, opportunity, and motivation to teach formally or informally on the skills needed and the principles that guide them. This is sad because a great amount of accumulated experience goes to waste and it seems almost as if every trainee must learn all the lessons afresh for himself.

I should like to make a case for medical students receiving more detailed instruction and demonstrations in the subject than they do at present. Only by introducing the subject at an early stage (for instance, using lectures, videos, interviews with patients, and role play) will it be seen as part of the orthodox medical curriculum rather than as the esoteric obsession of one or two medical philosophers.

From my extramural activities I have two further points to support my case. Firstly, my experience as a patient has made me much more aware of the very great benefit that a little well expressed sympathy brings. Secondly, from many interviews with members of the public about medical matters I have a very strong impression that doctors are no longer expected to be omniscient and omnipotent and that our patients genuinely want to be trusted with more knowledge of their conditions and to have the opportunity of discussing their feelings. If they do not get that opportunity from us, then there are many alternative practitioners who will give it—if nothing else.

Conclusion

I do not suggest that there should be any major change in medical attitudes or teaching, but simply that talking to seriously ill patients is a subject in need of greater emphasis in the curriculum. It is a skill (not a divine gift) and it can be taught like any other aspect of medical care. It can be done well by doctors (and can give satisfaction when done well), but above all it should be seen by all of us as a vital and appreciated part of the job of looking after sick people.

Further reading

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