Breakng bad news—Quo vadis?

Background

Almost everybody has heard horror tales of someone who was shocked after a doctor told him or her bad news in a rude manner. Breaking bad news represents a communication challenge. It is taught as a situation, where things can go utterly wrong. It has been viewed as the culmination point of difficult conversations, where the quality of a health care provider’s communication skills will be exposed without mercy. What the term ‘professional’ refers to, has been defined mainly by professionals themselves and goes back to seminal papers in the nineties of the last century (e.g. [1–3]).

What we know: training works

Since those early days a large amount of research has demonstrated that communication skills training (CST) is feasible and successful: participants of a training course usually communicate in a different way than they did before (e.g. [4], reviews in: [5,6]). The evidence seems to be so convincing that CST in breaking bad news has become part of formal training for oncologist as laid down in the guidelines of the European Society for Medical Oncology (ESMO) and the American Society of Clinical Oncology (ASCO) [7]. Questions relating to the optimum duration of CST, the best didactic methodology, the provision of booster sessions or feedback during clinical activities, etc. remain to be answered [6].

Therefore, a recent paper in this issue of PEC merits attention because it uses innovative teaching methods: The paper from East Tennessee State University (Gorniewicz) et al.; this issue in PEC presents a workshop format that has been offered to medical students and residents [8]. It uses a mixture of different didactic interventions and successfully improved participant behaviour with an intervention time of 4 h workshop plus one hour spent with training material stored on a CD-ROM. The approach is innovative insofar as the content of the workshop was developed with the help of interviews with real patients who defined problem areas in communication with cancer patients. Thus, intervention goals, role plays with simulated patients, and reflective questions were based upon real life experience. Even though we do not know which elements of the multi-faceted didactic approach are responsible for the impressive results, we may state that less time than usually spent with BBN training might be sufficient to improve communication.

The dilemma: communication is improving – patients don’t profit

These encouraging results, however, do not solve a major dilemma in the area of BBN: By and large, results show that patients do not profit from a professional who has received proper communication skills training (e.g. [5,6]). It should be noted that there is one more optimistic paper by Fujimori [9] that found a reduction in depression in those patients who had seen an oncologist from the intervention group. This is however, in contrast to the results of a large study by Curtis et al. [10], who were unable to find any improvement in patients’ reported quality of communication, quality of end of life care, and depression scores; family responses corroborated these findings. It was even more striking that patients seen by residents from the intervention group had higher depression scores than those seen by residents from the control group. In the following section, a list of possible reasons to explain the dilemma of successful training with no impact on patient outcome is presented.

Do we train the wrong communication skills?

As stated above, patients had little say in developing training curricula, experts decided what should be taught and learned. Some papers have shown that experts themselves differ largely in their evaluation of professional communication [11,12], not to speak of differences between experts and patients. Whereas CST usually stresses the importance of responding to emotional needs of the patient, patients expect high quality information first and foremost from oncologists. Forsey et al. [13] compared doctors’ and nurses’ accounts of emotional care for parents of children with leukaemia. Doctors relied on the quality of continuous care of the child and on the provision of (positive) prognostic information; they ‘did not think they could reassure parents by eliciting and explicitly discussing parents’ fears. In contrast, nurses relied on psychological skills and explicit discussion of parents’ emotions to provide reassurance’. In the same clinical population Young [14] compared parents’, experts’, and doctors’ account of emotional support. Parents valued a doctor’s perceived medical competence and drew emotional support from his or her authority; they did not distinguish between emotional and instrumental quality of interaction, whereas experts and doctors viewed these two aspects of an interaction as distinct entities. Mendick et al. [15] showed that breast cancer patients and their surgeons shared a common agenda, in that both groups stressed
the importance of honest information, information that preserved hope, displayed expertise, and a sense of relationship. Patients, but not surgeons wanted more information about the functioning of a hospital environment. Surgeons, but not patients stressed the importance of detailed information to make the right decision. In a series of papers on the provision of hope a similar picture emerged: hope was largely attributed to the sense of being informed completely and honestly (e.g. [16–19]), although professionals continuously have to strike a balance between information and hope [20]. Quantitative papers point in the same direction: Merseburger [21] reported that patients with prostate cancer rated the importance of emotional support and involvement of their family as low, whereas information needs were rated as highly relevant. In a paper by Butow [22] patients asked a total of 2829 questions about diagnosis, treatment, history, prognosis, or other medical issues, whereas only 250 questions were targeting psychosocial issues.

Taking these results together one might ask whether the typical CST in the field of breaking bad news is biased towards the provision of emotional support and neglecting the art of giving information.

Do we use sub-optimal research instruments?

Many papers use video-taped consultations in which different ways of breaking bad news are portrayed and then shown to real or surrogate patients (e.g. [23]). A recent paper by Tanco et al. [24] may serve as an example to illustrate the problem: the authors had oncology patients view video vignettes in which actors portrayed doctors giving bad news with an equal amount of empathic statements but with different modes of framing the information: in the more optimistic version, the physician added vague information to the medical facts giving the information an optimistic twist. In the less optimistic video, the physician provided explicit information about the lack of further treatment options – which in fact mirrored the clinical situation correctly. Patients who watched the more optimistic presentation of bad news were much more positive about the physician’s perceived compassion, they would more likely recommend the more optimistic doctor, and rated him as more trustworthy. This study seems to raise a big question: should we forsake truth in order to achieve higher empathy scores? Or do we have reason to assume that the results of this study are not as meaningful as one might think at first sight? I think this is the case. Contrary to clinical practice where the pace of informing the patient is at least, to some extent, informed by the patient’s pace, the actors portraying the doctor in the video-vignettes have to follow a fixed grid of sentences which are uttered at a pre-set speed. Thus, they do not have a chance to respond to patients’ desire to pause a little and digest what they just heard or to get more or perhaps less information. In my view this design violates an essential element of patient-centred communication: an adaption of the pace of giving information to the patients’ verbal or non-verbal signs of acceptance and understanding, an essential part of the so-called alignment (e.g. [25]). In my view, the gist of patient-centred communication is the acceptance of the unpredictable nature of human interactions; breaking bad news is indeed the most difficult version of this, because it confronts the receiver – and sometimes the deliverer – with existential questions that push both persons to the limits of what they can bear. Showing standardised videos to patients in order to evaluate the effect of CST does not mirror real world interactions, which in the best of all instances should be led by the momentary and fluid state of both interlocutors.

Do we use sub-optimal guidelines?

The same holds true for standardised guidelines of the Do’s in breaking bad news (e.g. [26]). Some empirical literature has shown that cancer patients’ do not respond to the steps of this approach equally well [27]. Perhaps a list of the Don’t Do’s might be more helpful and could be short. In order to be concordant with the fundamental principle of patient-centred communication - adapt content and style of communication to the individual patient’s needs. In my view it should include one categorical imperative: Never be faster than your patient. Gorniewicz J et al. illustrate the importance of this rule showing an interview with a patient that ‘highlighted the importance of pausing after delivering bad news in order to attend to a patient’s emotional response before sharing additional information’ [8].

Do we miss a major problem: the transfer from seminar to clinical practice?

We know from the literature that the seminar performance of workshop participants improves. We do not know to what extent these improvements are transferred to clinical practice. Based upon my experience in running communication skills trainings for doctors of all medical disciplines and on different levels of professional expertise I must state that performance in seminars has almost no bearing on performance in clinical practice. I should add that CST offered by our institution always combines training in seminars plus feedback on the job, e.g. during ward-rounds or in the outpatient clinic. The lack of transfer goes both directions: the ‘communication hero’ in role play displays nothing of his or her achievements during ward rounds, the ‘disaster participant’ turns out to be a warm-hearted doctor who listens to his or her patients and radiates confidence with no visible effort.

References


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