

COMMUNICATION OF BAD NEWS

The diagnosis of esophageal cancer, a retained sponge, a newborn with spina bifida, the probable need for transition to comfort care, an iatrogenic perforation of small bowel, a procedure not covered by insurance - each of these scenarios requires the surgeon to be the bearer of unwelcome, life-threatening, life-changing news to persons directly affected by the information - the patient, parents, family, and the surgical team. Interpersonal and communication skills are a core competency for trainees preparing for a career as physicians. Emotional intelligence is becoming increasingly recognized as a valued attribute of health professionals. The goal is communications “that result in the effective exchange of information and collaboration with patients, their families, and health professionals.” (1)

Points to consider when communicating bad news:

1. Respect, sensitivity, and empathy are vital
2. Environment/space where news is shared
3. Who is authorized to disclose and provide further discussion of implications of bad news?
4. Culture, ethnicity, religion, spirituality of patient and family
5. Patient literacy
6. Language proficiency - is a translator required?
7. Patient and family options for dealing with the news
8. Hospital guidelines if medical error is involved

Where Should Bad News Be Shared

Communication of all medical information requires consideration for confidentiality as well as respect and sensitivity. The setting should provide privacy, either in the clinic office or a room where the conversation can be held without interruption. Attention also needs to be paid to the patient’s cultural, psychological, religious, and spiritual beliefs. When needed and appropriate, communicating bad news should involve professionals such as hospital chaplains or other team members, as well as translators when language barriers emerge (2).

A box of tissues should be available. When the surgeon believes it is appropriate, she should invite trainees or a medical student to observe the interaction.

Communicating bad news should not be delegated to trainees or medical students. If trainees or students are queried by patients, families or friends about diagnoses or other issues that have not been communicated, they should respectfully refer these queries to the attending surgeon. Radiology and ultrasound technicians and other staff or observers, including trainees and students, who notice indications of possible problems should be careful with what they say to patients and families as they are unlikely to be authorized to discuss findings (3).

Dialogue, Not Monologue

The surgeon should introduce him/herself, particularly, if there is any chance they are not well known to the person or persons in the room, and offer a greeting as appropriate. As the information is verbalized, the surgeon should use the clearest and most understandable words that convey the truth of the diagnosis or situation. The surgeon should be aware that medical literacy of patients and families varies and affects comprehension. Patient literacy involves more than educational attainment. Persons with high school education or lower, as well as learning disabilities and age-related decline in cognition, contribute to health illiteracy (5). Even university-educated persons may not understand the language of medicine. The emotional

ACS/ASE Medical Student Core Curriculum Communication of Bad News

impact of bad news may also cause lapses of understanding. The patient, parent, spouse, or family member should be encouraged to ask questions or even interrupt if something is unclear. Enough time should be set aside for a true dialogue so the surgeon can be assured that communication has occurred. The “teach back” method is a technique recommended for health information sharing. As the surgeon or member of the team tries to explain the issue to the patient and family, they ask the persons involved to explain or repeat key points to be certain that the information is being comprehended and internalized. Handouts, diagrams, and illustrations can be useful in some scenarios (6). Realistically, the surgeon understands that much of the information may not be absorbed in the first meeting, and might consider scheduling a subsequent visit for further conversations, if necessary.

Cultural Issues Relating to Bad News

In the West, patient autonomy is a cornerstone of medical ethics, but in some cultures, the family tradition requires that particular family members such as the senior male be told first and also be involved in information exchange with the patient. If there is enough time to work through these cultural constraints, the surgeon might request a chaplain or social worker to assist. A professional translator may be required as well.

Communication of Medical Error

When medical error is involved, physicians must disclose the error. Hospitals have disclosure policies; therefore, the hospital’s risk management office should be notified immediately after the incident and may want to be involved in early communication with the patient and family (7).

One study suggested that physician body language projecting concern while disclosing an error improves the physician-patient relationship (8). Respect and empathy are almost always recognized and appreciated even when the message is difficult to understand.

Patient Perspective

Patients’ impressions of the communication experience include:

- How the physician behaved, acted, spoke, and the perceived honesty and emotional support provided by the physician
- The amount of time involved
- Use of comprehensible medical terms

A positive experience will enhance future interactions and cooperative treatment goals (4).

Effect on the Surgeon and Surgical Team

In this era of increasing focus on physician wellness and the avoidance of burnout, the surgeon and the surgical team must be aware that communicating bad news, especially that involving medical error, can take an emotional toll on the care providers (second victim). The surgeon and team may need to seek counselling from the hospital-provided services or pursue other options.

How Can Students Learn About Communicating Bad News

1. Observation of a surgeon-patient conference wherein bad news is shared is one of the most valuable methods of learning about the process. Every situation has unique aspects and some surgeons are more skilled than others in this procedure. The student will need permission from the surgeon to observe. Taking advantage of every opportunity is advised.
2. Simulation plays a vital role in every area of medical communication involving patients and families, as well as other health professionals (9).
3. **M&M** -- Surgical morbidity and mortality conferences, sometimes labelled morbidity, mortality, and improvement (MMI), offer case studies of surgical operations or situations wherein less-than-optimum outcomes occurred. These case studies are discussed by surgeon peers of the involved surgeon with the goal of quality improvement in similar situations (10).

Questions

1. Medical students are vital members of the health care team. If there is bad news to be communicated,
 - a. The medical student can be trusted to communicate bad news to the patient.
 - b. The medical student should seek out a family member to explain the bad news before telling the patient.
 - c. The primary physician should communicate bad news to the patient and family.
 - d. The head nurse should communicate any bad news to patients and families.
 - e. Risk management must always be consulted before bad news is shared with the patient.
2. Patients are very perceptive about communication of bad news from health care professionals. They frequently notice
 - a. The duration of time spent in the communication session.
 - b. The color of the shirt the physician is wearing.
 - c. If their family has information before they do.
 - d. How quickly the discharge orders are written.
 - e. The hospital where their physician trained.
3. As the resident surgeon for Emergency General Surgery, your patient suffers an arrest but responds to CPR. The procedure is aborted and your attending asks you to speak with the husband in the waiting room. The plan is to transfer her to the SICU. It is not clear what her mental status might be post-operatively. At introduction, you become aware that the husband doesn't understand English. His teenage daughter is with him. You need to discuss the intraop event, the plan, and the uncertainty and prognosis. How should you proceed in communicating with the husband?
 - a. Ask the daughter if she speaks English and can help you explain the situation to her father.
 - b. Speak louder and more distinctly.
 - c. Contact the hospital interpretation service and request a translator.
 - d. Smile and try to use kindness to put the patient and her family at ease.
 - e. Go out to the nurse's station and find out if anyone can help with translation.

ACS/ASE Medical Student Core Curriculum Communication of Bad News

Answers

1. Medical students are vital members of the health care team. If there is bad news to be communicated,
 - a. The medical student can be trusted to communicate bad news to the patient.
 - b. The medical student should seek out a family member to explain the bad news before telling the patient.
 - c. **The primary physician should communicate bad news to the patient and family.**
 - d. The head nurse should communicate any bad news to patients and families.
 - e. Risk management must always be consulted before bad news is shared with the patient.

2. Patients are very perceptive about communication of bad news from health care professionals. They frequently notice
 - a. **The duration of time spent in the communication session.**
 - b. The color of the shirt the physician is wearing.
 - c. If their family has information before they do.
 - d. How quickly the discharge orders are written.
 - e. The hospital where their physician trained.

3. As the resident surgeon for Emergency General Surgery, your patient suffers an arrest but responds to CPR. The procedure is aborted and your attending asks you to speak with the husband in the waiting room. The plan is to transfer her to the SICU. It is not clear what her mental status might be post-operatively. At introduction, you become aware that the husband doesn't understand English. His teenage daughter is with him. You need to discuss the intraop event, the plan, and the uncertainty and prognosis. How should you proceed in communicating with the husband?
 - a. Ask the daughter if she speaks English and can help you explain the situation to her father.
 - b. Speak louder and more distinctly.
 - c. **Contact the hospital interpretation service and request a translator.**
 - d. Smile and try to use kindness to put the patient and her family at ease.
 - e. Go out to the nurse's station and find out if anyone can help with translation.

References

1. ACGME Common Program Requirements. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRs_2017-07-01.pdf. Accessed 13 Jan 2019.
2. Prentice J, Nelson A, Baillie J, Osborn H, Noble S. 'Don't blame the middle man': an exploratory qualitative study to explore the experiences of translators breaking bad news. *J R Soc Med.* 2014 Jul; 107(7): 271–276.
3. Maynard DW. Delivering bad news in emergency care medicine. *Acute Med Surg.* 2016 May 16;4(1):3-11. doi: 10.1002/ams2.210.
4. Sobczak K, Leoniuk K, Janaszczyk A. Delivering bad news: patient's perspective and opinions. *Patient Prefer Adherence.* 2018 Nov 12;12:2397-2404.
5. National Institutes of Health. National Library of Medicine. Health Literacy. <https://nnlm.gov/initiatives/topics/health-literacy>. Accessed 14 Jan 2019.

**ACS/ASE Medical Student Core Curriculum
Communication of Bad News**

6. Agency for Healthcare Research and Quality. Health Literacy Universal Precautions Toolkit, 2nd Ed. Use the Teach-Back Method: Tool #5. <https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2-tool5.html>. Accessed 14 Jan 2019.
7. Mazor KM, Simon SR, Gurwitz JH. Communicating with patients about medical errors; a review of the literature. *Arch Intern Med.* 2004;164(15):1690-1697.
8. Hannawa AF, Shigemoto Y, Little TD. Medical errors: Disclosure styles, interpersonal forgiveness, and outcomes. *Soc Sci Med.* 2016 May;156:29-38.
9. Westmoreland KD, Banda FM, Steenhoff AP, Lowenthal ED, Isaksson E, Fassl BA. A standardized low-cost peer role-playing training intervention improves medical student competency in communicating bad news to patients in Botswana. *Palliat Support Care.* 2018 Oct 17:1-6.
10. Wall AE, Tarpley MJ, Heitman E. M&M conferences provide forum for discussion of ethical issues. *Bull Am Coll Surg.* 2018 Aug; 103(8)).

Authors/Contributors

Margaret Tarpley, MLS (Goals & Objectives and Content Author)
Vanderbilt Institute for Global Health