

# How Do I Break Bad News?



Hospice *friendly*  
Hospitals  
PROGRAMME

How Do  
I Break  
Bad News?



## **Contents**

Introduction	3
What is Bad News?	4
Principles of Breaking Bad News to Patients	5
How Should I Tell Bad News?	7
Telling the Bad News	12
Breaking Bad News to a Sick Child	16
How Do I Handle Difficult Questions?	17
When Sudden Death Occurs	20
Guidelines on Giving Bad News By Telephone	25
References	28



## **Introduction**

This booklet aims to offer guidance and support to members of a multidisciplinary team involved in breaking bad news to patients, their families and/or significant others. It is to ensure that, as far as possible, any trauma involved in hearing bad news should relate to the actual news and not to the manner in which it is imparted.

This guide is to aid best practice. It is not intended to be prescriptive. At times best practice is not possible, for a variety of reasons.

Each team member has a duty to respect patient confidentiality and to demonstrate responsibility towards any information relevant to the patient. When involved in breaking bad news, we must be aware as staff of the potential consequences, and the need to be accountable, for our actions.

These guidelines were developed as part of the *Care for People Dying in Hospitals Project*, an Irish Hospice Foundation initiative in partnership with the Health Service Executive – Dublin North East. This is an adapted second edition. In developing this document we gratefully acknowledge the kind permission of the Mater Misericordiae University Hospital, Dublin, to use its guidelines on communicating bad news.

## **What is Bad News?**

Buckman says bad news is “any news that drastically and negatively alters the patient’s view of his or her future.”

Thayre and Hadfield suggest that, “losses may take many forms: a loved one’s death; devastating diagnosis which shatters hopes, dreams, aspirations; disability; impairment; or poor prognosis confirming or confronting the recipient’s worst fears.”

## **Principles of Breaking Bad News to Patients**

### **Patients have a right to**

- Accurate and true information
- Receive or not receive bad news
- Decide how much information they want or do not want
- Decide who should be present during the consultation, i.e. family members including children and/or significant others
- Decide who should be informed about their diagnosis and what information that person(s) should receive

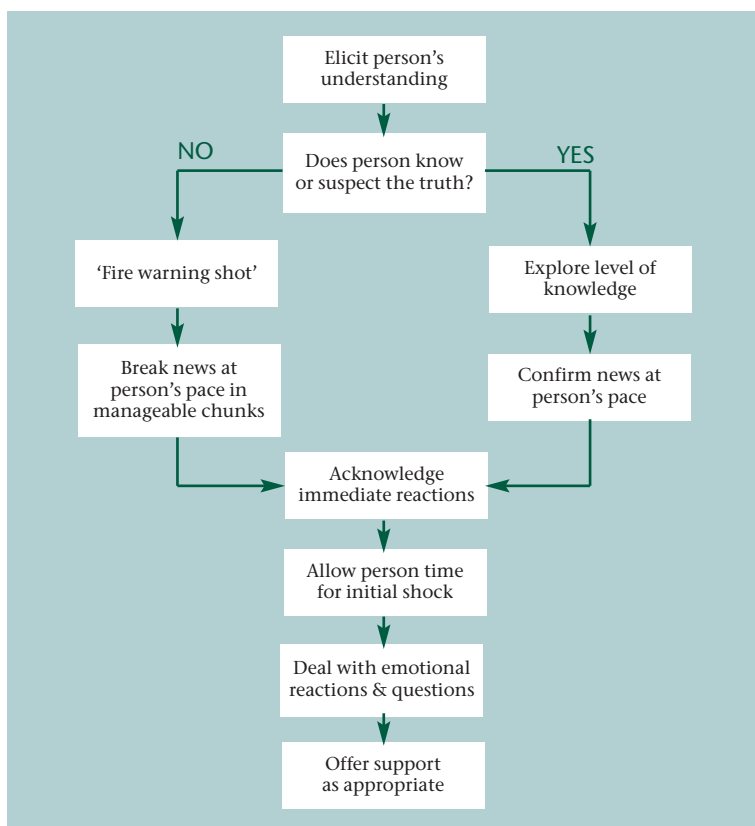
### **Patients and circumstances differ**

The impact of bad news is influenced by the difference between the patient's expectations, including his or her ambitions and plans, and the medical reality of the situation (Buckman, 1992). When breaking bad news to patients and/or their family and significant others, their capacity to understand the information being offered should be considered. While the legal age of consent for medical treatment is 16, in general, when dealing with people under 18, their parents or guardians should be involved.

We should also respect denial of bad news, which is a natural response. Communication happens through time, not only in one place and location. Consider communication as a process, and plan for follow-up. Different types of communication are appropriate in different situations, such as communications between patient/family and professional; between patient and family; and between professionals.



## A Process for Breaking Bad News



*Recommended manner of breaking bad news (Faulkner, 1998)*

The standard by which we should assess the quality of how we have broken bad news to patients is to ask ourselves:

*If the person was my relative would I have been happy with how the news was given?*

## **How should I tell bad news?**

### **Identify correct patient and family**

It is vital that the team first identify the correct patient, and where appropriate the correct family members and/or significant others, who have permission to be informed. The person breaking the bad news is responsible for ensuring that all information available is accurate and relates to the correct patient. All shared information must be documented in the named patient's record.

### **Who should break bad news?**

Ideally, bad news should be imparted by the lead consultant or senior non-consultant hospital doctor, who is known to the patient or in whom the patient has trust. In the exceptional circumstances of sudden death (See page 20) a senior member of the nursing staff may have to break bad news. In essence, the task of breaking bad news should not usually be given to junior staff. It is recommended that one other member of the multidisciplinary team, such as a nurse, social worker or pastoral carer, should be present (or at least available) when bad news is being broken and during ongoing consultations.

### **Who else should be informed?**

If members of the multidisciplinary team actively involved in the immediate direct care of the patient are absent during the breaking of bad news, the absent members of the multidisciplinary team should be informed as soon as possible. Such discussions should be documented in the patient's clinical notes and should include the key phrases that were used. With

the patient's consent the general practitioner, and other medical advisers, should be promptly informed about what the patient has been told and how he/she has responded to the information.

### **Where should I tell bad news?**

The location for telling bad news is important. Every effort should be made to ensure privacy and confidentiality and to help the patient feel comfortable. If the patient is bed-bound it may be necessary to transfer the patient in his/her bed to a suitably private room. If possible, but only with the patient's permission, try to ensure that the patient has the support of a key relative or friend of their choosing while the bad news is being broken. It is ideal if you can get a private room, with comfortable chairs at an even height, and with no objects or furniture, such as a desk, between the person giving the information and the patient and/or others in receipt of the bad news.

Pagers and mobile phones can be disruptive. It is best to leave them with a colleague or ensure the volume is turned down. You should also apologize if it is vital to bring a pager/mobile phone into the meeting. A 'Meeting in Progress' or 'Do not Disturb' notice on the door is also helpful as it can help to avoid unnecessary and distressing interruptions.

The discussion might need to be conducted by the patient's bed side. Check with the patient that this is agreeable. If so, the curtains should be drawn. The person relaying the bad news should also try to sit near the patient, at eye level, rather than standing at the end of the bed.

*Consider the volume of your communication - bear in mind that curtains are not sound-proof and you may be conveying information that is distressing both to the patient and to others around him or her.*

### **When do I tell bad news?**

As early as possible in the diagnostic process the multidisciplinary team should begin to prepare the patient for the possibility of bad news. It should be a goal of good practice that patients are informed of significant information as soon as it is confirmed, provided they are in a fit state to receive the information and have access to support should they wish. Be mindful that some patients prefer to receive bad news by themselves and their wishes must also be respected.

In many cases, the need to break bad news can be anticipated, for example, during the post-surgery ward round or following the arrival of histology reports. It is vital that sufficient time be set apart for communicating bad news and that it be planned into work schedules.

### **What should a patient be told?**

The definitive answer is the truth, and nothing but the truth. The doctor's primary responsibility is to the individual patient. Responsibility to relatives and/or significant others is important but secondary. However, always ask the patient how much information they already have about their condition and how much they want to know.

Knowing how much information the patient wants to receive will guide you in informing them without overloading them with information. It also gives the patient a sense of some control over the process.

Remember, it can be difficult to take in information while bad news is being broken. As Buckman (2007) states, it is always

worth asking the patient if he or she would prefer to be fully informed or if they would rather that you talk with a family member or friend about their medical situation. It is important to obtain the patient's permission to discuss his or her care with family members or friends.

Take your lead from the patient. Listening to their concerns conveys respect and acknowledging that the news is difficult for them is also helpful.

To ensure that the patient understands any implications, give accurate and reliable information. The information given should reflect the needs of the patient at that time, for example, if consenting to a procedure or treatment, or requesting more information on an illness or prognosis. It is often difficult for people to take in all the information during one meeting. It may be necessary to arrange a follow-up meeting to allow the patient to come to terms with the news and to ask any additional questions they might need answered.

The patient, not the family, should be the first person to be informed of the news, except in the case of a minor. Patients with an intellectual disability or cognitive impairment, or who are minors, have a right to information regarding their health. This should be approached with special preparation and sensitivity and should involve people who can support the individual, like family members, significant others, or care workers who know the person well.

*It is good to use non-verbal cues to convey warmth, sympathy, encouragement or reassurance to the patient.*

### Varying responses to bad news

People have varying responses when receiving bad news.

Some common ones are:

Denial	Shock
Anger	Guilt
Blame	Agitation
Helplessness	Sense of unreality
Misinterpreting information	Regret/anxiety

### Cultural and language difficulties

If there are language difficulties, a trained and independent (non-family) interpreter should be used. Never use young children, even if they are the only ones available with the language skills. If using an interpreter, face-to-face rather than telephone conversations are preferred. Be aware that the culture, race, religious beliefs and social backgrounds of the patient, families and/or significant others may affect how he/she deals with the information received. If you are unsure about particular cultural implications, always ask for more information - never make assumptions.

## Telling the Bad News

### How do I give information?

Before proceeding to tell the bad news, it is important to assess the patient, the family and/or significant other's understanding of the situation. This should be done prior to and throughout the meeting. This allows the patient to recap and to tell you what they know about their medical situation. You will then get a sense whether the patient has an idea of the seriousness of his or her condition. Here are a few questions that Buckman (2007) suggests can be used to ascertain this information:

- *“What did you think was going on with you when you felt the lump?”*
- *“What have you been told about all this so far?”*
- *“Are you worried that this might be something serious?”*

It is important to note the language and vocabulary that the person uses, and it is good to use the same vocabulary in your responses. Lubinsky (cited in Buckman, 2007) points out that this alignment is very important because it will help you assess the gap between the patient's expectations and the actual medical situation – this is often unexpectedly wide. It also helps your patient understand what you are saying if you use the same level of vocabulary, particularly in this possibly overwhelming time.

Before you break bad news, prepare your patient that bad news is coming, for example: “The results are not as good as we expected....” “Yes, it could be serious ....” “We are concerned by

the test results ....” “Your test results are due back later today.....” “I’m afraid I have bad news ....” This ‘warning’ gives your patient a few seconds longer to psychologically prepare for the bad news.

Information must be given honestly but sensitively, without euphemisms. Again, use language that is appropriate to your patient’s comprehension, with minimal use of medical and technical jargon. Avoid words such as ‘myocardial infarct,’ say “he has had a heart attack.” “He has died,” rather than “he has passed on.” “He has cancer,” rather than “He has a tumour.”

It may be useful to use drawings, diagrams, and leaflets to reinforce the information, if appropriate. Go at the patient’s or relatives’ pace. Pause to allow them reflect on information given. When necessary repeat the information. Allow time for people to express feelings. Be aware of your own and other people’s body language. Check regularly that information is understood and repeat when necessary.

### **Demonstrating empathy**

It is important to demonstrate empathy during and following the breaking of bad news.

One of the hardest things about breaking bad news is responding to the patient’s emotions. It is sometimes tempting to relieve our own and the patient’s anxiety by downplaying the seriousness of the news (Buckman, 2007), or by avoiding the patient’s emotional reaction to the news. It is far better to acknowledge the patient’s emotions as they arise. Three simple techniques can assist you:

- Listen for and identify the emotion(s) that the patient is



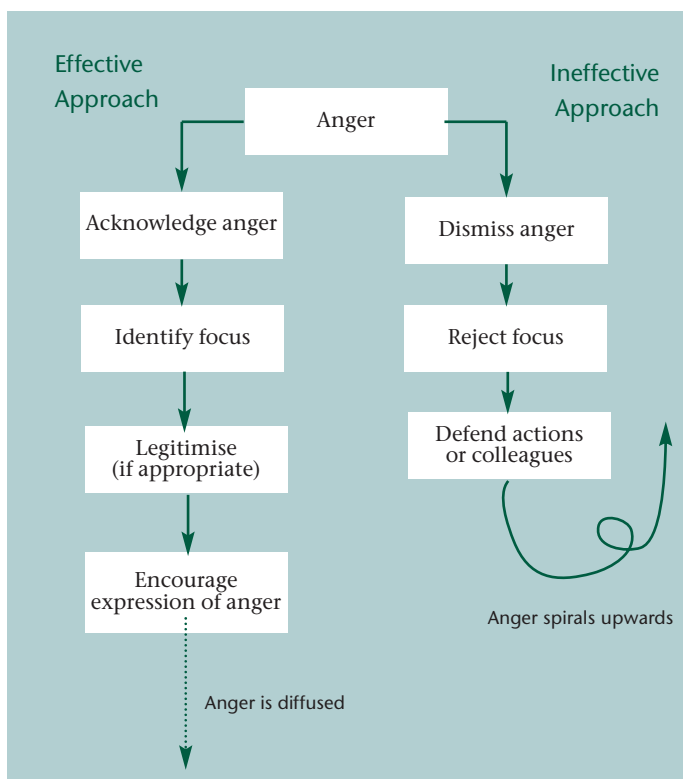
feeling. If you are not sure which emotion(s) the patient is experiencing, you can use an exploratory response, such as “How does that make you feel?” or “What do you make of what I’ve just told you?”

- Identify the cause or source of the emotion (most likely to be the bad news that the patient has just heard).
- Show your patient that you have identified both the emotion and its origin, for example, “Hearing the result of the bone scan is clearly a major shock to you.” “Obviously this piece of news is very upsetting for you.” “I can see this is very distressing.” “That’s not the news you wanted to hear, I know.”

Buckman, 2007

Empathic responses help to validate your patient’s feelings and show that you have given some consideration to their feelings, for example, “I wish the news were better.” Letting your patient know that showing emotion is perfectly normal can help to minimize any feelings of embarrassment, discomfort or isolation that they may feel.

On hearing bad news, patients and/or family will often respond with strong emotions. There may be guilt, anger or blame, or all of these. Anger can be misdirected at the members of the multidisciplinary team. It is important that health professionals establish the cause of the anger, where it is directed, and whether it is justified. The recipient of the bad news can then be helped to understand the true cause of the anger.



*Methods of dealing with anger (Faulkner, 1998)*

For some patients their anger may be persistent or destructive, in which case the anger may need to be challenged. However, for many people, such anger is often part of their defence mechanism following bad news and is a stage they can work through with time and support.

### **Supporting the patient & family following bad news**

It is important to ensure that any concerns raised are addressed. Written information should be given on useful contacts and numbers. Don't be afraid to say, "I don't know." Be empathic and also aware that casual remarks can be misunderstood. The patient, family and significant others also need private time. They should also be reassured that they are not expected to remember or understand all the information. They should be encouraged to check what they have remembered or understood with members of the care team. If appropriate, follow-up meetings should be offered.

### **Breaking Bad News to a Sick Child**

Telling children bad news is painful for you, and for them. Before such a conversation, however, parents/guardians and the health team should meet to discuss how the child might be best approached. This will depend on a number of circumstances, among them the child's age, personality, and of course the prognosis of the illness.

Essentially, the child has to be told in language, and at a pace, he or she understands. Try to identify what the child already knows, and build on that, checking regularly to see if the child grasps the new information.

A child should be told bad news as soon as possible: he or she may already have picked up that there is something wrong.

While you may be distressed yourself, the important thing is that the child knows he or she is not isolated. Depending on

your relationship, and if the child is not uncomfortable, you may wish to hug the child, indicating your love and support.

Over time the child may probably repeat many questions about his or her illness. This is similar to a child who has been told about the serious illness, pending death or death of a parent. Such questions should be answered patiently and clearly in words the child understands.

### **How Do I Handle Difficult Questions?**

Difficult questions may include, “Am I going to get better?” “Am I going to die?” “How long do I have?” Listen to and acknowledge the question and check the reason behind it and if the answer is really wanted. You might say, “Would you like us to talk about that today or would you like to leave it to another day?” A sample answer may be: “That’s a difficult question, there are no simple answers. We can hope to control your illness, but can’t hope to cure it.”

If the question is asked, the issue of “time left” should be discussed. Avoid giving a prognosis with a definite time scale and also expressing the notion that “nothing more can be done.” It is important to offer hope at some level, for example, “We cannot cure you but we hope to control your disease” or “We will do our best to keep you as comfortable as possible.” Do not be afraid to say, “I don’t know.”

It is sometimes appropriate to indicate some sense of timescale to allow an individual to prepare for his or her own death or to allow relatives to prepare for the loss of their loved one. In this instance, time should be broken into blocks, i.e. hours to days,

days to weeks, weeks to months and months to years. Within the time scale there must be flexibility, for example, “You may have a number of months,” or “You may have months rather than years.”

At the end of the consultation, arrange for a time in the immediate future, for example within 24 hours, to review the situation with the patient and his/her family and/or significant others.

Ask the patient if he/she would like someone to be contacted on his/her behalf. Offer the patient detailed information and contact numbers of the various support services, such as pastoral care, nurse specialists, disease-specific support groups, palliative care services, counselling services and social workers. Be aware of the temptation to overload a patient with information.

Document in the medical and nursing notes what the patient and/or the family members/significant others have been told and their reactions.

### **Self Care**

Breaking bad news can take a toll on the person delivering it to the patient. Be aware of your own feelings and those of others involved. Peer group and other staff support may be valuable. This is especially important if you have recently experienced a bereavement.

## Summary

DO	DO NOT
Allow time	Overload with information
Ensure privacy and confidentiality and respect both	Distort the truth
Ensure honest and simple language is used	Give false reassurance
Let the patient talk	Feel obliged to keep talking all the time
Listen to what the patient says	Withhold information
Be sensitive to the non-verbal language	Assume that you know what is concerning the patient
Gauge the need for information on an individual basis	Criticise or make judgements
Allow for silence, tears and other patient reactions	
Document and liaise with the multidisciplinary team	

*Adapted from Jennifer Barraclough's Do's and Don'ts (1999)*

## **When Sudden Death Occurs**

Each case of sudden death is unique and the needs of the family and/or significant others must be assessed on an individual basis. However, the following guidelines (which are similar to the general guidelines on breaking bad news), may be helpful in cases involving sudden death. The short period before the breaking of bad news - the journey to the hospital, during resuscitation or when being shown into a family room - may produce a range of emotions such as fear, hope, anger, and sorrow.

The most experienced member of staff available should be allocated to the family and/or significant others. Where appropriate, other members of the multidisciplinary team should be involved in the process. Involve pastoral care as soon as possible and in accordance with the family's/significant others' wishes. Social workers are a useful resource when supporting families and children in sudden death.

When possible the team should prepare the family/significant others for the possibility of bad news as early as possible on the telephone or during the resuscitation process. You could say, for example, "The news is not good ....." Inform the family/significant others as soon as death is confirmed. It is important to say what you mean, to use the word 'dead' and 'died' rather than he has 'gone' or 'passed away.' The deceased should be referred to by name.

Find out what the family/significant others know - fill in the details. Give accurate and reliable information so that the

family/significant others understand what has occurred. If requested, inform the family and/or significant others of the people who were present at the time of death. When a nurse has broken the bad news, many families may benefit from speaking with the doctor who took care of the patient. This can help families to understand and accept the process and nature of the death, especially if complications arose or the death was unexpected.

When a doctor has broken the bad news it is preferable that he/she hand the family into the care of a nurse who can stay with them and answer any questions that might arise, rather than leave the family standing alone on a corridor not knowing what to do. If a nurse was present when the person died, the family may wish to speak with him or her, again to aid understanding and acceptance.

It is important that staff members have access to support following involvement with bereaved family/significant others.

### **Viewing the body**

- Provide a private, dignified environment for viewing the body.
- Viewing the body will help to confirm the death for the family/significant others.
- It provides an opportunity for positive identification.
- If there are disfiguring injuries, give informed choice prior to viewing.
- Advise the family that, if there is a post-mortem, intubation tubes and intravenous lines must be left in.



- Allow the family/significant others to decline viewing the body.
- In consultation with the family consider the needs of the children.
- During the viewing invite the relative or significant others to touch and hold the deceased as appropriate.

### **Attend to formalities**

There are many formalities surrounding the death of a patient. You should document details of next-of-kin, information given, plans, interventions and, if necessary, reactions to bad news and/or changes in prognosis or outcomes.

The role of the Coroner should be remembered. When sudden death has been reported to the Coroner, the family and/or significant others must identify the deceased in the presence of a garda.

If appropriate, the possibility of a post-mortem should be discussed and relevant information literature should be provided. Be aware that consent from the next-of-kin is not required for a Coroner's post-mortem as there is a legal requirement to comply with such post-mortems. This can be a very distressing and sensitive issue for families and needs to be discussed sensitively and explained thoroughly. The explanation to the families and their reactions must be recorded.

In the case of a hospital post-mortem (one not involving the Coroner) the consent of the family is required and must be documented – a consent form must be completed and signed by

the next-of-kin and held on record by the hospital. The family and/or significant others should be told about the issue of tissue or organ retention and disposal. The possibility of organ donation should be discussed.

### **Personal belongings & arrangements after death**

Document personal valuables and to whom they were returned. The hospital should offer to dispose of soiled or damaged clothing, unless the death is a case for the Coroner and forensic examination may be required. When handing over personal belongings use the special family handover bags provided by the hospital.

**Under no circumstances should you hand over personal belongings in a plastic bag.**

Arrangements should be made for identification prior to the family and/or significant others leaving the hospital. The process for follow-up should be explained, for example, how to arrange to take the body home, viewing arrangements if deceased is to go to the hospital mortuary, and how to contact the hospital mortuary technician.

Also, opportunities to return and speak with staff or view the deceased should be offered, if appropriate. Repeat information when necessary. It is good practice to provide a telephone number, preferably a direct line, on which you may be contacted, and to ensure that the family and/or significant others have transport home. Contact details for the mortuary staff and/or post-mortem co-ordinator should also be given. Families should also be advised that the post-mortem co-ordinator may contact them.

Relevant information on grief and bereavement support groups should be provided. Inform the multidisciplinary team, GP and/or primary care teams of the death.

## **Guidelines on Giving Bad News By Telephone**

The telephone is the least desirable mode of communication for breaking bad news. It should only be used in exceptional circumstances. Each scenario is unique and needs to be assessed on an individual basis. Where possible it is good to have two contacts to ring in the case of an emergency.

A senior member of the medical/nursing staff should be the person who makes the phone call. Before making the call, it must be ensured there is sufficient time and privacy. The caller must ensure that:

1. He/she has accurate information prior to initiating the call.
2. The conversation is begun by identifying the hospital, clinical area he/she is calling from, and by introducing him/herself with full name and position.
3. He/she confirms the identity of the person receiving the call and also his/her relationship to the patient. It is inadvisable to give information to children under the age of 18 years.
4. The recipient, if possible, has someone with him/her. It may be helpful to speak to this person also. The caller should suggest that the recipient sits down for the conversation.

The nature of the bad news should be explained sensitively. You could say for example, “I’m very sorry I have some bad news to tell you.” Following the breaking of bad news, it is important to allow time and some moments of silence for the information to be understood. Questions should be answered as sensitively and honestly as possible, using repetition as appropriate. It is good to be prepared for a variety of responses and to provide as much emotional support as possible. You might also test for the recipient’s understanding of the situation.

The options regarding possible treatments should be reinforced. Be aware that the recipient will not retain much of what is said after the initial bad news has been broken. It is good to be prepared for a variety of responses, and to provide as much emotional support as possible. You might also test for the call recipient’s understanding of the situation.

As the person receiving the bad news may be in shock, the caller may have to be directive, for example, tell the person to make a cup of tea, have a cold drink, to sit down, or to contact someone who can be with them.

The caller should:

1. Offer to stay on the phone until the person indicates they are ready to finish the conversation.
2. Request and document a second person’s name and phone number, including this person’s relationship to the recipient, and offer to make contact with this person on his/her behalf.
3. Inquire if the recipient wishes to come to the hospital.

4. Consider practicalities, such as travel arrangements to the hospital, parking facilities and who the recipient will meet on arrival. Remember the bereaved are part of the process of care.

Reiterate your name at the end of the conversation and, where possible, give the recipient a contact name and telephone number to write down.

At night-time the caller is responsible for informing the receptionist of the person or persons' intention to visit the hospital and for arranging how and where they will be met.

It is important that the caller and recipient have access to support following the conversation at the earliest possible opportunity.

It is the caller's responsibility to ensure that arrangements are made within the department for follow up, when necessary.

It is wise to be aware that culture, race, religious belief or social background may affect how the receiver will deal with the information given.

## References

Barraclough J. (1999) *Cancer and Emotion*, 3rd ed. John Wiley, Great Britain.

Buckman R. (1992) *How to Break Bad News*, a guide for health care professionals. University of Toronto Press, Toronto.

Buckman R. (2007) SPIKES Makes Bad News Easier, *Conversations in Care*.

[http://www.conversationsincare.com/web\\_book/chapter05.html](http://www.conversationsincare.com/web_book/chapter05.html) [accessed 12 March 2007].

Faulkner A. (1998) ABC of palliative care: Communication with patients, families and other professionals. *British Medical Journal*. 1998; 316;130-132

McCartan P., Fanning. M and Conlon T, (1999) *Breaking Bad News*, a literature review and guidelines for breaking bad news to patients and relatives, Beaumont Hospital, Dublin, Ireland.

Thayre K. and Hadfield Law L. (1995) Never going to be easy: Giving bad news. *Nursing Standard* 9 (50), 3-12.

UKCC (1996) *Code of Professional Conduct* UKCC, UK.

[www.hospicefriendlyhospitals.net](http://www.hospicefriendlyhospitals.net)

Hospice *friendly*  
Hospitals  
PROGRAMME

32 Nassau Street, Dublin 2, Ireland.  
T +353 (0) 1 6730068 F + 353 (01) 1 6730040  
E [info@hospicefriendlyhospitals.net](mailto:info@hospicefriendlyhospitals.net)

An Irish Hospice Foundation Programme  
in partnership with the Health Service Executive

