ON GIVING BAD NEWS: THE LATEST AND THE GREATEST

Dear Learner:
Here is a collection of some of the more recent abstracts on this important topic for your reading pleasure. This will serve as supplemental reading for the PEN Module 1: Giving Bad News.

Enjoy,

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**PURPOSE:**
To teach medical students how to deliver a diagnosis of cancer using role-play with a cancer survivor volunteer.

**METHOD:**
Medical students participated in a curricular module on "breaking bad news." Its novel aspect was the inclusion of role-playing exercises during which the student communicated the initial diagnosis of cancer to a cancer survivor volunteer. The clinical scenario was based on the volunteer's own history of cancer. The exercise required the student to become knowledgeable about the volunteer's cancer and its mode of presentation, deliver the diagnosis using previously demonstrated methods, and then receive verbal feedback from the volunteer. A panel discussion with the cancer survivor volunteers concluded the module. The efficacy of this curricular module was assessed by the students' performance during the role-playing exercise, gain in
confident in communicating bad news, and overall rating of the learning experience.

**RESULTS:**
The interaction of the students with the cancer survivors was the strength of this curriculum, providing the students with an important perspective on physician-patient relationships and coping with cancer. The students demonstrated a high level of adherence to preferred communication techniques, gained significant confidence with the task of "breaking bad news," and were very satisfied with the module. Participation in these role-playing exercises by the cancer survivor volunteers was viewed as emotionally demanding but also rewarding. Recruitment and retention of the volunteers were not obstacles to this activity.

**CONCLUSION:**
Role-playing with cancer survivor volunteers can be an effective method of teaching medical students how to communicate bad news.

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**OBJECTIVE:**
Communicating bad news about a child's illness is a difficult task commonly faced by intensive care physicians. Greater understanding of parents' scope of experiences with bad news during their child's hospitalization will help physicians communicate more effectively. Our objective is to describe parents' perceptions of their conversations with physicians regarding their...
child's terminal illness and death in the pediatric intensive care unit (PICU).

**DESIGN:**
A secondary analysis of a qualitative interview study.

**SETTING:** Six children's hospitals in the National Institute of Child Health and Human Development Collaborative Pediatric Critical Care Research Network.

**PARTICIPANTS:** Fifty-six parents of 48 children who died in the PICU 3-12 months before the study.

**INTERVENTIONS:** Parents participated in audio recorded semistructured telephone interviews. Interviews were analyzed using established qualitative methods.

**MEASUREMENTS AND MAIN RESULTS:** Of the 56 parents interviewed, 40 (71%) wanted to provide feedback on the way information about their child's terminal illness and death was communicated by PICU physicians. The most common communication issue identified by parents was the physicians' availability and attentiveness to their informational needs. Other communication issues included honesty and comprehensiveness of information, affect with which information was provided, withholding of information, provision of false hope, complexity of vocabulary, pace of providing information, contradictory information, and physicians' body language.

**CONCLUSIONS:**

The way bad news is discussed by physicians is extremely important to most parents. Parents want physicians to be accessible and to provide honest and complete information with a caring affect, using lay language, and at a pace in accordance with their ability to comprehend. Withholding prognostic information from parents often leads to false hopes and feelings of anger, betrayal, and distrust.

Future research is needed to investigate whether the way bad news is discussed influences psychological adjustment and family functioning among bereaved parents.

PURPOSE: To find out how patients perceived the disclosure of news about their cancer as regards the physician counseling and how they perceived the flow of information between hospital-based and family physicians.

METHODS: 272 cancer patients were polled with a 16-item questionnaire.

RESULTS: 252 cancer patients, 92.6% of those asked, completed the questionnaire. 37.7% (f: 35.4%, m: 41.8%) stated that the fact that they had cancer was presented to them 'very empathically' or 'empathically'. 62.3% (f: 64.7%, m: 58.3%) stated that it was presented to them 'not so empathically' or 'not at all empathically'. When patients had been counseled by family physicians they were more likely to state that it had been done 'very empathically' or 'empathically', in contrast to when they had been counseled by hospital-oncologists or self-employed specialists (81.8% vs. 41.2% vs. 41.2%; p=0.001). Significantly more patients thought that they had been given adequate opportunity to ask the questions they considered important when counseled by a family physician (81.8%) as compared to counseling by a hospital-oncologist (43.5%; p=0.002) or a self-employed specialist (44.3%; p=0.001). 56.8% preferred to discuss the suggested cancer therapies with an oncologist. 87.5% of patients considered the exchange of information between the hospital-based specialists and their family physician 'very important' or 'important'; more than half of all patients stated that this exchange of information was 'rather poor' or 'poor'. 
CONCLUSIONS:

Oncologists should involve family physicians in disclosing bad news to patients.

There are considerable deficiencies regarding information-exchange in cancer care in Austria. Copyright (c) 2008 John Wiley & Sons, Ltd.


BACKGROUND:
Disclosing cancer is a difficult task for junior doctors.

METHODS: We conducted a survey of 4th-year (of 6 years) medical students' (N = 50) expectations of training in breaking bad news and then designed a course for students in their 5th-year oncology clerkship. The course comprised (a) a group discussion that taught a 6-point protocol for delivering a diagnosis (N = 40), (b) a videotaped simulated interview with actors to assess protocol implementation and communication skills (N = 18), and (c) feedback from a senior physician. The impact of the course was assessed during the end-of-year faculty examination (N = 55).

RESULTS:
Most students considered breaking bad news most difficult for the diagnosis of cancer or neurodegenerative disease and desired appropriate training. Their primary concerns were attitude and choice of words. During the interview, their greatest difficulty was asking patients what they want to know. In the end-of-year examination, students who took part in both the group discussion and a simulated interview did significantly better in remembering items of the 6-point protocol than those who had only taken part in the group discussion.
CONCLUSION:
This pilot study shows that our course improves students' knowledge in breaking bad news such as cancer. However, its effectiveness after graduation still needs to be determined. Assessing knowledge is feasible using interviews with simulated patients in France.

Realistic hope helps patients cope


BACKGROUND:
Hope is important to patients, yet physicians are sometimes unsure how to promote hope in the face of life-threatening illness.

ANALYSIS:
Hope in medicine is of two kinds: specific (hope for specific outcomes) and generalized (a nonspecific sense of hopefulness).

At the time of diagnosis of a life-ending condition, the specific goal of a long life is dashed, and there may be no medically plausible specific outcome that the patient feels is worth wishing for. Yet the physician may nonetheless maintain an open-ended hopefulness that is compatible with the physician's obligation to be truthful; this hopefulness can help sustain patient and family
through the turbulent period of adaptation to the unwelcome reality of major illness.

As this adaptation evolves, the physician can help patients and families adapt to suffering and loss of control by selecting and achieving specific goals such as improvement of the patient’s environment in hospital or hospice, pain control, and relief of sleeplessness. Thus hope for specific (but far more modest) future events can again become a positive part of the patient’s emotional landscape.

The authors do not propose that physicians remain upbeat no matter the circumstance, for they must respect the constraints of reality and the patients’ mortality.

However, physicians can provide both cognitive and affective support as patients learn how to adapt. Hope and hopefulness are both important in this process.

**SUMMARY:**

Hope is always important to patients. Physicians can and should promote hopefulness without endorsing unrealistic hope.


Medical training teaches physicians to sit when breaking bad news, though there have been no controlled studies to support this advice. We aimed to
establish cancer patients' preference for physician posture when physicians break bad news using a randomized controlled crossover trial in a department of palliative care at a large US cancer center. Referred patients were blind to the hypothesis and watched video sequences of a sitting or standing physician breaking bad news to a cancer patient and 168 of 173 participants (88 female) completed the study. Sitting physicians were preferred and viewed as significantly more compassionate than standing physicians (P < 0.0001) but other physician attributes and behaviors were generally rated as of equal or more importance than posture. In summary, cancer patients, especially females, prefer physicians to sit when breaking bad news and rate physicians who adopt this posture as more compassionate. However, sitting posture alone is unlikely to compensate for poor communication skills and lack of other respectful gestures during a consultation.