General Surgery – Breaking Bad News

Key Points for good practice- Breaking Bad News

Preparation

- Are you the right person to give the news? Do you need someone more senior? If so, when would they be available?
- Environment- ideally a quiet, comfortable, private room – is this always possible? Does your ward have a quiet room available?
- Minimize interruptions- e.g., try and make sure someone else holds your bleep for you, consider diverting telephone calls if there is a telephone in the room.
- Do not appear rushed or in a hurry.
- Know as much about the case as you can- e.g., social circumstances of family etc. Read through the medical notes before you enter the room!
- Consider whether you need an interpreter. A professional (or stranger) is better than family-a relative may not interpret everything you say if they feel the patient will be upset by the information.
- Consider whether there may be cultural attitudes, which will affect how the family reacts.
- Introduce any members of the team- e.g., trainees who are with you.
- Brace yourself for an emotional task!

Breaking the News

- Explore what is known by the patient/family already.
- Give information with honesty and sensitivity – not abrupt, brutal.
- Try to use simple language, avoiding medical jargon and euphemisms. Use emotive words like cancer, malignant etc. with care. Try to avoid being too certain or too vague.
- Take care with prognostication. Never give specific time periods.
- Do not take all hope away- find some reason to be optimistic.
- Allow time for questions. Reply honestly to all questions (including "I don't know" if that is the case).
- Do not be worried by periods of silence.
- Learn to recognize and cope with denial- respect the individual's response but do not be party to the denial
- Recognize and cope with family denial- "Don't tell him Doctor, it will kill him". This can lead to a conspiracy of silence- the sufferer often knows that their condition is terminal or serious but is unable to talk about it. Do not impose the truth but, if the patient asks, do not lie.
- Avoid false reassurances.

- Acknowledge that dealing with uncertainty is often harder than knowing the diagnosis.
- Show empathy but do not lose control.
- Try not to overload family members with too much information on the first meeting.
- Do not stay too long. Closure can be difficult. Make sure you have arranged follow- up (see next section) then leave the room, preferably leaving a nurse with the family members for a period of time. Most consultations last 15 to 30 minutes. Some consultations may need to be more prolonged but over an hour is generally too long

Follow- up after giving bad news

- Arrange a review appointment relatively soon- e.g., following day or within a few days. You may need to have a series of review appointments. Make the family aware of who to contact if they have questions in the meantime- e.g., ward staff yourself etc.
- Make sure the family know if there are further results awaited and how they will get these.
- Provide written information if available- e.g., Patient information leaflets; support group literature etc. Suggest writing down any questions they think of before the next meeting.
- Document in the notes what information the family have been given and who was present.
- At review appointments, update the news- e.g., if further test results are available.
- There may be ongoing bad news to communicate. It is vitality important to build up a relationship with the family and see them at times when there is no bad news as well. In this way you can avoid being seen as 'the messenger of death'.
- Offer to talk to other relatives e.g., absence of parents, if they would find this helpful. However, beware of demanding relatives- your first responsibility is to the patient and his/her next of kin. Remember confidentiality.
- Liaise with the Primary Health Care Team (GP) and any other relevant professionals.
- Consider a debriefing for the staff involved (do not forget interpreters).

Common faults in the breaking of Bad News

- Not doing it and hoping someone else will pick up the pieces- avoiding the patient; never seeing them alone; always in a hurry.
- Putting off the evil hour- e.g., by ordering more tests.
- Being economical with the truth.
- The use of euphemisms such as 'passed away'.
- Deliberately not picking up patient cues.
- Getting the patients name wrong.
- Fidgeting.

- Looking out of the window.
- Going into undertaker mode.
- Being smug because you have got the diagnosis correct.
- Identifying with the patient or family so that your own personal feelings get in the way.
- Saying things like "*I know exactly how you feel"*; "*Try to look on the bright side*!"; "*You can always have another baby*"; "*You'll get over it"*