How Doctors Break Bad News

New ways to talk with patients encourage honesty and empathy; letting patients speak first

By Sumathi Reddy

The doctor in the grainy video is standing up, shifting uncomfortably as he spouts medical jargon that members of his patient's family don't understand.

When the reality sets in—that their father and husband is dead—the family's intense emotions fluster the doctor. He awkwardly suggests an autopsy before rushing away to respond to his chirping beeper.

It is a low-budget training video that Andrew Epstein, a medical oncologist at Memorial Sloan Kettering Cancer Center in New York, uses often as he teaches medical students the art of breaking bad news.

"If you don't balance out the physiological basis of disease and treatment of disease with the psychosocial side of medicine, you're at risk" of alienating patients and their families, Dr. Epstein tells a group of students at a training session last week.

Doctors are trying new ways of solving an old problem—how to break bad news, which is as much a staple of doctors' lives as ordering blood work and reviewing scans. One issue: Patients and their families, of course, aren't all going to respond in the same way. Research into the effectiveness of training doctors in how to deliver bad news has turned up mixed results, with patients often not noticing any benefit.

"How much do people want to know? What techniques should be used? It's a moving target," says Dr. Epstein, who is also trained in palliative medicine.

Among pointers his students are taught: Always deliver bad news in a private, quiet area. Ask patients what they already know about their medical situation and if it is OK to share the news you have. Use silence to acknowledge sadness or other emotions. Avoid medical jargon. Speak clearly but sensitively.

And empathize. "This is clearly terrible news that I have given you. I can't imagine what you're going through," says Dr. Epstein, giving the students an example of empathetic statements.

The skills can also be useful in daily life outside medicine as most people find themselves at times having to deliver unwelcome news.

"Breaking bad news is actually a golden opportunity to deepen the patient-doctor relationship," says Nila Webster, a stage-IV lung-cancer patient in Revere Beach, Mass. "For a doctor to be willing to be emotionally available is a tremendous gift for any patient."

Ms. Webster, 51 years old, left the cancer center at Massachusetts General Hospital this year

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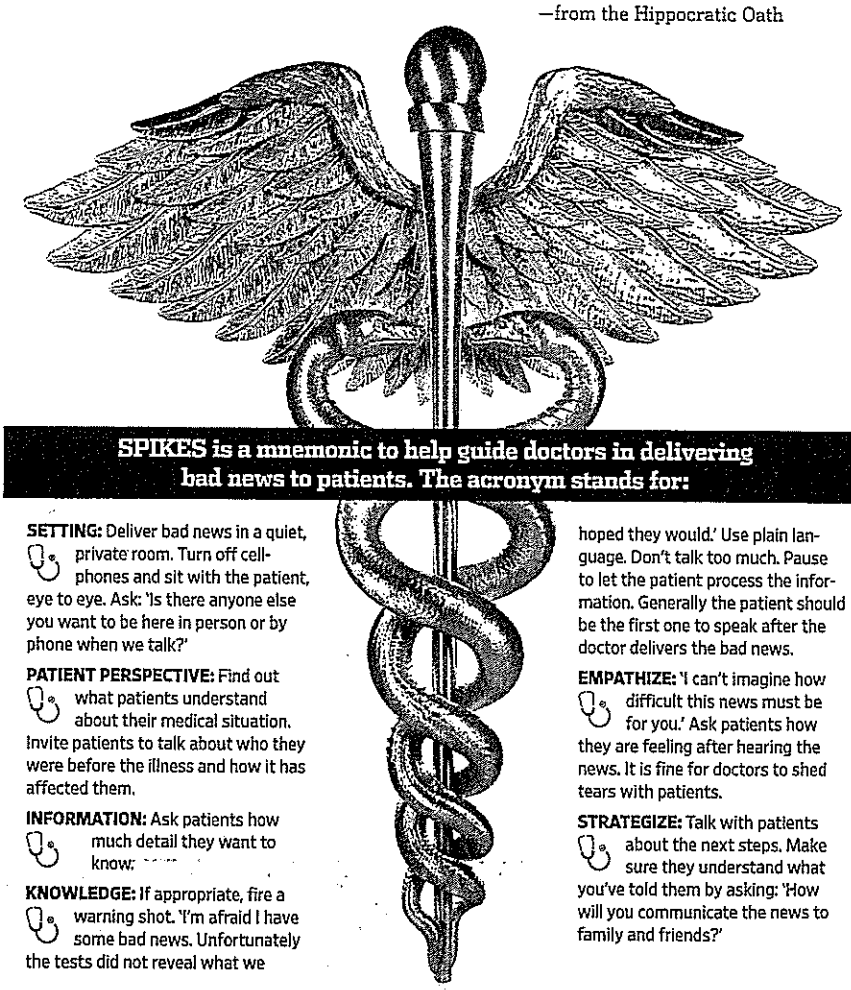
"...sympathy and understanding may outweigh the surgeon's knife or the chemist's drug."

—from the Hippocratic Oath



SPIKES is a mnemonic to help guide doctors in delivering bad news to patients. The acronym stands for:

SETTING: Deliver bad news in a quiet, private room. Turn off cellphones and sit with the patient, eye to eye. Ask: 'Is there anyone else you want to be here in person or by phone when we talk?'

PATIENT PERSPECTIVE: Find out what patients understand about their medical situation. Invite patients to talk about who they were before the illness and how it has affected them.

INFORMATION: Ask patients how much detail they want to know.

KNOWLEDGE: If appropriate, fire a warning shot. 'I'm afraid I have some bad news. Unfortunately the tests did not reveal what we hoped they would.' Use plain language. Don't talk too much. Pause to let the patient process the information. Generally the patient should be the first one to speak after the doctor delivers the bad news.

EMPATHIZE: 'I can't imagine how difficult this news must be for you.' Ask patients how they are feeling after hearing the news. It is fine for doctors to shed tears with patients.

STRATEGIZE: Talk with patients about the next steps. Make sure they understand what you've told them by asking: 'How will you communicate the news to family and friends?'

Sources: Dr. Andrew Epstein, Memorial Sloan Kettering Cancer Center; Dr. James Tulsky, Duke University; Dr. Robert Arnold, University of Pittsburgh; Dr. J. Randall Curtis, University of Washington.

Dr. Andrew Epstein, left, a medical oncologist at Memorial Sloan Kettering Cancer Center in New York, leads a monthly seminar for medical students on how to discuss bad medical news with patients and their families.

BAD NEWS

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because she was saddened at how a doctor told her about a setback. A drug trial was under way at the hospital that might have helped her, but she was told there was no room for her.

The oncologist "suggested I go try a couple of other hospitals," Ms. Webster says. "It was like this long relationship was over and the doctor was ready to pawn me over to another hospital."

YOUR HEALTH

Perhaps no specialty deals with having to break bad news to patients more than oncology. One study estimated an oncologist breaks bad news as many as 20,000 times over a career. Patient and family reactions can run the gamut from extreme sadness and weeping to shock and disbelief to anger. Some doctors tell of patients—or more frequently their family members—punching walls, yelling at them or even threatening to shoot them, in extreme cases.

TANYA LAM FOR THE WALL STREET JOURNAL

"Often what happens is clinicians just keep talking and it's just white noise for the patient," says James Tulsky, chief of Duke Palliative Care at Duke University. "You need to attend to the fact that this is really serious news and attend to the emotion."

Dr. Tulsky is one of the developers of VitalTalk, a nonprofit that trains medical professionals in communication skills and empathy, with the aim of developing healthier connections between patients and clinicians. He says doctors delivering bad news should be brief, clear and to the point. "Pause after delivering the bad news. Allow the patient to process that. Generally the patient should be the first one to speak after you deliver the news."

At Sloan Kettering, Dr. Epstein's session includes teaching two mnemonics, acronyms often taught in medical school to help students remember information like treatment protocols. One mnemonic he uses is SPIKES, aimed at helping doctors break bad news to patients, and NURSE, for exploring emotions. Dr. Epstein said he includes the memory prompts "because I think we need all the help we can get."

(SPIKES stands for setting, patient perspective, information, knowledge, empathize/explore emotions and strategize/summarize. NURSE stands for name emotion, understand, respect, support and explore emotions.)

Kate Hogan Green, of Westerville, Ohio, was 12 weeks pregnant when she learned she was going to have a baby girl who had tested positive for Down syndrome. The 40-year-old decided to continue with the pregnancy. At 18 weeks she saw a perinatologist who told her at an ultrasound appointment that her baby also had nonimmune fetal hydrops, a separate condition in which fluid accumulates and that often results in death.

"I'm sitting there with jelly on my stomach and he's telling me the baby has this condition. I didn't have a clue what that was," she recalls. "He said the baby will likely not survive. He said that we could terminate." Ms. Green recalls being handed scratchy paper towels as she sobbed.

She switched specialists and about a month later the fluid cleared up. She now has a 14-month-old daughter, Lorelei Clair Green, who has Down syndrome.

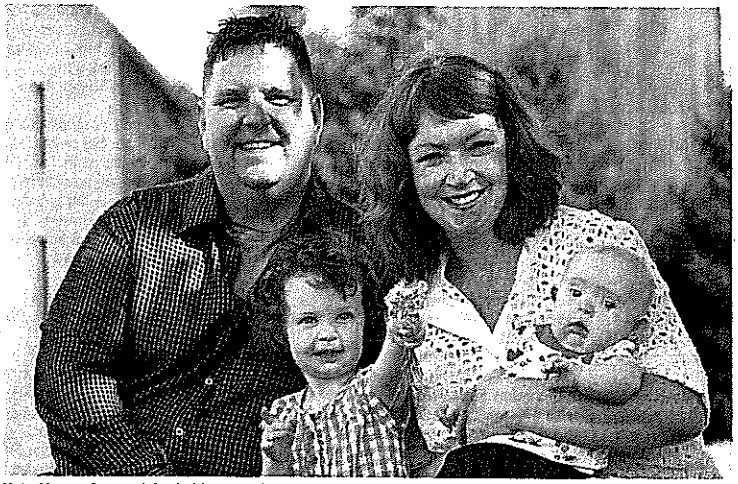
A 2011 study in the Annals of Internal Medicine found that giving oncologists feedback on recorded conversations they had with patients made them twice as likely to use more empathic statements in future talks than were doctors who didn't receive feedback. Patients also reported greater trust in the doctors who had gotten feedback. The study, led by Dr. Tulsky, involved 48 oncologists and 300 recorded conversations with patients.

However, a 2013 study found that doctors and nurse practitioners who received communication-skill training focused on end-of-life care were rated no higher by patients than medical professionals who didn't receive the training. The study, published in JAMA, included 391 doctors and 91 nurse practitioners.

Another study, published online in February in JAMA Oncology, found the majority of about 100 cancer patients who watched videos with actors playing doctors preferred the on-screen physicians who relayed a more optimistic message. The finding appears to run counter to most doctors' advice that bad news should be given sensitively but not sugar coated. The researchers said the study underscores the importance of doctors building a relationship with patients so delivering bad news doesn't have too much of a negative impact.

Helen Riess, a psychiatrist at Massachusetts General Hospital, says she has seen the importance of empathy training for doctors. "I noticed that my patients were spending way too much time feeling upset after their medical visits," she says.

Dr. Riess, who is the director of the hospital's empathy and relational science program, founded Empathetics, which offers online empathy courses. The training includes interpreting and managing patients' emotions through facial expressions and body language. It also teaches doctors how to manage their own emotions during serious patient discussions. "Delivering bad news unsettles everybody, not just the patient," she says.



FROM LEFT: TAYLOR MONDAY; NATALIE KEYSSAR FOR THE WALL STREET JOURNAL

Kate Hogan Green, right, holding Lorelei, left her perinatologist after being abruptly told the baby had a fatal condition. The condition later cleared up. At left are Ms. Green's husband, Bryan, and Adelaide, 3.

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