Breaking bad news in oncology: like a walk in the twilight?

While communicating good news is a pleasurable experience in our everyday lives, professional or private, communicating bad news is an uncomfortable experience for both the giver and the receiver.

The expression ‘bad news’, used to describe difficult communications, is open to interpretation and misunderstanding since it seems to refer to a one-off communication instead of a process and because it evokes the idea of an impersonal transmission of information.

Bad news is defined as any information that produces a negative alteration to a person’s expectations about their present and future [1]. Sigmund Freud often quoted the evangelic saying ‘the truth will set you free, without truth there can be no freedom’. However, the truth regarding bad news can be dangerous because it deals with the essence of life. Does one give all the details of a clinical case or explain most of the case while holding back some details or be vague while at the same time not hiding the seriousness of the illness? Each of these approaches can reveal the truth; each can represent the way, the form and the opportunity to communicate bad news.

There are, however, many variables to be taken into account such as the clinical situation, the gravity of the illness, the possibility of a cure, the prognosis, life expectancy and the patient’s capacity to understand and sustain a conversation of this kind with his or her doctor.

And the doctor? Is he or she aware that in our finite condition it is not always possible to have an absolutely truthful exchange, that it is not always possible to tell everything? Absolute honesty is probably not even part of our relative, imperfect and unfinished human condition and it would therefore be a mistake to think that we can see and make others see everything clearly. However, a doctor must at least try to say everything that can be said given the circumstances and so this becomes our everything.

Many cancer patients see themselves as damaged, irreversibly traumatized, however their reactions differ greatly. Some have an absolute need to know the truth, even a terrible truth, about their state of health. They need to know the truth in order to fight and to live. Not knowing the truth or living in doubt even when done with the best intentions, leaves these patients in a state of anxiety, an ambiguous darkness that corrodes and destroys hour by hour more than the illness itself. At the other extreme there are patients who cannot accept the reality of their situation, who do not want to know the truth, concealing it in every way possible and are able to ignore or explain away even the most evident symptoms. Between these two extremes we find the remaining and largest group of cancer patients.

So what is required of the doctor: full disclosure, nondisclosure or individualised disclosure? A doctor’s world is made up of two planets; one is epistemological and is therefore based on science and connected to his or her professional competency. The other is defined by the doctor’s values, convictions, choices and emotions. For this reason, before exploring the world of the patient, the doctor has to explore his or her own world, face fears and anxieties and learn to recognise and control them. It is an extremely difficult task but if done properly it leads the doctor to construct that therapeutic alliance which allows the patient to listen to bad news without being overcome by it; to hear a possible truth, said with delicacy, without being dismissive or brutal and without shame. Life itself can also be perceived as a fatal illness but it is possible to live it serenely tearing away the mask of this obscure illness without being petrified by it. It is impossible to separate the destructive violence of certain illnesses which sometimes triumph but together doctor and patient can collaborate to penetrate this darkness building up the capacity to resist and to hope.

Apart from this process, the doctor must choose appropriate communicative behaviour and follow certain rules which can help to make the doctor/patient conversation less painful. The difficulties inherent in giving or receiving bad news about health such as the different approaches, attitudes and the abilities which make these moments less painful have been well documented in recent years [2–12].

In our everyday life each of us deals with time and space and these elements also influence communicating bad news. It is necessary to find a private area where the patient can feel as comfortable as possible without interruptions from colleagues or telephones and dedicate ample time to the conversation (listen and be listened to). Allow the patient to choose if he or she wishes to see the doctor alone or in the company of a family member, a relative or a friend. It is important to understand the patient’s capacity to face difficult news, which is one of the principal variables affecting the doctor, and often leads to profound discomfort thereby altering his or her ability to communicate. Being aware of the family and social environment in which the patient is living and experiencing the illness, knowing his or her educational background, job and lifestyle are elements which help create a bridge between the two protagonists of the conversation.

The patient’s reference system has to be identified, examining what he or she knows, what the illness means for the patient, the consequences of the illness on everyday life and activities and
what the patient’s expectations are. This means listening very
carefully to the patient to gain this information so that bad news
can be introduced gradually using appropriate language that can
be understood, avoiding technical or specialist terminology and
continually verifying what the patient has understood from
the conversation. The patient should also be encouraged to ask
for clarification during the conversation and should be given
enough time to express feelings and emotions. A therapeutic
programme must be established and agreed to, explaining the
options available and the advantages and disadvantages of each
of the various choices possible, once again clarifying whenever
necessary. The conversation should then be summarized
mentioning again the agreements which have been reached
and setting a date for the next visit.

Leaving aside for a moment the approaches which clinical and
psychological research have identified to help make this task less
painful and for which a doctor is never totally prepared, the way
to break bad news is never easy. Perhaps individualized
disclosure and a shared decision-making process bring the
patient to the bad news not in accordance with a pre-fixed
standard but in a way which takes into account the patient’s
history, character, cultural level, capacity to understand and
many other variables which can at that moment influence the
impact of bad news.

It is extremely difficult to respect all these variables and for
this reason the job of the doctor, if he or she has established this
objective, is even more delicate because in the end bad new is
bad news and whoever has to announce it, share it, help and
support it must have or acquire those abilities which allow him
or her to communicate confidently and delicately with kindness
and honesty.

Much progress has been made in recent years and much has
been written on communicating bad news. However, if the road
is not as obscure as it seemed in the past it is still not as clear as
we would like. We are walking in the uncertainty of twilight.

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