



**NATIONAL BREAST  
AND OVARIAN  
CANCER CENTRE**

**COMMUNICATION SKILLS TRAINING INITIATIVE**

# **BREAKING BAD NEWS**

**EVIDENCE FROM THE LITERATURE  
AND RECOMMENDED STEPS**

This literature review forms part of a communication skills training module presented in a professionally facilitated and interactive workshop

**PREPARED BY THE NATIONAL BREAST AND OVARIAN CANCER  
CENTRE**

**FUNDED BY THE AUSTRALIAN GOVERNMENT  
DEPARTMENT OF HEALTH AND AGEING**

*Breaking bad news: Evidence from the literature and recommended steps* was developed by the Centre for Health Research & Psycho-oncology on behalf of the National Breast Cancer Centre:

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**Recommended citation:**

**National Breast and Ovarian Cancer Centre. *Breaking bad news: Evidence from the literature and recommended steps*, 2007. National Breast and Ovarian Cancer Centre, Surry Hills, NSW.**

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The National Breast and Ovarian Cancer Centre is funded by the Australian Government Department of Health and Ageing.

**\* In February 2008, National Breast Cancer Centre incorporating the Ovarian Cancer Program (NBCC) changed its name to National Breast and Ovarian Cancer Centre (NBOCC).**

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# NATIONAL BREAST AND OVARIAN CANCER CENTRE

## COMMUNICATION SKILLS TRAINING INITIATIVE

Benefits of effective communication between treatment team members and people with cancer include improvements in the patient's psychosocial adjustment, decision making, treatment compliance and satisfaction with care.<sup>1</sup> Since 1997 the National Breast and Ovarian Cancer Centre (NBOCC) has sought to improve the communication skills of oncology health professionals in Australia through the provision of the Communication Skills Training Initiative.

The NBOCC Communication Skills Training Initiative is implemented through:

- the development and provision of standardised communication skills training modules and recommendations for best practice
- building capacity to implement communication skills training through conducting workshops for communication skills trainers
- development and maintenance of a website to support and promote communication skills training for health professionals
- supporting the implementation of local training workshops that use a best practice approach.

The Communication Skills Training Initiative supports the implementation of the NBCC<sup>\*</sup> and National Cancer Control Initiative's *Clinical practice guidelines for the psychosocial care of adults with cancer*<sup>1</sup>.

For further information on the NBOCC's Communication Skills Training Initiative:

[www.nbocc.org.au/commskills](http://www.nbocc.org.au/commskills)

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<sup>1</sup> National Breast Cancer Centre and the National Cancer Control Initiative. *Clinical practice guidelines for the psychosocial care of adults with cancer*. National Breast Cancer Centre, Camperdown, NSW: 2003.

<sup>\*</sup> **In 2008, National Breast Cancer Centre Incorporating the Ovarian Cancer Program (NBCC) changed its name to National Breast and Ovarian Cancer Centre (NBOCC)**

# ACKNOWLEDGEMENTS

NBOCC gratefully acknowledges the support of individuals and organisations who contributed to the development of this communication skills module.

## **Funding**

Funding for the development of this guide was provided by the Australian Government Department of Health and Ageing.

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# INTRODUCTION

This module has been developed after a major search and review of the relevant literature. Each study referred to in this document is given a number (referring to the Reference list) and a “level” indicating the type of study undertaken. All retrieved articles were reviewed using the following NHMRC Levels of Evidence.<sup>2</sup>

- Level I** Evidence is obtained from a systematic review of all relevant randomised controlled trials, usually found in meta-analysis.
- Level II** Evidence is obtained from at least one properly designed randomised controlled trial.
- Level III** Evidence is obtained from well-designed controlled trials without randomisation; or from well designed cohort or case control analytic studies, preferably from more than one centre of research; or from multiple time series, with or without the intervention.
- Level IVa** Evidence is obtained from descriptive studies of provider practices, patient behaviours, knowledge, or attitudes or a systematic review of the descriptive studies.
- Level IVb** Represents the opinions of respected authorities based on clinical experience or reports of expert committees.
- Level QS** Evidence from qualitative studies. [NB: this level has been added to the standard NHMRC levels of evidence given the significant amount of qualitative research.]

Much of the evidence reported in the Module is of the prevalence of psychosocial morbidity, preferences for information, and current practices, for example. In these types of studies, Level IV evidence is the highest level of evidence that can be collected and should therefore be considered the gold standard. A smaller number of studies provide Levels II and III evidence; including studies evaluating communication training programs for health professionals, for example.

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<sup>2</sup> NHMRC National Breast Cancer Centre Psychosocial Working Group. *Psychosocial clinical practice guidelines: Information, support and counseling for women with breast cancer*. 2000.

# LITERATURE REVIEW

Bad news has been defined as “situations where there is either a feeling of no hope, a threat to a person’s mental or physical wellbeing, a risk of upsetting an established lifestyle, or where a message is given which conveys to the individual fewer choices in life” (Level IVa).<sup>1</sup>

Communicating bad news to people with cancer is an integral role for the health professional involved in cancer care. By its very nature, the diagnosis can be tremendously difficult for everyone involved. From the doctor’s perspective, it can be one of the most personally difficult roles s/he must perform.

The importance of the breaking bad news interaction cannot be overlooked, and research has highlighted that the way health professionals approach this encounter can have a significant impact on the patient’s adjustment and functioning (Level IVa).<sup>2,3</sup> The way in which diagnostic news is delivered affects not only the person’s understanding of the illness, but can also impact on longer term psychological adjustment (Level III, Level IVa).<sup>4,5</sup> For example, reaction to the diagnosis of a life-threatening illness has recently been accepted in criteria for post traumatic stress disorder. As such, it is imperative that bad news is conveyed in a manner that minimises the potential harm to patients, their families and even the health professionals themselves.

Creagan (1993) reviewed the literature (Level IVa) specifically on the diagnosis of cancer and identifies five stages of reactions to diagnosis, including:

1. denial, associated with a general feeling of disbelief and inability to accept the diagnosis
2. anger, which may be a time of focused or unfocused rage, envy and resentment towards oneself, significant other, primary care givers or the health care system
3. bargaining, where patients may enter into a pact or covenant with a “higher power”
4. depression, which is associated with several behaviours that reflect sadness and loss
5. acceptance, being the final stage where the patient recognises that the progression of the cancer may be inevitable.<sup>6</sup>

Most existing guidelines, and the relatively small amount of research in this area, have focused on giving the initial diagnosis, but this is just the first step. Further news, such as recurrence or metastases, may prove more difficult to communicate than the initial diagnosis. Evidence indicates that the psychological impact of news of a recurrence may be more devastating than the initial diagnosis (Level III).<sup>4</sup>

## DISEASE VERSUS PATIENT-CENTRED APPROACHES TO DISCLOSURE

The bad news consultation involves consideration of not only the level and type of information, but also the method in which it is conveyed (Level IVb).<sup>7</sup> Studies suggest that the health professional may utilise one of two main approaches: disease-centred and patient centred (Level II, QS).<sup>8,9</sup> In the disease-centred approach, the health professional is a technical expert who is task focused, blunt and less empathetic (Level II, III, QS).<sup>8-10</sup> The patient-centred health professional is emotional, non-dominant and involves the patient in decision-making, conveys the appropriate level of information and conveys hope (Level II, III, QS).<sup>8-10</sup> Schmid Mast et al. (2005) also include an emotion-centred approach in which the health professional behaviour is very empathetic and sympathetic (Level III).<sup>10</sup> Many doctors express the difficulty they have with providing honesty in their approach while maintaining a hopeful and supportive atmosphere (Level IVa).<sup>11</sup>

A patient-centred style has been found to result in more positive outcomes, including satisfaction with consultation and reduced negative emotions (Level III).<sup>10,12</sup> A preference for patient centred style when prognosis is poor has also been found (Level II).<sup>8</sup> Patients prefer clinicians whom they perceive as having knowledge expertise and would, therefore, be able to answer their questions (Level QS),<sup>13</sup> however having a friendly manner and being honest are also highly valued traits in health professionals (Level QS).<sup>13</sup> It appears that health professionals must have adequate technical knowledge and skills when it comes to breaking bad news; however, affective components of communication must also be present.

Patient centred style may not be appropriate for all patients and all circumstances, especially if this behaviour is unfamiliar to the patient (Level III, IVa).<sup>10,14</sup> The effectiveness of health professionals' approach in conveying bad news may depend on how the patient evaluates the clinicians' competence and performance i.e. whether they rate according to task-focused or affective behaviours (Level II).<sup>8</sup> It has been suggested that in order to break bad news effectively, health professionals should have a number of strategies that they may call on to assist them depending on the context and the interaction between patient, family and the doctor (Level QS).<sup>15</sup> Aside from the context, clinician characteristics may influence the approach taken. Female clinicians are more likely to use facilitating behaviours (open ended questions and elucidate preferences) in consultations than males (Level IVa).<sup>14</sup> As Friedrichsen et al. (2000) argue, it is important that the health professional is committed to both the illness and the person when discussing bad news (Level QS).<sup>9</sup>

There are four main goals to the bad news consultation: gathering information, providing information, supporting the patient, and developing a strategy or treatment plan with the patient (Level IVa).<sup>16</sup> Strategies for achieving these goals are addressed in the following literature review.

## **PREPARING FOR THE CONSULTATION (SETTING)**

Demographic variables such as age, gender and education may impact the level of importance that the context of the consultation is given. For example, younger and less educated patients rate the context as less important than older more educated patients (Level IVa).<sup>17</sup> Overall, the content of the consultation is rated as more important than the context within which it takes place (Level IVa).<sup>17</sup> However, the following evidence clearly indicates the importance of context as well.

### **Privacy**

The limited empirical data available have indicated that the context within which bad news is passed on is an important consideration for health professionals. The consultation should take place in a private place with no chance of interruptions and should be face-to-face with the patient (Level IVa, IVb).<sup>3,16 18-20</sup> While having privacy and a face-to-face discussion have been rated as important by patients, few have mentioned the quality of the physical surroundings as important (Level IVa, QS).<sup>13,21</sup>

### **Consultation timing and time**

Health professionals must consider when the bad news consultation should take place and this may depend on the type of news and severity of the patient's disease. In one study, 41% of patients believed that bad news should be given without delay (Level IVa)<sup>21</sup> and in another, perceived delay resulted in lower satisfaction (Level III).<sup>12</sup>

The length of the visit has also been associated with patient satisfaction with communication (Level III).<sup>22</sup> Allowing enough time for the breaking bad news consultation was rated as important by at least 70% of patients, doctors and nurses in an Australian study (Level IVa).<sup>23</sup>

### **Involvement of others in the consultation**

The need for support both during and after the consultation has led some authors to suggest that the patient have another person present during the consultation (Level IVa).<sup>16,18</sup> While some patients agree that having another person present is an important support (Level QS),<sup>13</sup> other research suggests that many patients do not want another person present (Level IVa).<sup>1,17,21,23</sup> Patient satisfaction is higher when preferences for having people present in the consultation are met, even when those preferences are to be alone (Level III).<sup>12</sup> This suggests that having someone present during the consultation should be up to the individual patient, giving patients time to decide on how best to inform significant others about the news (Level IVa).<sup>23</sup>

## **ASSESSING THE PATIENT'S CURRENT KNOWLEDGE OF THEIR SITUATION**

Before disclosing bad news, it is important to determine exactly what the patient knows about his/her illness (Level IVb).<sup>24</sup> Clinicians may overestimate the level of understanding that patients have regarding their diagnosis, prognosis and treatment and patient misunderstanding may occur even when information is provided (Level IVa).<sup>25,26</sup> While the information provided by oncologists in an Australian study was rated as very clear (45%) or clear (38%) for the majority of participants, 24% of patients with localised disease thought their cancer was metastatic and conversely, 17% of metastatic patients thought their cancer was localised. In addition, only 60% of patients understood treatment goals. Coping mechanisms such as denial may prevent patients from understanding prognosis and treatment outcomes (Level IVa).<sup>25</sup>

## **ASSESSING THE PATIENT'S PREFERENCE FOR INFORMATION**

Three main models of information disclosure have been defined in the literature: non disclosure, full disclosure and individualised disclosure.<sup>18</sup> In the past, health professionals have taken a paternalistic role when it comes to breaking bad news, often withholding news of prognosis, treatment options and even diagnosis from the patient. Reasons for this non-disclosure of information have been discussed frequently in the literature, and range from the bleak treatment outcomes for patients of the past (Level IVa),<sup>16</sup> to obeying the wishes of the family (Level IVb),<sup>7</sup> to the health professional's concern over how the news will affect the patient (Level III, IVb).<sup>20,27</sup> However, the acknowledgement that lack of disclosure may increase patient fear and anxiety and the support for patient autonomy in contemporary medical ethics have resulted in the promotion of a more tailored approach to breaking bad news which takes into account the preferences and needs of patients rather than relying on clinician discretion (Level II, III, IVa).<sup>25,28-31</sup> In fact, the right of the patient to accurate and reliable information is rated as essential by patients, doctors and nurses in a number of studies (Level IVa, QS).<sup>13,17,19,21,23,28</sup>

### **Amount of Information**

Health professionals often underestimate the amount of information that is wanted by their patients (Level IVa).<sup>28</sup> As a result, recent literature in the area has shifted away from examining clinician attitudes and has instead begun to focus on identifying patient preferences for disclosure (Level III, IVa).<sup>8,10,17,25</sup> The information preferences of patients have been the subject of numerous recent studies (Level III, IVa).<sup>21,27,32</sup> A UK study involving 2331 people with cancer showed that 87% wanted all information possible irrespective of whether it was good or bad, while 98% wanted to know if their illness was cancer (Level IVa).<sup>32</sup> Similarly, a study with 101 patients found that 94% wanted as much information as possible (Level IVa).<sup>33</sup> A UK study involving 195 adults found that 78% wanted full information and 25% wanted full involvement in decision-making (Level IVa).<sup>34</sup> A study looking at the amount of information given by nurses and

physicians to people with cancer found that more than one third of nurses and almost one half of physicians failed to give enough information of their own initiative, and that nurses gave more information than physicians (Level IVa).<sup>35</sup> Research has shown that adequate information is related to increased psychological wellbeing (Level I).<sup>36</sup>

### **Content of Information**

While oncologists have acknowledged that disease recurrence, treatment side effects and lack of treatment options is the most difficult news to break to patients (Level IVa),<sup>16</sup> it appears that many patients want to have at least a moderate amount of information regarding these issues, irrespective of the stage of their disease. A study conducted in Australia on people with melanoma indicated that 69% of patients wanted to know everything about their diagnosis, while 29% wanted to know a moderate amount (Level IVa).<sup>21</sup> In terms of prognosis, 61% wanted to know everything they could while 29% wanted to know a moderate amount. Finally, for treatment information, 81% wanted to know everything and 16% wanted to know a moderate amount (Level IVa).<sup>21</sup>

Prognostic information has been investigated with people with metastatic cancer and many believe that the time they were told the cancer had spread was the best time to be told about treatment options (84%), symptoms and treatment side effects (81%), and survival likelihood (59%) (Level IVa).<sup>37</sup> The highest information priority for people with breast cancer was related to knowing the chances of cure and stage of disease followed by treatment options (Level IVa).<sup>38</sup> Similarly, results of a study conducted with 126 people with metastatic cancer indicated that 72-99% of patients wanted prognostic information ranging from side effects and treatment options to survival time (Level IVa).<sup>37</sup>

While Australian patients are now routinely told their diagnosis, there have been few studies documenting how many people seek or receive prognostic information. In an Australian study, only 27% of people with breast cancer or melanoma interviewed 6–12 months after their diagnosis said they had been told their prognosis, whereas 57% wanted prognostic information (Level IVa).<sup>39</sup> Even when people with cancer are provided with information they may have difficulty retaining it (Level IVb).<sup>3,40</sup> In fact, patients may ask nurses additional questions once the physician has left the consultation room (Level IVb).<sup>41</sup> Women with early stage breast cancer were surveyed about their preferences to be told specific types of prognostic information (Level IVa).<sup>42</sup> In this sample there was considerable variation in preference for different types of information. The proportions of women indicating a preference for specific types of prognostic information are listed below:

- the probability of cure (94% of women);
- the chances that the recommended treatment would work (91%);
- staging details (92 per cent);
- 10-year survival figures with adjuvant therapy (60%);
- 10-year survival figures without adjuvant therapy (45%);

- the risk of the cancer shortening their lives compared to other life events (45%);
- the longest survival of women in their situation (53%);
- the average survival of women in their situation (44%); and
- the shortest survival of women in their situation (44%).

Providing information about treatment options is an important part of the bad news consultation. Authors suggest that discussing treatment options may be a good news antidote to the bad news patient receive and may provide hope for the patient (Level III, IVa).<sup>12,21</sup> Satisfaction with consultations regarding treatment may be higher than satisfaction with consultations about diagnosis and prognosis (Level III).<sup>12</sup>

A qualitative study with health professionals, people with advanced cancer and their carers found that when raising end-of-life issues patients and caregivers believed that the health professional intuition should guide consultations (Level QS).<sup>43</sup>

### **Demographic and disease influences on information needs and disclosure**

Not all patients have the same information needs, and complying with these preferences is an important part of respecting patient autonomy (Level IVa).<sup>31</sup> Factors that may influence the level of information wanted, especially with regard to prognosis, include age and severity of illness (Level IVa).<sup>28</sup> Those over 70 years of age often want less information (Level IVa).<sup>32,33</sup> In addition, males rate the content of the information as more important than females and the supportive elements as less important (Level IVa).<sup>1,17</sup> It is therefore up to the health professional to discern the preferences for each patient and approach the bad news consultation accordingly (Level IVb),<sup>20</sup> with oncologists advocating for an approach that leaves it up to the patient to determine the amount of information and family involvement (Level IVa).<sup>2</sup>

Patient age, gender and severity of illness may influence information disclosure. A review of communication needs of people with cancer found that information needs depend on disease type, extent of disease and personal circumstances (Level IVa).<sup>30</sup> In addition, research has shown that clinicians may show more facilitating behaviours (ie use more open ended questions and elucidate preferences) when patients are older, have greater symptoms and clinicians rate their illness as more severe (Level IVa).<sup>14</sup> Different cultures may also have different levels of disclosure (Level IVb).<sup>44</sup> In Japan, Southern and Eastern European countries such as Spain, Italy and Estonia, there is a lower level of disclosure than in Western countries such as USA (Level IVb).<sup>44</sup> Inferring preferences from demographic and cultural characteristics may result in a mismatch as clinicians may infer incorrectly. It is important to obtain preferences from patients themselves (Level IVa, IVb).<sup>14,20</sup>

### **Decision-making preferences**

Patients may differ in their willingness to participate in decision making, however those that do want to be directly involved have a need for information (Level IVb).<sup>45</sup> A review

of communication needs in people with cancer suggests that patients may take on one of three decision-making roles. The first is an active role where the patient is involved in and makes all decisions regarding treatment. The second or collaborative role involves the shared decision-making between patient and clinician, while the third involves the patient taking on a more passive role and allowing the doctor to make the treatment decisions (Level IVa).<sup>30</sup> A number of studies have suggested that the collaborative role is the most preferred by patients (Level III, IVa).<sup>1,38,46,47</sup> In a trial of educational methods to improve patient involvement in decision-making, it was found that clinicians who actively sought patient involvement were more likely to have patients who participate in the decision-making process (Level II).<sup>48</sup>

A review of the literature suggests that education, gender, age and disease severity may influence decision-making roles (Level III, IVa).<sup>49,50</sup> Some research has shown that younger women (Level IVa),<sup>34,38</sup> and more educated women want more active roles (Level IVa).<sup>38</sup> Other studies have found that age does not predict decision-making role preferences (Level II, IVa);<sup>1,8,30</sup> and demographic characteristics of men do not appear to predict decision-making preferences (Level IVa).<sup>1</sup> Patients' disease status may impact on their preference for a role in decision-making (Level III).<sup>50</sup>

While it has been suggested that giving patients control over decision-making may result in them regretting the option they had chosen late on (Level QS)<sup>15</sup>, ineffective communication of information may have a negative effect on their decision-making ability (Level IVa).<sup>51</sup> In addition, patient preferences for certain decision-making roles and level of information may not always be achieved (Level III, IVa);<sup>38,46,47</sup> and people's preferences may change over time (Level III).<sup>50</sup> The mismatch between patient preferences for decision-making and the actual roles they assume is not necessarily a result of the preferences for a more active role (Level III, IVa).<sup>38,47</sup> Once again, the literature illustrates the need for clinicians to consider the specific needs of every patient and attempt to assist patients in achieving their preferred level of involvement, as well as reviewing a person's preference for involvement in decision-making throughout the treatment process and at each phase of care.

### **Information needs of family members**

As the consultation may involve the patient and family, there may be differing preferences for information between the family and the patient (Level II).<sup>8</sup> It is suggested that health professionals use the same guidelines with the family as with the patient when breaking bad news (Level IVb).<sup>24</sup> Reconciling the information needs of the patient with those of the family is often a difficult task for health professionals, and family collusion is an important issue to consider, particularly in different cultural contexts (Level IVa).<sup>2,44,52</sup> One study found that male oncologists and non-Western oncologists were more likely to withhold a prognosis at the family's request than female and Western oncologists (Level IVa).<sup>2</sup> Collusion was found to be three times as common in patients over 65 years (Level IVa).<sup>53</sup> Once permission is given by the

patient, having separate conversations with the patient and family may be one way of addressing these different needs (Level QS).<sup>54</sup>

### **Recording information preferences and disclosure**

The importance of recording patient preferences for information and the extent of information that has been conveyed to the patient is also an important part of breaking bad news. The documentation of the information given to patients in the bad news consultations has been shown to be inadequate (Level IVa).<sup>53</sup> As patients are often cared for by multidisciplinary teams, the extent of information communicated to patients must be well documented (Level IVa).<sup>11</sup>

## **PROVIDING INFORMATION TO THE PATIENT**

The technical expertise of the health professional breaking the bad news to the patient has been rated as very important by patients in a number of studies (Level IVa).<sup>17,21</sup> Therefore, there is a need for health professionals to be up to date on each patient's diagnosis and treatment options in order to give as accurate information as possible. Researchers also suggest that there is a need to prepare patients adequately for bad news (Level IVa).<sup>16,19</sup> Patients who are prepared for the consultation experience greater satisfaction and lower anxiety with the consultation (Level IVa).<sup>12</sup>

The way that clinicians present information significantly affects people's recall of information (Level IVa).<sup>55</sup> People retain more information when it is tailored to their needs, rather than being given it in a standard format (Level III).<sup>4</sup> In addition to the level and type of information that is being conveyed to the patient, health professionals must also consider the clarity of this information. This issue has been discussed in a number of studies, with many authors suggesting that the use of simple, jargon-free language may improve patient understanding of information (Level IVa, IVb, QS).<sup>7,13,25</sup> As Kirwan et al argue, using correct terminology provides health professionals with an opportunity to correct patient's misconceptions about their illness (Level IVa).<sup>53</sup> Doctors, nurses and patients rate the use of simple language as essential in breaking bad news to patients (Level IVa);<sup>23</sup> and 30% of patients preferred the use of jargon-free language (Level IVa).<sup>13</sup> The use of euphemisms may be dependent on cultural beliefs, with a study on Western and non-Western oncologists showing that non-Western oncologists were more likely to use euphemisms (Level IVa).<sup>2</sup> While using the word "cancer" may produce an increase in the patient's anxiety in the short-term, it may also reduce ambivalence, improve the patient's ability to cope and improve honest communication (Level II).<sup>56</sup>

Having the opportunity to ask questions, and obtain information about prognosis and treatment options may result in better health outcomes (Level III, IVa, QS).<sup>1,12,13,17,21,49</sup> Encouraging patients to ask questions may also assist patients to control the duration of the conversation and the amount of information being conveyed (Level IVa).<sup>29</sup>

## Information aides

The nature of the news being conveyed to patients may affect the ability of patients to recall the information accurately. A number of strategies for improving patient recall and understanding have been explored in the literature (Level II, III).<sup>57</sup> A systematic review found that providing patients with written information and audio recordings improved patient recall in five out of nine studies (Level II, III).<sup>57</sup> Tape recordings of the consultation have been shown to improve understanding, as have personalised follow up letters (Level II).<sup>58,59</sup>

Question asking is one way in which patients can be active in consultations. An Australian study has investigated two means of promoting question asking of people with cancer (Level II).<sup>60</sup> One was the provision of a question prompt sheet to patients prior to their initial consultation with their oncologist. The second was the active endorsement and systematic review of the question prompt sheet by their oncologist. Provision of the question prompt sheet prolonged consultations and increased patient anxiety; however, when oncologists specifically addressed the prompt sheet, anxiety levels were significantly reduced, consultation duration was decreased and recall was significantly improved. The use of a sheet or brochure that provided commonly asked questions to prompt patients in their consultation was supported by 76% of patients (Level IVa).<sup>21</sup>

However, a review of the evidence suggests that the provision of this information should be assessed on an individual basis in terms of preferences, prognosis, and level of support (Level III, IVa).<sup>57</sup>

## ADDRESSING EMOTIONAL CONCERNS

The approach that health professionals take to breaking bad news can not only affect patient understanding and decision-making, but also patient adjustment and functioning (Level IVa).<sup>11</sup> Health professionals are an important source of support (Level IVa).<sup>2</sup> As such, the relationship between the patient and the health professional may impact on the effectiveness of communication (Level QS).<sup>9,43</sup> Having not only familiarity but also a personal relationship with patients assists health professional in communicating bad news and anticipating reactions (Level IVa, QS).<sup>9,11,13,45</sup> However, having a close relationship with the patient may result in losing neutrality and objectivity as they are drawn into patient and family emotional reactions. (Level QS).<sup>61</sup> In addition, a strained relationship may block information and communication (Level QS).<sup>61</sup>

The attitude of the health professional toward addressing psychological concerns and the willingness of patient to initiate these consultations can have implications for the recognition of these concerns (Level IVb).<sup>62</sup> A recent review of the literature suggests that acknowledging and responding to the patient's verbal and non-verbal cues is an important focus for health professionals when trying to determine psychological distress (Level IVb).<sup>62</sup> Patients may respond to the news in a wide variety of ways and health

professionals need to take an individualised approach when reacting to patients (Level IVb).<sup>24</sup> Some patients find receiving bad news more difficult than others and may not acknowledge the information they receive (Level IVa).<sup>25</sup> Possible responses to bad news include disbelief, humour, denial, fear, hope (both realistic and unrealistic), guilt, anxiety and prolonged rage (Level IVb, IVa).<sup>11,24</sup> Reactions specific to family members may include shielding and anticipatory grief (Level IVb).<sup>24</sup> Nurses have been shown to provide more instrumental (ie medical) information than affective (ie emotional) information to patients (Level IVa).<sup>63</sup>

Patient wellbeing and satisfaction are improved and anxiety is reduced when health professionals address emotional needs (Level III, IVa).<sup>12,30</sup> It is therefore important to identify the cause of the response and acknowledge this, provide more information and then assess whether this information has any effect on the patient's emotions (Level IVb).<sup>24</sup> Providing uninterrupted talk time, clarifying and interpreting patient cues, and using open ended questions may all facilitate the expression of psychological distress during the bad news consultation (Level IVb).<sup>62</sup> In addition, the use of emotional words by nurses has been shown to improve disclosure of emotions in patients (Level II).<sup>64</sup> Perceptions of clinician behaviour may also influence psychological morbidity and interpersonal skills of the clinician may impact on psychological functioning (Level IVa).<sup>65</sup>

## **PATIENTS' PREFERENCES IN RELATION TO CURRENT GUIDELINES**

The relationship between patient preferences and existing guidelines are not well understood (Level IVa).<sup>51</sup> However, a number of studies have attempted to identify the specific information needs of patients and compared them with those set out in current guidelines. The preferences for melanoma patients when compared to the current breaking bad news guidelines items indicated that while the majority of recommendations in the guidelines received support from the patients, two recommendations were seen as unimportant (Level IVa).<sup>21</sup> These included having the doctor help tell others about the diagnosis, and telling the patient about cancer support services. Having another health professional present was also identified as unimportant (Level IVa).<sup>21</sup> The involvement of family in the consultation and also the offer of assistance by health professional to tell others was not supported in another study that rated the importance of the breaking bad news guidelines (Level IVa).<sup>23</sup> One factor that was rated as important by patients that was not included in the guidelines was feeling confident that they were getting the best treatment (Level IVa).<sup>21</sup> This finding is consistent with another study that examined the specific information needs of 351 patients according to highest and lowest priority (Level IVa).<sup>17</sup> Doctor's technical knowledge was rated as most important with 7 of the 10 highest rated items related to clinician expertise along with type and extent of information, with the remaining three relating to facilitation (Level IVa).<sup>17</sup>

## **BARRIERS TO EFFECTIVELY BREAKING BAD NEWS**

While the importance of clear concise communication cannot be underestimated, there are a number of barriers which may prevent this communication. These barriers include collusion with patient or even the family, lecturing, blocking, and premature reassurance (Level IVa, IVb).<sup>2,62,66</sup> Nurses use more blocking behaviours when communicating with people with a recurrence of their disease (Level IVa).<sup>66</sup> Health professionals may have difficulties in responding to patient emotion, balancing patient hope and the need for honesty and handling family issues such as anger and denial (Level III, IVa).<sup>2,67</sup> They may also have a fear of causing pain, fear of being blamed, and fear of therapeutic failure (Level IVb).<sup>24</sup> Health professionals report a lack of training in breaking bad news (Level III, IVa).<sup>68-70</sup> Even when the health professional does possess the necessary communication skills, a lack of time, health system constraints, a lack of support from colleagues or even a lack of effort on clinicians' behalf to assess information needs of patients may hinder the effective communication of bad news to the patient (Level IVa).<sup>11,16,30,71,72</sup>

Cultural constraints may impact on the ability of the health professional to communicate to the patient and family and health professionals need to be aware of each patient's cultural beliefs and values (Level IVb).<sup>73</sup> Specifically, language barriers may prevent comprehension of the information being conveyed by the health professional (Level IVb).<sup>74</sup> Even the type and amount of information sought by the patient may vary according to the cultural values and beliefs held (Level IVa).<sup>52</sup> In addition, the level of involvement of the family in discussions and decisions may depend on their cultural background (Level IVb).<sup>74</sup>

Using interpreters from the same language group as the patient/family may resolve some language barriers by explaining the information in the person's native language, helping them to ask questions and reducing any misunderstanding (Level QS).<sup>75</sup> However the use of interpreters can be problematic depending on whether the interpreter is a professional or has a relationship with the person with cancer (Level QS).<sup>75</sup> By using family members as interpreters, it is argued that the nature of the information may be altered to reduce any patient distress (Level QS).<sup>75</sup>

## **IMPACT OF THE BREAKING BAD NEWS CONSULTATION ON CLINICIANS**

The emotional impact of bad news on the health professional may be overlooked (Level III).<sup>67</sup> Failure to disclose truth due to fear about their own mortality, unrealistic expectations, denial, personal fears, believing patients do not want to know the truth, and taking away hope may all impact on the disclosure of bad news to patients (Level IVb).<sup>45</sup> One study suggests that clinicians fear losing control of their emotions as well as their behaviour and patient reactions can often impede the consultation of bad news with people with cancer (Level QS).<sup>61</sup> According to clinicians, the demand of breaking

bad news can impact on their emotional wellbeing, confidence, professionalism as well as patient trust (Level QS).<sup>61</sup> Similarly, nurses report feeling fear, inadequacy and distress when present during bad news consultations (Level QS, IVa).<sup>72,76</sup> Clinicians with internal locus of control may have a lower level of burnout than clinicians with external locus of control (Level III).<sup>77</sup> Doctors who report sub-optimal communication skills experience the most anxiety and least confidence when dealing with patients' problems (Level IVa).<sup>78</sup> Clinicians who are more comfortable with breaking bad news may have less burnout (Level IVa).<sup>78</sup>

## **IMPROVING COMMUNICATION SKILLS**

In order to remove any health professional related barriers to effective communication, researchers have begun to focus on developing interventions to improve communication skills. Support has been shown for interventions that focus on improving specific skills of breaking bad news when compared to consultation based interventions (Level III).<sup>67</sup> Other workshops have provided timely and new information to participants (Level III);<sup>79</sup> and have resulted in greater awareness of and ability to deal with difficult patients, including asking open ended questions, addressing psychosocial factors, expressing empathy, and clarifying expectations (Level II).<sup>80</sup> Overall, research suggests that using a didactic component and including practice opportunities are best for intervention workshops as practice removes anticipatory anxiety and apprehension (Level III).<sup>79</sup>

# PRINCIPLES AND STEPS FOR BREAKING BAD NEWS

## GENERAL PRINCIPLES FOR BREAKING BAD NEWS

The following principles were derived from the Girgis et al (1995)<sup>3</sup> Breaking Bad News Consensus Guidelines, which were developed through review of evidence and national consensus.

- One person should be responsible for breaking bad news.
- The patient has a legal and moral right to information.
- Your primary responsibility is to the individual (ie your patient).
- The person involved should be given accurate and reliable information.
- The person involved should be asked how much s/he wants to know.
- The person should be prepared for the possibility of bad news as early as possible in the diagnostic sequence.
- If several tests are being performed, avoid giving the results of each test individually.
- The person should be told the diagnosis as soon as it is certain and when the patient is ready.
- The person should be ensured of privacy and made to feel comfortable.
- Ideally, family and significant others should be present.
- If possible, another health professional should be present.
- The person's general practitioner and other medical advisers should be informed of her/his situation and the level of development of her/his understanding.
- Eye contact and body language should be used to convey warmth, empathy, encouragement or reassurance, if culturally appropriate.
- If communication difficulties exist (eg hearing impairment, language differences), strategies should be adopted to address these, such as use of a trained health interpreter where language differences are evident.
- It is important to be sensitive to the person's culture, race, religious beliefs and social background.
- The clinicians who are breaking the bad news should acknowledge their own shortcomings and emotional difficulties in undertaking this task.

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<sup>3</sup> Girgis, A & Sanson-Fisher, RW. Breaking Bad News: Consensus guidelines for medical practitioners. *Journal of Clinical Oncology*, 1995, 13:2449-2456.

## RECOMMENDED STEPS FOR BREAKING BAD NEWS

The SPIKES protocol, developed by Baile et al (2000)<sup>4</sup>, is a useful 6-step strategy for breaking bad news. The following list of recommended steps includes those developed by Girgis et al (1995)<sup>5</sup> as part of the Breaking Bad News Consensus Guidelines, presented under the headings of the SPIKES protocol.

Table 1: S – Getting the Setting Right

<b>S - GET THE SETTING RIGHT</b>
<ul style="list-style-type: none"> <li>▪ <b>Facilitate privacy.</b> Give the person the bad news in a place that is quiet and private. If in a hospital and it is not possible to find a private room, at least pull the curtains around the bed.</li> </ul>
<ul style="list-style-type: none"> <li>▪ <b>Sit down and maintain eye contact</b> (in cultures where this is appropriate). Ensure that the person is clothed, and sit at eye level with her/him when you are talking.</li> </ul>
<ul style="list-style-type: none"> <li>▪ <b>Avoid physical barriers</b>, such as a desk between you and the person.</li> </ul>
<ul style="list-style-type: none"> <li>▪ <b>Manage time constraints and interruptions.</b> Allow enough uninterrupted time during the initial meeting for the person to think about what you are telling her/him so that s/he can discuss it with you and ask you questions. Ensure that interruptions (including from beepers and telephone calls) do not occur. If the first consultation needs to be short due to time constraints, be certain to arrange a second consultation as soon as possible to follow up on the information given.</li> </ul>
<ul style="list-style-type: none"> <li>▪ <b>Encourage a second person to be present if appropriate.</b> Being confronted with bad news is a potentially stressful experience for people and they may recall little of what they have been told. Having a family member or friend with them may be a great support, but it is the patient's choice.</li> </ul>
<ul style="list-style-type: none"> <li>▪ <b>Arrange to provide other methods to convey the information.</b> People may recall little of what they have been told in a bad news consultation. Providing them with written materials, video tapes, tapes of consultations, etc, will assist them to recall and understand the information, as well as share it with others as they wish.</li> </ul>

<sup>4</sup> Baile WF, Buckman R, Lenzi R et al. SPIKES – A six-step protocol for delivering bad news: Application to the patient with cancer. *The Oncologist*, 2000, 5:302-311.

<sup>5</sup> Girgis, A & Sanson-Fisher, RW. Breaking Bad News: Consensus guidelines for medical practitioners. *Journal of Clinical Oncology*, 1995, 13:2449-2456.

Table 2: P – Find Out What The Patient Knows Or Perceives

<b>P - FIND OUT WHAT THE PATIENT KNOWS OR PERCEIVES</b>
<ul style="list-style-type: none"> <li>▪ <b>Before you tell, ask.</b> Assess the person’s understanding of the situation, using a simple question like “what have you been told about your situation so far?” The person may already be quite aware that the prognosis is likely to be bad, or s/he may have very little awareness of this. Her/his response will be a good indicator of how much information you will need to give, including correcting any misinformation or addressing potential denial.</li> </ul>

Table 3: I – Get an Invitation From The patient To Share The Information

<b>I - GET AN INVITATION FROM THE PATIENT TO SHARE THE INFORMATION</b>
<ul style="list-style-type: none"> <li>▪ <b>Assess how much the person wants to know</b> Some people want to know as much as possible about their condition; for others, more detailed information can increase their anxiety levels. It is important that you give each person a choice about how much information s/he receives. The following examples are useful ways of asking. <i>“When all the results are available, some patients want to know in detail what the results are and what they might expect in the short and long term. Other patients prefer not to be given this information unless it is really necessary. How do you feel?”</i> <i>“At this stage, do you want to know all the information or just the basic information? I can elaborate on it at a later stage if you don’t want all of the information now”.....</i> <i>“I can tell you about a range of things at the moment, such as the different treatment options, the success rates of these options, the side effects of different treatments.....”</i>  Accept the person’s right not to know, but you still need to be give sufficient information to allow her/him to give informed consent.</li> </ul>
<ul style="list-style-type: none"> <li>▪ <b>People’s desire for amount of information changes, so ask again next time you see the patient.</b></li> </ul>

Table 4: Give The Knowledge and Medical Facts

<b>K - GIVE THE KNOWLEDGE AND MEDICAL FACTS</b>
<ul style="list-style-type: none"> <li>▪ <b>Warn the person that bad news is coming</b> <i>eg "I'm sorry to tell you that ..."</i></li> </ul>
<ul style="list-style-type: none"> <li>▪ <b>Give the information honestly and in simple language, though not bluntly.</b> Avoid technical jargon or euphemisms – such as 'tumour', 'growth', 'metastasis', 'illness' – which obscure the truth. If the person has cancer, then use this word.</li> </ul>
<ul style="list-style-type: none"> <li>▪ <b>Tailor the amount of information to the person's request.</b> The starting point should be compatible with the person's current understanding of the situation and her/his vocabulary. As the person may still be adjusting to the news, the facts may need to be repeated or revised several times and on different occasions.  Where relevant, write the information down, use pamphlets and diagrams, offer relevant leaflets or booklets or audiotape the consultation. The Cancer Council in your state and other organisations has a series of booklets especially written for patients and their careers, which provide information on different types of cancer and treatment options, and on issues such as coping with emotions and how to relax.</li> </ul>
<ul style="list-style-type: none"> <li>▪ <b>Give information in small chunks and check understanding.</b></li> </ul>
<ul style="list-style-type: none"> <li>▪ <b>Avoid giving a prognosis with a definite time scale.</b> If possible, give the person a broad, realistic time frame that will allow the person to sort out her/his personal affairs while s/he is still well enough.</li> </ul>
<ul style="list-style-type: none"> <li>▪ <b>Avoid the notion that "nothing more can be done".</b> Even if the disease is too far advanced for curative treatment, try to reassure the person that you will provide support (medical and non-medical) for as long as is needed to make her/his remaining life as comfortable as possible. Where the treatment is palliative, do not pretend that it is likely to cure the disease.</li> </ul>

Table 5: Address The Patient's Emotions With Empathic Responses

<p><b>E - ADDRESS THE PATIENT'S EMOTIONS WITH EMPATHIC RESPONSES</b></p>
<ul style="list-style-type: none"> <li>▪ <b>Encourage the person to express her/his feelings.</b>                      People react in different ways to bad news, eg with anger, denial, disbelief, sadness, acute distress, shock or numbness. Allow and encourage the person to express her/his feelings freely, eg by crying, talking about concerns, fears, anger, anxieties, etc. Explore the main reasons for the emotion, eg "can you tell me what you're most worried about right now?" Emphasise that everything does not have to be covered in the one discussion.</li> </ul>
<ul style="list-style-type: none"> <li>▪ <b>Let the person know that you accept her/his feelings and concerns.</b>                      You don't have to feel the emotion yourself or agree with the viewpoint. Acknowledge and validate the person's feelings, by letting her/him know that it is quite normal to feel this way, for example. This will help the person feel accepted and make her/him more likely to discuss concerns s/he may have.</li> </ul>
<ul style="list-style-type: none"> <li>▪ <b>Respond to the person's feelings with empathy.</b>                      The following are examples of empathic statements.  <p style="margin-left: 40px;"><i>"I can tell you weren't expecting to hear this news"</i></p> <p style="margin-left: 40px;"><i>"I wish the news were better"</i></p> <p style="margin-left: 40px;"><i>"I was also hoping for a better result"</i></p> <p style="margin-left: 40px;"><i>"I can see how upsetting this is for you"</i></p>                     Touch can be used to convey warmth, sympathy, encouragement or reassurance.                      Periods of silence can help the person "absorb" the news, gather their thoughts and express their emotions.                      Have tissues available for the person and her/his friends/relatives.</li> </ul>
<ul style="list-style-type: none"> <li>▪ <b>Provide information about appropriate support services.</b>                      Depending on the person's needs or emotional state, give the person information about the availability of various support services – eg chaplains, cancer support groups, palliative care services and bereavement counselling for families of patients, financial, transport or childcare assistance – and suggest referral to these if that is what the person wants. Reinforce the fact that the general practitioner will also be an important source of support.</li> </ul>

Table 6: S – Strategy & Summary

<b>S - STRATEGY &amp; SUMMARY</b>
<ul style="list-style-type: none"> <li>▪ <b>Summarise the main points</b> of the consultation and assess the person's understanding.</li> </ul>
<ul style="list-style-type: none"> <li>▪ <b>Address any further questions.</b> Ask if there is anything further the person would like to discuss.</li> </ul>
<ul style="list-style-type: none"> <li>▪ <b>Offer assistance to tell others the bad news.</b> Ask the person who s/he would like to tell about the situation and then offer assistance and support in telling these people – including children, other family members or employees – if that is what the person wants. Encourage family meetings to discuss issues which arise over time, and answer questions honestly. If the person receiving the bad news has children, ask about the confidence of the parent in talking with the children about the diagnosis. Provide relevant information which guides parents in how to approach this task. Indicate that, in general, more open communication within the family, rather than keeping secrets, helps all members to cope. Be prepared to check about children's adjustment at follow-up consultations.</li> </ul>
<ul style="list-style-type: none"> <li>▪ <b>Make firm plans for next contact and provide interim contact details.</b> Arrange a further appointment to review the situation within a stated time period (eg within 24 hours to two weeks). Indicate your availability for contact to address any questions or concerns in the meantime, or if you are not available, provide the name and contact details of an alternative person.</li> </ul>
<ul style="list-style-type: none"> <li>▪ <b>Document and share information given to the person and family members.</b> Document what the person has been told, which family members or other people have been told, who is permitted to know about the situation, and the person's reaction to the news. Be concise and include this information on the person's medical record. This will help ensure the consistency of information available to all health care providers involved in the person's care. Include this information on the discharge summary which goes to the person's general practitioner and to any other relevant health care professionals when she leaves your clinic.</li> </ul>

# REFERENCES

1. Davison BJ, Parker PA, Goldenberg SL. Patients' preferences for communicating a prostate cancer diagnosis in medical decision making. *BJU International* 2004;93:47-51.
2. Baile WF, Lenzi R, Parker PA, Buckman R, Cohen L. Oncologists' attitude toward and practices in giving bad news: an exploratory study. *Journal of Clinical Oncology* 2002;20(8):2189-2196.
3. Back AL, Arnold RM, Baile WF, Tulsy JA, Fryer-Edwards K. Approaching Difficult Communication Tasks in Oncology. *CA Cancer J Clin* 2005;55(3):164-177.
4. Roberts CS, Cox CE, Reintgen DS, Baile WF, Gibertini M. Influence of physician communication on newly diagnosed breast patients' psychologic adjustment and decision-making. *Cancer* 1994;74:336-341.
5. Sardell AN, Trierweiler SJ. Disclosing the cancer diagnosis. *Cancer* 1993;72(11):3355-3365.
6. Creagan E. Psychosocial issues in oncology practice. *Mayo Clinic Proceedings* 1993;68:161-167.
7. Chisholm CA, Pappas DJ, Sharp MC. Communicating bad news. *Graduate Education* 1997;90(4):637.
8. Dowsett SM, Saul JL, Butow PN, Dunn SM, Boyer MJ, Findlow R, et al. Communication styles in cancer consultation: preferences for a patient-centred approach. *Psycho-oncology* 2000;9:147-156.
9. Friedrichsen M, Strang PM, Carlsson ME. Breaking bad news in the transition from curative to palliative cancer care - patient's view of the doctor giving the information. *Support Care Cancer* 2000;8:472-478.
10. Schmid Mast M, Kindlimann A, Langewitz W. Recipients perspective on breaking bad news: How you put it really makes a difference. *Patient Education and Counseling* 2005;58:244-251.
11. Fallowfield L, Jenkins V. Communicating sad, bad, and difficult news in medicine. *The Lancet* 2004;363:312-319.
12. Schofield PE, Butow PN, Thompson JF, Tattersall MHN, Beeney LJ, Dunn SM. Psychological responses of patients receiving a diagnosis of cancer. *Ann Oncol* 2003;14(1):48-56.
13. Randall TC, Wearn A. Receiving bad news: patients with haematological cancer reflect on their experience. *Palliative Medicine* 2005;19:594-601.
14. Zandbelt LC, Smets EMA, Oort FJ, Godfried MH, de Haes HCJM. Determinants of physicians' patient-centred behaviour in the medical specialist encounter. *Social Science & Medicine* 2006;63(4):899-910.
15. Friedrichsen M, Strang PM. Doctor's strategies when breaking bad news to terminally ill patients. *Journal of Palliative Medicine* 2003;6(4):565-574.
16. Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP. SPIKES - A six-step protocol for delivering bad news: Application to the patient with cancer. *The Oncologist* 2000;5:302-311.
17. Parker PA, Baile WF, de Moor C, Lenzi R, Kudelka AP, Cohen L. Breaking bad news about cancer: Patient's preferences for communication. *Journal of Clinical Oncology* 2001;19(7):2049-2056.
18. Girgis A, Sanson-Fisher RW. Breaking bad news: Consensus Guidelines for medical practitioners. *Journal of Clinical Oncology* 1995;13(9):2449-2456.

19. Ptacek JT, Eberhardt TL. Breaking bad news: A review of the literature. *JAMA* 1996;276(6):496-502.
20. Vandekieft GK. Breaking bad news. *American Family Physician* 2001;64(12):1975-1978.
21. Schofield MJ, Beeney LJ, Thompson JF, Butow PN, Tattersall MHN, Dunn SM. Hearing the bad news of a cancer diagnosis: The Australian melanoma patient's perspective. *Annals of Oncology* 2001;12:365-371.
22. Levinson W, Roter D, Mullooly JP, Dull VT, Frankel RM. Physician-patient communication. The relationship with malpractice claims among primary care physicians and surgeons. *JAMA* 1997;277(7):553-559.
23. Girgis A, Sanson-Fisher RW, Schofield MJ. Is there consensus between breast cancer patients and providers on guidelines for breaking bad news. *Behavioral Medicine* 1999;25(2):69.
24. Buckman R. *How To Break Bad News. A Guide for Health Professionals*. Baltimore: John Hopkins University Press, 1992.
25. Gattellari M, Butow PN, Tattersall MHN, Dunn SM, Macleod CA. Misunderstanding in cancer patients: why shoot the messenger? *Annals of Oncology* 1999;10(1):39-46.
26. Lobb EA, Butow PN, Kenny DT, Tattersall MHN. Communicating prognosis in early breast cancer: Do women understand the language used? *Medical Journal of Australia* 1999;171(6):290-294.
27. Tanida N, Yamamoto N, Sashio H, Nakamura Y, Sakagami T, Sawada Y, et al. Influence of truth disclosure on quality of life in cancer patients. *International Journal of Clinical Oncology* 1998;3:386-391.
28. Fallowfield LJ, Jenkins VA, Beveridge HA. Truth may hurt but deceit hurts more: communication in palliative care. *Palliative Medicine* 2002;16:297-303.
29. Tattersall MHN, Butow PN, Clayton JM. Insights from cancer patient communication research. *Hematology/Oncology Clinics of North America* 2002;16:731-743.
30. Hack TF, Degner LF, Parker PA. The communication goals and needs of cancer patients: A review. *Psycho-Oncology* 2005;14:831-845.
31. Kiesler DJ, Auerbach SM. Optimal matches of patient preferences for information, decision-making and interpersonal behaviour: Evidence, models and interventions. *Patient Education and Counseling* 2006;61:319-341.
32. Jenkins V, Fallowfield L, Saul JL. Information needs of patients with cancer: Results from a large study in UK cancer centres. *British Journal of Cancer* 2001;84(1):48-51.
33. Fallowfield L, Ford S, Lewis S. No news is not good news: information preferences of patients with cancer. *Psycho-oncology* 1995;4:197-202.
34. Barnett MM. Does it hurt to know the worst? Psychological morbidity, information preferences and understanding of prognosis in patients with advanced cancer. *Psycho-oncology* 2006;15:44-55.
35. Sainio C, Eriksson E. Keeping cancer patients informed: a challenge for nursing. *European Journal of Oncology Nursing* 2003;7(1):39-49.
36. Devine EC, Westlake SK. The effects of psychoeducational care provided to adults with cancer: meta-analysis of 116 studies. *Oncology Nursing Forum* 1995;22(9):1369-1381.
37. Hagerty RG, Butow PN, Ellis PA, Lobb EA, Pendlebury S, Leighl N, et al. Cancer patients preferences for communication of prognosis in the metastatic setting. *Journal of Clinical Oncology* 2004;22(9):1721-1730.
38. Degner LF, Kristjanson L, Bowman D, Sloan JA, Carriere KC, O'Neil J, et al. Information needs and decisional preferences in women with breast cancer. *JAMA* 1997;277(18):1485-1492.

39. Butow PN, Kazemi JN, Beeney LJ, Griffin A, Dunn SM, Tattersall. When the diagnosis is cancer. Patient communication experiences and preferences. *Cancer* 1996;77:2630-2637.
40. Ley P. *Communicating with patients. Improving communication, satisfaction and compliance*. London: Croom Helm, 1988.
41. Radziewicz R, Baile W. Communication skills: breaking bad news in the clinical setting. *Oncology Nursing Forum* 2001;28(6):951-953.
42. Lobb EA, Kenny DT, Butow P, Tattersall M. Women's preference for discussion of prognosis in early breast cancer. *Health Expectations* 2001;4:48-57.
43. Clayton JM, Butow PN, Tattersall MHN. When and how to initiate discussion about prognosis and end-of-life issues with terminally ill patients. *Journal of Pain and Symptom Management* 2005;30(2):132-144.
44. Mitchell JL. Cross-cultural issues in the disclosure of cancer. *Cancer Practice* 1998;6(3):153-160.
45. Glass E, Cluxton D. Truth-telling. Ethical issues in clinical practice. *Journal of Hospice and Palliative Nursing* 2004;6(4):232-242.
46. Keating NL, Guadagnoli E, Landrum MB, Borbas C, Weeks JC. Treatment decisions in early stage breast cancer: should surgeons match patients' desired level of involvement? *Journal of Clinical Oncology* 2002;20:1473-1479.
47. Gattellari M, Butow PN, Tattersall MHN. Sharing decisions in cancer care. *Social Science Medicine* 2001;52:1865-1878.
48. Street R, Voigt B, Geyer C, Manning T, Swanson GP. Increasing patient involvement in choosing treatment for early breast cancer. *Cancer* 1995;76:2275-2285.
49. Benbassat J, Pilpel D, Tidhar M. Patient's preferences for participation in clinical decision making: A review of published surveys. *Behavioral Medicine* 1998;24(2):81-90.
50. Butow PN, Maclean M, Dunn SM, Tattersall MHN, Boyer MJ. The dynamics of change: cancer patients' preferences for information, involvement and support. *Annals of Oncology* 1997;8(9):857-863.
51. Thorne SE, Bultz BD, Baile WF. Is there a cost to poor communication in cancer care? A critical review of the literature. *Psycho-oncology* 2005;14:875-884.
52. Mystakidou K, Tsilika E, Parpa E, Katsouda E, Vlahos L. Patterns and barriers in information disclosure between health care professionals and relatives with cancer patients in Greek society. *European Journal of Cancer Care* 2005;14(2):175-181.
53. Kirwan JM, Tincello DG, Lavender T, Kingston RE. How doctors record breaking bad news in ovarian cancer. *British Journal of Cancer* 2003;88:839-842.
54. Clayton JM, Butow PN, Tattersall MHN. The needs of terminally ill cancer patients versus those of caregivers for information regarding prognosis and end-of-life issues. *Cancer* 2005;103(9):1957-1964.
55. Siminoff LA, Fetting J, Abeloff M. Doctor-Patient Communication about Breast Cancer Adjuvant Therapy. *Journal of Clinical Oncology* 1989;7(9):1192-1200.
56. Dunn SM, Patterson PU, Butow P, Smartt HH, McCarthy HW, Tattersall M. Cancer by Another name: A randomized trial of the effects of euphemism and uncertainty in communicating with cancer patients. *Journal of Clinical Oncology* 1993;11:989-996.
57. Scott TJ, Harmsen M, Pricor MJ, Entwistle VA, Sowden AJ, Watt I. Recordings or summaries of consultations for people with cancer. *The Cochrane Database of Systematic Reviews* 2003(2):1-11.
58. Hogbin B, Jenkins V, Parkin A. Remembering bad news consultations: an evaluation of tape-recorded consultations. *Psycho-Oncology* 1992;1:147-154.

59. Damian D, Tattersall M. Letters to patients: improving communication in cancer care. *Lancet* 1991;338(8772):923-925.
60. Brown RF, Butow PN, Dunn SM, Tattersall MHN. Promoting patient participation and shortening cancer consultations: a randomised trial. *British Journal of Cancer* 2001;85(9):1273-1279.
61. Friedrichsen M, Milberg A. Concerns about losing control when breaking bad news to terminally ill patients with cancer: physician's perspective. *Journal of Palliative Medicine* 2006;9(3):673-682.
62. Ryan H, Schofield P, Cockburn J, Butow PN, Tattersall MHN, Turner J, et al. How to recognise and manage psychological distress in cancer patients. *European Journal of Cancer Care* 2005;14(7-15).
63. Kruijver I, Kerkstra A, Bensing J, van de Wiel H. Communication skills of nurses during interactions with simulated cancer patients. *Journal of Advanced Nursing* 2001;34(6):772-779.
64. Razavi D, Delvaux N, Marchal S, Durieux J, Farvacques C, Dubus L, et al. Does training increase the use of more emotionally laden words by nurses when talking with cancer patients? A randomised study. *British Journal of Cancer* 2002;87(1):1-7.
65. Mager WM, Andrykowski MA. Communication in the cancer bad news consultation: patient perceptions and psychological adjustment. *Psycho-Oncology* 2002;11(1):35-46.
66. Wilkinson SM. Factors which influence how nurses communicate with cancer patients. *Journal of Advanced Nursing* 1991;16(6):677-688.
67. Amiel GE, Ungar L, Alperin M, Baharier Z, Cohen R, Reis S. Ability of primary care physician's to break bad news: A performance based assessment of an educational intervention. *Patient Education and Counseling* 2006;60(1):10-15.
68. Wilkinson SM, Leliopoulou C, Gambles M, Roberts A. Can intensive three-day programmes improve nurses' communication skills in cancer care? *Psycho-Oncology* 2003;12(8):747-759.
69. Wilkinson SM, Gambles M, Roberts A. The essence of cancer care: the impact of training on nurses' ability to communicate effectively. *Journal of Advanced Nursing* 2002;40(6):731-738.
70. Ptacek JT, Ellison NM. Health care providers' perspectives on breaking bad news to patients. *Critical Care Nursing Quarterly* 2000;23(2):51-60.
71. Maguire P. Breaking bad news: explaining cancer diagnosis and prognosis. *Medical Journal of Australia* 1999;171:288-289.
72. Jarrett N, Payne S. A selective review of the literature on nurse-patient communication: has the patient's contribution been neglected? *Journal of Advanced Nursing* 1995;22(1):72-78.
73. Mystakidou K, Parpa E, E. T, Katsouda E, Vlahos L. Cancer information disclosure in different cultural contexts. *Support Care Cancer* 2004;12:147-154.
74. Trill MD, Holland J. Cross-cultural differences in the care of patients with cancer : a review. *General Hospital Psychiatry* 1993;15(1):21-30.
75. Goldstein D, Thewes B, Butow P. Communicating in a multicultural society II: Greek community attitudes towards cancer in Australia. *Internal Medicine Journal* 2002;32:289-296.
76. Dunniece U, Slevin E. Nurses' experiences of being present with a patient receiving a diagnosis of cancer. *Journal of Advanced Nursing* 2000;32(3):611-618.
77. Libert Y, Merckaert I, Reynaert C, Delvaux N, Marchal S, Etienne A-M, et al. Does psychological characteristic influence physicians communication styles? Impact of

physicians locus of control on interviews with a cancer patient and a relative. *Supportive Care in Cancer* 2006;14(3):230-242.

78. Ramirez AJ, Graham J, Richards MA. Burnout and psychiatric disorder among cancer clinicians. *British Journal of Cancer* 1995;71:1263-1269.
79. Baile WF, Kudelka AP, Beale E, Glober G, Myers EG, Greisinger AJ, et al. Communication skills training in oncology. *Cancer* 1999;86(5):887-897.
80. Brown JB, Boles M, Mullooly JP, Levinson W. Effect of clinician communication skills training on patient satisfaction: A randomised control trial. *Annals of Internal Medicine* 1999;131:822-829.