

# CASE TEACHING NOTES

for

## "To Tell the Truth: Delivering Bad News to Patients"

by

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### INTRODUCTION / BACKGROUND

The Ohio State University medical school curriculum includes a two-year course titled "Patient Centered Medicine." The course is structured around different content areas, such as ethics, palliative medicine, professionalism, violence, sexuality, addiction, etc., and is a mix of lectures and small group sessions. This case has been used in the course to teach first-year students some aspects of ethics, patient communication, and giving bad news. Before working through this case, the students have had an introductory lecture covering the basics of giving bad news and should be ready to apply those principles to "real life" medical situations. Source material for this case can be found at the following two websites:

Truth-telling and Withholding Information." Ethics in Medicine. University of Washington School of Medicine:  
<http://eduserv.hscer.washington.edu/bioethics/topics/truth.html>

Breaking Bad News." Ethics in Medicine. University of Washington School of Medicine:  
<http://eduserv.hscer.washington.edu/bioethics/topics/badnws.html>

### Objectives

After completing this case, students will be able to:

- Discuss whether or not patients want to know bad news.
- Discuss physician strategy for giving bad news as it relates to timing, content, and delivery.
- Discuss thoughts regarding who should deliver bad news to a patient (primary care physicians versus specialists).
- Apply the Buckman protocol for delivering bad news to patients.

### BLOCKS OF ANALYSIS

Most medical students do not relish the thought of giving bad news to patients. In fact, experienced physicians are often concerned about the specifics of giving bad news. This case is designed to help students explore the issues associated with the delivery of bad news and is centered on the following issues:

#### *What is "bad news"?*

While this question may seem obvious, it is important to remember that what the physician feels is "bad news" may not match what the patient feels is "bad news" and vice versa. I am reminded of a situation in which a patient had an episode of facial tingling that lasted several hours. The patient saw her physician, who ordered diagnostic tests. When the tests came back saying the patient had a transient ischemic attack ("mini-stroke"), the physician was concerned about delivering this bad news to the patient. However, when told, the patient responded, "Oh, what a relief...I thought it was MS."

Physicians often tell patients that they have chronic diseases (hypertension, diabetes, high cholesterol, etc.). Those illnesses are so commonplace in the medical field that the physician may forget that these represent

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“bad news” to some patients. As an example, the diagnosis of diabetes may be devastating to a patient who witnessed a relative with amputations or on dialysis due to its complications. It is important for the physician in training to remember the patient’s perspective when determining what constitutes “bad news.”

### ***Do patients want to know?***

Contrary to what many physicians have thought in the past, recent studies have proven that most patients do want to know the truth about their health conditions. In fact, 90% of patients surveyed would want to know about a diagnosis of Alzheimer’s disease or cancer. In the 1960s, only 10% of physicians believed it appropriate to tell a patient about a fatal cancer diagnosis. However, 20 years later, 97% of physicians felt the disclosure would be appropriate.

Today, most physicians believe that telling patients the truth fosters trust and demonstrates respect. The patient should be told all relevant information regarding the illness, expected outcomes, treatment options, risks and benefits of treatment, and other needed information based on the patient’s specific values and needs.

### ***What if the family doesn’t want me to tell?***

Sometimes, families will ask that the physician withhold the diagnosis from the patient. Most often, the justification for this is commendable—the family wants to spare the patient a painful or difficult experience. However, those fears are usually unfounded. In rare situations, the family may reveal that telling the truth will cause the patient extreme distress, or may cause predictable harm to the patient. In those situations it may be appropriate to withhold the information. Most often, telling the truth in a thoughtful and empathetic manner will be more appropriate than withholding.

### ***Is it ever justified to withhold the truth?***

There are two instances where withholding the truth may be justified. In the case where disclosure is likely to cause real and predictable harm, it may be appropriate not to disclose. In addition, if the competent patient asks not to be told the results or the truth, it may be appropriate to respect this desire. It is important to treat this instance like an informed consent. The patient should be notified regarding the consequences of this action, and if those consequences are accepted, the patient may not be told.

### ***Who should tell?***

Sometimes there isn’t a right answer to this question. At times, the primary caregiver may be the best person to deliver bad news. However, often, it’s the specialist or another caregiver that finds him/herself in a position to give the news to the patient. In any case, the care team should do its best to work together and deliver care as effectively as possible.

### ***How do I break bad news?***

While there are many recognized approaches to giving bad news, one effective method has been described by Buckman and broken into six steps that can be applied to almost any situation. The protocol is attached, and can also be found at the website at <http://eduserv.hscer.washington.edu/bioethics/topics/badnws.html>.

## **CLASSROOM MANAGEMENT**

This case is intended for a group of 12 to 20 students. Begin the class by letting the students know that the case is designed to focus on different aspects of delivering bad news to a patient. Inform them that in their future clinical practices they will be wrestling with questions concerning whether or not patients want to

know the truth about their condition, how much the patients should be told, at what time they should be told, and who should be the one to tell the patient the news. Then, ask a student to read the case aloud to the class. Alternatively, the facilitator can use the case as an opportunity for role-play. Four students can participate, with one student playing the role of the patient, John Davidson, one student playing the role of Dr. Miller, one student playing the role of Dr. Quaid, and one student acting as narrator.

After the case is read or acted out, ask the class to assume that the pathology report came back as adenocarcinoma of the colon, and there are likely metastatic lesions on the liver. Next, divide the class into two separate groups. Identify group #1 as the “when and who” group and group #2 as the “how and what” group. Ask the two groups to meet in separate areas of the classroom. Use the blackboard to describe the tasks to be accomplished by each group.

On the blackboard, write down the following questions to be answered by group #1:

1. When is the optimal time to break the bad news—before the patient and wife leave for the cruise or after they return?
2. Who should optimally break the bad news—the specialist or primary care physician?
3. Who should be optimally present for the bad news discussion—the patient alone or the patient and his wife?

Obviously, each of these questions has two potential answers. In their group discussion, ask students to explore the advantages and disadvantages associated with each option, to select the option they feel is best, and to list reasons that support each of their answers. Request that the group arrives at a consensus, and ask them to choose a spokesperson to present their answers to the rest of the class.

On the blackboard, write down the following questions to be answered by group #2:

1. What should be said to the patient/couple regarding bad news? Please create a script that describes the specific language to be used by the physician.
2. How should the physician go about organizing his/her approach to breaking bad news to the patient/couple? What specific steps should he/she follow in breaking bad news?

Group #2’s questions are obviously more open-ended as compared to group #1. Ask students to fully answer each question, and choose a spokesperson who will present their answers to you and group #1.

After each presentation by the spokesperson, provide time for the other group and yourself to ask questions and make comments regarding the presentation. Allow 15 minutes for the discussion phase and 20 minutes for the presentation and question/answer component.

Issues that may surface in group discussion and presentations:

- Several factors would tempt one to withhold the diagnosis, and these should be recognized. One would be the concern that the patient would suffer psychological harm that would interfere with his planned trip. Students may discuss how open discussion and sensitive disclosure would allow the patient and his wife to decide if the trip is still important to them versus spending more time with their grandchildren for instance. It would also spare the patient the potential for suffering advanced symptoms while traveling, perhaps necessitating emergency care in a foreign locale.
- Ensure that the students know that in this case there is not much empirical evidence to suggest that severe psychological harm would occur if the patient knew the diagnosis, and lacking some compelling reason to think it would occur, it is insufficient grounds to withhold information. Try and ensure that

the students do not confuse discomfort at giving bad news with justification for withholding the truth. In this case, the man should most likely be told his diagnosis, prognosis, and treatment options.

The Buckman bad news protocol lists language and specific steps that are effective in breaking bad news to patients. Print out the document from the website at <http://eduser.vhscer.washington.edu/bioethics/topics/badnws.html> (also available as an attachment to this case) and distribute this document to the class. Tell students this material was developed by a practicing oncologist, has been widely disseminated in medical school curricula, and has been found to be effective in research studies on this topic. Facilitate a discussion on the similarities and differences between their answers to questions posed to each group (particularly group #2) and the Buckman protocol.

Next, tell students you would like to conduct a brief role-play. Go with group #1's presentation on when this discussion will occur, who should communicate the diagnosis to the patient (primary care physician or specialist), and who should be present for the discussion (patient alone or patient and spouse together). Ask for two or three volunteers (depending on whether or not group #1 suggested the spouse be present)—one to play the physician, and one to two to play the patient/spouse.

At the end of the role-play, thank the volunteers and ask them to comment on what this exercise felt like to them. Ask the class to constructively critique the performance of the physician, with an emphasis on what he/she did well.

In closing, the facilitator can share clinical experiences, both good and bad, in which he/she had experience sharing bad news with a patient. The facilitator should stress that no approach works perfectly every time, and that preparation and sensitivity are valued qualities in every situation.

## REFERENCES

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Robert Buckman has outlined a six-step protocol for breaking bad news. The steps are:

*1. Getting started.*

The physical setting ought to be private, with both physician and patient comfortably seated. You should ask the patient who else ought to be present, and let the patient decide—studies show that different patients have widely varying views on what they would want. It is helpful to start with a question like, “How are you feeling right now?” to indicate to the patient that this conversation will be a two-way affair.

*2. Finding out how much the patient knows.*

By asking a question such as, “What have you already been told about your illness?” you can begin to understand what the patient has already been told (“*I have lung cancer, and I need surgery*”), or how much the patient understood about what’s been said (“*the doctor said something about a spot on my chest x-ray*”), the patient’s level of technical sophistication (“*I’ve got a T2N0 adenocarcinoma*”), and the patient’s emotional state (“*I’ve been so worried I might have cancer that I haven’t slept for a week*”).

*3. Finding out how much the patient wants to know.*

It is useful to ask patients what level of detail you should cover. For instance, you can say, “Some patients want me to cover every medical detail, but other patients want only the big picture—what would you prefer now?” This establishes that there is no right answer, and that different patients have different styles. Also this question establishes that a patient may ask for something different during the next conversation.

*4. Sharing the information.*

Decide on the agenda before you sit down with the patient, so that you have the relevant information at hand. The topics to consider in planning an agenda are: diagnosis, treatment, prognosis, and support or coping. However, an appropriate agenda will usually focus on one or two topics. For a patient on a medicine service whose biopsy just showed lung cancer, the agenda might be: a) disclose diagnosis of lung cancer; b) discuss the process of workup and formulation of treatment options (“*We will have the cancer doctors see you this afternoon to see whether other tests would be helpful to outline your treatment options*”). Give the information in small chunks, and be sure to stop between each chunk to ask the patient if he or she understands (“*I’m going to stop for a minute to see if you have questions*”). Long lectures are overwhelming and confusing. Remember to translate medical terms into English, and don’t try to teach pathophysiology.

*5. Responding to the patient’s feelings.*

If you don’t understand the patient’s reaction, you will leave a lot of unfinished business, and you will miss an opportunity to be a caring physician. Learning to identify and acknowledge a patient’s reaction is something that definitely improves with experience, if you’re attentive, but you can also simply ask (“*Could you tell me a bit about what you are feeling?*”).

*6. Planning and follow-through.*

At this point you need to synthesize the patient’s concerns and the medical issues into a concrete plan that can be carried out in the patient’s system of health care. Outline a step-by-step plan, explain it to the patient, and contract about the next step. Be explicit about your next contact with the patient (“*I’ll see you in clinic in 2 weeks*”) or the fact that you won’t see the patient (“*I’m going to be rotating off service, so you will see Dr. Back in clinic*”). Give the patient a phone number or a way to contact the relevant medical caregiver if something arises before the next planned contact.

Excerpted from: <http://eduser.vhscer.washington.edu/bioethics/topics/badnws.html#buckman>

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