

# Breaking bad news – whose responsibility is it?

## Introduction

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This module aims to assist healthcare professionals in developing their skills in breaking bad news to patients in a variety of clinical settings. It will examine the many difficult complexities that one may encounter as a patient or healthcare professional when faced with the delivering or receiving bad news. Throughout this module, the reader will be directed to key literature to assist them in developing their skills and understanding regarding breaking bad news. The reader will also be asked to reflect on their own experiences and consider how they can improve their skills in breaking bad news.

This module should take approximately 2-4 hours to complete, made up of activities, reading, thinking and reflection.

## Learning objectives

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The activities and content of this module are built around the following learning objectives:

- To define 'bad news'
- To consider who should break bad news
- To understand why delivering bad news can be complex
- To identify the skills required that will assist you when delivering bad news
- To identify strategies and tools that could assist you to improve these skills.

## Background

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A diagnosis of cancer, which is the disease most feared by society today, is the disease that most symbolises death (Morton, 1996). Breaking bad news is one of the most difficult tasks faced by healthcare professionals and is perhaps, most associated with a cancer diagnosis. It is important to recognise that this difficult task can also be experienced by healthcare professionals working in a variety of clinical settings such as critical care units, accident and emergency departments and in paediatric care (Morton et al, 2000).

The impact of a cancer diagnosis is individual, and can produce stress and anxiety in the recipient. Clarke et al (2002) considers how the impact of a cancer diagnosis may affect patients. In essence, a person faced with an initial diagnosis of cancer is violated by an invading pathology that cannot be quelled by any measure of self or inner resource. More often when a patient received a cancer diagnosis, it is delivered by a doctor in a hospital setting who may have had very little if no training. Healthcare professionals need to consider the impact of breaking bad news not only on the patient and their family, but also on themselves

Historically, doctors have been the primary deliverers of bad news to patients and they are often poorly trained and emotionally ill equipped (Buckman, 2005). However, this process can involve a wide range of healthcare professions such as nurse consultants and clinical nurse specialists.

Recently, there has been a renewed interest in developing specific educational initiatives to prepare healthcare professionals in breaking bad news. While most initiatives have previously

focused on medical staff, some now offer training to a wider range of healthcare professionals (Blok et al, 1999).

For example, the UK NHS Plan (DH, 2000) stated that there will be joint training in communication skills across all healthcare professionals and that by 2002, advanced communication skills will form part of continuing professional programmes.

McCulloch's study (2004) looked at the patient's experiences of receiving bad news from healthcare professionals and found 90% of the patients singled out the clinical nurse specialist as the most useful point of contact. One of the key roles of the clinical nurse specialist is to follow up the patient after the news has been delivered, to offer emotional support.

From my clinical experience, the way a recipient receives bad news can have a lasting negative effect. This is supported by Fallowfield (1993) who suggests that ineffective or insensitive delivery of 'bad news' can have a long-term hostile impact upon the recipient leading to a potential bitter focus of distress.

## **What do we mean by bad news?**

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What is 'bad news'? Is it about telling a patient that they have a cancer diagnosis or that their cancer cannot be cured? Does 'bad news' only relate to those who are given a cancer diagnosis? Before we can consider who should be breaking bad news, we need to clarify what we mean by bad news in the context of cancer care.

Many authors have put forward several definitions as to what is classified as breaking bad news. Firstly, Ptacek and Eberhardt (1996) define bad news as 'where there is feeling of no hope, a risk of upsetting established life style', or 'where there is a threat to psychological or physical well being'. These authors also suggest that 'bad news is considered to be bad when the news results in cognitive, behavioural or emotional deficits in the person receiving the news and this lasts beyond the bad news encounter'.

However, Buckman (1984) considers bad news to be 'news that alters a person's view of the future: drastically and negatively', and again in 1992, he defines breaking bad news as 'any news that drastically and negatively alters the patient's view of her or his future'. Finally, after analysing 138 written narratives from patients who had just been given a diagnosis of cancer, Salander (2002) concludes that 'Rather than an event, 'bad news' is better described as a process reflecting how physicians and hospital staff lived up to the patient's expectations of the protection from the threat of danger to their lives'.

Lance Armstrong, a professional cyclist recalls when he was told he had metastatic testicular cancer and how this had a huge impact on his self-image. He reports that he 'left home in October 1996 as one person and came home another' (Armstrong, 2000).

Breaking bad news may not just be about having a cancer diagnosis. Bad news could be telling a patient that they 'can't go home today as you need to have a blood test before you go'. It could be that the physiotherapist informs a patient that they can't go home until some safety equipment has been delivered to their home. Bad news could be a midwife telling a mother to be, that her unborn child is going to be a girl and not a boy. All of these issues can be perceived by the recipient to be 'bad news'. It is the little things that have an impact on day-to-day life that can have the most profound affect on individual patients.

### Thinking Point:

'Bad news is an uncomfortable experience for both the giver and the receiver' (Aitini & Aleotti, 2006)

Individuals remember different things following bad news interviews. Reflect on the following two quotes from patients.

- The doctor was very kind to me when she told me I had cancer, but I don't remember any thing of what she said to me on that day, I just remember she was very kind.
- When I was told that I had cancer, I felt my whole world collapse around me.

## Activity 1 (allow approximately 30 minutes)

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### Task 1:

Think of a time when you were given 'bad' or difficult news. It could be in any context, for example relationships, education, family health etc.

- Where were you given the news?
- How were you given the news?
- Was the environment appropriate and was the timing right?

Reflect on how you felt both emotionally and physically.

**Allow 30 minutes**

### Resources required to complete this activity

#### Background reading

Aitini E & Aleotti P (2006) Breaking bad news in oncology: like a walk in the twilight? *Annals of Oncology*. 17: 359–360. doi:10.1093/annonc/mdl012

Armstrong L (2000) *It's not about the bike: My journey back to life*. Putnam, New York.

Arnold SJ & Koczwara B (2006) Breaking Bad News: Learning Through Experience. *Journal of Clinical Oncology*. 24(31) 5098-5100.

Blok GA, Dalen V, Jager KJ, Ryan M, Wijnen RMH, Wright C, Morton JM, Morley M & Cohen B (1999) The European Donor Hospital Education Programme (EDHEP): Addressing the training needs of doctors and nurses who break bad news, cared for the bereaved and request donations. *Transplant International: Official Journal of the European Society of Organ Transplantation* 12(3):161-7.

Buckman R. (1984) Breaking Bad News – Why is it so difficult? *British Medical Journal* 288: 1597-9.

Buckman R (1992) How to Break Bad News: A Guide for Healthcare Professionals. Papermac, London.

Buckman RA (2005) Breaking Bad News: The S.P.I.K.E.S strategy. *Community Oncology*. 2(2): 138-142.

Clarke D. Flanagan J. & Kendrick K. (2002) *Advanced nursing practice in cancer and palliative care*. Palgrave Macmillan, New York.

Department of Health (2000) NHS Plan. The Stationery Office, London, UK.

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4002960](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002960)

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Fallowfield L. (1993) Giving bad news. *Lancet*. 341: 476-478.

McCulloch P (2004) The patient's experience of receiving bad news from health care  
*Professional Nurse*. 19: 5.

Morton R (1996) Breaking bad news to patients with cancer. *Professional Nurse*. 11(10): 669-71.

Morton J. Blok GA. Reidi J. Dalen J & Morley M (2000) Enhancing communications skills with bereaved relatives. *Anaesthetic & Intensive Care*

Ptacek JT & Eberhardt TL (1996) Breaking bad news: A review of the literature of the American Medical Association. 276: 496-502.

Salander P. (2002) Bad news from a patient's perspective: An analysis of the written narratives of newly diagnosed cancer patients. *Social Science & Medicine*. 55: 21-732.

## Who breaks bad news?

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Whose role is it to tell a patient they have a cancer diagnosis or that there is no further treatment possible? Is the designation of the healthcare professional more important than their ability to communicate effectively?

As part of my research project for my MSc in Advanced Practice, I looked at the views of 200 nurses regarding who breaks bad news in cancer nursing. The data was collected using mixed quantitative and qualitative methodology. The aim of the research was to explore nurse's views of how well the difficult task of breaking bad news to a patient with a cancer diagnosis was carried out in their clinical area. I also wanted to find out if nurses were involved in these consultations.

Sixty one nurses responded, and of those, 75% reported that the consultant was the person who conducted bad news interviews in their clinical area. Only 7% reported that clinical nurse specialists conduct breaking bad news interviews. This reflected on an individual nurse's confidence in breaking bad news and the level of training in breaking bad news techniques.

Healthcare professionals need to be both competent and confident because it is a crucial time for patients when they are first told that they have a cancer diagnosis.

The benefits and training needs of nurse's breaking bad news have been discussed by many authors (Deeny & McGuigan, 1999; Dunniece & Slevin, 2000; Breier-Mackie, 2001; May, 1993; Schofield; 2003; and Duff 2009). They concluded that training in this subject can be tremendously valuable, enhancing nurse's skills and confidence in this area. It raises the question 'should breaking bad news training be mandatory'?

While clinical nurse specialists were not always be present at these interviews, they did provide care and support for the patient following the interview. The presence of a competent, experienced nurse at breaking bad news interviews could be valuable in order to facilitate answering the patient's questions, and provide support and direction when dealing with the practical and psychosocial concerns that the patient may have.

When the respondents were asked 'how well was the bad news delivered by the doctor ', 30% reported that the interviews were carried out very well. However, 58% felt that the consultations had been delivered 'fairly well' and 12% reported these interviews were carried out 'poorly'.

Maybe the responsibility for breaking bad news should not be left to one member of the team. 13% of the respondents suggested that the improvement of written communication between the medical and nursing teams, would allow for more nurses to be aware when these consultations were planned for, and would enable them to attend the consultations.

#### **Thinking Point:**

Reflect on the following comment made by a senior nurse who worked in a critical care setting:

'Only let staff break bad news if they are competent in communication skills. I don't think training helps, I think you either can or you can't break bad news well.'

Do you think the ability to communicate well is inherent or can communication skills be taught?

## **Activity 2 (allow approximately 30 minutes)**

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**Task 1:** Think about your own area of practice and a situation where you may be giving difficult news to patients that they don't want to hear. Identify two occasions when you have given a patient difficult news, one where the exchange went well and one where the exchange didn't go to plan. Reflect on the differences between the two examples.

- What worked well and why?
- What didn't work well and why?
- What could you do differently next time?

**Allow 30 minutes**

## Resources required to complete this activity

### Background reading

Arnold SJ & Koczwara B (2006) Breaking Bad News: Learning Through Experience. *Journal of Clinical Oncology*. 24(31) 5098-5100. <http://jco.ascopubs.org/cgi/reprint/24/31/5098>

Breier-Mackie S. (2001) Patient autonomy and medical paternity: can nurses help doctors to listen to patients? *Nursing Ethics*. 8(6): 510-521.

Deeny K & McGuigan M (1999) The value of the nurse-patient relationship in the care of cancer patients. *Nursing Standard*. 13(33): 45-47.

Duff E, Firth E, Barr K, & Fox A. (2009) A follow up study of oncology nurses after communication skills training. *Cancer Nursing Practice*. (8): 27-31.

Dunniece U. Slevin E. (2000) Nurses Experience of being present with a patient receiving a diagnosis of cancer. *Journal of Advanced Nursing*. 32(3): 611-618.

May C. (1993) Disclosure of a terminal prognosis in a general hospital: the nurse's view. *Journal of Advanced Nursing*. 18: 1362-1368.

Schofield PE. Butow PN. Thompson MHN. Tattersal LJ. Beeney LJ. Dunn SM. (2003) Psychological responses of patients receiving a diagnosis of cancer. *Annals of Oncology*. 14: 48-56. <http://annonc.oxfordjournals.org/cgi/reprint/12/3/365?ck=nck>

## Exploring the impact for patients who have received bad news

From personal experience of working as a senior nurse in the field of oncology and neurology, I have found patients tend to remember the consultation where bad news was delivered. Maguire and Faulkner (1988) suggest that anecdotal evidence shows that breaking bad news too abruptly, will disorganise the patient psychologically and impair adaptation or provoke denial. Also, Fallowfield (1993) and Koopmeiners et al (1997) believe that recipients of bad news can often remember, where, when and how the bad news was communicated. An example from my own area of practice concerns one patient who frequently attended an outpatient clinic for her cancer treatment. This patient could not enter one particular consultation room in the clinic as it brought about painful memories of when she was given her cancer diagnosis.

It has become evident that the way bad news is delivered can have lasting negative effects on the patient and families well-being. Schofield et al (2003) carried out a survey in Australia involving 131 patients who were newly diagnosed with melanoma. These patients were asked to complete a hospital anxiety and depression scale questionnaire at the time of the delivering the bad news, and then at in further intervals of four and thirteen months. The authors also looked at the impact of the implementation of communication strategies aimed at preparing the patient for the possible diagnosis of cancer, including allowing the patient to have someone with them at the time of diagnosis, allowing the patient to have as much written and verbal information as they want at the time of diagnosis, and talking about the patients feelings regarding the diagnosis. These communication strategies were found to optimise patient satisfaction when receiving a cancer diagnosis. In addition, the study found that communication strategies may improve the patient's short and long-term psychological well-being.

The delivery of bad news can have a negative impact on the patient and family. While providing psychological support for my patients and their family, the family members have often reported feelings of 'guilt', 'helplessness' and wanting to 'take the pain themselves'. Feelings of 'disbelief' and 'why' have also been disclosed. It is important for healthcare professionals to recognise that when they deliver 'bad news', what ever that may be, they need to consider how this news can impact on the patient and the family unit.

## **Emotional labour**

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One interesting concept concerns the emotional labour surrounding breaking bad news consultations. James (1989) defines emotional labour as dealing with other people's feelings. A core component of this is the regulation of emotion. James suggests that emotional labour facilitates and regulates the expression of emotion in the public domain.

Hochschild (1983) and Smith (1992) suggest that emotional labour can be differentiated by three characteristics:

- voice-to-voice or face-to-face contact with the public
- the employee is required to reproduce an emotional state in another
- the employees exercise a degree of control over their emotional activities.

Emotional labour is unusual in many professions but it appears to be more common amongst nurses and doctors. The recognition of emotional labour in healthcare allows for the provision of support, such as clinical supervision, experiential learning and peer support. Finally, the recognition of emotional labour amongst the medical and nursing team is a skill and is not easily recognised or quantified. It is argued that breaking bad news requires a large degree of emotional labour by healthcare professionals and the patient, and this may be why some nurse are not comfortable with breaking bad news (Maguire & Faulkner, 1998; Wilkinson, 1991).

Another aspect of breaking bad news, which can evoke emotional labour, is the concept of delivering bad news to those who have learning disabilities. Individuals with learning difficulties are living longer and are as at risk of developing cancer as the population at large. The communication skills practiced by healthcare professionals needs to be adapted to meet the needs of those who have learning disabilities (Fobat et al, 2008).

Breaking bad news can bring about uncomfortable feelings and emotions in the person who is delivering the bad news such as anxiety, sadness and lacking in confidence. One way to help individuals to cope with these uncomfortable feelings and emotions is for the person delivering the news to use distancing tactics. An example from my own area of practice where distancing tactics were used concerns a consultant who delivered a cancer diagnosis to a patient on a ward round with a team of medical students. There was no eye contact from the doctor and the news was delivered while the consultant was standing up at the patients' bedside.

The concept of using distancing strategies has been discussed by Maguire (1985) who suggests nurse and doctors use distancing tactics to protect themselves emotionally. These distancing tactics included using closed questioning skill, time constraints or retreating to practical tasks such as 'making the tea' and some times, avoiding giving the bad news. It is evident that these tactics are not a deliberate act but used as a way of protecting ones self. Dunniece and Slevin (2000) believe that these distancing tactics are employed for fear of causing further upset or distress to the patient. Furthermore, these fears and inadequacies can raise awareness of the nurses and doctors own mortality.

## Activity 3 (allow approximately 30 minutes)

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**Task 1:** Think of an occasion in the past when you may have avoided a 'bad news' discussion with a patient? Identify the factors that influenced your decision. If you were now faced with a similar situation, how would your response differ?

**Allow 30 minutes**

**Task 2:** What resources are available to you in support of breaking bad news? You may want to consider the following points.

- Environment (clinic, ward, quiet room etc.)
- Staff (are you on your own, do you have a colleague with you, can you refer the patient on for further support)

**Allow 30 minutes**

### Resources required to complete this activity

#### Background reading

Bruera E. Palmer JL. Pace E. Zhang K. Willey J. Strasser F & Bennett MI (2007) A randomized, controlled trial of physician postures when breaking bad news to cancer patients. *Palliative Medicine*. 21: 501–505.

Dunnice U & Slevin E. (2000) Nurses Experience of being present with a patient receiving a diagnosis of cancer. *Journal of Advanced Nursing*. 32(3): 611-618.

Fallowfield L. (1993) Giving bad news. *Lancet* 341: 476-478.

Forbat L. McCann L & Hutchens R (2008) Cancer and people with learning disabilities: Critical issues in theory, practice and experience. *British Journal of Learning Disabilities*. 36:147-148.

Gray B (2009) The emotional labour of nursing 1: exploring the concept. *Nursing Times*. 3.3.09. 26-29. <http://www.nursingtimes.net/nursing-practice-clinical-research/the-emotional-labour-of-nursing-1-exploring-the-concept/2002711.article>

Hochschild AR (1983) *The managed heart: the commercialization of human feelings*. University of California Press, Berkeley, CA.

James N. (1989) Emotional labour: skill and work in social regulation of feelings. *Sociological Review*. 37: 15-42.

Koopmeiners L. Post-White J. Gutknecht S Ceronsky C. Nickelson K. Drew D. Mackey KW (1997) How Healthcare Professionals contribute to hope in patients with cancer *Oncology Nursing Forum*. 24(9):1507-13.

Lloyd-Williams M (2002) Breaking bad news to patients and relatives. *BMJ* 2002;325:S11 (13 July). [http://www.gp-training.net/training/communication\\_skills/consultation/badnews.mht](http://www.gp-training.net/training/communication_skills/consultation/badnews.mht)

Maguire P (1985) Barriers to psychological care of the dying. *British Medical Journal*. 291: 1711-1733.

Maguire P. & Faulkner A. (1988) Communicate with Cancer Patients: 2 Handling uncertainties, collusion and denial. *British Medical Journal*. 297: 972-974.

Schofield PE. Butow PN. Thompson MHN. Tattersal LJ. Beeney LJ. Dunn SM. (2003) Psychological responses of patients receiving a diagnosis of cancer. *Annals of Oncology*. 14: 48-56. <http://annonc.oxfordjournals.org/cgi/reprint/12/3/365?ck=nck>

Smith P (1992) *Emotional labour of nursing*. Macmillan, London.

Wilkinson S, (1991) Factors which influence how nurses communicate with cancer patients. *Journal of Advanced Nursing*. 16: 677-688.

## **Frameworks for breaking bad news**

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A framework is a hypothetical description of a complex entity or procedure. It is a structure used to solve or address complex issues. Also, breaking bad news guidelines, which can be produced locally or nationally, may also be used to assist healthcare professional to deliver bad news to patients. Guidelines are documents that aim to summarise and standardise the approach to breaking bad news, address practical issues and identify best practice.

There are several models of breaking bad news. Two of the more recent ones are Kaye's model (2002) and Buckman's S.P.I.K.E strategy (2005). While these models appear to be similar, Buckman's paper describes much of the emotional issues that one should consider when delivering bad news and discusses an easier way to remember the important facts when delivering bad news. Kaye's 10 steps to breaking bad news appears to be brief and it is structured in a 'list' format.

Frameworks are valuable in that they provide a structure for breaking bad news and may have a checklist format. However, they do have their limitations. Specific training can develop a healthcare professional's skills and confidence in breaking bad news.

### **Breaking bad news training**

In recent years a variety of resources have emerged highlighting the importance of communication skills training for healthcare professionals working in cancer care. Friedrichsen et al (2000) suggest that breaking bad news training requires commitment and interest from the learner, and they must have an ability to balance empathy and sympathy effectively. Not all nurses will necessarily be able to carry out this demanding role without extensive training. This is, perhaps, an argument against making it part of mandatory training for nurses because they would need to have an interest in the subject and wish to develop their skills in this area.

A study carried out by Fallowfield et al (2002) looked at 160 doctors over 34 UK cancer centres, and concluded that training courses do improve key communication skills significantly. A national programme for advanced communication skills training has been developed in response to the National Institute for Health and Clinical Excellence (NICE) guidance 'Improving Supportive and Palliative Care for Adults with Cancer' (2004). The three day course is open to senior nurses, allied health professionals and doctors who are working mainly in cancer and palliative care. The training programme is learner centred and experiential.

It is now a measure in the Manual for Cancer Services (2008) that core members of the multidisciplinary team who have direct clinical contact with patients should have attended the national advanced communications skills training.

Duff et al (2009) followed up senior cancer health professionals who had attended communication skills training and found they reported significant improvements in confidence after training. However, these skills need to be consolidated and maintained

### **Evaluating how bad news is given**

The way bad news is delivered can have a lasting effect on either the person delivering or receiving the bad news. It is evident from the literature that breaking bad news training can improve communication skills having a positive lasting effect on the client and the healthcare professional. All senior healthcare professionals working with cancer patients in England have to undertake an advanced communication skills course to improve their skills in breaking bad news. In order to determine how well bad news is delivered in our institutions, we need to evaluate our practice. This can be achieved through patient satisfaction surveys, audits against breaking bad news standards and anecdotal feedback from our clients.

#### **Thinking Point:**

Do you think communication skills training in breaking bad news should be mandatory amongst nurses and doctors within your institution?

Reflect on the following statement: 'It's not what you say, it's the way you say it.'

### **Activity 4 (allow approximately 40 minutes)**

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**Task 1:** Who has the responsibility for breaking bad news in your organisation? Are there any policies stating which health care professional can break bad news to patients?

**Allow 10 minutes**

**Task 2:** What guidelines do healthcare professionals follow in your organization? Are the guidelines produced by a professional body or produced locally?

- Review the local, national and international guidelines
- Are these guidelines implemented locally?
- Are these guidelines easily accessible?

**Allow 20 minutes**

**Task 3:** What training in communication skills have you benefited from? What benefit have you derived from them?

**Allow 10 minutes**

#### **Useful resources**

##### **Useful websites**

National Institute for Health and Clinical Excellence (NICE)

[www.nice.org.co.uk](http://www.nice.org.co.uk)

National Cancer Peer Review (NCPR)

<http://www.cquins.nhs.uk/>

Breaking Bad News...Regional Guidelines

[http://www.dhsspsni.gov.uk/breaking\\_bad\\_news.pdf](http://www.dhsspsni.gov.uk/breaking_bad_news.pdf)

Breaking Bad News

<http://www.patient.co.uk/doctor/Breaking-Bad-News.htm>

Breaking bad news

[http://www.gp-training.net/training/communication\\_skills/consultation/badnews.htm](http://www.gp-training.net/training/communication_skills/consultation/badnews.htm)

### **Background reading**

Baer A. Freer JP, Milling DA. Potter WR. Ruchlin H & Zinnerstrom KH (2008) Breaking Bad News: Use of Cancer Survivors in Role-Playing Exercises. *Journal of Palliative Medicine*. 11(6) 885-892.

Baile WF. Buckman R. Schapira L & Parker PA (2006) Breaking Bad News: More Than Just Guidelines. *Journal of Clinical Oncology*. DOI: 10.1200/JCO.2006.06.2935.

Barnett MM. Fisher JD. Cooke H. James PR & Dale J (200) Breaking bad news: consultants' experience, previous education and views on educational format and timing. *Medical Education*. 41: 947-956.

Buckman RA. (2005) Breaking Bad News: the S.P.I.K.E Strategy. *Community Oncology*. 2(2): 138-142. <http://www.communityoncology.net/journal/articles/0202138.pdf>

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Eggy S. Penner L. Albrecht TL. Cline RJW. Foster T. Naughton M. Peterson A & Ruckdeschel JC (2006) Discussing Bad News in the Outpatient Oncology Clinic: Rethinking Current Communication Guidelines. *Journal of Clinical Oncology*. 24(4): 716-719. DOI: 10.1200/JCO.2005.03.0577.

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Friedrichsen MJ. Strang PM & Carlsson ME (2000) Breaking bad news in the transition from curative to palliative care – patient's view on the doctor giving information. *Support Cancer Care*. 8: 472-478.

Kaye P (2002) Model: 10 steps to breaking bad news.

<http://www.bibalex.org/supercourse/supercourseppt/7011-8001/7321.ppt>

NICE (2004) *Improving Supportive and Palliative Care for Adults with Cancer*. NICE. London. <http://www.nice.org.uk/nicemedia/pdf/csgspmanual.pdf>

## Discussion Board

The discussion board is a forum in which you can exchange ideas with other participants. This activity relates to the work you will have completed in earlier tasks and provides an opportunity for you to explore the difference in perspectives between the participants.

### Discussion Board

#### When will it take place

For a 3 month period from date of publication of this article.

#### Which discussion thread

Breaking bad news

#### What is expected of you as a participant

In particular consider the following:

- How can we improve the experience of breaking bad news for the both the healthcare professional and the patient?
- Who should be responsible for breaking bad news? Is the designation of the healthcare professional more important than their ability to communicate effectively?
- How can we train and support health professionals in the future?

## Summary of this module

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By completing this module you should have developed an insight into the different factors affecting breaking bad news interviews.

You should have had an opportunity to reflect upon your own practice in breaking bad news, what skills are required and considered ways in which they could be improved in the future.

The discussion board activity is aimed at expanding your thinking beyond your own practice, to consider what changes may be needed at a local and national level if the issue of breaking bad news is to be managed in a coordinated and effective manner.

### On completion of this module you will have had the opportunity to:

- Define what is meant by 'bad news'
- Gain insight into the impact of breaking bad news, both from the perspective of the health professional and the patient
- Understand why delivering bad news can be complex
- Consider who should deliver bad news
- Consider what skills are required by the health professional breaking bad news
- Reflect critically upon your experiences of breaking bad news
- Identify strategies and tools that will help you when delivering bad news

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