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# Hospice Medical Memo

A quarterly newsletter for physicians

130 Forest Glen Drive  
Columbus, NC 28722

Phone: 828-894-7000  
Toll-free: 800-617-7132  
Fax: 828-894-2675

Web: [www.hocf.org](http://www.hocf.org)



## Healing Words: Communicating Bad News —by Garry Snipes, MD

Study after study has shown that the way physicians communicate information, particularly “bad news,” to their patients has a major impact on key aspects of the therapeutic encounter, including patient acceptance and adherence to our advice; clinical outcomes; satisfaction with care; and the grief experience of families who lose a loved one. And yet, despite evidence showing that communication is a teachable skill, only recently have medical schools, residencies and post-residency training programs begun to include this topic among educational offerings to prospective and practicing physicians.

It turns out that there is a better way, and a less effective way, to deliver bad news. So what is the best way to do it?

### Setting up and getting started.

In order to be able to provide good information to people, it is important to review the relevant facts and information of the medical situation at hand, and be prepared to explain it in easily

understandable, non-clinical language. Be sure to allow sufficient time for the meeting and select a meeting space that will accommodate everyone and permit confidentiality. Depending on the wishes of the patient, it is usually best for there to be a “support person” present for the patient if this meeting is to convey unfavorable or potentially upsetting information. To the extent possible, arrange for the meeting to be uninterrupted. I find it useful to sit adjacent to the patient without any desk or other obstructions between me, the patient or the family.

### Find out what the patient and family know.

One of the best and most useful questions in medical communication is “What is your understanding of your current medical situation?” And then just shut up and listen, perhaps asking more leading or follow-up questions to elicit information. It is essential to understand the perception of the patient and family in order to know how to structure the subsequent discussion.

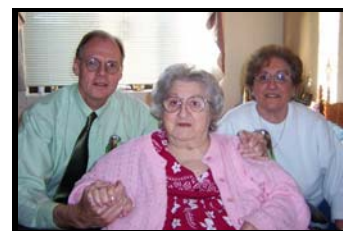
### Find out how much the patient wants to know.

A good way to determine this is to ask the question, “Are you the kind of person who likes to know in detail about your medical problems, or do you just like to have a general understanding?” The scope of information desired will also help you know how to proceed. Cultural preferences may become evident during this phase of the discussion.

### If bad news is coming, consider firing a “warning shot” before getting too detailed.

A phrase like this may be useful: “Mr. Jones, I was hoping to have better results from your tests to discuss today. But there are some problems that we need to go over.” This may get the meeting past the initial phase of shock and allow the patient and family to process and re-engage so as to continue the discussion. And again, after this statement, respectful silence and careful listening to the response can guide the encounter.

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### Share the information on diagnosis and next steps.

Provide information in manageable chunks using non-technical syntax and grammar appropriate to the educational and cognitive level of those who you are counseling. Allow time for processing, response and questions in real time. Never forget how you might feel if you were on the other side of the encounter.

### Allow the patient and family to react in their own way.

Witnessing strong emotion on the part of others and being supportive is a difficult task for most of us, and yet it is incredibly important when delivering news of profound significance to our

## Who to call at Hospice of the Carolina Foothills

- Jean Eckert  
Executive Director
- Garry Snipes, MD  
Medical Director
- Sharon Maddox, RN, MPH  
Director of Patient Care Services
- Doug Brooks, RN  
Admissions Nurse

- Shannon Slater, LPC  
Bereavement Care Coordinator
- Maureen Murphy  
Program Liaison

To reach any of us, please call our Hospice Administration & Program Center in Columbus, NC at 828-894-7000 or 800-617-7132.



### HEALING WORDS, *continued...*

patients. The mind-set of most physicians is to fix things and so it is especially difficult for us to simply sit and allow people to express their grief, fear and anger without feeling the need to intervene. But that is exactly what is required in this situation.

#### Reassure patients that you have a plan and treatment options, and that you will be walking this path with them.

Fear of abandonment is almost a primal reaction to life threatening circumstances on the part of patients. Patients will want assurance that you will be with them, whether they are to receive curative therapy or palliative care. Even if there is no effective curative treatment for the patient, there are always things that can be done to improve or maintain quality of life and relieve suffering, and it is important to reassure the patient at this point that you will be working with them to make this happen, whatever

that entails. Set up a time to follow up for additional discussion and reassure patients and families that you are available for questions that will inevitably occur after the meeting.

#### Final comments

A useful approach to difficult discussions with many patients is encouraging a mix of optimism and realism by “hoping for the best and preparing for the worst” (or, alternately, “preparing for less than the best outcome”). Such a strategy often provides an opening to explore the patient’s fears and concerns while conveying an attitude on the part of the physician of empathy and an intention to do the very best for the patient under the circumstances.

Clearly, conveying bad news is just the beginning of the discussion of life threatening illness. Conversations regarding values, goals and preferences regarding disease-modifying and palliative care constitute a separate topic with their own special considerations, which will be the subject of

a subsequent column in this newsletter.

The word “doctor” in the original Greek meant “teacher”. When it comes to conveying bad news, the competent physician becomes a caring mentor for the patient and loved ones, combining expertise in medical science with empathic support to serve as a shepherd in this difficult time.

#### References:

1. Rabow MW, Hauser JM, Adams J. Supporting Family Caregivers at the End of Life, JAMA 291:483-491, 2004.
2. EPEC Physician’s Handbook. Module 2: Communicating Bad News, EPEC Project, 1999. (can be accessed on line on the EPEC website, [www.epec.org](http://www.epec.org))
3. Back, Arnold, Quill T. Hope for the Best, and Prepare for the Worst, Ann Intern Med 138:439-443, 2003.

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#### Has your patient lost a loved one?

Hospice offers ongoing support groups for those in our community who are grieving the loss of a loved one. We invite them to join us for encouragement and ongoing support on the first Tuesday of each month from noon to 1 p.m., and on the last Thursday of each month from 6:00—7:00 p.m. On Tuesdays, participants may bring a

bag lunch; drinks and dessert will be provided.

Our holiday grief program, “Getting Through the Holidays When Someone You Love Has Died” will be offered on Tuesday, November 14th at 7:00 p.m. and Thursday, November 30th at 10:00 a.m. This program is designed to assist adults who are facing the holidays after the death of someone special

and to help people learn how to best reach out to friends who are grieving.

Groups and seminars are offered at the Hospice Administration & Program Center in Columbus. No registration is necessary, and there is no charge. In addition, grief support counseling is available to anyone in the community. For information, please call Shannon Slater at 828-894-7000.



