

## **Appendix 2**

### **The Do's and Don'ts of Communicating Bad News**

#### **Do:**

- ❖ Wherever possible, sit down to be on the same level as the patient – this is reassuring and courteous and signifies that you are 'with' them.
- ❖ Spend the first part of the interviewing **listening** to what the patient is saying or asking.
- ❖ Note questions or topics avoided by the patient.
- ❖ Watch for non-verbal messages, e.g. posture, eye contact, hands, facial expression
- ❖ Respect the patient's right to 'denial'. Patients will often 'selectively perceive' only that information they can cope with at that point in time.
- ❖ Remember that more than 60% of what you communicate is by non-verbal means, e.g. posture, eye contact, attitude.
- ❖ Allow pauses for taking in and digesting what you said – move at the patient's pace.
- ❖ Attempt to give information that is appropriate for that individual patient's needs at that particular point in time.
- ❖ Realise that most patients become aware of their situation gradually rather than in a 'one off' confrontation.
- ❖ Realise that it is possible to communicate the 'gentle' rather than the 'bitter' truth by one's attitude and by emphasising positive aspects of the present or future situation.
- ❖ Realise that patients can and often do cope positively with the truth about their illness.
- ❖ Realise that certain euphemisms may be appropriate, e.g. tumour or growth. Try to find out what the patient understands by these words.
- ❖ Use the word 'cancer' if appropriate.
- ❖ Realise that the patient who 'denied' or did not want the information about his illness in the past may need and be ready for information at another time.
- ❖ Realise there is no general rule as to how much to tell.
- ❖ Try to include all the family (including children) in the sharing of information.
- ❖ Realise that hope is best communicated by genuine concern and reassurance of continuing care 'no matter how things develop'.
- ❖ Express your humanity and warmth.
- ❖ Realise that patients will often be shocked on hearing bad news and that their many questions may only surface later.
- ❖ End meeting in which bad news is imparted by arranging to meet again in the near future to answer any questions. This also demonstrates to the patient your commitment to them.
- ❖ Write any information or insight you may have given or received in the patient's notes and tell other staff what you have said.

#### **On the other hand:**

- ❖ Do not ask the relatives whether or not the patient should be told. (This is unfair both on them and the patient).
- ❖ Do not agree not to tell the patient because the family forbids this.
- ❖ Do not be afraid of patients and relatives expressing negative feelings or crying. This reaction may be entirely appropriate and not caused by your clumsiness.
- ❖ Do not tell lies which may lead to a breakdown of trust at a later stage.
- ❖ Do not give more information than the patient needs and is asking for.
- ❖ Do not use language that is too technical for the patient and family to understand.
- ❖ Do not use misleading euphemisms, e.g. ulcer.

- ❖ Do not have general rules about “telling” e.g., “Everybody must be told everything” or “Nobody must be told anything”.
- ❖ Do not always answer direct questions directly. It may be appropriate to do so but often direct questions such as “It may be cancer” or “Am I dying” contain hidden questions such as “Will I have uncontrolled pain?” or “Should I make a will?” Replying initially with a question such as “I wonder what makes you ask that” can discover these hidden questions? One may discover that the patient already knows, tells you and is looking for clarification or reassurance.
- ❖ Do not talk from the end of the bed with one foot in the door!

**And finally:**

- ❖ Be aware that it is unethical and technically a breach of confidentiality to tell the relatives without the patient’s consent.