

■ I Wish I Had Better News

Bassem Saab, MD

"This package is a landmark in medical education and pioneering work for clinical practice. It is an outstanding instructional and educational learning tool on how physicians should communicate with their patients and their families in their most difficult moments. "

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To my father, Hassib Saab, and to Rene Campbell, Shakira Bagan, Ibtisaj Na'aman and others who courageously accepted death and showed willingness to donate what was given to them to improve the life of others.

Bassem Saab, MD

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Foreword

As an important educational tool "I Wish I Had Better News" comes at a timely moment in our local medical history. It provides a balanced approach to communicating bad news, while taking into account a patient's attitudes and desires, and the parallel role of supportive resources, such as family and friends.

A few decades ago, breaking the bad news of a fatal diagnosis to a patient really was bad news. It often meant that the patient was condemned to a hopeless, painful and premature end. This is no longer the case. Advances in medical science, particularly in early detection procedures, have made it possible to detect and treat serious diseases at earlier, more manageable stages. This has happened in Lebanon for example in the case of breast cancer. In the 1960s, most cases came to the doctor at advanced stages, and all that could be done by then was palliative care. In the past twenty years, consecutive reports have indicated that more and more cases are detected in the first two stages of the disease. At that level, most cases will be cured and survival rates will be excellent.

That serious disease is becoming increasingly manageable should prompt physicians to squarely face the issue of communicating "bad" news to their patients. Another contributing element is the multiplicity of therapeutic options that patients must choose from. Codes of medical ethics and the Lebanese law protect the right of patients to receive all information regarding their condition, and to be able to choose the course of action. Respect for the patient's right to choose can only be fulfilled if that patient receives a full disclosure of their situation.

The Lebanese patient has also changed. Recent studies suggest that almost half of surveyed individuals would opt for full disclosure of a serious—even lethal—condition. Our public is more educated, more aware that medicine can help even in conditions with the worse "reputation", and more desirous to be allowed a chance to participate in shaping their destiny and preparing their end, if that is the case. Although some patients may want to deny what is happening to them, a physician cannot use this to compensate for what has not been said.

Days when news broke suddenly through a slip of a technician's tongue or an overheard conversation should be gone forever. But they should not be replaced by a blunt and cold approach of telling the truth without sensitivity to a patient's specific situations.

The Ministry of Public Health is gratified to have contributed to the production of this very important tool in the training of our future physicians. We congratulate the Lebanese Society of Family Medicine, and especially Dr. Bassem Saab, for assuming a leadership role on the issue of patient-doctor communication in the past few years. It is our sincere hope that this videotape receives the largest possible audience within Lebanon, and even in neighboring Arab countries with which we share cultural and social characteristics. It is a unique contribution to improving the quality of care and the professionalism of medical practice in this part of the world.

Dr. Walid Ammar

Director-General

Lebanese Ministry of Public Health

Preface

Communicating to a patient who has a fatal illness or a serious condition is something that most physicians find very difficult. Yet, the way that a physician handles this most delicate of responsibilities can have a profound impact on the way the patient is able to bear the news. Three years ago we produced a training package on basic communication skills for health professionals. That elicited the feedback that further training was needed for complex issues, breaking bad news being the most urgent among them.

Medical students and other health professionals may finish their training without being formally taught how to break bad news. Like patients, doctors have their own misconceptions when it comes to health-related issues. Contrary to research findings from this part of the world, medical students and health professionals believe that most patients do not want to be told that they have a grave health problem. Other reasons for failing to communicate bad news properly include fear of death, and, most important, an absence of role models.

Bad news is not restricted to a fatal diagnosis. Telling a patient that they have diabetes, hypertension, or other chronic diseases may be also difficult. The concepts depicted in this package will equip a physician to expertly handle both scenarios.

The material includes a critique, four triggers and two scenarios. In addition to its educational value, the critique aims to evaluate how much and what kind of knowledge the viewer has gained from this series. The triggers are meant to stir discussion and act as preludes to the clips in the scenarios. The clips walk you through a series of interviews, starting with a nonspecific complaint, and leading to informing the patient and the family of the prognosis. All the material is based on real events.

We suggest that the viewer stop the video when prompted to do so and to comment on the material. To demonstrate competence, we advise medical students to role-play each part of the scenario. Higher-level health professionals may synthesize their own scenarios and role-play them. In addition, teachers may evaluate whether their students have gained skills by observing the interaction between them and standardized patients.

It is our sincere hope that this package will improve the quality of communication between health professionals, and patients and their families in an area that requires the utmost sensitivity and skill.

Bassem Saab, MD
January 2005

Learning Objectives

This series will help students and professionals to:

- Identify the importance of breaking bad news properly.
- List the characteristics of a proper setting in which to break bad news
- Demonstrate how to prepare the patient for bad news
- Identify patients' responses that permit you to break bad news
- Show how to gradually disclose bad news
- Show how to work with the family for better outcomes
- Name strategies that help health professionals cope with the effect of telling bad news
- Demonstrate how to talk to the family about organ donation

Use of the video critique

Three clips (video critique) are included at the beginning. The video critique is repeated at the end of the program. Comparing the students' response before and after the program allows teachers to see if their students have understood the information presented.

Teachers are expected to photocopy the Pre and Post Intervention Critique Forms and to distribute them to be completed by their students. It is advised to stop the video when the indication is given and to comment. During this period the students comment on the doctor's/secretary's words and behavior.

Expected answers are shown in the Objective Response Form at the end of the booklet. A student is expected to have the responses shown on the left column of the form. Each response is given the mark shown on the right column. Correct responses are also shown between {} in the Key to Video Critique page. If a student has an additional correct response, we suggest giving it a bonus-one mark. To get a percentage grade, teachers can use the following formula: $\text{Score} = \text{Total mark} \times 100/28$.

Name: _____ Date: _____

Pre- and Post Video Critique Form

Instructions

Please follow along with the video and comment on the secretary's and doctor's statements and behavior in the underlined space provided.

Example

Comments are shown in bold on the line.

Patient: This burning is becoming worse than before (*pointing to the sub-sternal and stomach area*). It is really bad. I feel I am really desperate and do not know what to do (*speaking rapidly, anxious body language*).

Doctor: Last time I gave you a medication. Are you taking it as prescribed?

Closed question

Patient: Yes, I'm taking the Maalox but yet I am not able to sleep, and feel nervous.

Doctor: So in addition to the abdominal discomfort you have a sleep problem and you are nervous.

Clarification

Patient: That is right.

Doctor: What do you mean when you say nervous?

Clarification through a directive open-ended question

Patient: Just nervous.

Doctor: Do you mean easily irritable, or do you feel worried, or have tremors, or other things?

Clarification through a menu/laundry list

Video Critique

Ms. Nasser, 44 years old, had a screening mammography, which revealed a suspicious lesion. Family history is positive for breast cancer in two paternal aunts.

Secretary: (*talking to Ms. Nasser over the phone*) Ms. Nasser, the doctor wants to see you and talk to you about your mammography result.

Ms. N: (*speaking quickly and worried*) Oh my God. Is there anything wrong? Please tell me.

Secretary: It seems so. I booked you an appointment next week.

Ms. N: Next week! I need to see him today.

Secretary: (*phone ringing*) Hold on Ms. Nasser. (*responding to the phone*) Hello, Primary Care Clinic, how can I help you? (*checks the computer for appointment*). Yes you are set for next Thursday at 9:30 am. Bye. (*puts the phone down and continues with Ms. Nasser*) Sorry madam. The doctor is quite busy the coming few days. I can give you an appointment after 4 days.

Please Stop & Comment. You have two minutes.

Dr: (*stands up and greets the patient*) Hello Ms. Nasser, the secretary told me that you were quite worried when she called you to come and see me.

Ms. N: I was not able to sleep for the last 5 days. Well, you know my two aunts died from breast cancer and your secretary called me and told me that I have something wrong in my mammography.

Dr: (*surprised*) She told you that your mammography is not good?

Ms. N: Yes, and she refused to let me see you on that day.

Dr: I apologize for that. I should have called myself and arranged for an immediate appointment.

Ms. N: You should do that next time.

Dr: You are right. Now, do you know why we did a mammography?

Ms. N: Yes, I recall we talked about that before. It is mainly to detect tumors early.

Dr: That is right. The mammogram showed a lesion, but this does not mean that it is malignant.

Ms. N: (*relieved*) I knew it, this cannot be cancer!

Dr: Yes it may not be. But we cannot be sure before we take a biopsy.

Please Stop & Comment. You have four minutes.

Ms. Nasser had the biopsy. The pathology report was positive for malignancy. The doctor, who is the family physician of the sister's family too, called her sister and asked her to come with her to see him the next day.

(The sister walks alone into the doctor's office leaving the patient in the waiting area)

Dr: (shakes hands with the sister) I see you are alone, where is your sister?

Sister: Please lower your voice. I do not want her to know that she has that disease.

Dr: I see. *(Pause)* What is the level of your sister's education?

Sister: High school. What does this have to do with her tumor?

Dr: After the surgery your sister will need chemotherapy and radiotherapy; do you think that she knows that this is not a treatment for a simple condition?

Sister: *(pause, moving her head sideways lifting her eyebrows)* Maybe she will know, but we have to try our best not to tell her.

Dr: I am interested to know the rationale for not wanting your sister to know.

Sister: This will make her feel weak and will affect her ability to fight the disease.

Dr: This is a common concern. At this point she seems not ready to know. I will not tell her that she has cancer; but if later on she asks for the truth I cannot hide the diagnosis from her.

(Doctor calls the patient)

Dr: How are you feeling today Ms. Nasser?

Ms. N: I feel good. Thank you for calling and accepting me in a short period.

Dr: Not at all. I want to discuss the pathology report with you. What do you think?

Ms. N: I assume it did not show anything significant; I am still 44 years- old.

Please stop and comment. You have four minutes.

Commentary

In the clips that we just observed, the sister had her own concept of hiding the truth to help the patient fight the disease. This is a common belief in this part of the world. The doctor acknowledged her view but at the same time asked a reflective question in order to make the sister realize that it may not be easy to conceal the facts. Keeping in mind that family members tend to lose their objectivity when dealing with a close relative, the physician made it clear that his first commitment is to the patient. Listening to patients helps health professionals to determine the caretakers' preferences. In this case, the patient signaled that she is not ready to take the bad news. This, however, does not mean that the physician should not tell the facts later on, if asked by the patient.

Trigger 1: Yes it happened

(Several persons waiting in the lounge facing the intensive care unit (ICU). Inside the ICU there was a 27- year-old lady. She developed serious complications after delivery. A health professional emerges from the door and calls on a relative. The mother comes forward.)

Dr: I want you to know that your daughter is in bad shape. We are dealing with the situation. *(Doctor disappears)*

(Later on)

DR: I am sorry. Your daughter passed away.

(Loud cries are heard throughout the ward. The mother throws herself to the ground. At this time an elderly patient with a covered eye on a wheel chair emerges from the lift facing the ICU entrance. The crying goes on for a while.)

Commentary

Most of you may have noticed that the main problem here is the wrong setting. Health professionals should never break bad news in public places, over the phone, or when walking with the patient or a family member in the hospital corridor or other common areas. Make sure that you give your information in a quiet place, while seated, unhurried, and with no interruptions. Turn off your mobile or pager, or don't respond to them. Tell your staff not to interrupt you.

Scenario 1

Clip 1: Unfolding the Story

Mrs. Y C, 74- year- old, has hypertension and hyperlipidemia.

Dr: How are you Mrs. C? (*stands and shakes hand*). How can I help you?
{Open question}

Mrs. C: I am getting tired easily and I have had a low-grade fever for the last five days. Remember, I called you by phone over the weekend and told you that; you advised me to take paracetamol.

Dr: Yes, and you told me that you had a running nose.

Mrs. C: Right. Now the running nose is over. I am worried about the easy fatigability.

Dr: I see. Getting tired usually happens with a common cold.
{Legitimizing concern}. Do you have other complaints?

Mrs. C: Not really. I did not go to work for the last week.

Dr: You must really be bothered by your symptoms to skip work. This is not like you.

Mrs. C: Yes, I like my work. This exhaustion is affecting my usual activities.

Dr: Do you have a sore throat or difficulty with swallowing? **{Closed questions}**

Mrs.C: No, doctor.

Dr: Do you have abdominal pain, nausea or diarrhea?

Mrs.C: Sometimes I get abdominal pain.

Dr: Abdominal pain! **{Facilitation}**

Mrs.C: Yes, I feel something catchy here (*Puts hand over right upper abdomen*). This has been going on and off for the last few weeks.

Dr: Does this pain radiate somewhere?

Mrs.C: Sometimes it penetrates to the back.

Dr: Does it wake you up at night?

Mrs.C: No, no.

Dr: Any problem with urination?

Mrs.C: No problem with that.

Dr: Well, your main concern is easy fatigability and low-grade fever. You also have right abdominal pain radiating to the back. **{Summarizing}** Is there anything that you like to add?

Mrs. C: No.

Dr: If you do not have anything to add I would like to examine you now. I will look at your throat; examine your neck, heart, lungs, abdomen, and back. **{Preparing patient for the physical exam}**

Mrs. C: (smiling) Ok.

After the physical exam

Dr: You have a low-grade fever; otherwise, there are no significant findings. Since you have had the fever for 5 days, I would like to do a complete blood count and an ESR. **{Medical jargon}**

Mrs. C: What is that Dr.?

Dr: The complete blood count is a blood test, which will help me know if you have an infection or anemia. The ESR is a non-specific test that will be high in several conditions like infection, inflammation and tumors. **{Preparing for possible bad prognosis}** If any is abnormal, we have to do more tests. Do you have any questions?

Mrs. C: No, thank you.

Dr: *(writes lab order and gives it to Mrs. C)* Let me see you after 3 days to check the results and see how you are doing.
(Dr and Mrs. C stand up and shake hands).

Clip 2

Three Days Later

Dr: How are you today Mrs. C.?

Mrs. C: Still the same

Dr: I reviewed your lab results. I noted that you have a drop of 5 points in your hematocrit over 2 months. Since you eat a balanced diet, I am a bit worried. **{Preparing for possible bad prognosis}**

Mrs. C: *(saying it quickly with an anxious tone)* Worried?

Dr: Yes, it means that you are losing blood somewhere. You may be bleeding into your bowels. Do you have any change in your bowel movements or stool color?

Mrs.C: No, the color as usual, is light brown and I am not aware of bleeding somewhere else.

Dr: To determine the cause of the abdominal pain I suggest that we do an ultrasound of the abdomen. I would like also to look into your bowels. Sometimes we may bleed without noticing. The source of bleeding can be a polyp, ulcer or a tumor **{Preparing for possible bad prognosis}**.

Trigger 2: Hide and Seek

A few days later, Mrs. C is admitted to the hospital. An ultrasound of the abdomen shows several target lesions in the liver suggestive of metastasis.

(The doctor is conducting his evening round.)

Dr: How are you now Mrs. Chaar?

Mrs.C: The same. Do we have news regarding the ultrasound?

Dr: *(raising his head, hand, and eyebrows)* Nothing significant. **{Minimizing the problem}** We have a few lesions that may turn to be an infection.

Clip 3: Preparing the Patient

(A friend in the room)

Dr: *(shaking hands with the friend)* I am your friend's doctor.

Friend: Hello, I am a close friend of Mrs. C.

Dr: *(sitting and looking at the patient)* I would like to tell you about the ultrasound result. Would you like me to talk to you now or pass by later when your friend finishes her visit? **{Eye contact, offering privacy}**

Mrs.C: She is a close friend. Please tell me now.

Dr: I am sorry to tell you that I have bad news. *(Pause)* **{Preparing opening statement}**

Mrs.C: *(pause, lift eyebrows, sighs)* Doctor, you have to tell me what I have. I live alone and I need to tell my children who are living abroad if there is anything serious.

Dr: There are several lesions in the liver. This may explain the pain in your abdomen. The source of these lesions may be the colon. We can be certain of that tomorrow after we do the colonoscopy. **{Gradual disclosure of bad news}**

Clip 4-7: Disclosure and the Aftermath

Clip 4

(The doctor informs one of the patient's children by e-mail about the findings.)

I am the family physician of your mother. I am sorry to give you bad news. Two weeks ago your mother informed me of symptoms including fatigue and pain in the abdomen. A complete blood count showed a drop in her hematocrit. We also detected trace blood in one of three specimens of stools. A colonoscopy revealed a tumor in the sigmoid colon. The liver showed several lesions that are most probably metastases from the colon.

She was told that she has a mass and that we are waiting for the pathology report. She asked whether this could be cancerous. I told her that this is possible, but we cannot be sure before getting the pathology report.

Now she is in good shape and seems to have high morale. We have to decide on the treatment once we get the official pathology report.

One more time, sorry for that.

(The daughter responds by e-mail on the same day)

Dear Dr,

Many thanks for your e-mail. I appreciate your sending it to me although I am of course very upset by the news. I always feel it is better to know these things as one can then decide what to do. My mother always mentions the kind care you give her and how attentive you are to all her complaints. I am glad her morale is good and I hope you don't mind if I email you in the future. Do you think it would be best if I come right away? I have lots of questions (about survival, choice of treatment etc.) and will e-mail again once my mind is clearer. Please let me know if you want me to do anything for her now and also later.

Clip 5

Two days after the colonoscopy

Dr: Mrs. C, do you remember the time we talked about how the liver lesions could be secondary to a problem in the colon? **{Summarizing}**

Mrs. C: Yes, yes I do.

Dr: As expected, the source of the liver lesions is the colon. We found a tumor 14 cms away from the anal opening. We took pieces from it for examination.

Mrs.C: Could it be cancer? **{Leading question}**

Dr: (looking at the patient). It could be, but we have to wait for the pathology report. **{Gradual disclosure of bad news}**

Mrs.C: What is to be done if it turns to be cancer?

Dr: Let us first wait for the pathology report. If this is cancer I like to get an oncologist to talk to you about the different options. **{Giving hope by letting patient know that there are options}**. By the way, your daughter responded to my e-mail. She will be here after tomorrow. I would like you to know that whatever the result is, I will be around to help you *(touches the patient)*. **{Standing by the patient}**

Commentary

As a primary care physician you may be at an advantage for knowing your patients (what they know, whether they are the type who want to know the truth about their disease, etc.). If you lack information, explore a patient's knowledge and beliefs regarding the illness. Several times the patient sets the direction and pace of the interview. So be ready to pick up all verbal and nonverbal messages by maintaining eye contact and active listening.

When feasible, prepare the patient early on for the possibility of a bad illness. This process may start before getting a definite diagnosis-in this case a drop of hematocrit. It is good to explain to the patient the indications of the tests ordered. This should be done tactfully without causing unnecessary worries.

Other important steps taken by the physician in this case were:

1. Used opening statements

Dr: I am sorry to tell you that I have bad news.

2. Monitored patient understanding

Dr: Mrs. C, do you remember the time we talked about how the liver lesions could be secondary to a problem in the colon?

3. Ensured continuous care

Dr: I would like you to know that whatever the result of the pathology is, I will be around to help you.

4. Instilled hope by letting the patient know that there is treatment.

Dr: If this is cancer, I would like to get an oncologist to talk to you about the different treatment options.

Clip 6

Two days after the colonoscopy her children arrived from abroad.

(Doctor walks in. The children are there)

Dr: Good morning *(shakes hands with children)*. Hope you had a smooth flight.

Daughter: It was okay, thank you.

Mother: They arrived late at night and had a few hours of sleep.

Dr: It is fortunate to have children like you. You were able to come within a short period. You and your families are quite supportive and caring. *(talking to the mother)* How are you Mrs. C?

Mrs.C: I am waiting to hear from you the result of the biopsy, Doctor.

Dr: Do you remember why we did the biopsy? **{Checking patient's knowledge}**

Mrs.C: Yes, to see if the mass is cancerous.

Dr: Judging from what I know of you, you seem to be a person who wants to know what is there irrespective of how serious the condition is. **{Checking again for patient's preference}**

Mrs.C: I am a believer, I accept God's will. **{Invitation to break news}**

Dr: I am sorry. (*sitting next to the patient on a chair and looking at her*) I wish I had better news. The biopsy showed what we were afraid of: cancer (*pause. The children show evidence of distress*). **{Breaking bad news in presence of supportive persons, eye contact}**

Mrs. C: (*looking with fixed eyes at the face of the doctor*) Cancer! (*pauses for few seconds. Doctor nods head forward*). How serious is it?

Dr: It is serious, **{Avoiding minimization of the problem}** but there may be treatment for it. **{Instilling realistic hope}** The oncologist will drop by shortly to explain to you the treatment plan. Do not hesitate to ask questions.

Clip 7

(*Meeting with the family in the mother's room after the oncologist explained the treatment plan*)

Dr: Did the oncologist clarify the treatment plan?

Son: Yes, I will also take the opinion of an oncologist friend abroad.

Daughter: I may be able to stay here till the end of the summer (*tearful*). My children will also come.

Mrs. C: (*talking to the crying daughter*) Do not worry. Things will be all right.

Son: If she cannot go with us I will see if I can have a temporary work here; my employers accepted to give me a leave without pay if needed. My husband and I agreed to transfer our daughter to a school here. **{Mobilizing resources}**

Dr: Good, you have looked at several options in such a short period. The idea of getting the grandchildren to spend some time here is great! **{Supporting family}** (*talking to Mrs. C.*) It may be a good idea to attend to things you want to do with the family or alone?

{Encouraging patient to fulfill wishes}

(*Doctor leaves. the son 1 follows him into the corridor.*)

Son: Doctor, can I talk to you alone?

Dr: Sure, you can come to my office. **{Arranging for privacy}**

Commentary

When you tell a patient or a family member bad news, denial is a possibility. It is normal for concerned persons to ask for more than one opinion. As a physician you should not be a barrier; in fact it may be a good idea that you support the caretaker and family members to do that.

Clip 8: Dissecting feelings

In the doctor's office

Son: I understand that the prognosis is not good. If we were around we may have caught the disease at an early stage (*nodding head sideways*).

Dr: Yes (*pause, eye contact*) the 5 years survival is around 5 percent. In such situations it is not unusual for relatives to feel guilty. I do not think your presence could have made a difference **{Dealing with guilt feeling}**.

Son: (*moving head vertically with closed eyes*) What if we do not give chemotherapy?

Dr: This is an option especially when the survival rate is low and considering the quality of life when subjected to chemotherapy. In fact, in some places only palliative care is offered in such situations. You may like to discuss this option with your sister and mother. You may need to examine your feelings closely so that one-day you do not regret this choice. **{Bio-psychological approach}**

Son: (*nodding head in acceptance*) We have to discuss it with her and go by her decision.

Dr: Yes, it is tough! In the mean time it is important to see if she has any pending business or matters that need to be finalized. You may like to talk to her about that too. **{Finalizing unfinished business}**

Commentary

Our beliefs may affect our actions. A doctor who considers death as a defeat may unnecessarily prolong suffering. It is important to be aware of your own values and beliefs. By doing so you are less likely to tip a dying patient/family to a specific option that may make them feel guilty. Instead, you have to encourage them to examine all options and then to make the decision.

Another important issue is not to minimize the problem. Giving a rosy picture for a terminal illness may delay finalizing unfinished business that the patient/family needs to undertake.

Clip 9: Health Professionals Heal Themselves

Dr: I would like to talk about how I feel about a patient of mine who's currently in hospital. I am taking care of a 74-year-old lady, who is living alone. She is very well preserved and mentally competent. She has a son and a daughter; both live abroad and are very supportive of their mother.

Last week, she came complaining of fatigue, and I ran some tests on her and discovered that she has advanced colon cancer, with metastases to the liver. We talked about treatment options, and her son is planning to move to Lebanon to stay with his mother during her treatment.

Colleague: How does that make you feel?

Dr: (sighing) Well, I have a lot of mixed feelings inside (*pause*). This case reminds me of my father's death. A few years ago I diagnosed him with a case of laryngeal cancer and told him about the diagnosis. He elected to receive radiotherapy and after a year the radiotherapist told him that he was cured. However the tumor was still there. After total laryngectomy he had wound dehiscence and we ended with gastrostomy. My family questioned the value of keeping my father informed about each step. **{Counter transference}**

Facilitator: Are you worried that the family will blame you for telling the patient about her disease?

Dr: This is always a possibility. I'm so aware that when we break bad news, the family stops listening to what we are saying and may blame us for feeling so sad and angry. In this case, though the children and the patient wanted to know the diagnosis, it was not easy talking about the prognosis. **{Acknowledging difficulty}**

Colleague: Uh-huh (*Pause*).

Dr: The other issue is that they asked whether not taking chemotherapy would be a viable option. I said that, given the poor prognosis, and the quality of life during chemotherapy, this choice might indeed be appropriate, but we need to discuss this with Mrs. C and the oncologist.

In a way she made it easier for me, by telling me that she is a believer, and that she wants to know the diagnosis. The children appear so supportive too. I feel I will not be alone in managing her last days (*Relief*). Sometimes, I wonder how I would feel if someone were to tell me that I had a poor prognosis. Would I want to know? How would I manage the rest of my days? Would I suffer? **{Personalizing death}**

Colleague: It is scary to think that the countdown has started. It also sounds like the family is indeed grateful for how you are taking care of their mother. It is no surprise that this case reminds you of your difficult days with your father. Do you like to add anything?

Dr: Thanks for your supportive words.

Commentary

Breaking news about a terminal illness is not an easy task. This may be due to the feeling of defeat, helplessness, or by personalizing the situation by envisioning your own death. Acknowledging difficulty is a prerequisite for seeking a colleague with good listening skills. Talking to such a person usually helps the physician. Health professionals need to realize that death is inevitable, and that when medicines and technology fail, good care may help relieve the anguish. In some medical centers and clinics, Balint groups deal with such situations.

Trigger 3: Briefing Family Members

The father of four daughters has severe heart failure and now has a new myocardial infarction. Daughter 1 comes in the morning to visit her father.

Daughter 1: *(Paged the doctor and waiting for reply while pacing the place and looks anxious. The phone rings; daughter picks the phone and starts talking quickly.)* Doctor, I am the daughter of Jamil Bahlouk. Please tell me how he is doing today?

Dr: Hello, I wish I had better news than yesterday. He is still the same.

Daughter 1: Please do anything to make him live.

(Around noon comes Daughter 2 and meets Daughter 1 who was with the father in the room.)

Daughter 2: How is he, sister?

Daughter 1: He had a rough night.

Daughter 2: Rough night! I will talk to the doctor right now *(she picks the phone and pages the doctor.)*

(Minutes pass and the doctor has still not answered.)

Daughter 2: *(angrily talking to sister)* What kind of doctor is he? You page him and he does not respond. *(phone rings)*

Daughter 2: (*talking quickly*) Doctor, my sister told me that my father is not improving. I am worried. May I see you now to discuss his situation?

Dr: It is not possible. I am busy with other patients.

(*Hours later, Daughter 3 calls from home asking for the doctor.*)

Commentary

Meeting family members is important. They are the ones who care for the patient day and night, providing us with missing information, and alerting our attention to a symptom or sign. However, sometimes they can be a source of distress, especially when their beloved is critically ill. To minimize unpleasant encounters, the physician needs to set regular meetings with the family, or a designated member, in a quiet and comfortable place. Every effort should be made to come on time to such conferences and to not be hurried. The health professional who conducts such meetings should be well aware of all the details related to diagnosis, treatment, and prognosis that has been discussed thus far with the patient and the family.

Scenario 2

Khaled, the son of Mr. and Mrs. B, is in a deep coma after a car accident three days ago

Clip 1

Doctor: Good Morning.

Mother: Good Morning, Doctor, any new development? (*anxiously*)

Doctor: Let us talk in a quiet place (moves to an office). {Proper setting}.

As you know, we have been monitoring the situation for the past three days. Unfortunately, your son did not show any improvement. His brain is not functioning and he is in a deep coma. We call this situation brain death.

Father: Brain death! What do you mean?

Doctor: I mean that the other vital organs are functioning but the brain is not. When the brain is dead all the senses are knocked down. This is an irreversible condition.

Mother: What can be done?

Doctor: (*nodding his head*) I wish I could tell you that we can do something. Two neurologists confirmed the brain death, and the EEG done more than once confirmed that the brain is dead.
(*silence*)

Mother: (*sobbing with tears in her eyes*) It is hard to let him go.

Doctor: (*giving the mother a tissue*) Yes, it is hard. Remember the prayer "God, I do not ask you to stop death, but I ask you to be gentle with him". **{Culturally appropriate response}**. Let me assure you that Khaled is not suffering and not feeling any pain. **{Comforting family}**

Clip 2

A day later

Father: (*anxious*) Any thing new?

Doctor: (*nodding head sideways*) I am sorry, no.

Father: Since we cannot do anything, we have to accept God's will.

Doctor: It is a hard time you are passing through. What I am going to say may sound harsh. **{Preparing statement}** You may want to consider an important issue. You are not obliged to do this, but it is my duty to ask you to consider the possibility of organ donation. I know this will not bring your son back, but in my experience the families who lose a beloved person feel good about changing the life of others to the better.

Father: Organ donation?

Doctor: (*keeping eye contact*) Think about it. Both, religious and secular leaders encourage this. Here is a booklet that answers several questions on organ donation. I also have an article about a family who lost two sons in a car accident and found consolation in helping others by organ donation. If you have any questions, do call me.

Father: What about body disfigurement?

Commentary

The waiting list for a cornea or other tissues/organs is quite long worldwide. Besides not doing harm to our patients we have a duty to do good to patients and the society. As physicians we are at the forefront to facilitate the process of organ donation. Unfortunately we usually fail to raise the issue. In Lebanon, organ donation is rare (annually, four donations per year for each million of the population), about one-third the figures quoted for Saudi Arabia and Kuwait. Lack of training is responsible for

that. Other barriers are well understood; we do not want to distress an already stressed family, or we are afraid that they become angry with us. There is more fear than the situations accommodates. A good doctor-patient/family relationship makes this process easier. You need to identify and talk to the most resilient member. Give the bad news and request to think about organ donation in different sessions **{Decoupled request}**. Issues that can be discussed in such situation include acceptability of this by the major religions in our area, the benefits of donating organs to the bereaved family and the recipient, and lack of disfigurement.

Trigger 4: Not all bad news are death-related

Patient: I am coming to check the results of my annual check up.

Dr: The only problem I see is an elevated blood sugar of 158. Usually it should not be higher than 110.

Patient: (*worried well*) What a catastrophe!

Dr: Catastrophe. Why did you say that?

Patient: I have an uncle who had diabetes and ended up with an amputation and died shortly after that.

Commentary

Telling a person that they have a chronic disease can be stressful. One may not be worried, especially if the disease has no symptoms. Another may overreact as in this case. It is always helpful to explore the patient's knowledge/experience about the entity being investigated and, when possible, calm them by highlighting the availability of effective therapy that, if followed, will prevent or delay complications.

Video Critique Answer Key

Ms. Nasser, 44 years-old, had a mammography, which revealed a suspicious lesion. Family history is positive for breast cancer in two paternal aunts.

Secretary: Ms. Nasser, the doctor wants to see you and talk to you about your mammography result.

Ms. N: (*speaking quickly and worried*) Oh my God. Is there anything wrong? Please tell me.

Secretary: It seems so **{Wrong setting}**. I booked you an appointment next week

Ms. N: Next week! I need to see him today.

Secretary: *(phone ringing)* Hold on Ms. Nasser. *(responding to the phone)* Hello, Primary Care Clinic, how can I help you? *(checks the computer for appointments)*. Yes you are set for next Thursday at 9:30 am. Bye. *(Puts the phone down and continues with Ms. Nasser)* Sorry madam. The doctor is quite busy the coming few days. **{Lack of empathy}** I can give you an appointment after 4 days.

Dr: *(stands up and greets the patient)* Hello Ms. Nasser, The secretary told me that you were quite worried when she called you to come and see me. **{Stands, greets in a cultural accepted way}**

Ms. N: Not only worried, I was not able to sleep for the last 5 days. Well, you know my two aunts died from breast cancer and your secretary calls me and tells me that my mammography is not good.

Dr: *(surprised)* She told you that your mammography is not good?

Ms. N: Yes, and she refused to let me see you on that day.

Dr: I apologize for that. I should have called myself and arranged for an immediate appointment **{Assumed responsibility}**.

Ms. N: You should do that next time.

Dr: You are right. Now, do you know why we did a mammography **{Checking for patient's knowledge and preparing for possible bad prognosis}**.

Ms. N: Yes, I recall we talked about that before. It is mainly to detect early tumors.

Dr: That is right. The mammogram showed a lesion but this does not mean that it is malignant **{Realistic hope}**.

Ms. N: *(relieved)* I knew it, this cannot be cancerous? **{Denial}**

Dr: Yes it may not be. But we cannot be sure before we do a biopsy. **{Avoiding minimizing the problem}**

Ms. Nasser had the biopsy. The pathology report was positive for malignancy. The doctor, who is the family physician of the sister's family too, calls her sister and asks her to come with her to see him the next day. {Arranged for family support}.

(The sister walks alone into the doctor's office leaving the patient in the waiting area)

Dr: (*shakes hands with the sister*) I see you are alone, where is your sister?

Sister: Please lower your voice. I do not want her to know that she has that disease.

Dr: I see. (pause) What is the level of your sister's education? **{Closed question}**

Sister: High school. What does this have to do with her tumor?

Dr: After the surgery your sister will need chemotherapy and radiotherapy; do you think that she will not know that this is not a treatment for a simple condition? **{Reflective question}**

Sister: (*Pause, moving her head sideways lifting her eyebrows*) May be she will know, but we have to try our best not to tell her.

Dr: I am interested to know the rational for not wanting your sister to know. **{Exploring believes}**

Sister: This will make her feel weak and will affect her ability to fight the disease.

Dr: This is a common concern. **{Legitimizing concern}** At this point she seems not to be ready to know. **{Recognized denial}** I will not tell her that she has cancer; but if later on she asks for the truth I cannot hide the diagnosis from her. **{Primary responsibility to patient}**

(Doctor calls the patient)

Dr: How are you feeling today Ms. Nasser?

Ms. N: I feel good. Thank you for calling and accepting me in a short period.

Dr: Not at all. I want to discuss the pathology report with you. What do you say? **{Checking for readiness}**

Ms. N: I assume it did not show anything significant; I am still 44 years old.

Grading Guide: Responses to the Video Critique

Wrong setting	2
Lack of empathy	1
Stood up	1
Culturally accepted greeting	1
Assumed responsibility	1
Checked for patient's knowledge	2
Prepared for possible bad prognosis	2
Realistic hope	2
Avoiding minimizing the problem	2
Arranged for family support	2
Proper greeting	1
Closed question	1
Reflective question	2
Exploring believes	1
Legitimizing concern	1
Recognized denial	2
Primary responsibility to patient	2
Checked for readiness	2
Bonus	
Total	28
Final grade	sum of correct answers x 100/28

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Quotations about the work:

"I reviewed this package with admiration. I believe it is a great tool to educate our students, residents, and faculty role models"

Roger Zoorob, MD MPH, FAAFP

Professor and Chair, Family and Community Medicine
Vanderbilt University and Meharry Medical College, Nashville, TN

"I read over the script and think it will be very helpful for many medical students. Actually around here doctors usually don't give patients any news at all, they avoid their questions altogether"

Lama Chahine

Third year medical student

Ninety three percent of eighty four medical students who are going to graduate within a year reported that they did not have the chance to break bad news to a patient with advanced cancer. Sixty five percent of the same group did not observe a senior physician informing a patient about his/her terminal illness. These data show the need to educate medical students and health professionals on how to break bad news. This is what this package aims at.

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