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BREAKING BAD NEWS: A BASIC ETHICAL DILEMMA IN A MEDIC'S ACTIVITIES

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ABSTRACT

In a conceptual aspect bad news is a tridimensional event consisting of the processes of breaking and receiving the news and the resulting consequences for the patient's and his relatives' lives. The necessity for this act is determined by the impossibility for the patient to control the information received. The accent is put on breaking bad news related to incurable diseases and conditions with lethal exit. Traced are the stages and the psycho-emotional reactions of the individual in the course of the procedure, as well as the possible approaches to the management of these reactions.

The process of disclosing prospective unfavorable information is interpreted as a complex intervention method that requires not only communication skills but also a well-weighted response to the patient's needs and emotional reactions, as well as an adequate correlation to the medic's own feelings and concepts.

Key words: unfavorable information, disease with lethal exit, psycho-emotional reactions, communication skills.

INTRODUCTION

The concept of putting to death the bearer of bad tidings originates back in Antiquity (Sophocles, around 420 BC). Other representatives of that era pleaded: "Don't shoot the messenger!" During the Middle Ages in Europe the Christian religion, mainly the Roman Catholic Church, required the dying patient to be told the truth so that he may be given the viaticum. The sick should in no case be deprived from the possibility to perceive their death, prepare to meeting God and take final leave of their relatives (3, 4).

Until the early 1960's, disclosing a "severe" diagnosis to the patient was considered contraindicated with consideration to the communication between the physician and the patient. Sociological surveys indicate that while during this period nine of every ten physicians stood firmly against the disclosure of a cancer diagnosis by the end of the 1970's 90% of the doctors interviewed stuck to informing patients of a life-threatening condition (13). The justification of this failure to inform is based on the paternalistic attitude of doctors (11) who believe that enlightening a patient about the illness and its severity could adversely affect the individual's resistance resources in the course of treatment. To support this they also brought forward the argument that it was better for a patient with unfavorable diagnosis to live the rest of his or her life with less mental stress.

Results from experimental studies conducted in the beginning of the twenty-first century have shown that most cancer patients (more than 80%) want to receive as much information as possible and most want to know whether they have cancer or not (10, 13).

Nature and contents of bad news within the framework of the information model

Informing the patient about a life-threatening condition or telling the family about the death of a relative is discussed in the literature as the most frequent example of a communication situation where bad news is broken (9). Perceiving and rationalizing, experiencing and assessing the negative message are a bilateral process. The information about an illness that is not directly threatening the patient's life but

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requires in the course of the treatment a radical change in the behavioral life style is interpreted and emotionally treated like bad news as well. In a conceptual aspect, bad news is a tridimensional phenomenon which comes down to the nature or the news, the processes of disclosing and receiving and the resulting consequences for the patient's life.

Therefore, many things in medicine beyond terminal conditions are bad news. The main message is: **"I will not let you down!"** The need to act is determined by the impossibility for the patient to control the data in the information received.

What is bad news? – bad news depends on the patient's expectations; there are news that adversely affect the patient's feelings about their future; some diagnoses (e.g. cancer) could be bad news almost without consideration to the actual prognosis; bad news is not just about dealing with very bad prognosis; for the parents all information about a chronic or even a prolonged illness is bad news (sometimes even bad news about innate or hereditary issues is considered "less" bad); pregnancy could be bad news under certain circumstances.

Doctors keep telling patients bad news although they do not always perceive it as such (e.g. telling someone that he/she has high arterial pressure or epilepsy and has to be in treatment for the rest of their lives).

Some **causes** for breaking bad news are:

- a cancer that progresses despite the therapy undertaken; treatment becomes useless;
- the status of a patient with cancer worsens much faster than expected which points to unfavorable prognosis;
- the death of a patient is expected earlier than the patient and his relatives are prepared for;
- a disabling illness which is very likely to lead to worsening of the condition and dependence of the patient upon external help (e.g. severe neurological diseases such as multiple sclerosis, amyotrophic lateral sclerosis, hemiplegic, paraplegic, etc.)
- where the illness is progressing and the conditions is worsening complications and complaints could be expected such as pain, asthma (that could be well influenced by palliative care)

Why is it hard to break bad news? - empathy with patient's suffering; reluctance to hurting the patient; on doctor's side could be perceived as a defeat or failure; it could change the established doctor/patient relation; it could put a barrier between the doctor and the patient; unpredictable response/reaction of the patient (anger, pain, fear, etc.); reminds the doctor of his own experiences of bad news and severe losses, potentially at the death of a family member.

Because it is difficult to break bad news the doctor avoids disclosing it or serves very carefully to protect himself rather than to protect the patient. Even when he "catches" himself saying: "The patient does not want to know" he should ask himself whether he does not rather mean: "I don't want to tell the patient."

Through the speech and overcoming the corruption of words is implemented that human field in which the doctor thinks and experiences his own world; he enters into contact with the patients and accesses their individuality, reality and conception of the world (8).

Why is it hard to receive bad news? – the pain caused by the changed perspective of the future for some people; often it comes quite suddenly and causes shock; removes hope and confirms the worst fears; loss of control on the future; anxiety due to the effect of the news on the family; empathy with doctor's difficulties in breaking bad news.

Loyalty and the right to self-determination of the patient require all information about the nature of the illness and the consequences to be given to the relatives only with the patient's consent. The patient must be sure and has to believe that the doctor is trustworthy.

Difficulties for the relatives:

- *Remorse* (conflict between the desire to be close to the patient and desire to flee him and the burden caused by the disease)
- *Feeling guilty* (guilty for being able to live longer and guilty for not being able to help anymore)
- *Emotional burden of experiencing the relative's physical and mental decline*
- *Confrontation with own death*
- *Feeling threatened by expected loss* (destruction of the hope for shared future and the perception of their own conception of the world)
- *Changes in the family hierarchy* (the father who was once a source of protection and defense is now in the need for protection and dependent)
- *Uncertainty in communications* (how often can one speak with the patient about his illness?

How much can one share his own experiences and difficulties with the patient?)

Breaking bad news in medicine is directly related to incurable or fatal conditions. Where the truth about the coming lethal end is told to the patient emerges the question whether the doctor has become in the course of his professional evolution more humane or not so empathic. The answer is still hanging. However, it can be categorically affirmed that the needs of the dying patient have not changed for centuries while the physician's ability to satisfy these needs and respond adequately to these righteous demands has been destructed.

It has been established that patients would like to be informed of the coming fatal end when they still dispose of their own forces and psychological potential, i.e. the effect of the news seems less threatening if death is to be in a more remote future than if it is "at the doorsill". For the family it is also more advantageous if discussions about potential changes or reconstructions (including in the house, the life, financial, etc.) are conducted while the patient is still in a good condition (11). Usually, the communications on this subject are postponed in time not in patient's best interest but because the family is unsure of their attitude, which varies between fear, incertitude and, quite frequently, from self-interested motives. The phases in breaking bad news differentiated in specialized literature still stick to the classification of their original author Kübler-Ross (1, 2). They show up in the following sequence **(table 1)**:

Table 1. *Psycho-emotional reactions and management approaches in breaking bad news*

"We are not capable of staring long time at the sun and we can not always look into the eyes of death" - unknown author

PHASES	STAGES	APPROACHES
I. First phase • **Denial**	"This can not be true"; Bad joke, delusion; changed results	- Six-step protocol for breaking bad news;
• **Isolation**	Thoughts about health and illness; life and death; immortality; recapitulation *"my life, my illness, my death"*, despair, seclusion, deadly sin 5	- Leading presence and empathy - doctor and psychologist; - resistive defense and stability
• ***Rarely shock***	Paleness, sweating, tremor, lack of orientation and self-control, stupor	- not entertaining unrealistic hopes
II. Second phase Anger, rage	Alternating aggressive accusations and inconsolable lamentation; "Why me?"; "Who is to blame"; "Sacrificial lamb" envy, rage against the living; rejecting own responsibility for harmful habits	- let emotions out – "emotional valve", "vent"; - do not resist aggression – put up with it so that information processing is not blocked; - possibility to dissolve stress
III. Third phase Bargaining	"Double accounting"; expecting remuneration for good behavior; postponing death; building up a "rampart" of hope	- not eliminating definitively the "safety valve" against despair; - gradually destroying illusions; right measure between "productive lie" and "destructive truth"
IV. Fourth phase Depression	Sadness and grief for passing life; Sharing, discussing and ordering – more rare; discrepancy between patient's and family's expectations about the exit of the condition – sometimes parallel	- looking at the bright side of existence and not only into grey shades of it - "the relatives' lives will continue as usual" – examples - Sharing pain - Allow patient to grieve - Interfering in the conflict patient/family
V. Fifth phase Acceptance	Calmly expecting the coming end; lassitude, exhaustion; consent; lack of feeling or emotions; conscience of a finished fight	- Accompanying in dying; - Hospice care; - Condign death; - Care oriented toward the family

Patients are always grateful when instead of bad news they are given hope, whether rightful or unrealistic. A doctor should never have recourse to false statements – not excluding an unpredictable or happy turn of events is enough.

Hope may unlock conflicts caused by two reasons: the family has understood that there is no more room for hope although the patient can not give it up; the relatives desperately stick to the last spark of hope while the patient is ready to accept death but in the same time feels that the family is not prepared to do the same. The interference in this conflict between the patient and his environment is necessary and healing; it saves from excess grief before death.

In all cases, explaining and disclosing the truth to the patient should not destroy the "protective dykes" that he needs especially when confronted with the vision of forthcoming death. The rampart of hope, mutual aid and empathy has to be preserved whatever happens. The fear of death should not have the last word. Hope must be opposed to it. This process of resistance appears as an irreplaceable auxiliary against the otherwise almost unbearable reality. This is about one of the most sensitive areas of control on uncertainty for finding the "right measure" (H. Bunte, 1988) in the narrow strip between the "productive lie" and the "destructive truth" (Thielicke, 1988). This means conveying the right message in the right moment between limited and unlimited information to intervene successfully on threatening or lost physical and mental integrity of the person, including mortal fear, terror and despair.

Breaking bad news may be achieved following a method, which in modern literature is summarized with reference to the author's name as "the six-step protocol of Robert Buckmann" (1992) and updated by W.F. Baile et al (2000). The analytical approach to the stages/"steps" and the proposed management and communication approaches to this process are discussed in another work of ours.

CONCLUSION

Breaking bad news is an essential and complex by nature interventional approach to communication between doctor and patient. The process of disclosing unfavorable information and prognosis requires not only communication skills but also a well-measured response to the patient's needs and emotional condition and adequate transposition into the doctor's own feelings and perceptions. Furthermore should be noted the involvement of the dilemma to inspire hope where it no longer exists. Here is outlined a fundamental and emblematic problem that requires answers to a number of questions that still remain open in the fields of pedagogy, psychology, graduation studies, post-graduation training and specialization of medics.

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