WILLIAM S. WILKE, MD, EDITOR

DOUGLAS W. MAYNARD, PhD
Dr. Maynard is a professor of sociology at Indiana University who has been researching the communication of bad (and good) news for more than 10 years. He has published numerous studies about how such news is delivered and received in the context of professional and nonprofessional encounters.

How to tell patients bad news: the strategy of "forecasting"

Physicians frequently have the uncomfortable job of conveying bad news, yet they have little training for this task. How does one tell a patient that he or she has cancer, or new parents that their child has a birth defect?

For the patient and the family, bad news marks a critical moment, a juncture in their lives, the end of normal life and the beginning of a new one, often something worse. When physicians impart bad news ineptly, it not only upsets the patient and the family unduly, it can erode their trust. Indeed, breakdowns in communication may account for a high percentage of malpractice suits.

Equivocation gives patients a reason to hear good news that isn't really there

I have found that physicians usually take one of three approaches: bluntness, stalling, or "forecasting," with the latter being the best approach.

BLUNTNESS: A RECIPE FOR BITTERNESS

Some physicians march straight in and blurt out the bad news. Although honest and straightforward, this approach leaves patients feeling isolated and angry, blaming the messenger rather than the news, and offended by the physician's lack of sensitivity.

AVOIDING THE ISSUE: STALLING

Other physicians go to the opposite extreme and try to avoid the issue. They may start to tell the truth clearly, but then retreat behind euphemisms, evasions, or false reassurances in response to direct questions or signs that the patient is upset.

Equivocation and stalling can give patients a reason to hear good news that is not really there, and continue in a state of denial. It can also have the opposite effect and leave the patient feeling more scared and desperate than if he or she had been explicitly but sensitively advised of the facts.

FORECASTING: THE BEST APPROACH

"Forecasting" means "to serve as an advance indication." Using this approach, the physician allows the patient to prepare to hear the bad news that the physician has indicated will be coming.

The technique can be as simple as prefacing the news with "I am sorry, but I have some bad news," and waiting for the patient to indicate that he or she is ready to hear it before going on. The physician can also provide nonverbal clues that bad news is coming: using a serious tone of voice and facial expression, taking the recipient into the office or conference room and closing the door, placing a comforting hand on the recipient's shoulder.

Often, the patient has guessed the news already: "It is cancer, isn't it?" Alternatively, the physician can ask the patient what he or she thinks the problem is. The physician can then confirm the patient's response, and go on from there.

Forecasting aids patients in the realization process by preventing disorientation. In contrast, stalling and being blunt are extremely disorienting to a patient.

UNDERSTANDING THE PATIENT'S EXPECTATIONS

Technique alone does not suffice when bringing bad news to a patient. The job requires sensitivity, tact, and an understanding of the patient's expectations, which can hamper the patient's understanding of the news. The effectiveness of a strategy depends as much on the patient's expectation and state of mind as on the strategy. The physician should keep in mind the patient's level of understanding, expectations, and culture.

Many patients do not want to know about a bad diagnosis, for cultural reasons or perhaps because it is the only way they can cope. As much as the physician feels that the truth must be faced, he or she must be sensitive to what the patient feels is adequate information.

For instance, in Ethiopia, bad news is not given in the afternoon, as it is thought to induce a restless night. In Japan, physicians traditionally tell the patient nothing that might cause him or her to lose heart, but they do inform the patient's family. The process is an elaborate but superficial effort at concealment, a dance around rather than a concealment of the truth.

In this country, attitudes about giving bad news have reversed. A 1961 survey found that 90% of physicians would not reveal the finding of cancer to a patient; by 1979, a similar survey found that 97% of physicians would reveal the diagnosis.

A physician must be sensitive to the context of the patient and family, and how much understanding they have about what is happening. The amount of forecasting needed will be very different for the family who has coped for months with a family member's terminal illness, as opposed to a patient or family facing the outcome of a sudden accident. ■

SUGGESTED READING

Beckman HB, Markakis KM, Suchman AL, Frankel RM. The doctor-patient relationship and malpractice. Lessons from plaintiff depositions. Arch Intern Med 1994; 154:1365–1370.

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WILLIAM M. STEINBERG, MD
Dr. Steinberg is a professor of medicine at George Washington University in Washington, DC, and is a past president of the American Pancreatic Association. His research interests include the diagnosis and management of pancreatic disorders.

Diagnosis and management of acute pancreatitis

The course of acute pancreatitis is mild and self-limited in most patients, but complications occur in 25%, and the overall mortality rate is 5% to 10%.[1] Timely recognition and management of factors that indicate severe disease may prevent catastrophic outcomes. Treatment is still mostly supportive, but endoscopic retrograde cholangiopancreatography (ERCP; for pancreatitis caused by gallstones) and empiric antibiotic therapy are under study and may be reasonable in certain situations. Studies of other therapies are underway as well.