BRIEF COMMUNICATION

Breaking Bad News: A Review of Strategies and their Appropriateness in the Rural Indian Setting

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A physician at some point in his career is bound to find himself as the harbinger of bad news. Depending on the specialty, some may find themselves delivering bad news more frequently than others. While that bad news can lie on a very narrow spectrum from the physician's point of view, the spectrum changes significantly when viewed from the eyes of the patient. Bad news is defined as any information which adversely and seriously affects an individual's view of his or her future.[1] While the most common perception of bad news is a terminal illness, it can be any life-altering diagnoses ranging from fetal demise to degenerative conditions to debilitating infections. A physician must equip himself with the skills to deliver this news in a way that there is a lack of neither information provided nor empathy offered.

There are several tried and tested strategies that are commonly adopted to deliver bad news.

The most well known is the SPIKES model proposed by Buckman.[2,3] The steps in this model are:

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- S - Setting: Ensure privacy and appropriate setting and environment for the discussion
- P - Perception: Understand the patient's perception of the illness
- I - Invitation: Explore how much information the patient needs. In other words, obtain the patient's invitation for details regarding the illness
- K - Knowledge: Warn the patient about the imminent bad news before breaking it and provide the information in chunks, all the while ensuring that he understands what is being conveyed
- E - Empathy: Listen to the patient, identify their emotions, and address the patient's emotions with empathic responses
- S - Strategy and summary: Summarize the information you have provided and formulate a clear plan with the next steps neatly chalked out.

This protocol provides easy steps that can be mastered with practice.

Another practical model suggested by Rabow and McPhee uses the mnemonic ABCDE.[4]

- A - Advance preparation
- B - Build a therapeutic environment/relationship
- C - Communicate well
- D - Deal with patient and family reactions
- E - Encourage and validate emotions.

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The BREAKS protocol for breaking bad news is another systematic and easy strategy.[5]

- B - Background information about the illness
- R - Rapport building
- E - Exploring the patient's knowledge about the illness
- A - Announce the bad news with a warning
- K - Kindling the patient's emotions
- S - Summarize the information and plan of action.

There are several other models that have been developed as comprehensive strategies to deliver bad news.[6] The underlying concepts across all these strategies lie broadly under the following categories:[7]

1. Deciding the amount of bad news to deliver or the extent of truth to be divulged
2. Addressing cultural and social issues
3. Managing psychological stresses
4. Training professionals to effectively deliver bad news.

The implementation of these concepts in the rural Indian setting presents several challenges. The common hurdles to overcome under the broad categories discussed above are:

1. Poor literacy and lack of information about illnesses - Patients and family members are not equipped with sufficient past knowledge to process the news given to them
2. Cultural and social norms related to terminal illness and death - Family members do not wish the physician to discuss end-of-life care with the patient. In some cultures, speaking of death is considered inauspicious, and the relatives want to insulate the patient from such talk. This also leads to concerns about collusion between the physician and the relatives.[8]
3. Patients, family members, and the physicians face different kinds of stress while handling bad news - Discussing psychological stresses and issues openly is still not a norm in rural India, and patients and their family members do not engage with the physician in such discussions.
4. Inadequate preparation to deliver bad news - Residents and physicians are not equipped to deliver bad news. A study interviewed 222 patients and their family members to understand their perspectives about medical information. The results of the survey showed that patients felt that they received insufficient information about their diagnosis and prognosis and were dissatisfied with the way it was communicated to them by their physicians.[9] A study done to assess the palliative care knowledge among 100 medical residents of a tertiary hospital in India found that 25% of the participants had no knowledge of palliative care, 51% said that the pertinent training given during residency was inadequate. Almost the same number reported a lack of confidence in providing palliative care.[10] From personal experience and discussions with colleagues and friends, I have come to realize that this is quite common among residents in India.

The existing models offer considerable methods to address the issues of urban patients in India. However, they fall short in providing effective methods to overcome the issues while addressing the rural populace. Some recommendations to address the specific challenges enumerated are:

1. Identify the literacy level of the patient and tailor the information such that he comprehends it. Prepare the information to be provided in the native language of the patient and generously use pictures to explain what cannot be put across in words.
2. Discuss about patient autonomy and medical proxy in the first consultation. If the patient chooses not to know about his diagnosis, ensure that a responsible medical proxy is identified who is acceptable to the patient. Assure the patient that anytime during the process, he can choose to know his diagnosis or change his medical proxy if he feels they are not acting in his best interest. This helps maintain the trust the patient reposes in the physician and does not make him feel abandoned.
3. Try to understand family dynamics before broaching sensitive subjects. Assure the patient about absolute confidentiality before discussing emotional and psychosocial stresses. Offer appropriate counseling to the patient and caregivers as they play a crucial role in the entire decision-making process.
4. Introducing lectures on breaking bad news, role-playing, and small group discussions as part of clinical training must be encouraged.[11] It is essential to train residents in the art of listening and speaking to patients, providing information in an effective and understandable manner, and most importantly showing empathy, which form the basis of breaking bad news.

While these recommendations are not absolute or exhaustive, they are a good starting point. Future research must specifically be directed toward an in-depth analysis of the challenges pertaining to the rural community. It will pave the way for developing specific protocols to fulfill the unmet need for effective medical communication in rural India.

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