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A Patient-centered Approach to Breaking Bad News: Communication Guidelines for Health Care Providers

Lisa Sparks, Melinda M. Villagran, Jessica Parker-Raley & Cory B. Cunningham

This investigation takes a patient-centered approach to examining strategies physicians use to deliver bad news to patients. Qualitative data were obtained from 68 patients who had received a message they perceived as negative information from a health care provider. Through grounded theory methodology, patient accounts were examined to reveal four provider strategies for breaking bad news. This investigation underscores the importance of using effective communication strategies to achieve patient satisfaction and compliance.

Keywords: Health Communication; Patient–Provider Relationship; Physician–Patient; Consumer–Provider; Breaking Bad News; Bedside Manner

Health information is the critical resource derived from successful health communication (Kreps, 1988, 2003). Effective and timely communication enables patients and their families to gather relevant health information about significant threats to health, and helps them identify strategies for avoiding and responding to these threats (Kreps, 2003). An increasing concern for physicians is how to communicate effectively and appropriately health information that is bad news to patients (Mast, Kindlimann, & Langewitz, 2005; Ptacek & Eberhardt, 1996).

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Although the task of breaking bad news is a fundamentally important part of many health care interactions, it can be intimidating to providers (Barnett, 2004). Delivering bad news is difficult for physicians; therefore, phrases like “dropping the bomb” are often used to describe the daunting task (Baile et al., 2000; Mueller, 2002). Although the undertaking of delivering bad news is challenging, it can be done effectively, creating increased patient satisfaction and decreased patient emotional responses (Mast et al., 2005).

Although physicians have always been the bearers of bad news, the increase in chronic illness and the concomitant increase in issues related to quality of life heighten the importance of understanding how the delivery of bad news affects patients and providers. The manner in which this communication occurs can significantly impact the patient’s level of satisfaction with his/her interaction with hospital staff and overall treatment by the health care providers (Whaley, 1999). In addition, the outcome of delivering health care information, particularly medical disclosures that result in bad news, has serious implications for the physician–patient interaction and is directly related to important communication variables such as patient satisfaction and compliance (Thompson, 1994). Moreover, recent research indicates that delivering bad news requires tricky and complex communicative strategies that tend to differ from other kinds of medical interaction (Gillotti, Thompson, & McNeilis, 2002).

Hippocrates argued that it should be the physician’s responsibility to determine the level of information patients should receive about their condition or diagnosis (Gillotti & Applegate, 1999; Maynard, 1991; Waitzkin, 1985). Despite this view toward disclosure, medical disclosure is a daunting task that physicians must undertake as a part of their daily work life. Patients, however, increasingly desire to know more about the state of their health and related diagnoses, which indicates that the ability to deliver health information in an appropriate way is now a necessity (Gillotti & Applegate, 1999). Patients increasingly want to know the truth about their diagnoses, particularly in acute situations such as cancer (Sparks, 2003).

Defining Bad News in the Health Communication Encounter

Bad news has been defined in the medical literature as pertaining to a multi-step process that creates situations where there is either a feeling of no hope, a threat to a person’s mental or physical well-being, a risk of upsetting an established lifestyle, or fewer choices in life (Barnett, 2004; Bor, Miller, Goldman, & Scher, 1993). Bad news in the health care context refers to any information that creates a negative view of a person’s health (Buckman, 1984). Although most of the medical literature on breaking bad news has focused on conveying diagnoses of objectively serious conditions, especially cancer (Hoy, 1985), bad news can range from a wart to psoriasis, pink eye, or infertility.

Regardless of the type of bad news, there are many reasons why physicians have difficulty breaking bad news. A common concern is how the news will affect the patient, and this is often used to justify withholding bad news. For example,

65 Hippocrates advised physicians to conceal information from patients because bad
news might cause a patient's condition to deteriorate (Mueller, 2002). Similarly, the
American Medical Association's first code of medical ethics advised physicians to be
leery of breaking bad news to ill patients (VandeKieft, 2001). More recently,
70 paternalistic models of patient care have given way to an emphasis on patient
autonomy and empowerment. The past several years have been associated with a
sharp increase in interest among researchers, educators, and practitioners about how
to communicate bad news to patients most effectively (Gillotti & Applegate, 1999;
Gillotti et al., 2002; Hoy, 1985; Mast et al., 2005; Ptacek & Ellison, 2000; Yedidia et al.,
2003).

75 *Demographic Effects on Bad News Delivery*

An important component of breaking bad news is that communication from
physicians can vary in its subjective and objective severity. When providers deliver
bad news, a number of different demographic characteristics potentially influence
how the news is delivered. Patients' and providers' sex, age, ethnicity, and education
80 level may modify the message strategy that providers use to deliver bad news.

The sex of provider/patient dyads alters providers' delivery of bad news. When
female providers encounter female patients, they are more likely to communicate
about preventative care, such as breast and pelvic exams (Franks & Bertakis, 2003).
Same-sex provider/patient dyads experience fewer communication barriers. As such,
85 providers engage in the comforting strategy consistently (Gjerberg, 2002).

The age of providers and patients modifies provider/patient interactions (Eva,
2002). Older providers play a parenting role and tend to comfort patients habitually
(Thom, 2001). Regardless of who is older or younger in the provider/patient dyad,
research demonstrates that age impacts patients' perceptions of communication
90 satisfaction (Eva, 2002).

The ethnicity of the patient also changes the providers' delivery of bad news. When
providers deliver bad news to Caucasian and African-American patients, they are
direct (Ishikawa, Roter, Yamazaki, & Takayama, 2005; Johnson, Roter, Powe, &
Cooper, 2004). Providers who deliver bad news to Latinos and Asians are consistently
95 comforting (Sleath, Rubin, & Huston, 2003; Sung, 1999).

When providers deliver bad news, they alter their communication strategies based
on patients' education levels. Patients who are less educated often have a lower
socioeconomic status. Thus, their quality of life tends to perpetuate illness and bad
health (Al-Shadli, Bener, Brebner, & Dunn, 2001). The frequency of office visits forces
100 patients with little education to form close relationships with providers. These close
relationships result in providers' use of more comforting and direct approaches to
deliver bad news. Due to a common misperception by some providers that more
educated patients know more about medical issues in general, patients with higher
education tend to receive less information and comfort when receiving bad news
105 from providers (Al-Shadli et al., 2001; Duran-Tauleria & Rona, 1999; Gergen, 1996;
Mitchell, Stewart, Pattenmore, & Asher, 1989).

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110 Patients' perception of bad news is probably impacted not only by demographic characteristics, but also by individual thoughts and experiences. Patients do not uniformly consider a majority of diagnoses as bad news. The perceived valence of a message typically lies in the mind of the receiver. Further, medical and psychological research has noted that perceptions of the severity of a message vary as a function of the individual (Davis, 1991). Even reactions to objectively severe news will vary depending on a host of personal factors, including age, familial obligations, and culture (Davis, 1991). For instance, while the vast majority of patients in English-speaking countries want to know about their diagnosis and treatment, the proportion of individuals who want and receive relatively full disclosure in other countries is much lower (Davis, 1991).

115 Effective doctor-patient communication can alter the patients' behavior both prior to (preventative) diagnosis and after a diagnosis is received while the patient is undergoing treatment (Dearing et al., 1996; Greenfield, Kaplan, & Ware, 1985; Kreps & O'Hair, 1995). Research suggests that many factors influence a patient's satisfaction with the manner in which communication and breaking bad news occurs. For instance, it is well documented that the style of bad news delivery can greatly affect the manner in which the patient reacts to the news (Kreps & O'Hair, 1995; Mast et al., 2005; Mueller, 2002).

Current Provider Education

120 In recent years, researchers have been paying a considerable amount of attention to understanding how physicians tackle the difficult encounter of breaking bad news to patients (Gillotti et al., 2002; VandeKieft, 2001; Voelker, 1999). Despite the fact that breaking bad news is frequently cited as one of a physician's most difficult duties, medical schools do not typically offer formal training in this complicated undertaking (VandeKieft, 2001; Yedidia et al., 2003). This void creates a demand for health communication scholars to assist healthcare providers in competently addressing the discomfort and uncertainty associated with breaking bad news (Cegala & Broz, 2002). When health care providers are given the opportunity to practice breaking bad news through skills training and simulated encounters, they feel more confident and less isolated (Eggly & Tzelepis, 2001; Wakefield, Cooke, & Boggis, 2003). Effective training allows providers to become aware of their personal attitudes and emotional reactions when breaking bad news. In addition, it helps skill physicians in crisis intervention and communication techniques (Abel et al., 2001; Ungar, Amiel, Beharier, & Reis, 2002).

125 **AQ2**
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145 Physicians note the importance of the physical and social settings of bad news interactions. Physicians agree that the news should be delivered in a comfortable location that offers patients privacy and is relatively quiet. The space should be large enough to accommodate multiple staff and family members comfortably (Buckman, 1992; Maynard, 1991). Second, the timing of the news is important; the information should be conveyed at a time that is convenient for the patient. If rushed, the physician may be perceived as uninterested in the patient and the process. In keeping

with the private nature of the setting, many authors also recommend structuring the environment and time to minimize interruptions (VandeKieft, 2001). However, evidence suggests that physicians may delay breaking bad news despite the fact that the majority of patients want to hear it (Blanchard, Labrecque, Ruckdeschel, & Blanchard, 1988; Hopper & Fischbach, 1989); some physicians want to avoid situations in which a prognosis is discussed (Seale, 1991), possibly because of the discomfort associated with such interactions.

The fact that communicating bad news is stressful to physicians has been repeatedly noted (Bacon, 1989; Buckman, 1992; Miranda & Brody, 1992; Seale, 1991; R. P. Strauss, Sharp, Lorch, & Kachalia, 1995; Sykes, 1989). The experimental social psychology literature of the 1970s demonstrated that giving bad news provokes anxiety, at least compared with the delivery of positive news. The transactional model of stress and coping (Lazarus & Folkman, 1984) suggested that the amount of discomfort experienced by physicians should vary with their experience of giving bad news, the perceived severity of the news itself, or their perceptions of being partly responsible for the occurrence of the news.

Despite a large amount of research about how to break bad news effectively, much of the literature lacks a theoretical communication framework, which makes it difficult for providers to organize and utilize the information. Such a schema, or strategic communication guide, would allow providers to match the bad news with an effective communication strategy that results in patient satisfaction.

Patient Satisfaction

The ultimate goals of physicians are patient compliance and healing (Hirsch et al., 2005). Often, however, physicians fail to realize that patient compliance may also result in patient satisfaction (Grant, Cissna, & Rosenfeld, 2000). Therefore, providers should do everything in their power to ensure that the patient is content with the medical service received. Furthermore, the impact of satisfaction often equals and sometimes exceeds symptom relief (Hirsch et al., 2005).

Techniques such as involving the patient in the consultation, exploring the patient's ideas and concerns, and assessing and responding to the patient's understanding have been described generally as elements of "patient-centered" communication (Hirsch et al., 2005; Mast et al., 2005). Patient-centered communication focuses on the patient as a "whole person" in the context of his/her psychological and social circumstances. Patient-centered communication has been associated with higher levels of general satisfaction and improved biomedical and functional outcomes (Wanzer, Booth-Butterfield, & Gruber, 2004).

Caring and comforting, technical competence, and communication are the physician behaviors most strongly associated with patient trust and satisfaction (Grant et al., 2000). A correlate of satisfaction that appears to relate to physician communication style is the patient's feeling of being confirmed (Grant et al., 2000). Health communication experts report that patients often feel as if they are objects rather than people due to disconfirming communication from health care

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professionals. Confirming communication, on the other hand, recognizes patients as unique human beings with personal problems (Grant et al., 2000).

Physicians most often feel comfortable providing objective information rather than comforting or consoling the patient (Tang et al., 2005) Similarly, patients are more satisfied with the “informational exchange” domain and are less satisfied with the “empathy” domain (Hirsch et al., 2005). Patients tend to be most satisfied with understanding their treatment plan, physician honesty, and being understood, and report being least satisfied with physician information concerning caring for their illness (Tang et al., 2005).

Summary and Rationale

The long-term effects of the ways in which patients receive bad news have not been adequately documented or researched. Not all physicians agree that how news is communicated has positive effects. Some have even suggested that the increased concern over the bad news process has made transactions more difficult because of the added stress and guilt associated with knowing that one has done it poorly (Persaud, 1993). As noted by others, receiving a medical diagnosis may be overwhelming regardless of the care the physician takes in communicating the news (Kaiser, 1993). Persaud (1993) argued that the increasingly vast amounts of bad news delivered often dwarf the issue of how it is delivered. On the other hand, the quality of the communication might set the tone for future interactions between the physician and patient. These contradictory arguments highlight the need for further research in the area of doctor–patient communication and breaking bad news in particular.

Also warranting further investigation is the manner in which a patient’s satisfaction is affected as a result of breaking bad news. During such a difficult time, it is important that doctors and researchers alike understand how the manner in which bad news is communicated influences the affective reaction (e.g., satisfaction) of the patient. Therefore, it is necessary that the proper measures be used in examining this multifaceted construct. The following research questions are proposed:

RQ1: What do patients regard as bad news from their providers?

RQ2: What message strategies do providers use when delivering bad news to their patients?

RQ3: How do providers alter their delivery of bad news based on a patient’s sex, age, ethnicity, and education?

Method

Participants

In an effort to study a variety of demographic characteristics, participants for the study were recruited using a network sampling technique. After receiving Human Subjects Review/Institutional Research Board approval to distribute surveys for this

230 study, persons who had experienced bad news interactions with health care providers
were recruited by students from communication courses at two different Midwestern
universities. Extra credit in the form of attendance points was offered for student
participation. Students who themselves did not recall a bad news interaction with a
235 provider were given an alternate equivalent extra credit opportunity. Next, all student
participants were asked to try and find two individuals within their own social
networks who had experienced bad news interactions with health care providers.
Students were instructed to find people from different generations and ethnic
backgrounds to complete the survey instrument. The sample size was constrained by
240 the number of persons who could actually recall a significant bad news interaction.

Through network sampling, 29 male participants and 39 female participants were
recruited to participate in the study; 48 participants were Caucasian, nine African
American, 10 Latino, and one Asian. The ages of participants ranged from 18 to 80
years.

Data Collection

245 Bad news was defined in the survey as:

Any information you received from your health care provider about yourself or a
loved one that you perceived as negative. Receiving bad news from a health care
provider could be as simple as a diagnosis of high blood pressure or as shocking as
a diagnosis of cancer.

250 Patients were asked three open-ended questions about the bad news interaction
they recalled. The first question asked, "What did the provider say to you when she or
he delivered the bad news?" The second question asked, "How did you feel about the
bad news itself?" The third question asked, "How did you feel about the way the
health care provider presented the bad news?" Patients recorded the answers to these
255 three questions. Patients also indicated demographic characteristics, including sex,
age, ethnicity, and education. Finally, participants were asked about the sex of the
provider who delivered the bad news and whether they perceived the provider to be
older, younger, or about the same age as themselves. In order to maintain anonymity,
unsigned surveys were collected in a systematic fashion and sealed in an envelope.

Data Analysis

260 To assess the first two research questions, the analytic process involved immersion in
the qualitative data using a grounded theory approach (A. L. Strauss & Corbin, 1990).
To assure the validity of the results, extensive audit trails, such as numbering and
assigning letters to all participant surveys, were maintained. In addition, thick
265 descriptions of the coding efforts were used to elaborate in full detail the variety of
themes that emerged (Lincoln & Guba, 1985).

Coding of the data was conducted using a patient-centered approach (Hirsch et al.,
2005; Mast et al., 2005) because the patient accounts often reflected their perceptions
of the interaction in terms of their needs and feelings related to the information. For

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270 this reason, the language used by the patients guided the development of codes and themes with short descriptors known as vivo codes (Morrow & Smith, 1995).

Data analysis began with open coding of a subset of the data, examining the words, phrases, and sentences of the patients (Keyton, 2001). During initial coding, a constant comparative method was used each time a new theme emerged to determine whether the new theme was encompassed within any other patient responses. Codes and themes were sorted and compared until data were saturated. Discrepancies in perceptions of message content between the two coders were discussed to come up with a final operational definition for each code. In this grounded theory approach, reliability did not come from agreement on *a priori* categories, but rather from consistency of meanings as the coders discussed the data (Atwood & Hinds, 1986; Denzin, 1989).

285 Members of the research team examined the 68 bad news accounts using an inductive approach to sort and assess the data based on message content, provider communication strategies, and patient satisfaction with provider ability to deliver the bad news. These general groupings are similar to those in existing research on breaking bad news (Ptacek & Ellison, 2000). Each participant's account of bad news was examined to determine what types of message content were present in the data. Appendix A includes eight general types of bad news recounted by participants, including terminal diagnoses, disease, the need for further medical exploration for a problem, recovery issues, heredity issues, infections, injuries, and the need for surgery.

290 Next, the researchers organized the data based on four message strategies that emerged from patient accounts of bad news. The four strategies that emerged from the data were indirect communication, direct communication, comforting communication, and empowering communication. In the next phase of analysis, two overarching themes of satisfying and unsatisfying message strategies emerged. Data were sorted to examine examples of patient satisfaction and dissatisfaction within each of the four message strategies. Appendices B and C include examples of patient accounts, types of content, and examples of satisfying or unsatisfying outcomes for each strategy. Finally, depending on the content of the bad news, suggestions for potentially appropriate message strategies for differing message content and relational characteristics were created.

Results

Provider Strategies for Breaking Bad News

305 *Indirect strategy.* Indirect communication involves little or no disclosure (Kakai, 2002). It relies on implied meanings, use of syntactic and discourse structure, and lexical choice (Miller, 1994). The indirect strategy is defined as using avoidance of topics in conversations, nonverbal distancing, and avoidance of socializing (Sias, Heath, Perry, Silva, & Fix, 2004). Indirect strategies are emotional barriers that providers use in an effort to protect themselves from becoming emotionally involved

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with the patient (Sheldon, 2004). Protection from emotional involvement with patients is a necessity for providers' mental and emotional survival. One patient recalled, "He said I had to have surgery. He told my husband I had cancer, but he never told me" (A-66). This patient's recollection of bad news is a prime example demonstrating the indirect strategy. Research shows that this provider used this strategy to detach himself emotionally from the patient diagnosed with cancer (see Appendices B and C).

Although the provider was indirect, the patient was satisfied, stating, "It was fine. He did a good job because he was factual and used words I knew" (A-66). In this bad news account, the indirect strategy was used to provide a cancer diagnosis gently and led to patient satisfaction (see Appendices B and C).

The indirect communication strategy should never be used when delivering terminal bad news. When communicating such devastating content, patients become frustrated and resentful when providers use the indirect strategy (Miller, 1994). One patient quoted her provider, "The condition of my father was serious and it was too soon to tell if he was going to recover" (A-13). When asked about her feelings regarding the bad news account, the patient stated, "The doctor didn't seem to understand how scared we were. Almost like she'll never and will never have to deal with losing her father" (A-13). During this interaction, the provider chose to use an indirect strategy that resulted in patient dissatisfaction. The patient was not satisfied with the bad news interaction because she perceived the provider to be unemotional about her family's tragic situation (see Appendices B and C).

Direct strategy. Direct communication ensures that both parties are working from the same definitions, and keeps ethical dilemmas from escalating. Due to Western politics of "liberal, democratic, individualistic and law-governed" philosophies, physicians prefer to use direct communication to increase patients' levels of decision-making and autonomy (Pellegrino, 1992, p. 14). The direct strategy is defined as an honest, straightforward approach (Smith, Nicol, Devereux, & Cornbleet, 1999). A patient recounted, "The doctor said my thyroid needed to be removed by surgery" (B-3). When asked about his satisfaction with the provider's bad news delivery, he commented, "He was very professional and educated me" (B-3). Such an account illustrates patients' appreciation of the direct strategy. The patient's emphasis on the provider's willingness to educate him demonstrates the powerful impact of direct communication (see Appendices B and C).

However, there are times when the direct strategy is an ineffective way to deliver bad news. According to one patient, his doctor said, "You have chronic bronchitis" (B-5). Although the interaction was direct, the patient claimed that the provider was "poor, he was unemotional and lacked professionalism" (B-5). Often, when providers use the direct strategy, they are perceived as unemotional and cold. As a result, caution should be used when utilizing the direct strategy (see Appendices B and C).

Comforting strategy. Comforting is an attempt to alleviate the emotional distress of another (Burlinson & Goldsmith, 1998). The comforting strategy is defined as using verbal and nonverbal immediacy in an attempt to alleviate shock, distress, and

355 devastation (Rosch, 2000). Care should be taken not to send nonverbal messages that
undermine the verbal message being conveyed. Several authors have emphasized the
benefit of touch while conveying the news (Buckman, 1984; Buis, de Boo, & Hull,
1991). To hold hands or give a hug can have a strong, positive, and lasting effect if
done at the right time and with the right patients (Beasley, Wheby, & Pruett, 1993;
Buckman, 1992). In addition, having supportive colleagues present, if necessary, may
360 bolster physicians' own comfort levels (see Appendices A and B).

One patient recalled, "The doctor told me, I was going to have to have knee
surgery. He made it sound as if they do this procedure on a daily basis. It was no big
deal" (E-25). In response to this bad news encounter, the patient proclaimed that his
provider was "very compassionate and made me feel very comfortable" (E-25). When
365 communicating about such a scary topic—surgery—it is important to manage the
patient's stress by being comforting (Rosch, 2000) (see Appendices B and C).

Research shows that comforting strategies are very effective for achieving patient
satisfaction. However, patients prefer the comforting strategy to be used in face-to-
face encounters. One patient remembers her provider's comforting strategy, "The
370 doctor said there is nothing to be alarmed about and explained what cervical cancer
was in depth" (E-38). Although this was a comforting response, the patient
complained:

I did not like the initial phone call she gave me to inform me of my problem. I
would rather she had called me in for another examination and told me in person
375 so I could see her nonverbal communication. (E-38)

Therefore, the comforting strategy should not be used during any provider/patient
interaction unless it is face-to-face (see Appendices B and C).

Empowerment strategy. Empowerment includes a personal, psychological dimen-
380 sion similar to self-efficacy and personal control, but is more comprehensive because
it acknowledges the inherent social dimensions of individual power (Ross, Doan, &
Church, 1991). The empowerment strategy enhances patient satisfaction when
providers help patients feel empowered by giving them choices about their medical
health. One patient remembered her provider saying, "We have two options,
385 medication or surgery. You can have surgery immediately or try medication for
a few months" (G-2). The patient claimed, "I felt empowered and encouraged after
the provider gave me options" (G-2). During this particular bad news account, the
empowerment strategy helped the patient to feel like she had some power over her
medical health. When patients feel that providers are giving them power over their
390 medical health, they have a better chance of a quick recovery (Ross et al., 1991) (see
Appendices B and C).

The empowerment strategy can also lower patient satisfaction if used incorrectly
during bad news accounts. For example, when a provider attempts to use the
empowerment strategy before breaking the bad news to the patient, it does not have a
positive effect. When a health care provider tells a patient that there is both good
395 news and bad news, and asks patients which news they would like to hear first,
patients still regard the prognosis as bad news. One patient quoted her provider, "He

said, 'I have good news and bad news, which one do you want to hear first?' I said 'bad.' He explained the procedure I just went through then he explained the problem" (G-1). The patient stated, "I could not recall the good news that the provider told me, only the bad news" (G-1). The empowerment strategy should only be used when discussing medical options after the bad news prognosis has been presented (see Appendices B and C).

Patient Demographics' Impact on Provider Strategies

Determining the frequency of use of various provider communication strategies reveals the most common way of breaking bad news. To examine potential differences in the use of emergent message strategies based on demographic characteristics, the bad news messages were sorted using the patients' sex, age, ethnicity, and education as grouping criteria. The goal of this phase of the analysis was to examine the message strategies inductively derived from the qualitative data to determine their frequency of use based on specific demographic characteristics, including: (1) interactions with same-sex or cross-sex provider/patient dyads (female provider/female patient, male provider/male patient, male provider/female patient, or female provider/male patient); (2) interactions with patients from various ethnic and racial backgrounds; and (3) and interactions with a provider perceived to be older than the patient, younger than the patient, or about the same age as the patient.

Frequency counts for each of the four inductively derived message strategies were analyzed ($\chi^2 = 38.13$, $p < .01$): direct strategy ($n = 35$), indirect strategy ($n = 5$), comforting strategy ($n = 23$), and empowerment strategy ($n = 5$). Next, each of the overall strategies was then divided into demographic subgroups. Demographic groupings were then assessed to determine the frequency of each message strategy based on the demographic characteristics. Patient/provider bad news interactions differed based on the sex, ethnicity, education, and age of the patients and providers.

Sex. Nineteen bad news accounts were exchanged between male patients and male providers. Male providers used the indirect strategy in 5.2% of these cases, the direct strategy in 68.4%, the comforting strategy in 21.1%, and the empowering strategy in 5.2%.

Ten bad news accounts were exchanged between male patients and female providers. Female providers used the indirect strategy in 10% of these cases, the direct strategy in 50%, the comforting strategy in 30%, and the empowering strategy in 10%.

Twenty-six bad news accounts were exchanged between female patients and male providers. Male providers used the indirect strategy in 7.6% of these cases and the direct strategy in 92.3%. The comforting and empowering strategies were not used.

Thirteen bad news accounts were exchanged between female patients and female providers. Female providers used the indirect strategy in 15% of these cases, the direct strategy in 46%, and the comforting strategy in 38%. The empowerment strategy was not used.

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440 *Age.* Eleven bad news accounts were exchanged between younger providers and older patients. Younger providers used the indirect strategy in 9% of these cases, the direct strategy in 45.5%, the comforting strategy in 18.2%, and the empowering strategy in 9%.

445 Fifty-one bad news accounts were exchanged between older providers and younger patients. Older providers used the indirect strategy in 7.8% of these cases, the direct strategy in 49%, the comforting strategy in 35%, and the empowering strategy in 7.8%.

Six bad news accounts were exchanged between providers and patients who were about the same ages. These providers used the direct strategy in 50% of cases and the comforting strategy in 50%. The indirect and empowering strategies were not used.

450 *Ethnicity.* Forty-nine bad news accounts were exchanged between providers and Caucasian patients. When providers delivered bad news to Caucasians, they used the indirect strategy in 6.1% of cases, the direct strategy in 57%, the comforting strategy in 32.7%, and the empowering strategy in 4%.

455 Nine bad news accounts were exchanged between providers and African-American patients. When providers delivered bad news to African Americans, they used the indirect strategy in 11% of cases, the direct strategy in 44%, the comforting strategy in 22%, and the empowering strategy in 22%.

460 One bad news account was exchanged between a provider and an Asian patient. When the provider delivered the bad news to the Asian patient, the comforting strategy was used.

465 Nine bad news accounts were exchanged between providers and Latino patients. When providers delivered bad news to Latinos, they used the indirect strategy in 11% of cases, the direct strategy in 33%, the comforting strategy in 44%, and the empowering strategy in 11%.

470 *Education.* Thirty-eight bad news accounts were exchanged between providers and patients with high school degrees. When providers delivered bad news to patients with high school degrees, they used the indirect strategy in 5.3% of cases, the direct strategy in 47.3%, the comforting strategy in 39%, and the empowering strategy in 7.9%.

475 Twenty-seven bad news accounts were exchanged between providers and patients with bachelor's degrees. When providers delivered bad news to patients with bachelor's degrees, they used the indirect strategy in 18.5% of cases, the direct strategy in 40.7%, the comforting strategy in 33.3%, and the empowering strategy in 7.4%.

480 Three bad news accounts were exchanged between providers and patients with advanced degrees. When providers delivered bad news to patients with advanced degrees, they only used the direct strategy.

These data reveal that, although there is some variation in bad news delivery among the demographic groupings, most physicians chose a direct strategy despite the unique characteristics of their patients. The direct strategy was consistently the most commonly used strategy, followed by the comforting strategy, the indirect

strategy, and the empowering strategy. This finding suggests that providers do not tend to consider patients' specific communication needs, but rather use a more formulaic approach to breaking bad news. Although participants reported satisfying and unsatisfying experiences with each of the four communication strategies, direct communication with the patients was used most often by both female and male providers with patients of various ages and from various ethnic and educational backgrounds.

Limitations and Future Research

Several limitations to this study are worth noting. First, this study used a survey to provide anonymity and ample time for patients to write detailed accounts of receiving bad news: however, researchers were not able to ask patients follow-up questions. Future research in this area should use focus groups and interviewing techniques to obtain richer, thicker, and more detailed communication nuances that emerge in recalled descriptions of breaking bad news accounts. Second, this study only investigated patients' experiences with bad news. Richer data could have been gathered had providers been included in the survey process. Third, the survey lacked requests for detail about the actual diagnosis that was considered bad news, which can certainly vary greatly under differential diagnostic conditions. It is vital that communication researchers continue to examine breaking bad news in a variety of health care contexts, paying particular attention to unique communicative cues that emerge from this complex, yet extremely important, interaction. Deeper understanding of the impact of cognition and emotion on the breaking bad news interaction is a vital component of future research in this area. Both patients and providers need continued guidance on how to make this interaction successful.

Breaking bad news happens so frequently in the health care profession that it is imperative that it be studied in the future. Researchers examining bad news interactions must continue to do so within a theoretical framework. Examining other variables that impact bad news interactions, such as provider disclosure, patient disclosure, and social support, would be useful. It would also be interesting to understand whether breaking bad news interactions are impacted by family communication. At present, very little information is available about the content of disclosure messages in the health care context, especially regarding breaking bad news. The present study makes a small, but significant, contribution to providing a communication framework for providers to use when breaking bad news.

Practical Applications

Formal and informal providers, educators, and trainers must be educated on how to communicate effectively and appropriately health information that is bad news to patients. Practical applications of these data are provided for people working with patients and their families, for message design and education, and for communication-based theory.

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Implications for Health Care Providers

525 **AQ4** The data presented here will be useful for medical health care providers who are faced with the numerous communicative challenges that come with breaking bad news. Provider communication strategies have been developed and defined in this study to reveal alternatives for providers to use based on their unique interactions with patients. These alternatives are aimed at delivering a patient-centered approach through tailoring the message to meet the needs of the patient. Health care providers can read the real-life accounts of bad news interactions within this study and adapt their communication strategies accordingly. By following the prescriptive patient-centered approach, providers will greatly increase the likelihood of enhancing their patients' satisfaction with the provider–patient interaction and the ways in which their patients will adapt to the health outcomes they will be facing.

Implications for Message Design and Education

535 Clearly, breaking bad news is a frightening and stressful aspect of the health care profession. Learning how to deliver bad news effectively is a valuable skill that is currently left out of most medical school curriculum and in-service programs (VandeKieft, 2001; Yedidia et al., 2003). The only exposure to provider–patient interaction that some medical students receive is a course entitled “bedside manner” (VandeKieft, 2001; Yedidia et al., 2003). Present provider–patient communication research needs to be integrated with applicable course content for medical students. Medical students should be exposed to various communication strategies to utilize when breaking bad news. Providers have a substantial amount of power over patient satisfaction and compliance. More training programs need to be created and implemented—not only for medical students, but also for practicing physicians. 540 By using the communication guidelines set forth, formal and informal providers, educators, and trainers can enable their students and employees to have greater confidence during bad news interactions. 545

Implications for Theory

550 There are a few theories that tap into the breaking bad news context, including dialectical theory (Baxter, 1986) and social exchange theory (Duck, 1976). Additional research to test such theories' application to breaking bad news would be fruitful. In addition, examining social identity theory (Harwood & Sparks, 2003; Robinson, 1996; Sparks & Harwood, in press; Tajfel & Turner, 1986) would allow researchers to understand further why providers communicate with patients based on preconceived stereotypes. There is an absence of a communication theory that encompasses patient/provider negative interactions as a result of a bad news diagnosis. 555

560 Within medical research, there are many findings regarding how to deliver bad news; however, these findings are not organized into a cohesive communication framework that is user-friendly for providers. Although the results of this study indicate a number of interesting approaches to breaking bad news, particularly as

reflected in the qualitative data, the overall results of this study reveal that, most often, providers go for the direct approach. Although direct communication can lead to patient satisfaction, it was also found to be dissatisfying for some participants. The qualitative data provide evidence that other strategies can lead to satisfaction for patients. A communication perspective on breaking bad news suggests that a formulaic approach is less appropriate when breaking bad news than considering the characteristics of the patients, the message content, and the context of the interaction. This study provides further evidence supporting the notion that medical education must give considerable time and attention to skills training for breaking bad news from a communication perspective. As the art of breaking bad news continues to be a central component of health care interaction, providers, practitioners, social scientists, and communication scholars cannot afford to ignore the impact of this extremely important communicative encounter with regard to its influence on health communication and health outcomes.

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Appendix A: Definition of Bad News

Bad news content	Working conceptualization	Patient account of bad news
Terminal	Communication about death	"All of your husband's vital organs have shut down. Here are the options."
Disease	Diagnosis of a disease	"The doctor told me my daughter had cancerous cells and they needed to be scraped, removed, and checked in the lab."
Exploration	Further medical procedures needed	"The test came back positive meaning we need to do further tests which can be painful and uncomfortable."
Recovery	Detailed information about recovery time and therapy	"She said I need to lose 100 pounds and severely alter my diet."
Hereditary	Medical condition is a result of genetics	"She called and said that I carried the cystic fibrosis gene and that there was a possibility my unborn child could have it."
Infection	Diagnosis of a type of infection treated with antibiotics	"He said they were still waiting on test results but believed the problem was a kidney infection."
Injury	Diagnosis of a severe sprain/break/tear/rupture	"The provider stated that I had an acute case of tendonitis in my lower legs."
Surgery	Communication about recommended surgical procedures	"My dentist told me that one of my cavities was so bad that they were going to have to do a surgical root canal."

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Appendix B: Patient Satisfaction

Strategy	Patient account of strategy	Content	Patient account of satisfaction
Indirect	"He said I had to have surgery. He told my husband I had cancer but he never told me."	Disease	"It was fine. He did a good job because he was factual and used word that I knew."
Direct	"He said my thyroid needed to be removed by surgery."	Disease	"The doctors were very professional and educated me."
Comforting	"The doctor told me I was going to have to have knee surgery. He made it sound as if they do this procedure on a daily basis. It was no big deal."	Surgery	"He was very compassionate and made me feel very comfortable."
Empowerment	"He said, 'We have two options, medication or surgery. You can have surgery immediately or try medication for a few months.'"	Exploration	"I felt very encouraged."

Appendix C: Patient Dissatisfaction

Strategy	Patient account of strategy	Content	Patient account of satisfaction
Indirect	"She said the condition of my father was serious and it was too soon to tell if he was going to recover."	Terminal	"She did not seem to understand how scared we were. Almost like she has never or will never have to deal with losing her father."
Direct	"He said, 'You have chronic bronchitis.'"	Infection	"Poor, he was unemotional and lacked professionalism."
Comforting	"She said there is nothing to be alarmed about and explained what cervical cancer was in depth."	Disease	"I did not like the initial phone call she gave me to inform me of my problem. I would rather she had called me in for another examination and told me in person so I could see her nonverbal communication."
Empowerment	"He said, 'I have good news and bad news, which one do you want to hear first?'"	Surgery	"He was stressed and as a result made me feel anxious."